CONTRACT ROUTING FORM

1. **Complete the information below BEFORE printing and completing items 2 through 7.** Items in red are required.
   Department: County Manager's Office
   Department contract file name (use effective date): BCBS_HR_20190701
   Project Code: Click here to enter text.
   Contract type: Contract
   Contracted Services/Goods: Health Insurance
   Contract Component: Master
   Change Order Number/Addendum Number: Click here to enter text.
   Vendor Name: BCBS of NC
   Effective Date: 07012019
   Approved by: Commissioners
   Commissioner Approval Date:5-6-2019
   Ending Date: Click here to enter a date.
   Total Amount: Click here to enter text.
   Is this contract funded by federal dollars? Yes☐ No☒

2. Department Head or his/her designee has read the contract in its entirety.
   By: _____(Department Head signature required)

3. County Attorney has reviewed and approved the contract ☒
   County Attorney has reviewed and rejects the contract ☐ Reason:_____
   _____
   _____
   This is an automatic renewal and does not require approval from the County Attorney: Yes☐ No☐

   △ If this box is checked the County Attorney's Office has reviewed the contract but has not made needed changes to protect the County because the contract is a sole source contract and the services required by the County are not available from another vendor.

4. Technical/MIS Advisor has reviewed the contract if applicable. Yes☐ No☐

5. Vendor has signed the contract. Yes☐ No☐

6. A budget amendment is necessary before approval. Yes☐ No☐
   If budget amendment is necessary, please attach to this form.

7. Approval

   ☐ Requires approval by the BOC - contracts over $100,000.00, contracts longer than three years and leases longer than one year. Follow Board submission guidelines.

   ☐ Requires approval by the Manager – contracts $100,000 or less.

8. Submit to Clerk.

Clerk's Office Only

☐ Finance Officer has signed the contract
☐ The Finance Officer is not required to sign the contract

BlueCross BlueShield of North Carolina

An independent licensee of the Blue Cross and Blue Shield Association

2019 Self-Funded RENEWAL CHANGE FORM

Group Name: County of Chatham
Client Manager: Dan Malloy
Group Number(s):062048

Benefit Plan Name: PPO
Benefit Period: 07/01/2019 to 06/30/2020

I. REQUIRED CHANGES:

In a continuing effort to offer quality, cost-effective health care coverage, the following changes have been made to Blue Cross Blue Shield of North Carolina (Blue Cross NC) base benefits. These changes are required either due to federal mandates or business practice changes and are effective upon the group's renewal date.

Benefit/Eligibility Description	Product Lines	Required Benefit/Eligibility Changes
Mammography (Diagnostic) *Effective 7/1/18 or upon renewal* *Non-grandfathered groups*	Blue Options ® Blue Value SM	Deductible and Coinsurance plans only • Covered at 100% after deductible

II. OPTIONAL CHANGES:

The following enhancements to Blue Cross NC base benefits are optional and would become effective upon the group's renewal date.

Benefit/Eligibility Description	Product Lines	Optional Benefit/Eligibility Changes	Choose Option
Health Savings Account *Effective 7/1/18 or upon renewal* *Non-grandfathered groups*	Blue Options SM Blue Options 123 SM Blue Value SM Blue Value 123 SM Blue Select ®	An HSA fund is available with eligible medical plan.	List fund contributions here: N/A

2019 Self-Funded RENEWAL CHANGE FORM

Mammography (Diagnostic) *Effective 7/1/18 or upon renewal Non-grandfathered groups*	Blue Options ® Blue Value SM	Deductible and Coinsurance plans only • Covered at 100% after deductible	Select One: • Keep current benefit
Prescription Drugs *Effective 1/1/19 or upon renewal Grandfather and Non-grandfathered groups*	Blue Options SM Blue Options 123 SM Blue Value SM Blue Value 123 SM Blue Select ®	Non-grandfathered plans that move from Blue Options HSA to the new HSA eligible medical plans with an HSA fund Standard - MAC B Pricing Penalty (if brand name drug with a generic equivalent is available and provider does not specify prescription must be dispensed as written)	Select One: • Keep current benefit
Pharmacy Point of Sale Rebates *Effective 1/1/19 or upon renewal Grandfather and Non-grandfather groups*	Blue Options SM Blue Options 123 SM Blue Value SM Blue Value 123 SM Blue Select ®	Point of Sale rebates are available for plans with an HSA fund. Pharmacy rebates from applicable medications will begin to be displayed (or passed through) directly to the member cost share amounts. The approved cost will be reduced by the rebated amount which will reduce the member cost share. If a member has met their deductible obligation, they will then be charged the coinsurance amount based on the cost of the drug minus the rebate. If they have not met their deductible, they will be charged the cost of the drug minus the rebate, based on remaining deductible obligation.	Select One: • None
Routine Vision Exams (Adults and Children) *Effective 1/1/19 or upon renewal Grandfather and Non-grandfather groups*	Blue Options SM Blue Options 123 SM Blue Value SM Blue Value 123 SM Blue Select ®	Not Covered	Select One: • Keep current benefit

Lens and Frame endorsement *Effective 1/1/19 or upon renewal Grandfather and Non-grandfather groups*	Blue Options SM Blue Options 123 SM Blue Value SM Blue Value 123 SM Blue Select ®		Select One: • Keep current benefit

III. GROUP CHANGE REQUESTS:

The group requests benefit and/or eligibility changes as noted below to be effective upon the group's renewal date. Blue Cross NC will review the benefit change requests to determine Blue Cross NC's ability to administer the benefits as described.

Benefit/Eligibility Description	Product Lines	Requested Eligibility Changes
Implement Specialty Copay Maximization Program eff. 7/1/2019	RX	
Implement Guided Health Rx eff. 7/1/2019	Rx	
ISL Deductible Increase to $135,000 eff. 7/1/2019	Stop Loss	
Implement Rx Savings Solutions eff. 7/1/2019	Rx	

IV. GRANDFATHERED STATUS:

Will the group be grandfathered for the benefit period **(yes/no)?** ____**NO**_____

V. SUMMARY OF BENEFITS AND COVERAGE (SBC):

The group intends for Blue Cross NC to develop and provide the SBC document(s) to the group for their plan offerings in order for the group to distribute to members as required by law **(yes/no*)?** _____**YES**_____
**If the group checks "no", Blue Cross NC is relieved of the contractual obligation to provide the SBC document(s) to the group unless Blue Cross NC is further notified in writing.*

VI. ESSENTIAL HEALTH BENEFITS BENCHMARK:

No Annual/Dollar limits for Essential Health Benefits under PPACA (*All grandfathered and non-grandfathered plans apply).*
Essential health benefits may be defined by any available state benchmark plan; to the extent essential health benefits are covered under the selected benchmark plan, dollar limits and annual limits must be removed. Unless otherwise selected, the North Carolina benchmark plan will be the default.

The group intends to use the default benchmark through North Carolina **(yes/no)?** _____**YES**_____
If no, what state benchmark does the group intend to use? _____

BlueCross BlueShield of North Carolina

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2019 Self-Funded RENEWAL CHANGE FORM

ATTESTATION *(To be signed upon Blue Cross NC approval of benefit and eligibility change)*:
By signing below, you agree to the following statements:

(1) The last signed Custom Group Summary, as modified by this and previous Renewal Change Forms, accurately describe the benefit selections, eligibility requirements and general Group Health Plan administration effective for the Benefit Period. Unless otherwise noted, Blue Cross NC will apply our prior approval and certification requirements and follow Blue Cross NC's medical policy to determine eligibility of payment. Any changes to the above selections and/or descriptions may require (1) approval through an additional Custom Group Summary, (2) a benefit exception request or (3) an amendment to the Administrative Services Agreement (ASA).

(2) The Plan Administrator and/or Plan Sponsor is responsible for all aspects of ensuring that the Group Health Plan (including the plan design) is in compliance with applicable laws and regulations, including but not limited to (where applicable), the requirements of the Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA), ERISA, and the Patient's Protection and Affordable Care Act and the Health Care and Education Reconciliation Act of 2010 (including the designation of a plan as a grandfathered plan) and all regulations and guidance. This responsibility has not been delegated to Blue Cross NC unless specifically delegated in the ASA. Plan Sponsor shall indemnify and hold harmless Blue Cross NC for any loss, liability, damage, expense, settlement, cost or obligation (including reasonable attorney's fees) from any resulting assessments, penalties and/or regulatory charges incurred or paid by Blue Cross NC related to the compliance with applicable laws.

Authorized Signature *(for Plan Administrator)*

Print Name: DAN LAMONTAGNE

Signature: _____

Title: COUNTY MANAGER

Date: 5-9-2019

This Instrument has been pre-audited in the manner required by the Local Government Budget and Fiscal Control Act.

_____
Vicki S. McConnell, Finance Officer

BlueCross BlueShield of North Carolina

An independent licensee of the Blue Cross and Blue Shield Association

2019 Self-Funded RENEWAL CHANGE FORM

FOR INTERNAL USE ONLY

Revisions made during the negotiation process must be tracked for internal reference only. This section will be completed by the Client Manager and Account Implementation Specialist.

Rev #	Revision Date	Section Revised	Revision Details	Supersedes Rev #

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

☐ New Group	Prospect Number: 217063	■ Renewal Group	☐ Renewal (As-is) ■ Renewal (Plan / Other Changes)	Group Number: 062048	Effective Date: 07/01/2019

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

Tax ID No (EIN): **56-6000284**

2. Physical Address:

12 East Street
ADDRESS 1 ADDRESS 2

Pittsboro	NC	27312	Chatham
CITY	STATE	ZIP CODE	COUNTY

Billing Address: (if different from above) **PO 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: **NA** 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 C.F.R. §147.131, a(n)

☐ Religious eligible organization (EBSA Form 700 or written notice to HHS is required) that is organized and operated as a non-profit

☐ Closely held for-profit entity as defined by 45 C.F.R. §147.131(b)(4) (EBSA Form 700 or written notice to HHS is required) that is an eligible organization per 45 C.F.R. §147.131(b)

☐ Religious Employer

■ None of the above

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

Visit us at ***BlueCrossNC.com***

BlueCross BlueShield of North Carolina

Group Name: **County of Chatham**

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 PERIOD:

10. **Health, Dental Blue, Dental Blue Select, Dental Blue Preferred, 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 60 days ☐ 0 day, effective on date of hire
☐ Next day following 30 days ☐ Next day following 90 days ☐ Self-Funded Groups Only:
☐ 1st of the month following 60 days ☐ 0 day, effective 1st of the month following the date of hire (51+): 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 (250+): 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. 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.

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 / Dental Blue Preferred

14. For Health Coverage:
Number of Eligible Employees: 526
Number of Enrolled Employees: 518

15. Group Employer Contribution for health coverage (select one):
■ Percentage ☐ Fixed
Employees: 100 % Dependents: varies by tier % 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:** 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.**

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
572

Group Name: **County of Chatham**

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 Blue Cross NC'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: _____

Address: _____ Phone: _____

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 Blue Cross NC 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 Blue Cross NC 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 1-2-3℠ (PPO) / Blue Value℠ (POS) / Blue Select℠ (PPO) 51+ / Blue Select Plus℠ (PPO) / Blue Local℠ with Atrium Health* / Dental Blue / Dental Blue Select / Dental Blue Preferred 51+ / 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 with Atrium Health 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 Blue Cross NC 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: **Blue Options- Modified Quote #5223944 ($135,000 ISL Deductible Option)**

Plan Name: **Blue Options**

Quote number and rates for groups. Small employers enrolling in two plans must indicate high and low plan.

$135,000 ISL Deductible
ISL Premium: $80.89 PEPM
Agg. Premium: $9.43 PEPM
Admin. Fee: $20.00 PEPM

Group Name: **County of Chatham**

25. Are you pairing your benefit with an HRA? ☐ Yes ☒ No

If yes, please choose: ☐ Integrated Blue Cross NC Fund Administrator (Health Equity) ☐ Other Fund Administrator

Is the group an S-Corp? ☐ Yes ☐ No

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

_____

26. **FULLY INSURED SMALL GROUPS (1-50 Eligible Employees if Grandfathered or Transitional, Otherwise, 1-50 Full-Time Equivalents)**

Please select your HSA Administrator Option:

☐ Integrated Blue Cross NC Fund Administrator (Health Equity) ☐ Other Fund Administrator

27. **LARGE GROUPS (51+ Eligible Employees if Grandfathered, Otherwise, 51+ Full-Time Equivalents, 26+ Self-Funded)**

Blue Options HSA℠ - HSA Eligible Plans

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. **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.

Group Name: **County of Chatham**

Blue 20/20 Vision

29. (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

(d) For Vision Coverage: Number of Eligible Employees _____ Number of Enrolled Employees _____

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 ☐ $15 ☐ $20 ☐ $25 **Lens copay** ☐ $10 ☐ $25 **Frame allowance** ☐ $100 ☐ $130 ☐ $150 ☐ $200 ☐ $250 ☐ $300 **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:

30. **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. (Required for small group self-funded plans)

☐ **Monthly Payments Online -** withdraw the Group's initial premium payment (a one-time payment). The Group will log into Blue Cross NC'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:

Required for small group self-funded plans. The automatic bank draft options shown above are available to renewal groups as well. Renewal groups may elect the desired options by logging into Blue Cross NC's Employer Services website at ***https://www.bluecrossnc.com/employer-services.***

Name of Bank Account Holder: **same as current**

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 drafts under Statement of Understanding.

Group Name: **County of Chatham**

31. **Agent Fee Payments:**
In applying for this coverage, the self-funded groups (26+) and insured groups (100+) 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 be half of a producer is available.

32. **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 **1** day of **July** (month), **2019** (year).

33. **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.

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: 05/09/2019 (MM/DD/YYYY)

Email Address: dan.lamontagne@chathamnc.org

Print Name: DAN LAMONTAGNE Title: COUNTY MANAGER

Agent Name: **Bryan Bickley** Date: **04/15/2019** (MM/DD/YYYY)

Agent Number: _____

This Instrument has been pre-audited in the manner required by the Local Government Budget and Fiscal Control Act.

Vicki S. McConnell, Finance Officer

BlueCross BlueShield of North Carolina

Group Name: County of Chatham

Contract Year: 07/01/2019 to 06/30/2020

Program Selection Chart (ASO and Balanced Funding 250-999 eligible subscribers)

Important contractual document. Please retain for your records.

Unless otherwise noted, all fees listed below will be billed as a Care Management fee on your monthly Statement of Account. Care Management fees are a component of Claims Expense and are included in your claims projections.

Program		Description
The programs below are incorporated into your medical benefits. The applicable fee is listed.		
Mental Health/Substance Abuse Management	$0.28 Per member per month	Provides utilization management for higher levels of care, including the provision of: preauthorization, referral to the Blue Cross NC provider network, care coordination, case management, and after-care planning.
Diagnostic Imaging Management (DIM) UDS 153	$0.35 Per member per month Include	Requires prior review for all CT, CTA, MRI, MRA, PET scans, Echocardiography and nuclear cardiology studies performed in an outpatient setting. Managed by American Imaging Management, Inc (AIM).
Medical Oncology Solution UDS 193	$0.21 Per member per month Include	Promotes the use of evidence-based treatment guidelines and quality outcomes by efficient use of chemotherapy and supportive agents.
Specialty Care Shopper Program UDS 194	$0.06 Per member per month Exclude	Guides providers and members to best imaging site by providing cost and quality transparency for CT and MRI studies. If included, SmartShopper must be excluded.
Sleep Study Management Program UDS 195	$0.10 Per member per month Exclude	Requires prior approval for sleep studies and related durable medical equipment.
Telehealth Service UDS 286	Pricing varies based on selection Per employee per month Exclude/Balanced Funding Ba	Provides services to members via remote consultation with a doctor who can diagnose health issues and prescribe medication. Package 1: Standard Package 2: Standard + Audio-only option Package 3: Standard & Behavioral Health w/Audio-only + Dermatology
Signature Service UDS 196 (SS PLUS SHA); UDS 197 (SS PLUS DED) UDS 198 (SS PREM SHA); UDS 199 (SS PREM DED) UDS 207 (SS ULT SHA); UDS 208 (SS ULT DED) Note: program is only available to ASO groups with 500+ enrolled subscribers	Pricing varies based on selection Per member per month Exclude	A high touch service solution designed to provide expert service and support, educate and drive engagement in your benefit programs, and simplify the overall healthcare experience for employers and members. *Group must have 10,000+ members to qualify for Dedicated support.

Program	Description
The standard programs below are charged at a rate of $0.79 PMPM.	
Healthy Outcomes Condition Care UDS 188	Provides support for members with Diabetes, Asthma, Coronary Artery Disease, Congestive Heart Failure, and Chronic Obstructive Pulmonary Disease. Includes printed material as well as telephonic disease management health coaching. Intensity of coaching varies by acuity.
My Pregnancy Program UDS 172	Supports expecting mothers through pregnancy and delivery. Includes educational material and tailored risk assessments.
Health Line Blue UDS 142	24/7 Nurse Line: Confidential health information resource staffed by highly trained registered nurses.
Online Wellness Programs UDS 192	Online Wellbeing Assessment*, Goal Setting and Tracking, Personal Health Record, Wellness Tools, Educational Materials, Wellness Courses, and Coaching. Wellbeing Assessment can be suppressed; see Wellness Plan selection below for more information. *Paper assessments have an additional cost of $16.50 per processed form.
Wellness Plan Design UDS 176	Achiever C (28) — Refers to the wellness experience in the Healthy Outcomes wellness portal. Design options range from non-tracking, participation-based, to activity or points-based, by which members complete wellness activities to reach a goal. Weekly reporting tracks activities completed and credits earned. **Note: Choosing Core A (1a) will suppress the Wellbeing Assessment.**

Wellness Tracking (check all that apply)	Employees only UDS 184 ☐	Pre-65 Retirees UDS 186 ☐	Employees, Spouses & Dependents over 18 UDS 184 ☐
	Employees & Spouses UDS 184 ☑	Post-65 Retirees UDS 187 ☐	N/A ☐

Customized Reporting
Subject to BCBSNC Approval

Additional fees may apply to customized reporting.

Program		Description
The programs below are optional at the indicated price.		
Depression Management UDS 173	$0.09 Per member per month Exclude	Disease management program that provides holistic support and ongoing education to help members manage and cope better with their depression.
Pain Management UDS 174 • Comprehensive • Fibromyalgia/Migraine	$0.36 $0.09 Per member per month Exclude	Disease management program that includes support for: back pain (including upper and lower back and neck); rheumatoid arthritis; migraines and tension headaches; fibromyalgia; tendonitis/bursitis; elbow and rotator cuff disorders; carpal tunnel syndrome; osteoarthritis; frozen shoulder; and regional musculoskeletal disorders.
Lifestyle Coaching UDS 175	$0.22 Per member per month Exclude	Live coaching program that encourages members to adopt healthier behaviors. Members receive one-on-one coaching through phone and email. Program Election Chart must be completed to receive complimentary BeHealthy campaign.
Eat Smart, Move More, Weigh Less UDS 148 *Not billed as a Care Management Fee*	$205.00 Per participant per Part Exclude	Part 1 is a 15-week weight management program. Part 2 is a 12-biweekly weight management continuation program. This will be billed through claims, not as a Care Management fee.
Rx Savings Solutions UDS 227	35% Shared Savings, quarterly Include	Analyzes prescription drug claims to deliver members personalized recommendations on medications that would achieve desired clinical outcomes and maximum savings. Included for Balanced Funding at no cost. PharmaSure groups must include.
GuidedHealth Rx Program UDS 023	$0.10 Per member per month Include	Identifies drug therapy opportunities and engages doctors to improve care and lower costs using an analysis of pharmacy and medical data.
SmartShopper Program UDS 189	$2.35 Per employee per month Exclude	SmartShopper is an engagement incentive program - part of the Blue Cross NC cost transparency tool. It pays members cash for shopping for certain procedures and selecting a cost effective provider. If included, Specialty Care Shopper must be excluded. Activation form must be completed and sent to Vitals.

Caveats:

1. Depression Management, Comprehensive Pain Management, and Fibromyalgia and Migraine Pain Management programs cannot be purchased if the Healthy Outcomes Condition Care program is carved out of the core package.
2. Member portal will only display programs purchased.
3. Please refer to the full rate exhibits for complete list of all rating assumptions and caveats.
4. Fees are effective as of the contract renewal date stated on this document, and are subject to change during the year.
5. Online wellness programs must be purchased if Health Assessment is chosen.
6. Lifestyle Coaching is not available to groups in Core A.
7. With regard to the Wellness Plan Design, if you choose to offer rewards, please consult with your tax advisor and attorney to ensure that the design and any rewards comply with all applicable laws and regulations. Employer remains responsible for designing and funding the rewards component.

By signing below, I agree that this document accurately reflects (1) the program selections that will be charged as care management fees and (2) the Wellness Plan Design selected and any additional fees, if any, that will be charged as administrative fees under the administrative services agreement with BCBSNC for the above-noted contract year. I further acknowledge that if any other incentives are provided by the Group (e.g. PTO) BCBSNC has no responsibility or liability with regard to the administration of those incentives other than providing necessary reports.

Plan Administrator Signature _____ Date 5-9-2019

This Instrument has been pre-audited in the manner required by the Local Government Budget and Fiscal Control Act.

Vicki S. McConnell, Finance Officer

Effective Date	July 1, 2019
Expiration Date	June 30, 2020
Group Name	County of Chatham
Service City	Pittsboro
COBRA Administrator	Flores & Associates
If not CobraServe, please provide COBRA Administrator phone number	704-335-8211
Summary Plan Description	YES
ERISA Number	501
ERISA Name	County of Chatham Group and Welfare Plan
Sponsor Name	County of Chatham
Sponsor Address (City, State Zip)	Street Address12 East Street CityPittsboro StateNC Zip Code27312
Sponsor Tax ID #	56-6000284
Sponsor Telephone	919-548-8301
Affiliate Name	N/A
Plan Administrator	County of Chatham
Plan Address	Street Address12 East Street CityPittsboro StateNC Zip Code27312

Uniform Benefit Changes

In a continuing effort to offer quality, cost-effective health care coverage, the following changes have been made to Blue Cross and Blue Shield of North Carolina's (Blue Cross NC's) base benefits. These changes are effective at the group's effective/renewal date.

Existing Benefit Design	Product Lines	Benefit Changes
		For groups with effective dates 07/1/2018 - 09/30/2019
Accumulators Blue Options HSA plans with aggregate deductibles and Out of Pocket Limits	Blue Options℠ Blue Value℠ Blue Local with Carolinas HealthCare System℠	For all non-grandfathered plans that move from Blue Options HSA with an individual deductible $3,000 or greater to the new HSA eligible medical plan with an individual deductible of $3,000 or greater and purchase it with an HSA Fund. • Plans will have embedded Deductible and Out of Pocket Limits
		For groups with effective dates 01/1/2019 - 12/31/2019
Routine Vision Exam Adults and Children Covered at 100%	Blue Options℠ Blue Options 1-2-3℠ Blue Value℠ Blue Value 1-2-3℠ Blue Local with Carolinas HealthCare System℠	For all non-grandfathered plans Blue Cross NC will longer cover routine vision exams embedded in the medical plan. • Routine vision exam not covered for adults and children
		For groups with effective dates 01/1/2019 - 12/31/2019
Lenses and Frames Riders (optional coverage) Partial coverage for eyeglasses and contact lenses	Blue Options℠ Blue Options 1-2-3℠ Blue Value℠ Blue Value 1-2-3℠ Blue Local with Carolinas HealthCare System℠	For all non-grandfathered plans Blue Cross NC will longer offer the lenses and frames riders. • Lenses and Frames riders removed; no longer offered
		For groups with effective dates 01/1/2019 - 12/31/2019
Telehealth (26+ Balanced Funding - Standard) Not covered	Blue Options℠ Blue Options 1-2-3℠ Blue Value℠ Blue Value 1-2-3℠ Blue Select℠	Blue Cross NC will add Telehealth benefits from MDLIVE to ASO groups with Standard Balanced Funding plan designs. • Telehealth – medical/acute care only • Covered at the PCP cost share
		For groups with effective dates 01/1/2019 - 12/31/2019
Interim Caries Arresting Medicament	Dental Blue® Dental Blue Select℠	Blue Cross NC will cover ADA dental code D1354 • Limited to members up through age 6, for primary teeth only
		For groups with effective dates 01/1/2019 - 12/31/2019
Blue Local with Carolinas HealthCare System	Blue Local with Carolinas HealthCare System℠	Blue Cross NC will change the name to the following: • Blue Local with Atrium Health

BlueCross BlueShield of North Carolina

AGENT FEES COLLECTION AGREEMENT

THIS AGENT FEES COLLECTION AGREEMENT (the "Agreement") is entered into on **July 1, 2019** ("Effective Date") by and between **Blue Cross and Blue Shield of North Carolina** ("BCBSNC"), a North Carolina corporation and an independent licensee of the Blue Cross and Blue Shield Association,

Bryan Bickley ("Agent"),

James A. Scott & Son, Inc. ("Agency"), and

County of Chatham ("Group"), each a "Party" and collectively "Parties."

BACKGROUND

Group will purchase certain health, dental, and/or stop-loss insurance products from BCBSNC and/or its affiliates ("Products") through the services of Agent, an appointed agent of BCBSNC and the Group's Agent of Record ("AOR"). Group understands that the law and BCBSNC, through its contract and BCBSNC Policies and Procedures, set some requirements for services provided by Agent to Group. Group also understands that Agent provides more services than those required by BCBSNC to Group. Group agrees to pay Agent an agreed upon set of fees for each of the Products ("Agent Fees") for such additional services. Group would like BCBSNC to bill Group the Agent Fees. Agent would like BCBSNC to collect Agent Fees from Group and pay Agent Fees to Agency. Group, Agent, and Agency understand that BCBSNC is not responsible for any portion of the agreed upon Agent Fees or for the additional services provided by the Agent.

AGREEMENT

1. **Services Provided by Agent to Group**. Agent shall provide services related to each of the Products to Group that are consistent with all applicable laws, any contracts Agent may have with BCBSNC, and BCBSNC Policies and Procedures. Agent agrees, represents, and warrants that it has the authority to bind Agency to this Agreement. Group understands that BCBSNC has no liability or responsibility for services provided by the Agent outside of what is required by BCBSNC's agent/agency contracts and BCBSNC Policies and Procedures.

2. **Amount of Agent Fees.** Group agrees to pay the following Agent Fees for services provided by Agent in connection with each of the Products starting the Effective Date (check one of the two options):

(Complete only the applicable boxes)

Product Type	Percent of Monthly Premium (per employee per month)	Flat Fees per Month (per employee per month)
Health		$10.00
Dental		
Stop-Loss		

3. **Agent of Record Change.** All Parties acknowledge that this Agreement does not restrict Group from changing or removing its AOR. Group understands that changing its AOR shall terminate this agreement and that any replacement AOR Agent Fees must be the same as the previous AOR's Agent Fees unless otherwise agreed upon by all the Parties.

4. **Remittance of Agent Fees to BCBSNC.** BCBSNC agrees to include Agent Fees in its monthly premium statement to Group for Products premium. Group shall include Agent Fees in its monthly remittance of premium payment to BCBSNC. While Agent Fees is held by BCBSNC, all parties agree that BCBSNC may earn interest or other investment income on such Agent Fees.

5. **Agent Fees to Agency.** BCBSNC shall pay Agent Fees to Agency on a monthly basis after receiving Agent Fees from Group. Should BCBSNC pay any amount of Agent Fees to Agency that BCBSNC, for any reasons, did not collect or was required to return from Group, BCBSNC shall notify Agency and BCBSNC shall recoup such Agent Fees amounts. BCBSNC, in its sole discretion, may recoup by demanding repayment from Agency or deduct such Agent Fees amounts from any future payments to Agency under any agreement between BCBSNC and Agency.

6. **Partial Payments.** In the event that Group does not remit the full amount of any monthly premiums and Agent Fees for any month, in its sole discretion, BCBSNC will review the amount and its policies and procedures at that time and determine whether to continue the Group's coverage. If the Group's coverage continues, Agent Fees will be paid to Agency for that time period of coverage. BCBSNC is not responsible for payment of Agent Fees if it does not receive Agent Fees from Group.

7. **Terminations.** This Agreement shall terminate: i) on the day that Group no longer purchases any Products as identified in this Agreement from BCBSNC; ii) on the effective date of when a Group changes its AOR or removes Agent as its AOR; iii) upon replacement with a new Agent Fees Collection Agreement; or iv) by any Party upon at least thirty (30) days prior written notice to all other Parties.

8. **Miscellaneous.** This Agent Fees Collection Agreement supersedes all prior Agent Fees Collection Agreements between the same parties. This Agreement embodies the entire agreement and understanding of the parties with respect of the subject matter of this Agreement. This Agreement may be amended, modified or supplemented only by written agreement of all of the parties hereto. The execution, interpretation, and performance of this Agreement shall be governed by the internal laws and judicial decisions of the State of North Carolina.

[Execution Page Follows]

BlueCross BlueShield of North Carolina

In WITNESS WHEREOF, the parties have executed this contract.

BLUE CROSS AND BLUE SHIELD OF NORTH CAROLINA

Signed: _____

Name: K. Steve Crist

Title: Vice President, Group Markets

Date: _____

GROUP

Signed: _____

Name: DAN LAMONTAGNE

Title: COUNTY MANAGER

Date: 5-9-2019

This Instrument has been pre-audited in the manner required by the Local Government Budget and Fiscal Control Act.

_____

Vicki S. McConnell, Finance Officer

AGENCY / AGENT

Signed: _____

Name: Bryan Bickley

Title: Vice President, Benefits Consultant

Date: 4/15/19

Agency: James A. Scott & Son, Inc.

Agency Tax ID: 54-0372970

BlueCross BlueShield of North Carolina

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(Complete only the applicable boxes)

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BlueCross BlueShield of North Carolina

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BLUE CROSS AND BLUE SHIELD OF NORTH CAROLINA

Signed: K. Steve Crist

Name: K. Steve Crist

Title: Vice President, Group Markets

Date: _____

GROUP

Signed: _____

Name: DAN LAMONTAGNE

Title: COUNTY MANAGER

Date: 5-9-2019

This Instrument has been pre-audited in the manner required by the Local Government Budget and Fiscal Control Act.

Vicki S. McConnell, Finance Officer

AGENCY / AGENT

Signed: _____

Name: Bryan Bickley

Title: Vice President, Benefits Consultant

Date: 4/15/19

Agency: James A. Scott & Son, Inc.

Agency Tax ID: 54-0372970

BlueCross BlueShield of North Carolina

Group Name: County of Chatham

Contract Year: 07/01/2019 to 06/30/2020

Program Selection Chart (ASO and Balanced Funding 250-999 eligible subscribers)

Important contractual document. Please retain for your records.

Unless otherwise noted, all fees listed below will be billed as a Care Management fee on your monthly Statement of Account. Care Management fees are a component of Claims Expense and are included in your claims projections.

Program		Description
The programs below are incorporated into your medical benefits. The applicable fee is listed.		
Mental Health/Substance Abuse Management	$0.28 Per member per month	Provides utilization management for higher levels of care, including the provision of: preauthorization, referral to the Blue Cross NC provider network, care coordination, case management, and after-care planning.
Diagnostic Imaging Management (DIM) UDS 153	$0.35 Per member per month Include	Requires prior review for all CT, CTA, MRI, MRA, PET scans, Echocardiography and nuclear cardiology studies performed in an outpatient setting. Managed by American Imaging Management, Inc (AIM).
Medical Oncology Solution UDS 193	$0.21 Per member per month Include	Promotes the use of evidence-based treatment guidelines and quality outcomes by efficient use of chemotherapy and supportive agents.
Specialty Care Shopper Program UDS 194	$0.06 Per member per month Exclude	Guides providers and members to best imaging site by providing cost and quality transparency for CT and MRI studies. If included, SmartShopper must be excluded.
Sleep Study Management Program UDS 195	$0.10 Per member per month Exclude	Requires prior approval for sleep studies and related durable medical equipment.
Telehealth Service UDS 286	Pricing varies based on selection Per employee per month Exclude/Balanced Funding Ba	Provides services to members via remote consultation with a doctor who can diagnose health issues and prescribe medication. Package 1: Standard Package 2: Standard + Audio-only option Package 3: Standard & Behavioral Health w/Audio-only + Dermatology
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Plan Administrator Signature _____ Date 5-9-2019

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Vicki S. McConnell, Finance Officer