CBA Blue
An independent licensee of the Blue Cross and Blue Shield Association.

NDCP

ENROLLMENT / CHANGE FORM

❑Addition ❑ Change ❑ Termination *Reason*: _____ Effective Date _____

If change or termination, complete only Employee's Name, Social Security Number, and the Change details.
Termination date includes last day of coverage.

EMPLOYEE INFORMATION

Employee Name Last First MI	Sex M F	Date of Birth / /	Social Security Number - -
Employee Home Address Street/Apt. City State Zip + Four County			Home Telephone ( ) -
Mailing Address (if Different From Home Address)			Business Telephone ( ) -

Status	**Marital Status**	**Coverage**	**Coverage: Check the box to select your Medical and Dental plans**
❑ Active ❑ COBRA ❑ Retired	❑ Single ❑ Married	❑ Employee Only ❑ Employee + One ❑ Family	**Medical:** OPremium OQuality OValue HSA OMEC ONONE **Dental:** OPremium OQuality ONONE

List Full Name of Your Eligible Dependents	**Relation To Employee** 1-Spouse 2-Child **<26 years of age** 3-Stepchild 4-Other	Gender (M or F)	Date of Birth	Social Security Number	If he / she is Handicapped or Disabled indicate H or D with effective date	If other insurance, Please List Name of Other Insurance Carrier & Type of Coverage (Medical, Dental) for each dependent with effective dates
1			/ /	- -		
2.			/ /	- -		
3.			/ /	- -		
4.			/ /	- -		
5.			/ /	- -		
6.			/ /	- -		

Will this plan replace existing coverage? D Yes D No If yes, please provide a **Certificate of Prior Health Insurance Coverage (HIPAA certificate)** to your employer as soon as you receive it from your prior insurer.

I verify that this information is true to the best of my knowledge. I authorize my employer to deduct from my pay any required contributions and understand that my enrollment will continue until the Plan renews or I experience a qualifying event. Please see Human Resources for additional information.

_____ _____

Employee Signature Date

Is employee eligible for Medicare?

❑ Y ❑ N Effective Date_____

Is spouse/dependent eligible for Medicare?

❑ Y ❑ N Effective Date_____

THIS SECTION TO BE COMPLETED BY EMPLOYER: EMPLOYER (OR PLAN SPONSOR) STATEMENT:

Employer Name: National DCP, LLC.	Hire Date / /	Effective Date / /
PC# (Required)	Employee Title	
Employer Authorized Signature:		
Print Name:	Date: / /	Telephone

Mail to: CBA Blue, P.O. Box2365 South Burlington, VT 05407-2365

CBA Blue FAX NUMBER 802-862-7661

Fax to: CBA Blue Eligibility Department

WAIVER OF COVERAGE FORM

EMPLOYEE NAME (Please Print):

WAIVER OF GROUP MEDICAL COVERAGE (Please Check One):

❑ I waive my employer's group health insurance coverage for myself and dependents (if any).

❑ I am enrolling in my employer's group health insurance coverage but I am waiving coverage for my dependents (if any).

WAIVER OF GROUP DENTAL COVERAGE (Please Check One):

❑ I waive my employer's group dental insurance coverage for myself and dependents (if any).

❑ I am enrolling in my employer's group dental insurance coverage but I am waiving coverage for my dependents (if any).

REASON FOR WAIVER OF GROUP COVERAGE (Please Check One):

❑ Coverage through spouse's employer:

Employer Name:_____

Insurance Company:_____

❑ Other reason (please explain)

_____

_____

_____

EMPLOYEE STATEMENT:

As a result, I waive my, and/or my dependents' (if any) eligibility to enroll in my employer's group health plan(s) at this time. I understand that I and/or my dependents may enroll under these plans in the future only within 30 days from loss of other group coverage or at the time of my employer's annual open enrollment.

_____ _____

EMPLOYEE SIGNATURE **DATE**

Initial Notice of Coverage Rights Under COBRA

Introduction

You are receiving this notice because you have recently become covered under Dunkin' Donuts Franchisee & Distribution Center Health Plan (the Plan). This notice contains important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan. **This notice generally explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect the right to receive it.** When you become eligible for COBRA, you may also become eligible for other coverage options that may cost less than COBRA continuation coverage.

The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage can become available to you when you would otherwise lose your group health coverage. It can also become available to other members of your family who are covered under the Plan when they would otherwise lose their group health coverage. For additional information about your rights and obligations under the Plan and under federal law, you should review the Plan's Summary Plan Description or contact the Plan Administrator.

You may have other options available to you when you lose group health coverage.
For example, you may be eligible to buy an individual plan through the Health Insurance Marketplace. By enrolling in coverage through the Marketplace, you may qualify for lower costs on your monthly premiums and lower out-of-pocket costs. Additionally, you may qualify for a 30-day special enrollment period for another group health plan for which you are eligible (such as a spouse's plan), even if that plan generally doesn't accept late enrollees.

What is COBRA continuation coverage?

COBRA continuation coverage is a continuation of Plan coverage when coverage would otherwise end because of a life event known as a "qualifying event". Specific qualifying events are listed later in this notice. After a qualifying event, COBRA continuation coverage must be offered to each person who is a "qualified beneficiary". You, your spouse, and your dependent children could become qualified beneficiaries if coverage under the Plan is lost because of the qualifying event. Under the Plan, qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage (herein called continuation coverage).

If you're an employee, you'll become a qualified beneficiary if you lose your coverage under the Plan because of the following qualifying events:

- Your hours of employment are reduced, or
- Your employment ends for any reason other than your gross misconduct.

If you're the spouse of an employee, you'll become a qualified beneficiary if you lose your coverage under the Plan because of the following qualifying events:

- Your spouse dies;

- Your spouse's hours of employment are reduced;
- Your spouse's employment ends for any reason other than his or her gross misconduct;
- Your spouse becomes entitled to Medicare benefits (under Part A, Part B, or both); or
- You become divorced or legally separated from your spouse.

Your dependent children will become qualified beneficiaries if they lose coverage under the Plan because of the following qualifying events:

- The parent-employee dies;
- The parent-employee's hours of employment are reduced;
- The parent-employee's employment ends for any reason other than his or her gross misconduct;
- The parent-employee becomes entitled to Medicare benefits (Part A, Part B, or both);
- The parents become divorced or legally separated; or
- The child stops being eligible for coverage under the Plan as a "dependent child."

When is COBRA Coverage available?

The Plan will offer continuation coverage to qualified beneficiaries only after the Plan Administrator has been notified that a qualifying event has occurred. When the qualifying event is the end of employment or reduction of hours of employment, death of the employee, or the employee's becoming entitled to Medicare benefits (under Part A, Part B, or both), the employer must notify the Plan Administrator of the qualifying event.

You Must Give Notice of Some Qualifying Events

The employee or other covered individual or family member has the responsibility to inform the Plan Administrator of a divorce, legal separation, or a child's loss of dependent status within 60 days of the qualifying event or the date on which group coverage would be lost because of the event. If you fail to provide the proper notice within 60 days, continuation coverage might not be available.

How is COBRA Coverage Provided?

Once the Plan Administrator receives notice that a qualifying event has occurred, continuation coverage will be offered to each of the qualified beneficiaries. Each qualified beneficiary will have an independent right to elect continuation coverage. Covered employees may elect continuation coverage on behalf of their spouses, and parents may elect continuation coverage on behalf of their children.

COBRA continuation coverage is a temporary continuation of coverage that generally lasts for 18 months due to employment termination or reduction of hours of work. Certain qualifying events, or a second qualifying event during the initial period of coverage, may permit a beneficiary to receive a maximum of 36 months of coverage. There are also ways in which this 18-month period of COBRA continuation coverage can be extended:

Disability extension of 18-month period of COBRA continuation coverage

If you or anyone in your family covered under the Plan is determined by Social Security to be disabled and you notify the Plan Administrator in a timely fashion, you and your entire family may be entitled to get up to an additional 11 months of COBRA continuation coverage, for a

maximum of 29 months. The disability would have to have started at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period of COBRA continuation coverage.

Second qualifying event extension of 18-month period of continuation coverage

If your family experiences another qualifying event during the 18 months of COBRA continuation coverage, the spouse and dependent children in your family can get up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months, if the Plan is properly notified about the second qualifying event. This extension may be available to the spouse and any dependent children getting COBRA continuation coverage if the employee or former employee dies; becomes entitled to Medicare benefits (under Part A, Part B, or both); gets divorced or legally separated; or if the dependent child stops being eligible under the Plan as a dependent child. This extension is only available if the second qualifying event would have caused the spouse or dependent child to lose coverage under the Plan had the first qualifying event not occurred.

Are there other coverage options besides COBRA Continuation Coverage?

Yes. Instead of enrolling in COBRA continuation coverage, there may be other coverage options for you and your family through the Health Insurance Marketplace, Medicaid, or other group health plan coverage options (such as a spouse's plan) through what is called a "special enrollment period." Some of these options may cost less than COBRA continuation coverage. You can learn more about many of these options at www.healthcare.gov.

If you have questions

Questions concerning your Plan or your COBRA continuation coverage rights should be addressed to the contact or contacts identified below. For more information about your rights under the Employee Retirement Income Security Act (ERISA), including COBRA, the Patient Protection and Affordable Care Act, and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit www.dol.gov/ebsa. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.) For more information about the Marketplace, visit www.healthcare.gov.

Keep Your Plan Informed of Address Changes

In order to protect your family's rights, you should keep the Plan Administrator informed of any change in marital status or change of address for you or your family members. You should also keep a copy, for your records, of any notices you send to the Plan Administrator.

Plan contact information

NDCP
Benefits Specialist
3805 Crestwood Parkway, Suite 400
Duluth, GA 30096

Required Annual Federal Health Insurance Notices for Benefit Eligible Employees

1. Special Enrollment Rights

If you do not enroll yourself and your dependents in a group health plan after you become eligible or during annual enrollment, you may be able to enroll under the special enrollment rules under the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") that apply when an individual declines coverage and later wishes to elect it. Generally, special enrollment is available if (i) you declined coverage because you had other health care coverage that you have now lost through no fault of your own (or employer contributions to your other health care coverage terminate); or (ii) you have acquired a new dependent (through marriage or the birth or adoption of a child) and wish to cover that person. When you have previously declined coverage, you must have given (in writing) the alternative coverage as your reason for waiving coverage under the group health plan when you declined to participate. In either case, as long as you meet the necessary requirements, you can enroll both yourself and all eligible dependents in the group health plan if you provide notice to the Plan Administrator within 30 days after you lose your alternative coverage (or employer contributions to your alternative coverage cease) or the date of your marriage or the birth, adoption, or placement for adoption of your child.

See the Plan Administrator for details about special enrollment.

2. CHIP

You may also enroll yourself and your dependents in a group health plan if you or one of your eligible dependent's coverage under Medicaid or the state Children's Health Insurance Program (CHIP) is terminated as a result of loss of eligibility, or if you or one of your eligible dependents become eligible for premium assistance under a Medicaid or CHIP plan. Under these two circumstances, the special enrollment period must be requested within 60 days of the loss of Medicaid/CHIP coverage or of the determination of eligibility for premium assistance under Medicaid/CHIP.

See the Plan Administrator for details about special enrollment.

3. Grandfathered Status

The Plan believes that none of the group health plans available under the Plan are "grandfathered health plans" under the Patient Protection and Affordable Care Act (the "Affordable Care Act").

4. Special Rule for Maternity and Infant Coverage

Group health plans and health insurance issuers generally may not, under Federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, Federal law generally does not prohibit the attending provider or physician, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours, as applicable).

5. Special Rule for Women's Health Coverage

The Women's Health and Cancer Rights Act of 1998 ("WHCRA") requires group health plans, insurance issuers, and HMOs who already provide medical and surgical benefits for mastectomy procedures to provide insurance coverage for reconstructive surgery following mastectomies. This expanded coverage includes (i) reconstruction of the breast on which the mastectomy has been performed; (ii) surgery and reconstruction of the other breast to produce a symmetrical appearance; and (iii) prostheses and physical complications at all stages of mastectomy, including lymphedemas.

6. Notice Regarding Lifetime and Annual Dollar Limits

In accordance with applicable law, none of the lifetime dollar limits and annual dollar limits set forth in the Plan shall apply to "essential health benefits," as such term is defined under Section 1302(b) of the Affordable Care Act. The law defines "essential health benefits" to include, at minimum, items and services covered within certain categories including emergency services, hospitalization, prescription drugs, rehabilitative and habilitative services and devices, and laboratory services, but currently provides little further information. Accordingly, a determination as to whether a benefit constitutes an "essential health benefit" will be based on a good faith interpretation by the Plan Administrator of the guidance available as of the date on which the determination is made.

7. Patient Protection Disclosure

You have the right to designate any participating primary care provider who is available to accept you or your family members (for children, you may designate a pediatrician as the primary care provider). For information on how to select a primary care provider and for a list of participating primary care providers, contact the Plan Administrator. You do not need prior authorization from the Plan or from any other person, including your primary care provider, in order to obtain access to obstetrical or gynecological care from a health care professional; however, you may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals.

For a list of participating health care professionals who specialize in obstetrics or gynecology, contact the Plan Administrator.

8. Affordable Care Act Consumer Protections

(a.) Coverage for Children Up to Age of 26

The Affordable Care Act of 2010 requires that the Plan must make dependent coverage available to adult children until they turn 26 regardless if they are married, a dependent, or a student.

(b.) Prohibition of Lifetime Dollar Value of Benefits

The Affordable Care Act of 2010 prohibits the Plan from imposing a lifetime limit on the dollar value of benefits.

(c.) Your Health Insurance Cannot be Rescinded

The Affordable Care Act of 2010 prohibits the Plan, or any insurer, from rescinding your health insurance coverage under the Plan for misrepresentation.

(d.) Prohibition of Pre Existing Conditions

Effective January 1, 2014 The Affordable Care Act of 2010 prohibits the Plan, or any insurer, from denying any health insurance claim for any person because of pre-existing condition.

(e.) Prohibition of Restrictions on Annual Limits on Essential Benefits

The Affordable Care Act of 2010 prohibits the Plan, or any insurer, effective January 1, 2014 from placing annual limits on the value of essential health benefits.

(f.) Notice of Marketplace/Exchange

If this health insurance is unaffordable (your cost of the premium exceeds 9.56% of your income) as defined under the Affordable Care Act, you may have the right to subsidized health insurance purchased through an exchange/marketplace created pursuant to the Affordable Care Act.

9. Michelle's Law

Michelle's Law provides continued health and dental insurance benefits under the Plan for dependent children who are covered under the Plan as a student but lose their student status in a post-secondary school or college because they take a medically necessary leave of absence from school. If your child is no longer a student because he or she is out of school because of a medically necessary leave of absence, your child may continue to be covered under the Plan for up to one year from the beginning of the leave of absence.

10. The Genetic Information Nondiscrimination Act (GINA)

GINA prohibits the Plan from discriminating against individuals on the basis of genetic information in providing any benefits under the Plan. Genetic information includes the results of genetic tests to determine whether someone is at increased risk of acquiring a condition in the future, as well as an individual's family medical history.

11. Wellness

If your Plan includes a Wellness program that provides rewards or surcharges based on your ability to complete an activity or satisfy an initial health standard, you have the right to request a reasonable alternative should it be determined that it is not medically advisable for you to either complete the activity or satisfy the initial health standard.