WHITE PLAINS CHILDREN'S CENTER BENEFIT GUIDE 2021-2022

Medical

Dental

Vision

Life

Disability

PELNIK INSURANCE

This Benefit Book is designed to give you a snapshot of the benefits available to you. For each benefit we are providing summary information about the benefit, who is eligible, when you are eligible, how to make changes to your enrollment, the cost to you, if any, and where to get more detailed information about the benefit. And, as always, don't hesitate to ask if you have questions!

If you find a conflict in the information we provide here and the detailed policy documents, the benefit provided will be as detailed in the policy documents. Please bring any conflicts to our attention.

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Enrollment Guidelines

When to Enroll:

If you do not complete your enrollment elections within the designated time frame, you are waiving your opportunity to enroll or make changes. Your next opportunity will be during the next annual open enrollment period or if you experience a qualifying change in status.

Event:	Open Enrollment	New Hire	Qualifying Life Event
Benefits begin:	on 12/1/2021	as of your eligibility date	on the date of your QLE
You must enroll:	by 11/14/2021	within 30 days of eligibility	within 30 days of the QLE
Details:	Whether you are enrolling, waiving all benefits, or making changes in your existing enrollment, completing the enrollment process within the stated deadlines is critical. Please sign and return to HR the Enrollment Deadline Form in Appendix D which states that if you do not complete your enrollment elections within the designated time frame, you are waiving your opportunity to enroll or make changes.		Examples include: • Marriage, divorce/legal separation • Birth or adoption of a child • Loss/gain of spousal coverage • Loss of eligibility as/of a covered dependent • Change in class or full-time status

How to Enroll or Make Changes: Forms Enrollment

Enrollment forms for benefits are included in the Appendix of this book. For any updates to be effective, you must return completed forms to Kellie Haight by the appropriate deadline.

Product	Enrollment/Change Rules
Major Medical	Cannot change outside of OE or QLE United Healthcare Enrollment/Change Application
Dental	If election is not timely, a waiting period applies If dropped mid-year, can't re-enroll for 12 months Humana Enrollment Form
Vision	Humana Enrollment Form
STD	Salary changes take effect annually Sunlife Application
Group Life and AD&D	$25,000 Beneficiary Designation form

Section 125 Plan

Section125 Plan Administered by White Plains Children's Center

What is a Premium Only Plan?

White Plains Children's Center has established a Premium Only Plan, which allows you to pay your portion of premiums for qualified benefits with pre-tax dollars under IRC Section 125. This can result in significant savings on payroll deductions due to savings on Medicare, Social Security and unemployment taxes. As a result, you have more money to take home each pay period. Benefits that are offered the Premium Only Plan include: health, dental, and vision.

Please note that while a Section 125 plan reduces your taxable income, it also may reduce other benefits. Benefits that are calculated using your income (for example, Social Security or retirement benefits) will, in turn, be reduced.

Eligibility and Enrollment:

Your participation in this plan is automatic. If you do not want to participate, complete and return the negative election document in the Appendix. *Please note that you are covering a domestic partner, you are not eligible to pay for that coverage through the Section 125 plan.*

Your election will roll over year-to-year. You are only eligible to enroll in or withdraw from the POP during the annual open enrollment period, within a specified date of hire, or after a qualifying event (marriage, birth of a child, etc.).

Medical Insurance

Medical Insurance Provided by UnitedHealthcare Policy #08U6585:

Eligibility & Enrollment:

As a full-time employee working 30 hours a week or more, you have the option to elect or decline medical insurance for yourself and your eligible dependents. If you are enrolling as a new hire, benefit elections will be effective first of the month after hire.

Benefits You Receive:

White Plains Children's Center offers medical coverage through UnitedHealthcare.

To help you better understand your benefit costs and coverage options, you may review the Benefit Summary found in the appendix or access your Carrier Member account.

Plan Name	In-Network	Out-of-Network
Deductible (Individual/Family)	$2,500 / $5,000	$5,000 / $10,000
Out-of-Pocket Max (Individual/Family)	$5,000 / $10,000	$10,000 / $20,000
Benefits	In-Network	Out-of-Network
Preventive Care	No Charge	Not Covered
Primary Care	$25 Copay	50% after deductible
Specialist	$50 Copay	50% after deductible
Urgent Care	$50 Copay	50% coinsurance
Emergency Room	20% coinsurance + $500	20% coinsurance +$500
Rx – Tiers 1, 2, 3, 4	$10/$35/$70/$150 Refer to plan summary for complete details	

Cost to You:

Your premium contributions for White Plains Children's Center Health Care Benefits are deducted from your paycheck on a pretax basis, referred to as Premium Conversion under Section 125 of the IRS Code.

Cost Per Monthly Pay Period				
Coverage Level:	Employee	Employee + Spouse	Employee + Child(ren)	Family
White Plains Children's Center	$397.60	$397.60	$397.60	$397.60
Employee Deduction	$170.40	$738.40	$653.20	$1,363.19

United HealthCare Medical	
Customer Service Hotline	800-357-0978
Member Portal	https://www.myuhc.com/member/prewelcome
Mobile App	https://www.uhc.com/individual-and-family/member-resources/health-care-tools/health4me
Virtual Visits App and Info	https://www.uhc.com/individual-and-family/member-resources/health-care-tools/virtual-visits
Physician/Facility Look-Up	https://www.uhc.com/find-a-physician
Mental Health Provider Look-Up	https://provider.liveandworkwell.com/content/laww/providersearch/en/home.html?siteId=10275&lang=1
Pharmacy Look-Up	https://www.optumrx.com/oe_rxexternal/pharmacy-locator?type=PDPClientPharmacy
Prescription Drug List	https://www.uhc.com/employer/pharmacy/total-cost-management/prescription-drug-list

Dental Insurance

Dental Insurance provided by: Humana

Did you know your dentist may be able to spot other medical conditions by examining your teeth and gums? More than 90% of all systemic diseases have oral signs and symptoms, such as swollen gums, mouth ulcers and dry mouth. Several studies suggest that oral diseases, such as periodontitis (gum disease), can affect other areas of your body—including your heart. Receiving regular dental care can protect you and your family from the high cost of dental disease and surgery.

Eligibility & Enrollment:

As a full-time employee working 30 hours a week or more, you have the option to elect or decline dental insurance for yourself and your eligible dependents. If you are enrolling as a new hire, benefit elections will be effective on the first of the month following your date of hire.

Benefits You Receive:

White Plains Children's Center's dental plan is administered by Humana. Utilizing a dentist in their network may provide a cost savings for you as well as ease of claims filing.

Dental Insurance	NC Prev+ U&C 14	NC TRP U&C 14 100/80/50
Maximum Benefit	$1,000	$1,000
Annual Deductible	$50	$50
Service	In- Network	In- Network
Preventive & Diagnostic Services	100%	100%
Basic & Restorative Services	80%	80%
Major Services (12-month Waiting Period applies)	N/A	50%
Orthodontia (12 month Waiting Period)	N/A	20% Discount
Endodontics	N/A	50%
Periodontics	N/A	50%

Cost to You:

Your premium contributions for Dental Insurance are deducted from your paycheck on a pretax basis, referred to as Premium Conversion under Section 125 of the IRS Code.

Cost Per Monthly Pay Period				
Coverage Level:	Employee	Employee + Spouse	Employee + Child(ren)	Family
White Plains Children's Center	$23.44	$23.44	$23.44	$23.44
Employee – Preventive	$0	$29.65	$38.86	$74.66
Employee – Plan 2	$20.47	$64.41	$88.54	$132.46

More Information:

Humana Dental	
Please note that you will not receive an ID card in the mail. You can download one from your member portal.	
Customer Service Hotline	1-800-448-6262
Member Portal	https://www.humana.com/logon/
Mobile App	https://www.humana.com/mobile-apps/
In-Network Provider Look-Up	https://www.humana.com/dental-insurance/find-a-dentist

Vision Insurance

Vision Insurance provided by: Humana

Driving to work, reading a news article, and watching TV are all activities you likely perform every day. Your ability to do all of these activities, though, depends on your vision and eye health. Vision insurance can help you maintain your vision as well as detect various health problems. Your vision provider can identify early signs and symptoms of conditions such as glaucoma, cataracts, high blood pressure, diabetes, heart disease and high cholesterol.

Eligibility & Enrollment:

As a full-time employee working 30 hours a week or more, you have the option to elect or decline vision insurance for yourself and your eligible dependents. If you are enrolling as a new hire, benefit elections will be effective on the first of the month after hire. To help you better understand your benefit costs and coverage options, you may review the Benefit Summary found In the appendix (forms) or access your Carrier Member account.

Benefits:

Vision Care 130	In-Network	Out-of-Network
Exam – per 12 months	$10 Copay	Up to $35 allowance
Frames – per 24 months	Up to $50 wholesale allowance	$40 allowance
Lenses – per 12 months		
Single	$15 Copay	Up to $25 allowance
Lined Bifocal	$15 Copay	Up to $40 allowance
Lined Trifocal	$15 Copay	Up to $60 allowance
Lenticular	$15 Copay	Up to $100 allowance
Contact Lenses	$150 allowance for professional services and fitting	Up to $150 allowance

Cost to You:

Your premium contributions for vision insurance are deducted from your paycheck on a pretax basis, referred to as Premium Conversion under Section 125 of the IRS Code.

Cost Per Monthly Pay Period				
Coverage Level:	Employee	Employee + Spouse	Employee + Child(ren)	Family
Employee	$8.25	$16.50	$15.68	$24.64

More Information:

Humana Vision	
Customer Service Hotline	1-800-448-6262
Member Portal	https://www.humana.com/logon/
Mobile App	https://www.humana.com/mobile-apps/
In-Network Provider Look-Up	https://www.humana.com/vision-insurance/find-an-eye-doctor

Short-Term Disability Insurance

Short-Term Disability Insurance provided by: Sun Life

Short-term disability can protect your income should you become temporarily ill or injured and unable to work. Examples of qualifying conditions may include the birth of a child, prolonged sickness, or recovery after surgery. This plan offers a comprehensive benefit to help you achieve the best return-to-work scenario, financial protection when you are unable to work, and coverage that starts within days of a diagnosed illness or injury.

Eligibility & Enrollment:

As a full-time employee working 30 hours a week or more, you are automatically enrolled by White Plains Children's Center. If you are a new hire, coverage is effective on the first of the month following 30 days of employment.

Benefits You Receive:

Benefits are calculated based on your insurable income, which is defined as your gross weekly income from White Plains Children's Center in effect just prior to your date of disability, excluding include income received from commissions, bonuses, overtime pay, any other extra compensation, or income received from sources other than your Employer. If you are an hourly employee, only the first 40 hours worked per week are used in your salary calculation.

Please note that you are not eligible to receive short-term disability benefits if you are receiving workers' compensation benefits. Benefits may be reduced or offset by other sources of income.

Short-Term Disability Benefits	
Benefits Begin	Accident: day 1 | Sickness: day 8
Percentage of Income Replaced	You will receive 60% of your insurable income minus any offsetting income.
Maximum Weekly Benefit	$750
Maximum Duration of Benefits	13 Weeks

Cost to You:

At White Plains Children's Center, we want to do everything we can to protect you and your family. That's why White Plains Children's Center pays for the full cost of short-term disability insurance—meaning that you owe nothing out of pocket. Please note that you receive disability income, that income will be taxable to you.

More Information:

Sun Life STD	
Customer Service Hotline	1-800-247-6875
Member Portal	http://sunlife-usa.com/planmembers/
Online EOI Submission	https://www.sunlife-usa.net/eoi/
Online Claim Submission	https://www.sunlife-usa.net/claims/claimsOnline/index.cfm
Forms Library	https://www.sunlifedistributors.com/prodline/public/group/forms

Basic Life Insurance

Life Insurance provided by: Sun Life

White Plains Children's Center provides basic life insurance and accidental death and dismemberment (AD&D) insurance to eligible employees. Life insurance coverage can help protect your family in the event of an unexpected loss of life. This plan offers a comprehensive benefit that helps to ensure loved ones are not burdened with financial debt and to create an inheritance for heirs. The AD&D benefit provides an additional monetary benefit to employee or beneficiary when the employee experiences certain bodily injuries or death resulting from a covered accident while insured.

Eligibility & Enrollment:

As a full-time employee working 30 hours a week or more, you are automatically enrolled by White Plains Children's Center. If you are a new hire, coverage is effective on the first of the month after hire.

Benefits:

White Plains Children's Center provides a flat benefit amount of $25,000 to all employees. The coverage will be reduced to 65 percent at the age of 65 and, and to 50 percent at age 70.

Cost to You:

White Plains Children's Center pays 100% of the premium, there is no cost to you.

More Information:

Sun Life	
Customer Service Hotline	1-800-247-6875
Member Portal	http://sunlife-usa.com/planmembers/
Online EOI Submission	https://www.sunlife-usa.net/eoi/
Online Claim Submission	https://www.sunlife-usa.net/claims/claimsOnline/index.cfm
Forms Library	https://www.sunlifedistributors.com/prodline/public/group/forms

(DO NOT STAPLE)

Employee Enrollment Form
North Carolina

UnitedHealthcare®

Coverage Provided by "UnitedHealthcare and Affiliates":
☐ Medical coverage provided by UnitedHealthcare Insurance Company (Insurance)
☐ Medical coverage provided by UnitedHealthcare Insurance Company of the River Valley (Insurance)
☐ HMO Medical coverage provided by UnitedHealthcare of North Carolina, Inc. (HMO)
☐ Medical coverage provided by All Savers Insurance Company (Insurance)
Dental, Vision, Life insurance, Disability and AD&D coverage provided by UnitedHealthcare Insurance Company

To speed the enrollment process, please be thorough and fill out all sections that apply.

To Be Completed by Employer | **Requested Effective Date of Coverage/Date of Change** / /

Group Name | Policy Number

Date of Hire / /

Position/Title

Hours Worked per week

Salary $_____ Required only if Life, STD, or LTD Plan based on salary

Reason for Application
☐ New Group Plan ☐ New Hire
☐ Life Event/Date_____ ☐ Annual Open Enrollment
☐ Status Change_____
☐ Dependent Add/Delete
☐ Change Name/Address ☐ Late Enrollee
☐ Part time to Full time
☐ Waiving Coverage ☐ Termination
☐ Other _____

Employee Type
(Check all that apply)
☐ Active ☐ COBRA ☐ State Continuation
Start dt ____/____/____
End dt____/____/____
☐ Hourly ☐ Salary
☐ Union ☐ Non-Union ☐ Retired
☐ Other _____

A. Employee Information

If you are waiving all coverage, please complete sections A and B.

Last Name | First Name | MI | Social Security Number ___ – ___ – ____

Address | Apt # | City | State | Zip Code | Home/Cell Phone

Date of Birth / / | Gender ☐ M ☐ F | Marital Status ☐ Single ☐ Married ☐ Divorced ☐ Widowed | Work Phone

Language Preference, if not English

Email Address

Do you use tobacco?[1] ☐ Yes ☐ No
If yes, are you currently participating in a tobacco cessation program or do you intend to join one? ☐ Yes ☐ No

Primary Care Physician[2] Existing Patient? ☐ Yes ☐ No
Physician First & Last Name _____
Address _____
ID# ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ – ___ ___ ___ ___

Primary Care Dentist[3]
Dentist First & Last Name _____
ID# _____
Existing Patient? ☐ Yes ☐ No

B. Waiver of Coverage

I decline all coverage for:
☐ Myself
☐ Spouse
☐ Dependent Children
☐ Myself and all dependents

Declining coverage due to existence of other coverage:
☐ Spouse's Employer's Plan ☐ Individual Plan
☐ Covered by Medicare ☐ Medicaid
☐ COBRA from Prior Employer ☐ VA Eligibility
☐ Tri-Care
☐ I (we) have no other coverage at this time
☐ Other _____

I understand that by waiving coverage at this time, I will not be allowed to participate unless I qualify at a special enrollment period or as a late enrollee, if applicable, or at the next open enrollment period.

Date | Employee Signature if waiving all coverage

Employee Name ______________________________

C. Family Information

List All Enrolling (Attach sheet if necessary)

Relationship[4]	Last Name	First Name	MI	Sex	Date of Birth
Spouse /Domestic Partner				☐M ☐F	/ /

Social Security Number | | | — | | — | | | |

Do you use tobacco?[1] ☐Yes ☐No If yes, are you currently participating in a tobacco cessation program or do you intend to join one? ☐Yes ☐No

Primary Care Physician[2] Existing Patient? ☐Yes ☐No

Physician First & Last Name ______________________________

Address ______________________________

ID# ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ – ___ ___ ___ ___

Primary Care Dentist[3] Existing Patient? ☐Yes ☐No

Dentist First & Last Name ______________________________

ID# ______________________________

Relationship[4]	Last Name	First Name	MI	Sex	Date of Birth
Dependent				☐M ☐F	/ /

Social Security Number | | | — | | — | | | |

Do you use tobacco?[1] ☐Yes ☐No If yes, are you currently participating in a tobacco cessation program or do you intend to join one? ☐Yes ☐No

Primary Care Physician[2] Existing Patient? ☐Yes ☐No

Physician First & Last Name ______________________________

Address ______________________________

ID# ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ – ___ ___ ___ ___

Primary Care Dentist[3] Existing Patient? ☐Yes ☐No

Dentist First & Last Name ______________________________

ID# ______________________________

Permanently disabled and age 26 or older[5] ☐Yes ☐No

Relationship[4]	Last Name	First Name	MI	Sex	Date of Birth
Dependent				☐M ☐F	/ /

Social Security Number | | | — | | — | | | |

Do you use tobacco?[1] ☐Yes ☐No If yes, are you currently participating in a tobacco cessation program or do you intend to join one? ☐Yes ☐No

Primary Care Physician[2] Existing Patient? ☐Yes ☐No

Physician First & Last Name ______________________________

Address ______________________________

ID# ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ – ___ ___ ___ ___

Primary Care Dentist[3] Existing Patient? ☐Yes ☐No

Dentist First & Last Name ______________________________

ID# ______________________________

Permanently disabled and age 26 or older[5] ☐Yes ☐No

Relationship[4]	Last Name	First Name	MI	Sex	Date of Birth
Dependent				☐M ☐F	/ /

Social Security Number | | | — | | — | | | |

Do you use tobacco?[1] ☐Yes ☐No If yes, are you currently participating in a tobacco cessation program or do you intend to join one? ☐Yes ☐No

Primary Care Physician[2] Existing Patient? ☐Yes ☐No

Physician First & Last Name ______________________________

Address ______________________________

ID# ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ – ___ ___ ___ ___

Primary Care Dentist[3] Existing Patient? ☐Yes ☐No

Dentist First & Last Name ______________________________

ID# ______________________________

Permanently disabled and age 26 or older[5] ☐Yes ☐No

Relationship[4]	Last Name	First Name	MI	Sex	Date of Birth
Dependent				☐M ☐F	/ /

Social Security Number | | | — | | — | | | |

Do you use tobacco?[1] ☐Yes ☐No If yes, are you currently participating in a tobacco cessation program or do you intend to join one? ☐Yes ☐No

Primary Care Physician[2] Existing Patient? ☐Yes ☐No

Physician First & Last Name ______________________________

Address ______________________________

ID# ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ – ___ ___ ___ ___

Primary Care Dentist[3] Existing Patient? ☐Yes ☐No

Dentist First & Last Name ______________________________

ID# ______________________________

Permanently disabled and age 26 or older[5] ☐Yes ☐No

(1) This question does not apply to dependents under the age of 18. Tobacco means all tobacco products, including, but not limited to, cigarettes, cigars, and chewing tobacco. You should only check the "yes" box above if tobacco was used four or more times per week on average (excluding religious or ceremonial use) within the past 6 months by someone of legal age to purchase tobacco in the state of residence. (2) For UnitedHealthcare Compass, Navigate, Select, Select Plus, and other products requiring you to choose a Primary Care Physician (PCP), you must use the UnitedHealthcare directory of providers to choose a PCP for yourself and each of your covered dependents. (3) Please see employer representative as some dental plans require a Primary Care Dentist (PCD) selection. (4) For court ordered dependent, legal documentation must be attached. If a dependent does not reside with eligible employee, please provide address on a separate sheet. (5) If you answered "Yes" for Disabled and the dependent child is 26 years of age or older, unmarried, chiefly dependent upon subscriber for support and is not able to be self-supporting because of a physically or mentally disabling injury, illness or condition, please attach a medical certification of disability.

Employee Name _____

D. Product Selection

Please check the box for each coverage in which you or your dependents are enrolling.
If your employer offers a choice of plans, indicate which plan you are selecting. Indicate the dollar amount selected for the Life and Accidental Death & Dismemberment (AD&D), Supplemental Life, Short-Term Disability (STD), and Long-Term Disability (LTD) plans. Benefit offerings are dependent upon employer selection.

Person	Medical	Dental	Vision	Basic Life/AD&D	Supp Life/AD&D
Employee	☐ _____	☐ _____	☐	☐ $_____	☐ $_____
Spouse/Domestic Partner	☐	☐	☐	☐ $_____	☐ $_____
Dependent	☐	☐	☐	☐ $_____	☐ $_____

Person	STD	LTD
Employee	☐	☐

Life Insurance Beneficiary Full Name and Address (if applying for Life Insurance with UnitedHealthcare)		Relationship
Primary		
Secondary		

E. Prior Medical Insurance Information

Within the last 12 months, have you, your spouse, or your dependents had any other medical coverage?
☐ NO ☐ YES (if yes, please complete this section.)

Prior medical carrier name _____ Effective date ___ ___ ___ End date ___ ___ ___

Prior coverage type: ☐ Employee ☐ Spouse ☐ Child(ren) ☐ Family

F. Other Medical Coverage Information

This section must be completed. (Attach sheet if necessary.)

On the day this coverage begins, will you, your spouse or any of your dependents be covered under any other medical health plan or policy, including another UnitedHealthcare plan or Medicare? ☐ YES (continue completing this section) ☐ NO (skip the rest of this section)

Name of other carrier _____

Other Group Medical Coverage Information (only list those covered by other plan)	Type (B/S/F)*	Effective Date MM/DD/YY	End Date MM/DD/YY	Name and date of birth of policyholder for other coverage
Employee:				
Spouse Name:				
Dependent Name:				
Dependent Name:				
Dependent Name:				

*B. Enter 'B' when this dependent is covered under both you and your spouse's insurance plan (married)
S. Enter 'S' if you are the parent awarded custody of this dependent and no other individual is required to pay for this dependent's medical expenses.
F. Enter 'F' if this dependent is covered by another individual (not a member of your household) required to pay for this dependent's medical expenses.

Medicare – Employee Information: If enrolled in Medicare, please attach a copy of your Medicare ID card.

☐ Enrolled in Part A: Effective Date _____ ☐ Ineligible for Part A* ☐ Not Enrolled in Part A (chose not to enroll)**
☐ Enrolled in Part B: Effective Date _____ ☐ Ineligible for Part B* ☐ Not Enrolled in Part B (chose not to enroll)**
☐ Enrolled in Part D: Effective Date _____ ☐ Ineligible for Part D* ☐ Not Enrolled in Part D (chose not to enroll)**

Reason for Medicare eligibility: ☐ Over 65 ☐ Kidney Disease ☐ Disabled ☐ Disabled but actively at work

Are you receiving Social Security Disability Insurance (SSDI)? ☐ YES ☐ NO Start Date ___ ___ ___

Medicare – Spouse/Dependent Name: _____

☐ Enrolled in Part A: Effective Date _____ ☐ Ineligible for Part A* ☐ Not Enrolled in Part A (chose not to enroll)**
☐ Enrolled in Part B: Effective Date _____ ☐ Ineligible for Part B* ☐ Not Enrolled in Part B (chose not to enroll)**
☐ Enrolled in Part D: Effective Date _____ ☐ Ineligible for Part D* ☐ Not Enrolled in Part D (chose not to enroll)**

Reason for Medicare eligibility: ☐ Over 65 ☐ Kidney Disease ☐ Disabled ☐ Disabled but actively at work

*Only check "Ineligible" if you have received documentation from your Social Security benefits that indicate that you are not eligible for Medicare.
** If you are eligible for Medicare on a primary basis (Medicare pays before benefits under the group policy), you should enroll in and maintain coverage under Medicare Part A, Part B, and/or Part D as applicable.

G. Signature

Your enrollment in the plan is expressly conditioned upon your acceptance of all terms and conditions contained in this enrollment application. If you do not agree to the following terms and conditions, you may not complete your enrollment.

TERMS AND CONDITIONS

As a condition of my and/or my dependents' participation in the plan, and in consideration for the privileges that come from participation in the plan, I hereby agree for myself and/or for my dependents as follows:

I recognize and understand that the plan contracts with physicians and other providers that make up the plan network. I recognize that all physicians and other providers that participate in the plan network are subject to credentialing under applicable State regulations and pursuant to the plan's network credentialing process. I understand that such credentialing includes a review of provider education, training and licensure. However, by participating in the plan I hereby acknowledge and accept that the plan is not a provider of medical services, and I am aware that obtaining or not obtaining medical care involves significant risks such as serious injury and even death. I acknowledge that the credentialing of physicians and other providers does not in any way reduce this risk. I agree to assume all risks and responsibility for, and hold the plan harmless from, any and all claims for damages, including personal injury or death, medical expenses, disability, lost wages, and loss of earning capacity which may be incurred or associated with medical treatment obtained through a participating physician or other provider. I recognize that all physicians and other providers that participate in the plan network are independent contractors and not the plan's employees or agents and are solely responsible for any malpractice, adverse outcomes, or any other claims arising from medical treatment rendered to me and my dependents. I HEREBY AGREE THAT THE PLAN IS NOT RESPONSIBLE NOR LIABLE FOR ANY ADVICE, COURSE OF TREATMENT, DIAGNOSIS OR ANY OTHER INFORMATION, SERVICES OR PRODUCTS THAT I OR MY DEPENDENTS OBTAIN THROUGH A PARTICIPATING NETWORK PHYSICIAN OR OTHER PROVIDER.

I recognize and understand that the plan does not recommend, endorse or make any representation about the appropriateness or suitability of any specific tests, products, procedures, treatments, services, or opinions. I recognize that the plan, plan documents, and any health and wellness information provided by the plan, are not intended or implied to be a substitute for professional medical advice, diagnosis or treatment. I agree to confirm any medical information obtained from or through the plan with other sources, and will review all information regarding any medical condition or treatment with my physician. I HEREBY AGREE TO NEVER DISREGARD PROFESSIONAL MEDICAL ADVICE OR DELAY SEEKING MEDICAL TREATMENT BECAUSE OF SOMETHING I HAVE READ OR ACCESSED THROUGH THE PLAN.

I authorize UnitedHealthcare Insurance Company and its affiliates (collectively, "UnitedHealthcare") to obtain, use and disclose my medical, claim or benefit records, including any individually identifiable health information contained in these records. I understand these records may contain information created by other persons or entities (including health care providers) as well as information regarding the use of drug, alcohol, Human Immunodeficiency Virus (HIV), Acquired Immune Deficiency Syndrome (AIDS), mental health (other than psychotherapy notes), sexually transmitted disease and reproductive health services. I authorize any health care provider, pharmacy benefit manager, other insurer or reinsurer, hospital, clinic or other medical facility, health care clearinghouse, and any of their affiliates, representatives or business associates, to disclose my information to UnitedHealthcare and Affiliates. I understand that the purpose of the disclosure and use of my information is to allow UnitedHealthcare to facilitate the appropriate management of treatment, services, payment and benefits. I further understand that the information disclosed will not be used for purposes of eligibility, enrollment, underwriting and premium risk rating. I understand this authorization is voluntary and I may refuse to sign the authorization. I understand I may revoke this authorization at any time by notifying my UnitedHealthcare representative in writing, except to the extent that action has already been taken in reliance on this authorization. As required by HIPAA, UnitedHealthcare also requires that I acknowledge the following, which I do: I understand that information I authorize a person or entity to obtain and use may be re-disclosed and no longer protected by federal privacy regulations. This authorization, unless revoked earlier, expires 30 months after the date it is signed except in connection with a claim, the authorization shall be valid for the term of the coverage. As provided under North Carolina law, you have the right to ask for and to receive a copy of the authorization form.

I understand that I am completing a joint life and health application and that each response must be complete and accurate. I (we) request the indicated group medical coverage. I authorize any required premium contributions to be deducted from my earnings. I (we) have not given the agent or any other persons any required information not included on the application. I (we) understand that UnitedHealthcare is not bound by any statements I (we) have made to any agent or to any other persons, if those statements are not written or printed on this application and any attachments.

Please note that if you leave out information or make a misrepresentation on this form we may be allowed by law to take one or more of the following actions: terminate or non-renew your coverage or change your premium retroactively to the date your policy became effective.

Please maintain a copy of this authorization for your records.

Date	Employee Signature for all applying	Spouse Signature (if applying for coverage)

H. Census Information (optional)

NOTE: Responding to this question is optional and is not required. Data collected in this section will be used only to help communicate with enrollees and inform them of specific programs to enhance their well-being. This information will not be used in the eligibility process.

1. Race, check all that apply: ☐ White ☐ Black, African-American ☐ American Indian/Alaska Native ☐ Asian ☐ Native Hawaiian/Pacific Islander ☐ Other Race, please specify_____

2. Are you of Hispanic or Latino origin? ☐ Yes ☐ No

Small Group Employee and Individual Application and Enrollment Form - 1-100 Employees **NORTH CAROLINA**

The offering company(ies) listed below, severally or collectively, as the content may require, are referred to in the Small Group Employee and Individual Application and Enrollment Form as "Humana". To elect primary dentist, please complete reorder NC-51340-PP.

Life and Vision plans insured or administered by Humana Insurance Company. Dental plans insured or administered by HumanaDental Insurance Company or Humana Insurance Company. Short Term Disability, Long Term Disability and Workplace Voluntary Benefits Plans insured or administered by Kanawha Insurance Company.

Please print clearly and fill in each applicable circle. Proposed effective date: __/__/____

Employer / Group name	Employer / Group city	State
White Plains Children's Center	Cary	NC

Qualifying Event Instructions Date of Qualifying Event: __/__/____

❍ New business enrollment ❍ Open Enrollment event ❍ Dependent birth or adoption ❍ Loss of coverage
❍ New hire / Newly eligible ❍ Rehire / Reinstatement ❍ Marital status change ❍ Other_____

Enrollment information

Relationship	Last name, First name MI	Gender	Date of birth	Disabled? If yes, indicate reason below.		Social Security Number
Employee / Individual		❍ F ❍ M	__/__/____	❍ Y ❍ N		N/A (complete in Employee/ Individual Information section.)
Spouse / Domestic Partner		❍ F ❍ M	__/__/____	❍ Y ❍ N		
Child / Dependent		❍ F ❍ M	__/__/____	❍ Y ❍ N		
Child / Dependent		❍ F ❍ M	__/__/____	❍ Y ❍ N		
Child / Dependent		❍ F ❍ M	__/__/____	❍ Y ❍ N		
Other (specify):		❍ F ❍ M	__/__/____	❍ Y ❍ N		

Employee / Individual Information

Hours worked per week:	Date of full time hire: __/__/____		
Social Security Number	Street address		APT / Suite / Box
City	State	ZIP code	Phone # ( )
Language: ❍ English ❍ Spanish ❍ Other	E-mail address	Occupation	
Are you actively at work? ❍ Y ❍ N If not, reason: ❍ Retiree ❍ COBRA Other: _____		Annual salary $	

Prior / Existing Coverage: **IMPORTANT - DO NOT** cancel any existing coverage until you receive written notification from Humana of your acceptance for coverage.

Dental

1. Prior dental coverage during the past 12 months (individual or other group coverage)? ❍ N ❍ Y
2. Prior orthodontia coverage in the past 12 months? ❍ N ❍ Y

Prior dental insurance carrier name	Policy #	Prior coverage type:
	Effective date __/__/____	❍ Employee / Individual only ❍ Employee / Individual and spouse ❍ Employee / Individual and child(ren) ❍ Family
Prior carrier phone # ( )	Term date __/__/____	

Last name: | First name:

Coverage Options

Dental | **Group #:** | **Benefit #:** | **Class/Div:**

Coverage type:
❍ Employee / Individual only — Rate Amount $_____ Rate Frequency (Monthly)
❍ Employee / Individual and spouse — Rate Amount $_____ Rate Frequency (Monthly)
❍ Employee / Individual and child(ren) — Rate Amount $_____ Rate Frequency (Monthly)
❍ Family — Rate Amount $_____ Rate Frequency (Monthly)
❍ No Coverage (complete waiver)

Plan name:

Basic Life AD&D | **Group #:** | **Benefit #:** | **Class/Div:**

Basic dependent life ❍ N ❍ Y (If no, complete waiver.) | Class (employer will provide you with this information, if needed)

Voluntary Life AD&D | **Group #:** | **Benefit #:** | **Class/Div:**

Voluntary employees / individual life coverage ❍ N ❍ Y | Amount (min $15,000) $

Voluntary spouse life coverage? ❍ N ❍ Y | Amount (min $5,000) $ | Voluntary child(ren) life coverage? ❍ N ❍ Y

Vision | **Group #:** | **Benefit #:** | **Class/Div:**

Coverage type:
❍ Employee / Individual only — Rate Amount $_____ Rate Frequency (Monthly)
❍ Employee / Individual and spouse — Rate Amount $_____ Rate Frequency (Monthly)
❍ Employee / Individual and child(ren) — Rate Amount $_____ Rate Frequency (Monthly)
❍ Family — Rate Amount $_____ Rate Frequency (Monthly)
❍ No Coverage (complete waiver)

Plan name:

Short Term Disability | **Group #:** | **Benefit #:** | **Class:** | **Div:**

Short Term Disability ❍ N ❍ Y (If no, complete waiver.) Buy-up percent/amount _____

Long Term Disability | **Group #:** | **Benefit #:** | **Class:** | **Div:**

Long Term Disability ❍ N ❍ Y (If no, complete waiver.) Buy-up percent/amount _____

Workplace Voluntary Benefits: Optional riders availability based on employer / group election.

Accident | **Group #:** | **Benefit #:** | **Class:** | **Div:**

❍ Accident ❍ N ❍ Y Benefit Level: ❍ 1 ❍ 2 ❍ 3 ❍ 4

Coverage type: ❍ Employee / Individual only ❍ Employee / Individual and spouse ❍ Employee / Individual and child(ren) ❍ Family

❍ Optional Hospital Intensive Care Unit Benefits Rider ❍ $150 ❍ $300 ❍ $450 ❍ $600

❍ Optional Fracture and Dislocation Benefits Rider ❍ $750 ❍ $1,500

❍ Optional Accident Total Disability Benefits Rider: Elimination Period: ❍ 1 Day ❍ 7 Days ❍ 14 Days ❍ 30 Days
Monthly Benefit: ❍ $400 ❍ $500 ❍ $600 ❍ $700 ❍ $800 ❍ $900 ❍ $1000

Accident - 2012 | **Group #:** | **Benefit #:** | **Class:** | **Div:**

❍ Accident ❍ N ❍ Y Benefit Level: ❍ 1 ❍ 2 ❍ 3 ❍ 4

Coverage type: ❍ Employee / Individual only ❍ Employee / Individual and spouse ❍ Employee / Individual and child(ren) ❍ Family

Disability Income Plus | **Group #:** | **Benefit #:** | **Class:** | **Div:**

❍ Disability Income Covering Accident and Sickness ❍ N ❍ Y
Base Benefit Period: ❍ 3 Month ❍ 6 Month ❍ 1 Year ❍ 2 Year ❍ 3 Year
Base Elimination Period: ❍ 0/7 ❍ 7/7 ❍ 0/14 ❍ 14/14 ❍ 30/30 ❍ 60/60 ❍ 90/90 ❍ 180/180 ❍ 365/365

Monthly Benefit $

❍ Disability Income Covering Accident and Sickness with Waiver of Elimination Period ❍ N ❍ Y
Base Benefit Period: ❍ 3 Month ❍ 6 Month ❍ 1 Year ❍ 2 Year ❍ 3 Year
Base Elimination Period: ❍ 0/7 ❍ 7/7 ❍ 0/14 ❍ 14/14

Optional Disability Income Benefits: ❍ ICU / CCU Benefit ❍ $200 ❍ $400 ❍ $600 ❍ $800
❍ Physical Therapy Benefit ❍ COBRA Rider | COBRA Monthly Benefit $

Last name: | First name:

Disability Income Advantage **Group #:** **Benefit #:** **Class:** **Div:**

❍ Disability Income Advantage ❍ N ❍ Y
Base Benefit Period: ❍ 3 Month ❍ 6 Month ❍ 1 Year ❍ 2 Year ❍ 3 Year
Base Elimination Period: ❍ 0/7 ❍ 7/7 ❍ 0/14 ❍ 14/14 ❍ 30/30 ❍ 60/60 ❍ 90/90 ❍ 180/180 ❍ 365/365
Monthly Benefit $

Optional Riders: ❍ Hospital Confinement ❍ COBRA Rider | COBRA Monthly Benefit $

Whole Life /AD&D **Group #:** **Benefit #:** **Class:** **Div:**

❍ Whole Life / AD&D ❍ N ❍ Y | ❍ Whole Life 99 | ❍ Whole Life 65 | Employee / Individual Benefit $

❍ AD&D Rider ❍ Automatic Premium Loan Option

❍ Automatic Benefit Increase Rider ❍ $1 / Week ❍ $2 / Week | ❍ Employee / Individual Term Rider to 65 Employee / Individual Benefit $ | ❍ Family Term Rider Spouse Benefit $ Child(ren) Benefit $

Whole Life Spouse /AD&D **Group #:** **Benefit #:** **Class:** **Div:**

❍ Stand Alone Spouse / AD&D ❍ N ❍ Y | ❍ Whole Life 99 | ❍ Whole Life 65 | Spouse Benefit $

❍ AD&D Rider | ❍ Family Term Rider (Child Coverage Only) Child(ren) Benefit Amount $ | ❍ Automatic Premium Loan Option

Whole Life Children /AD&D **Group #:** **Benefit #:** **Class:** **Div:**

❍ Whole Life Child(ren) / AD&D ❍ N ❍ Y

Child(ren) listed here must also be included as dependents under the Enrollment Information section of this application.

❍ N ❍ Y Coverage on Child 1	Child 1 name	Child 1 Benefit $
❍ N ❍ Y Coverage on Child 2	Child 2 name	Child 2 Benefit $
❍ N ❍ Y Coverage on Child 3	Child 3 name	Child 3 Benefit $

Level Term Life **Group #:** **Benefit #:** **Class:** **Div:**

❍ Level Term Life / AD&D ❍ N ❍ Y | Coverage type: ❍ Employee / Individual only ❍ Spouse ❍ Child(ren) | Base Plan: ❍ 10-Year Term ❍ 20-Year Term Optional Benefit: ❍ Automatic Benefit Increase

Employee / Individual Benefit $ | Spouse Benefit $ | Child(ren) Benefit $

If your employer or group has elected the critical illness rider, have you or any dependent had a parent, brother, or sister with a history of heart attack, heart disease, stroke, or cancer diagnosis prior to age 60 ? ❍ N ❍ Y If yes, please indicate whether this applies to you (Employee / Individual), your spouse or a dependent.
❍ You (Employee / Individual) ❍ Spouse ❍ Dependent Name_____

Critical Illness **Group #:** **Benefit #:** **Class:** **Div:**

❍ Critical Illness ❍ N ❍ Y
❍ Critical Illness and Cancer ❍ N ❍ Y | Coverage type: ❍ Employee / Individual only ❍ Employee / Individual and spouse ❍ Employee / Individual and child(ren) ❍ Family

Optional Benefits: ❍ Automatic Benefit Increase ❍ Health Screening | Employee / Individual Benefit $

Does anyone on this application have a parent, brother, or sister with a history of heart attack, heart disease, stroke, or cancer diagnosis prior to age 60? ❍ N ❍ Y If yes, please indicate whether this applies to you (Employee / Individual), your spouse or a dependent. ❍ You (Employee / Individual) ❍ Spouse ❍ Dependent Name_____

Group Lump Sum Cancer **Group #:** **Benefit #:** **Class:** **Div:**

❍ Group Lump Sum Cancer ❍ N ❍ Y | Coverage type: ❍ Employee / Individual only ❍ Employee / Individual and spouse ❍ Employee / Individual and child(ren) ❍ Family

Does anyone on this application have a parent, brother, or sister with a history of cancer diagnosis prior to age 60 ? ❍ N ❍ Y
If yes, please indicate whether this applies to you (Employee / Individual), your spouse or a dependent.
❍ You (Employee / Individual) ❍ Spouse ❍ Dependent Name_____

Rider: ❍ Automatic Benefit Increase ❍ Health Screenings Base Benefit $

Cancer Expense **Group #:** **Benefit #:** **Class:** **Div:**

❍ Cancer Expense ❍ N ❍ Y | Coverage type: ❍ Employee / Individual only ❍ Employee / Individual and spouse ❍ Employee / Individual and child(ren) ❍ Family

❍ Lump Sum Benefit (Equal to 50% of Base Benefit Amount) | Rider: ❍ Hospital Indemnity Rider | Base Benefit $

Supplemental Health **Group #:** **Benefit #:** **Class:** **Div:**

❍ Supplemental Health ❍ N ❍ Y | Coverage type: ❍ Employee / Individual only ❍ Employee / Individual and spouse ❍ Employee / Individual and child(ren) ❍ Family

Last name:	First name:

Hospital Indemnity **Group #:**	**Benefit #:**	**Class:**	**Div:**

❍ Hospital Indemnity ❍ N ❍ Y	Coverage type: ❍ Employee / Individual only ❍ Employee / Individual and spouse ❍ Employee / Individual and child(ren) ❍ Family

Plan type: ❍ 1 ❍ 2 ❍ 3 ❍ 4

If your employer or group has elected the critical illness benefit, does anyone on this application have a parent, brother, or sister with a history of heart attack, heart disease, stroke, or cancer diagnosis prior to age 60? ❍ N ❍ Y If yes, please indicate whether this applies to you (Employee / Individual), your spouse or a dependent.
❍ You (Employee / Individual) ❍ Spouse ❍ Dependent Name_____

Beneficiary Information for Life, Disability and Workplace Voluntary Benefits

Primary beneficiary name (Last, First MI)	Relationship to Employee / Individual
Secondary beneficiary name (Last, First MI)	Relationship to Employee / Individual

Evidence of Health Status - Do not submit more than 90 days prior to the effective date.

Complete this section if you are selecting workplace voluntary (excludes Accident) benefits and/or Life over the guarantee issue amount.

1.	Is anyone on this application currently taking any prescribed medication, or do you periodically take medication for a recurrent condition?	❍ N ❍ Y
2a.	In the past 6 months has any applicant (over 18) used any tobacco product on average four or more times per week? This includes all tobacco products, except that tobacco use does not include religious or ceremonial use of tobacco. If yes, applies to: ❍ Employee ❍ Spouse/Domestic Partner ❍ Other ❍ Child (over 18)/Dependent	❍ N ❍ Y
2b.	Is any applicant (over 18) currently a smoker? If yes, applies to: ❍ Employee ❍ Spouse/Domestic Partner ❍ Other ❍ Child (over 18)/Dependent	❍ N ❍ Y
3.	In the past 12 months, have you missed 5 or more consecutive days of work due to an injury or illness other than as a result of a cold, the flu, back problems, strained/sprained/fractured/broken limb or as a result of pregnancy?	❍ N ❍ Y
4.	Has anyone on this application been diagnosed or received treatment for an immune system disorder (i.e. Lupus, ITP), AIDS or an AIDS-related complex? NOTE: AIDS (Acquired Immune Deficiency Syndrome) is a disease in which the body's immune system breaks down. AIDS is caused by the HIV (Human Immunodeficiency Virus) which enters the body and attacks the immune system. The progressive destruction of the immune system leaves the body susceptible to life-threatening infections, malignancies and ARC. ARC (AIDS Related Complex) is a condition with signs and symptoms which may include generalized lymphadenopathy, loss of appetite, weight loss, fever, oral thrush, skin rashes, unexplained infections, dementia, depression or other psycho neurotic disorders with no known cause.	❍ N ❍ Y
5.	Within the past 5 years, has anyone on this application been diagnosed with diseases or disorders related to, counseled, consulted, or treated by a doctor, including surgery, for any of the following:	

a.	Coronary artery disease, chest pain, heart surgery, or any disease of the arteries, or blood disorders; anemia; hemophilia; phlebitis; high blood pressure (reading higher than 140/90)?	❍ N ❍ Y
b.	Nervous, mental or emotional disorder; convulsions; epilepsy; unconsciousness; Multiple Sclerosis; Parkinson's Disease; Cerebral Palsy?	❍ N ❍ Y
c.	Stroke; Transient Ischemic Attack (TIA)?	❍ N ❍ Y
d.	Emphysema; asthma, or other disease of lungs, or respiratory organs?	❍ N ❍ Y
e.	End stage renal disease; disease of kidney?	❍ N ❍ Y
f.	Kidney stones; bladder?	❍ N ❍ Y
g.	Male or female organs; or infertility?	❍ N ❍ Y
h.	Cancer, and/or cancerous tumor; including skin cancer?	❍ N ❍ Y

i.	Diabetes; liver or thyroid disease; hepatitis; cirrhosis; or enlargement of the lymph nodes?	❍ N ❍ Y
j.	Stomach, gall bladder, digestive, intestinal, or colon disorders?	❍ N ❍ Y
k.	Rheumatoid arthritis; or back disorders; or joint disorders?	❍ N ❍ Y
l.	Paralysis, or any other physical impairment or deformity?	❍ N ❍ Y
m.	Chronic Fatigue Syndrome/Fibromyalgia?	❍ N ❍ Y
n.	Diseases of the eye, ear, nose, or throat? Disease or disorder which has led or may lead to a permanent or progressive loss of vision, hearing or speech?	❍ N ❍ Y
o.	Alcoholism or drug habit?	❍ N ❍ Y

Last name:	First name:

6.	Has anyone on this application been advised by a member of the medical profession to have any diagnostic test, hospitalization, or surgery that has not been completed within the past 5 years?	❍ N ❍ Y
7.	Within the past 5 years, has anyone on this application seen a health care provider or specialist for a routine physical/wellness exam, or been seen for any reason not previously disclosed?	❍ N ❍ Y
8.	Is anyone on this application currently pregnant? If yes, please indicate anticipated delivery date below. Anticipated delivery date:_____	❍ N ❍ Y
9.	**Hospital Indemnity only:** Can you perform your activities of daily living (ADL's) without need of assistance? ADL's include: Bathing, Transferring, Feeding, Dressing and Bowl/Bladder/Toileting.	❍ N ❍ Y

Relationship	Last name, First name MI	Height (ft / in)	Weight (lbs)
Employee		/	
Spouse / Domestic Partner		/	
Child / Dependent		/	
Child / Dependent		/	
Child / Dependent		/	
Other (specify):		/	

If you answered "yes" to any of the questions above, please provide details below and specify the question number. Attach additional signed and dated sheets (reorder NC-51340-MH), if necessary.

Question #	Person treated (Last name, First name)
Condition	Treatments received
Medications prescribed	Current or future treatments or medications
Date diagnosed _ _ / _ _ / _ _ _ _	Date last seen by a doctor _ _ / _ _ / _ _ _ _

Waiver (refusal of coverage)

I acknowledge that I have been given the opportunity to apply for group coverage available to me and my dependents through my employer / group. I proclaim that I was not pressured or forced by my employer / group, the writing agent, or Humana into waiving (declining) coverage. If I have waived any coverage offered to me or my dependents, my signature is evidence of this action.

I hereby waive coverage for (check all that apply):

Dental for:	❍ Myself	❍ My spouse	❍ My dependent child(ren)
Basic Life for:	❍ Myself	❍ My spouse	❍ My dependent child(ren)
Vision for:	❍ Myself	❍ My spouse	❍ My dependent child(ren)
Short Term Disability for:	❍ Myself		
Long Term Disability for:	❍ Myself		

Waive Coverage for Workplace Voluntary Benefits:

Whole Life for:	❍ Myself	❍ My spouse	❍ My dependent child(ren)
Level Term Life for:	❍ Myself	❍ My spouse	❍ My dependent child(ren)
Critical Illness for:	❍ Myself	❍ My spouse	❍ My dependent child(ren)
Group Lump Sum Cancer for:	❍ Myself	❍ My spouse	❍ My dependent child(ren)
Cancer Expense for:	❍ Myself	❍ My spouse	❍ My dependent child(ren)
Supplemental Health for:	❍ Myself	❍ My spouse	❍ My dependent child(ren)
Accident for:	❍ Myself	❍ My spouse	❍ My dependent child(ren)
Hospital Indemnity for:	❍ Myself	❍ My spouse	❍ My dependent child(ren)
Disability Income Plus for:	❍ Myself		
Disability Income Advantage for:	❍ Myself		

I decline to apply for group coverage because of:

- ❍ Spousal coverage
- ❍ Medicare supplement
- ❍ Individual coverage
- ❍ Coverage under another carrier's plan provided by my employer / group
- ❍ Other:_____

Notice

Disclosures to provide you with offers of services

Humana Insurance Company or HumanaDental Insurance Company may disclose your non-public personal information to affiliated companies in order to provide you with offers for products and services you may find of value which are not products offered by Humana Insurance Company or HumanaDental Insurance Company. You may opt out of these disclosures and from receiving products and services that result from these disclosures by following the opt out procedures described below.

Your "opt out" choice

At any time you may instruct Humana Insurance Company or HumanaDental Insurance Company not to share any of your non-public personal information with affiliated companies that will provide you offers of non-Humana products or services described in the above section entitles "Disclosure to provide you with offers of services." An opt out request will apply to all members or insured covered under a single identification number or account number and will continue to apply until you revoke your request.

If you wish to exercise your choice to opt out of these disclosures or to revoke a previous opt out request, you may use one of the following methods to notify us:

- You may telephone us at 1-866-861-2762. You will be asked to provide information including your name, date of birth, and member number. This information is necessary to process your request.
- You may send us your request in writing. You must include your date of birth and your member identification number, which you will find on your member ID card.
- You may mail the completed opt out request to us at Humana Privacy Office, P.O. Box 1438, Louisville, KY 40202.
- You may email your request to us at privacyoffice@humana.com.

Once your request has been processed, it will remain in effect until you request a change.

Agreement

True and complete acknowledgment

I understand, agree, and represent:

- I have read the Small Group Employee and Individual Application and Enrollment Form or it has been read to me and answers provided are true and complete to the best of my knowledge and belief.
- Neither my employer / group nor the agent can waive any question, determine coverage or insurability, alter any contract or waive any of Humana's other rights and requirements.
- If the Small Group Employee and Individual Application and Enrollment Form for coverage is accepted, coverage will be effective on the date specified by Humana on the policy or certificate.
- If I have a new dependent as a result of a qualifying event, I may in the future be able to enroll myself or my dependents provided I request enrollment within 31 days after the qualifying event.
- If I or my dependents become eligible for premium or rate subsidies under Medicaid or the Children's Health Insurance Program (CHIP), I may in the future be able to enroll myself or my dependents provided I request enrollment within 60 days after the qualifying event.
- In the event that I should decide to apply for coverage hereafter, that subsequent Small Group Employee and Individual Application and Enrollment Form shall be subject to the applicable terms and conditions of the master group contract(s), policy provisions or certificate provisions which may require additional limitations and waiting periods.
- Based on the coverage I have elected, I may be required to furnish evidence of health status satisfactory to Humana.
- If I am declining coverage for myself or my dependents (including my spouse) because of coverage under Medicaid or CHIP, I may in the future be able to enroll myself or my dependents provided that I request enrollment within 60 days after my coverage under these programs ends.
- If I am declining coverage for myself or my dependents (including my spouse) because of other coverage, I may in the future be able to enroll myself or my dependents provided that I request enrollment within 31 days after my other coverage ends.
- Humana reserves the right to delay coverage and/or deny life or dental coverage with any future submissions of the Small Group Employee and Individual Application and Enrollment Form for coverage.
- If any deductions are required for this coverage, I authorize those deductions from my earnings.
- If I am applying for coverage for my dependents (including my spouse) I attest by my signature below, I have gathered the necessary health information from my dependents in order to fully and truthfully complete the Small Group Employee and Individual Application and Enrollment Form.
- If I have selected workplace voluntary benefits, and if coverage is not issued as initially applied for, I hereby authorize Humana to decrease or increase the premium or rate amount stated on the Small Group Employee and Individual Application and Enrollment Form to cover the benefit actually issued.
- An act of fraud or an intentional misrepresentation of a material fact may void or terminate an individual's or group's coverage as specified under the terms of the Policy or Certificate. Providing incomplete, inaccurate, or untimely information may reduce an individual's or group's coverage or may increase past premium.
- Rates or premium quoted and the effective date requested are not guaranteed. The final rate or premium and effective date will be determined upon underwriting review and approval of the Small Group Employee and Individual Application and Enrollment Form by Humana.
- Any person who knowingly presents false information in an application for insurance or viatical settlement contract or a viatical settlement purchase agreement may be guilty of a felony and may be subject to fines and confinement in prison.

If you decide not to sign this agreement, we will decline to enroll you in an insurance product or to give you insurance benefits.

Authorization

My dependents and I understand and agree:

- The information obtained by use of this authorization may be used by Humana to make claims determinations, determine eligibility for coverage, eligibility for benefits under an existing policy and plan administration.
- Any information obtained will not be released by Humana to any person or organization except to reinsuring companies, the Medical Information Bureau, Inc. or other persons or organizations performing health care operations or business or legal services in connection with the Group Employee and Individual Application and Enrollment Form, claim or as may be otherwise lawfully required, or as I (we) may further authorize.

Last name:	First name:

Authorization for Release of Medical Records

If my dependents or I have selected life or disability, I authorize any third party to have information regarding myself. This includes any medical or non-medical information and to share any and all such information with Humana, its reinsurer or its legal representatives, and its affiliates. Once personal and health (including medical, dental, and pharmacy) information is disclosed pursuant to this authorization, the recipient may redisclose it and the information may not be protected by federal and state privacy requirements.

This authorization shall be valid for two years from the date I sign the application and I have the right to revoke this authorization at any time by writing to Humana's Privacy Office. I have also been advised that myself or a person authorized to act on my behalf may request a copy of the authorization form.

The Small Group Employee and Individual Application and Enrollment Form, together with any supplemental forms, will make up part of any contract and be the basis for any policy or certificate.

Signature - please sign below if enrolling or waiving group coverage.

If you decide not to sign this authorization, Humana cannot complete your plan enrollment or determine your premium rate due to the inability to obtain the necessary information.

Employee / Individual or legal representative signature: _____ Date: _____

Name and relationship of legal representative: _____

Spouse signature: _____ Date:_____
(Only if selecting Life coverage over the guarantee issue amount.)

Agent / Producer Information

If applying for workplace voluntary benefits, this section to be completed by Agent or Producer.

1. Agent / Agency of Record:	**2. Agent / Agency of Record:**
Name (print)	Name (print)
Humana Agent #	Humana Agent #
Commission split:	Commission split:
1. Writing Agent / Producer:	**2. Writing Agent / Producer:**
Name (print)	Name (print)
Humana Agent #	Humana Agent #
Commission split:	Commission split:

Will the coverage selected replace or change any existing life or disability insurance policy(s) and/or annuity(s)? ❍ N ❍ Y

As the Writing Agent / Producer, I acknowledge that I am responsible to meet with the primary applicant submitting the Small Group Employee and Individual Application and Enrollment Form in order to fully and accurately represent the terms and conditions of the plans and services of the offering or insuring entity, or one of its subsidiaries. These provisions are available to me and the primary applicant in the benefit summary document or other plan literature.

Signed at _____ _____
County State

Writing Agent's Signature _____ Date __ __/__ __/__ __ __ __

The original version of this Agreement is in the English language. If there are any discrepancies or conflicts between the English and any other version that has been translated into another language, the English version will control.

Benefits Notices

White Plains Children's Center

313 Maynard Rd
Cary, North Carolina 27511
(919) 469-2217
http://www.whiteplainschildrenscenter.org/

Created on: 11/03/2021

TABLE OF CONTENTS

Health Insurance Exchange Notice

For Employers Who Offer a Health Plan to Some or All Employees

New Health Insurance Marketplace Coverage Options and Your Health Coverage

PART A: General Information

When key parts of the health care law take effect in 2014, there will be a new way to buy health insurance: The Health Insurance Marketplace. To assist you as you evaluate options for you and your family, this notice provides some basic information about the new Marketplace and employment-based health coverage offered by your employer.

What is the Health Insurance Marketplace?

The Marketplace is designed to help you find health insurance that meets your needs and fits your budget. The Marketplace offers "one-stop shopping" to find and compare private health insurance options. You may also be eligible for a new kind of tax credit that lowers your monthly premium right away. Open enrollment for health insurance coverage through the Marketplace begins in October 2013 for coverage starting as early as January 1, 2014.

Can I Save Money on my Health Insurance Premiums in the Marketplace?

You may qualify to save money and lower your monthly premium, but only if your employer does not offer coverage, or offers coverage that doesn't meet certain standards. The savings on your premium that you're eligible for depends on your household income.

Does Employer Health Coverage Affect Eligibility for Premium Savings through the Marketplace?

Yes. If you have an offer of health coverage from your employer that meets certain standards, you will not be eligible for a tax credit through the Marketplace and may wish to enroll in your employer's health plan. However, you may be eligible for a tax credit that lowers your monthly premium, or a reduction in certain cost-sharing if your employer does not offer coverage to you at all or does not offer coverage that meets certain standards. If the cost of a plan from your employer that would cover you (and not any other members of your family) is more than 9.5% of your household income for the year, or if the coverage your employer provides does not meet the "minimum value" standard set by the Affordable Care Act, you may be eligible for a tax credit.[1]

Note: If you purchase a health plan through the Marketplace instead of accepting health coverage offered by your employer, then you may lose the employer contribution (if any) to the employer-offered coverage. Also, this employer contribution -as well as your employee contribution to employer-offered coverage- is often excluded from income for Federal and State income tax purposes. Your payments for coverage through the Marketplace are made on an after-tax basis.

How Can I Get More Information?

For more information about your coverage offered by your employer, please check your summary plan description or contact:

[1] An employer-sponsored health plan meets the "minimum value standard" if the plan's share of the total allowed benefit costs covered by the plan is no less than 60 percent of such costs.

Kellie Haight
313 Maynard Rd
Cary, North Carolina 27511
(919) 469-2217
haightk@gmail.com

The Marketplace can help you evaluate your coverage options, including your eligibility for coverage through the Marketplace and its cost. Please visit HealthCare.gov for more information, including an online application for health insurance coverage and contact information for a Health Insurance Marketplace in your area.

PART B: Information About Health Coverage Offered by Your Employer

This section contains information about any health coverage offered by your employer. If you decide to complete an application for coverage in the Marketplace, you will be asked to provide this information. This information is numbered to correspond to the Marketplace application.

3. Employer name White Plains Children's Center	4. Employer Identification Number (EIN) 58-1792551	
5. Employer address 313 Maynard Rd	6. Employer phone number (919) 469-2217	
7. City Cary	8. State North Carolina	9. ZIP code 27511
10. Who can we contact about employee health coverage at this job? Kellie Haight		
11. Phone number (919) 469-2217	12. Email address haightk@gmail.com	

Here is some basic information about health coverage offered by this employer:

- As your employer, we offer a health plan to:
  ☑ Some employees. Eligible employees are:
  Full Time Employees working 30+ hours per week.
- With respect to dependents:

  ☑ We do offer coverage. Eligible dependents are: Spouses and Children under the age of 26.

☑ If checked, this coverage meets the minimum value standard, and the cost of this coverage to you is intended to be affordable, based on employee wages.

Note: Even if your employer intends your coverage to be affordable, you may still be eligible for a premium discount through the Marketplace. The Marketplace will use your household income, along with other factors, to determine whether you may be eligible for a premium discount. If, for example, your wages vary from week to week (perhaps you are an hourly employee or you work on a commission basis), if you are newly employed mid-year, or if you have other income losses, you may still qualify for a premium discount.

Notice of Special Enrollment Rights

If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance or group health plan coverage, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing toward your or your dependents' other coverage). However, you must request enrollment within 30 days after your or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage).

If you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents. However, you must request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption.

If you or your dependent(s) lose coverage under a state Children's Health Insurance Program (CHIP) or Medicaid, you may be able to enroll yourself and your dependents. However, you must request enrollment within 60 days after the loss of CHIP or Medicaid coverage.

If you or your dependent(s) become eligible to receive premium assistance under a state CHIP or Medicaid, you may be able to enroll yourself and your dependents. However, you must request enrollment within 60 days of the determination of eligibility for premium assistance from state CHIP or Medicaid.

To request special enrollment or obtain more information, contact Kellie Haight at 313 Maynard Rd, Cary, North Carolina 27511, (919) 469-2217, haightk@gmail.com.

Women's Health and Cancer Rights Act (WHCRA) Notices

Enrollment Notice

If you have had or are going to have a mastectomy, you may be entitled to certain benefits under the Women's Health and Cancer Rights Act of 1998 (WHCRA). For individuals receiving mastectomy-related benefits, coverage will be provided in a manner determined in consultation with the attending physician and the patient, for:

- All stages of reconstruction of the breast on which the mastectomy was performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance;
- Prostheses; and
- Treatment of physical complications of the mastectomy, including lymphedema.

These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under this plan. Therefore, the following deductibles and coinsurance apply: $2500/5000 deductible (in-network) and 80% coinsurance (in-network) and $5000/10000 deductible (out-of-network) and 50% coinsurance (out-of-network). If you would like more information on WHCRA benefits, call your plan administrator at (919) 469-2217.

Annual Notice

Do you know that your plan, as required by the Women's Health and Cancer Rights Act of 1998, provides benefits for mastectomy-related services including all stages of reconstruction and surgery to achieve symmetry between the breasts, prostheses, and complications resulting from a mastectomy, including lymphedema? Call your plan administrator at (919) 469-2217 for more information.

Mental Health Parity and Addiction Equity Act (MHPAEA) Disclosure

The Mental Health Parity and Addiction Equity Act of 2008 generally requires group health plans and health insurance issuers to ensure that financial requirements (such as co-pays and deductibles) and treatment limitations (such as annual visit limits) applicable to mental health or substance use disorder benefits are no more restrictive than the predominant requirements or limitations applied to substantially all medical/surgical benefits. For information regarding the criteria for medical necessity determinations made under the White Plains Children's Center Welfare Benefit Plan with respect to mental health or substance use disorder benefits, please contact your plan administrator at (919) 469-2217.

Premium Assistance Under Medicaid and the Children's Health Insurance Program (CHIP)

If you or your children are eligible for Medicaid or CHIP and you're eligible for health coverage from your employer, your state may have a premium assistance program that can help pay for coverage, using funds from their Medicaid or CHIP programs. If you or your children aren't eligible for Medicaid or CHIP, you won't be eligible for these premium assistance programs but you may be able to buy individual insurance coverage through the Health Insurance Marketplace. For more information, visit **www.healthcare.gov**.

If you or your dependents are already enrolled in Medicaid or CHIP and you live in a State listed below, contact your State Medicaid or CHIP office to find out if premium assistance is available.

If you or your dependents are NOT currently enrolled in Medicaid or CHIP, and you think you or any of your dependents might be eligible for either of these programs, contact your State Medicaid or CHIP office or dial **1-877-KIDS NOW** or **www.insurekidsnow.gov** to find out how to apply. If you qualify, ask your state if it has a program that might help you pay the premiums for an employer-sponsored plan.

If you or your dependents are eligible for premium assistance under Medicaid or CHIP, as well as eligible under your employer plan, your employer must allow you to enroll in your employer plan if you aren't already enrolled. This is called a "special enrollment" opportunity, and **you must request coverage within 60 days of being determined eligible for premium assistance**. If you have questions about enrolling in your employer plan, contact the Department of Labor at **www.askebsa.dol.gov** or call **1-866-444-EBSA (3272)**.

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of July 31, 2021. Contact your State for more information on eligibility –

ALABAMA Medicaid	CALIFORNIA Medicaid
Website: http://myalhipp.com/ Phone: 1-855-692-5447	Website: Health Insurance Premium Payment (HIPP) Program http://dhcs.ca.gov/hipp Phone: 916-445-8322 Email: hipp@dhcs.ca.gov
ALASKA Medicaid	**COLORADO Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)**
The AK Health Insurance Premium Payment Program Website: http://myakhipp.com/ Phone: 1-866-251-4861 Email: CustomerService@MyAKHIPP.com Medicaid Eligibility: http://dhss.alaska.gov/dpa/Pages/medicaid/default.aspx	Health First Colorado Website: https://www.healthfirstcolorado.com/ Health First Colorado Member Contact Center: 1-800-221-3943/ State Relay 711 CHP+: https://www.colorado.gov/pacific/hcpf/child-health-plan-plus CHP+ Customer Service: 1-800-359-1991/ State Relay 711 Health Insurance Buy-In Program (HIBI): https://www.colorado.gov/pacific/hcpf/health-insurance-buy-program HIBI Customer Service: 1-855-692-6442
ARKANSAS Medicaid	**FLORIDA Medicaid**
Website: http://myarhipp.com/ Phone: 1-855-MyARHIPP (855-692-7447)	Website: https://www.flmedicaidtplrecovery.com/flmedicaidtplrecovery.com/hipp/index.html Phone: 1-877-357-3268

GEORGIA Medicaid	MASSACHUSETTS Medicaid and CHIP
Website: https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp Phone: 678-564-1162 ext 2131	Website: https://www.mass.gov/info-details/masshealth-premium-assistance-pa Phone: 1-800-862-4840
INDIANA Medicaid	**MINNESOTA Medicaid**
Healthy Indiana Plan for low-income adults 19-64 Website: http://www.in.gov/fssa/hip/ Phone: 1-877-438-4479 All other Medicaid Website: https://www.in.gov/medicaid/ Phone 1-800-457-4584	Website: https://mn.gov/dhs/people-we-serve/children-and-families/health-care/health-care-programs/programs-and-services/other-insurance.jsp Phone: 1-800-657-3739
IOWA Medicaid and CHIP (Hawki)	**MISSOURI Medicaid**
Medicaid Website: https://dhs.iowa.gov/ime/members Medicaid Phone: 1-800-338-8366 Hawki Website: http://dhs.iowa.gov/Hawki Hawki Phone: 1-800-257-8563 HIPP Website: https://dhs.iowa.gov/ime/members/medicaid-a-to-z/hipp HIPP Phone: 1-888-346-9562	Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005
KANSAS Medicaid	**MONTANA Medicaid**
Website: https://www.kancare.ks.gov/ Phone: 1-800-792-4884	Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084
KENTUCKY Medicaid	**NEBRASKA Medicaid**
Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP) Website: https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx Phone: 1-855-459-6328 Email: KIHIPP.PROGRAM@ky.gov KCHIP Website: https://kidshealth.ky.gov/Pages/index.aspx Phone: 1-877-524-4718 Kentucky Medicaid Website: https://chfs.ky.gov	Website: http://www.ACCESSNebraska.ne.gov Phone: 1-855-632-7633 Lincoln: 402-473-7000 Omaha: 402-595-1178
LOUISIANA Medicaid	**NEVADA Medicaid**
Website: www.medicaid.la.gov or www.ldh.la.gov/lahipp Phone: 1-888-342-6207 (Medicaid hotline) or 1-855-618-5488 (LaHIPP)	Medicaid Website: http://dhcfp.nv.gov Medicaid Phone: 1-800-992-0900
MAINE Medicaid	**NEW HAMPSHIRE Medicaid**
Enrollment Website: https://www.maine.gov/dhhs/ofi/applications-forms Phone: 1-800-442-6003 TTY: Maine relay 711	Website: https://www.dhhs.nh.gov/oii/hipp.htm Phone: 603-271-5218 Toll free number for the HIPP program: 1-800-852-3345, ext 5218

Private Health Insurance Premium Webpage: https://www.maine.gov/dhhs/ofi/applications-forms Phone: -800-977-6740. TTY: Maine relay 711	
NEW JERSEY Medicaid and CHIP	**SOUTH DAKOTA Medicaid**
Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/ Medicaid Phone: 609-631-2392 CHIP Website: http://www.njfamilycare.org/index.html CHIP Phone: 1-800-701-0710	Website: http://dss.sd.gov Phone: 1-888-828-0059
NEW YORK Medicaid	**TEXAS Medicaid**
Website: https://www.health.ny.gov/health_care/medicaid/ Phone: 1-800-541-2831	Website: http://gethipptexas.com/ Phone: 1-800-440-0493
NORTH CAROLINA Medicaid	**UTAH Medicaid and CHIP**
Website: https://medicaid.ncdhhs.gov/ Phone: 919-855-4100	Medicaid Website: https://medicaid.utah.gov/ CHIP Website: http://health.utah.gov/chip Phone: 1-877-543-7669
NORTH DAKOTA Medicaid	**VERMONT Medicaid**
Website: http://www.nd.gov/dhs/services/medicalserv/medicaid/ Phone: 1-844-854-4825	Website: http://www.greenmountaincare.org/ Phone: 1-800-250-8427
OKLAHOMA Medicaid and CHIP	**VIRGINIA Medicaid and CHIP**
Website: http://www.insureoklahoma.org Phone: 1-888-365-3742	Website: https://www.coverva.org/en/famis-select https://www.coverva.org/en/hipp Medicaid Phone: 1-800-432-5924 CHIP Phone: 1-800-432-5924
OREGON Medicaid	**WASHINGTON Medicaid**
Website: http://healthcare.oregon.gov/Pages/index.aspx http://www.oregonhealthcare.gov/index-es.html Phone: 1-800-699-9075	Website: https://www.hca.wa.gov/ Phone: 1-800-562-3022
PENNSYLVANIA Medicaid	**WEST VIRGINIA Medicaid**
Website: https://www.dhs.pa.gov/providers/Providers/Pages/Medical/HIPP-Program.aspx Phone: 1-800-692-7462	Website: http://mywvhipp.com/ Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)
RHODE ISLAND Medicaid and CHIP	**WISCONSIN Medicaid and CHIP**
Website: http://www.eohhs.ri.gov/ Phone: 1-855-697-4347, or 401-462-0311 (Direct RIte Share Line)	Website: https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm Phone: 1-800-362-3002
SOUTH CAROLINA Medicaid	**WYOMING Medicaid**

Website: https://www.scdhhs.gov Phone: 1-888-549-0820	Website: https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/ Phone: 1-800-251-1269

To see if any other states have added a premium assistance program since July 31, 2021, or for more information on special enrollment rights, contact either:

U.S. Department of Labor
Employee Benefits Security Administration
www.dol.gov/agencies/ebsa
1-866-444-EBSA (3272)

U.S. Department of Health and Human Services
Centers for Medicare & Medicaid Services
www.cms.hhs.gov
1-877-267-2323, Menu Option 4, Ext. 61565

Paperwork Reduction Act Statement

According to the Paperwork Reduction Act of 1995 (Pub. L. 104-13) (PRA), no persons are required to respond to a collection of information unless such collection displays a valid Office of Management and Budget (OMB) control number. The Department notes that a Federal agency cannot conduct or sponsor a collection of information unless it is approved by OMB under the PRA, and displays a currently valid OMB control number, and the public is not required to respond to a collection of information unless it displays a currently valid OMB control number. See 44 U.S.C. 3507. Also, notwithstanding any other provisions of law, no person shall be subject to penalty for failing to comply with a collection of information if the collection of information does not display a currently valid OMB control number. See 44 U.S.C. 3512.

The public reporting burden for this collection of information is estimated to average approximately seven minutes per respondent. Interested parties are encouraged to send comments regarding the burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to the U.S. Department of Labor, Employee Benefits Security Administration, Office of Policy and Research, Attention: PRA Clearance Officer, 200 Constitution Avenue, N.W., Room N-5718, Washington, DC 20210 or email ebsa.opr@dol.gov and reference the OMB Control Number 1210-0137.

OMB Control Number 1210-0137 (expires 1/31/2023)

Newborns' and Mothers' Health Protection Act Notice

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 mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under Federal law, require that a provider obtain authorization from the plan or the insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

Genetic Information Nondiscrimination Act (GINA) Disclosures

Genetic Information Nondiscrimination Act of 2008

The Genetic Information Nondiscrimination Act of 2008 ("GINA") protects employees against discrimination based on their genetic information. Unless otherwise permitted, your Employer may not request or require any genetic information from you or your family members.

The Genetic Information Nondiscrimination Act of 2008 (GINA) prohibits employers and other entities covered by GINA Title II from requesting or requiring genetic information of an individual or family member of the individual, except as specifically allowed by this law. To comply with this law, we are asking that you not provide any genetic information when responding to this request for medical information. "Genetic information," as defined by GINA, includes an individual's family medical history, the results of an individual's or family member's genetic tests, the fact that an individual or an individual's family member sought or received genetic services, and genetic information of a fetus carried by an individual or an individual's family member or an embryo lawfully held by an individual or family member receiving assistive reproductive services.

USERRA Notice

Your Rights Under USERRA

A. The Uniformed Services Employment and Reemployment Rights Act

USERRA protects the job rights of individuals who voluntarily or involuntarily leave employment positions to undertake military service or certain types of service in the National Disaster Medical System. USERRA also prohibits employers from discriminating against past and present members of the uniformed services, and applicants to the uniformed services.

B. Reemployment Rights

You have the right to be reemployed in your civilian job if you leave that job to perform service in the uniformed service and:

- You ensure that your employer receives advance written or verbal notice of your service;
- You have five years or less of cumulative service in the uniformed services while with that particular employer;
- You return to work or apply for reemployment in a timely manner after conclusion of service; and
- You have not been separated from service with a disqualifying discharge or under other than honorable conditions.

If you are eligible to be reemployed, you must be restored to the job and benefits you would have attained if you had not been absent due to military service or, in some cases, a comparable job.

C. Right To Be Free From Discrimination and Retaliation

If you:

- Are a past or present member of the uniformed service;
- Have applied for membership in the uniformed service; or
- Are obligated to serve in the uniformed service; then an employer may not deny you
- Initial employment;
- Reemployment;
- Retention in employment;
- Promotion; or
- Any benefit of employment because of this status.

In addition, an employer may not retaliate against anyone assisting in the enforcement of USERRA rights, including testifying or making a statement in connection with a proceeding under USERRA, even if that person has no service connection.

D. Health Insurance Protection

- If you leave your job to perform military service, you have the right to elect to continue your existing employer-based health plan coverage for you and your dependents for up to 24 months while in the military.
- Even if you do not elect to continue coverage during your military service, you have the right to be reinstated in your employer's health plan when you are reemployed, generally without any waiting periods or exclusions (e.g., pre-existing condition exclusions) except for service-connected illnesses or injuries.

E. Enforcement

- The U.S. Department of Labor, Veterans' Employment and Training Service (VETS) is authorized to investigate and resolve complaints of USERRA violations.

For assistance in filing a complaint, or for any other information on USERRA, contact VETS at 1-866-4-USA-DOL or visit its Web site at *http://www.dol.gov/vets.* An interactive online USERRA Advisor can be viewed at *http://www.dol.gov/elaws/userra.htm.*

- If you file a complaint with VETS and VETS is unable to resolve it, you may request that your case be referred to the Department of Justice or the Office of Special Counsel, as applicable, for representation.
- You may also bypass the VETS process and bring a civil action against an employer for violations of USERRA.

The rights listed here may vary depending on the circumstances. The text of this notice was prepared by VETS, and may be viewed on the Internet at this address:
http://www.dol.gov/vets/programs/userra/poster.htm. Federal law requires employers to notify employees of their rights under USERRA, and employers may meet this requirement by displaying the text of this notice where they customarily place notices for employees. U.S. Department of Labor, Veterans' Employment and Training Service, 1-866-487-2365.

Appendix D: Acknowledgments