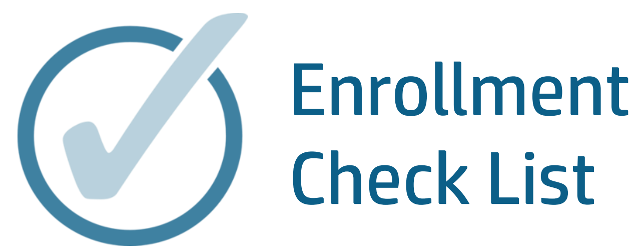
2021

Employee Benefits Guide



Enrollment Check List

Step 1: **Review** your Options

☐ Read this Guide and keep it available to review later.

☐ Ask questions and gather information about your previous year's health care expenses.

Step 2: **Plan** for Enrollment

☐ Consider your current benefit coverage and whether or not it will meet your needs for the upcoming year.

☐ Review other available coverage options such as your spouse's plan or your parent's plan (if you are an eligible dependent).

Step 3: **Complete** Enrollment

☐ Log into https://hollandhome.prd.mykronos.com on your Chrome browser or the Workforce Dimensions app to complete your enrollment.

Enrollment must be complete by *November 18, 2020.*

Welcome to your enrollment! Holland Home is excited to again offer an array of benefits including medical and prescription drug, dental, vision, short and long-term disability insurance, group and voluntary life insurance, voluntary accident, and FSA at a reasonable cost or no cost to you. We are committed to offering you coverage that will protect you and your family in the event you need it. The information in this Guide will provide the necessary benefit information you need to enroll in the benefits.

If you have any additional questions not answered here, please contact Human Resources at 616-235-5026 or benefits@hollandhome.org .

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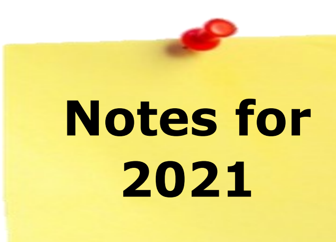

- ⇒ No plan design changes!
- ⇒ Please confirm your life insurance beneficiary information in Kronos Workforce.
- ⇒ Evidence of Insurability (EOI) form may be required for changes to voluntary life insurance and long term disability. EOI must be approved by Dearborn.
- ⇒ Passive enrollment — if you don't go online to enroll, all of your 2020 elections will roll over to 2021, except for FSA elections. You must re-enroll in health care and dependent care FSA each year.

Affordable Care Act (ACA) Requirement

Effective January 1, 2019 the Tax Cuts and Jobs Act (TJCA) updated the individual mandate to maintain health insurance or be responsible for a "shared responsibility payment". We hope to keep offering these benefits as a valuable part of your total compensation in the future. However, because we offer coverage to employees who work at least 30 hours and less than 1 year of service that satisfies the health reform requirements, you may not qualify for federal assistance to purchase an individual or family policy on the open market (the "marketplace").

Enrollment Information

Eligibility

You are eligible to enroll in benefits if you are regularly scheduled to work 24 or more hours/3 or more days per week.

Dependents

If you are eligible for insurance coverage, you may include your dependents on your plan as long as they meet the following requirements:

- **Your legal spouse**
    - An employee's spouse who is eligible for medical coverage under his or her own employer's group health plan as a full-time employee must enroll for that coverage. Such a spouse will not be eligible under Holland Home's medical plan. An employee's spouse who is eligible for coverage under his or her employer's group health plan as a part-time employee will not be subject to this provision and will not be penalized for declining to enroll for such coverage.
- **Your children** by birth, adoption, placement for adoption, stepchildren, and children for whom you have legal guardianship or a court-ordered support obligation, up to the end of the year they turn age 26, except in the case of permanent disability where they may be covered beyond age 26.

Enrolling

The benefits you elect now will be effective January 1, 2021 until December 31, 2021.

- Currently active employees are required to enroll or make changes during the annual Open Enrollment period that runs from **October 26, 2020 to November 18, 2020.**
- Remember that you must enroll in FSA each calendar year; your enrollment does not carry over from year to year.
- A new hire becomes eligible for benefits the 1st day of the month following a 60-day new hire waiting period. You must enroll within 30 days to have coverage for the remainder of the plan year.

Making Changes

You may make changes to the benefits you elect only if you have a qualified Life Event. Qualified Life Events include:

- Marriage, divorce, legal separation
- Birth or adoption of a child, commencement or termination of adoption proceedings
- Change in child's dependent status
- Death of spouse, child, or other qualified dependent
- Change in residence due to an employment transfer for you or your spouse
- Change in spouse's benefits or employment status
- Increase/decrease in scheduled hours

Medical & Prescription Coverage

Holland Home offers 3 medical plans through Blue Care Network HMO. All 3 plans are ***Healthy Blue Living*** plans that focus on lifestyle choices and reward you with lower out-of-pocket costs for living a healthy lifestyle. These Healthy Blue Living (HBL) plans offer a choice to lower your out-of-pocket costs by meeting health targets and participating in a wellness-focused program.

The High plan, Middle Plan, and Low plan include 2 different benefit levels: **Enhanced** and **Standard**. If you are newly enrolled in the plan, you automatically receive the Enhanced benefits for the first 90 days of coverage. To continue to receive the Enhanced benefits, you will need to meet certain requirements. See next page for details.

Medical Benefits	BCN High Plan		BCN Middle Plan		BCN Low Plan	
	ENHANCED	STANDARD	ENHANCED	STANDARD	ENHANCED	STANDARD
Deductible per calendar year	$750 single $1,500 family	$2,000 single $4,000 family	$2,000 single $4,000 family	$4,000 single $8,000 family	$2,000 single $4,000 family	$5,000 single $10,000 family
Coinsurance	20%	30%	20%	30%	30%	30%
True Out-of-Pocket *(incl. copays, deductible, coinsurance)*	$2,500 single $5,000 family	$5,500 single $11,000 family	$4,000 single $8,000 family	$6,350 single $12,700 family	$6,000 single $12,000 family	$6,600 single $13,200 family
Preventive	Covered 100%	Covered 100%	Covered 100%	Covered 100%	Covered 100%	Covered 100%
Primary care visit	$30	$40	$30	$40	$30	$40
Specialist visit	$35 after ded	$45 after ded	$35 after ded	$45 after ded	$35 after ded	$45 after ded
Urgent care	$60	$60	$60	$60	$60	$60
Emergency Room	$200 after ded	$300 after ded	$200 after ded	$300 after ded	$200 after ded	$300 after ded
Prescription Drug						
Tier 1A	$6	$10	$6	$10	$10	$20
Tier 1B	$25	$30	$25	$30	$30	$20
Tier 2	$50	$60	$50	$60	$60	$60
Tier 3	$80	$80	$80	$80	$80	50% max $100
Tier 4 Specialty	20% max $200	20% max $200	20% max $200	20% max $200	20% max $200	$60
Tier 5 Specialty	20% max $300	20% max $300	20% max $300	20% max $300	20% max $300	50% max $100
Mail order	3x copay less $10	3x copay less $10	3x copay less $10	3x copay less $10	3x copay less $10	3x copay less $10

Visit **BCBSM.com** to find participating providers & list of covered prescriptions

This is intended as an easy-to-read summary, not a certificate of coverage or proof of eligibility. For additional information, refer to the BCN benefit summaries.

Healthy Blue Living

BCN's medical plans include 2 different benefit levels: **Enhanced** and **Standard.** If you are newly enrolled in the plan, you automatically receive the Enhanced benefits for the first 90 days of coverage. To continue to receive the Enhanced benefits, you will need to meet certain requirements:

Requirements within first **90 days**	1) Complete online Health Assessment (www.bcbsm.com)
	2) Visit your Primary Care Physician (PCP) to complete Qualification Form

Requirements within first **120 days**	3) Participate in tobacco-cessation program or weight management programs and/or follow your PCP's recommendations, if required

If you do not complete the Health Assessment, qualification form, participate in a smoking cessation or weight management program, and make a commitment to actively work towards your PCP's recommendations within the first 90 days, you and your family will be moved to the Standard benefit level after 90 days.

Members who score all A's on the qualification form will NOT need to have the qualification form completed for another 2 or 3 years: 2 years for members age 40 or older, and 3 years for members age 18-39.

For more information, please refer to www.bcbsm.com or the HBL materials that will be mailed to you from Blue Care Network.

Telemedicine

Blue Cross Online Visits offers you access to healthcare professionals 24/7. You and your covered family members can see a doctor for minor illnesses such as cold, flu, or sore throat. A Blue Cross Online Visit can also help you save money! Your cost is an office visit copay ($30 or $40).

You can access the program via:

- Mobile app: Download the BCBSM Online Visits app
- Phone: 1-844-606-1608
- Website: bcbsmonlinevisits.com

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Mental Health Support

At some point in our lives, we all face a challenge or issue that seems difficult to resolve. When times are uncertain, and you're struggling with life challenges and need support, you have options.

Emotional Wellness App

Available for all employees of Christian Living Services

- Offered through Reliance Community Care Partners in partnership with OnlineCare
- Self-assessments and care guides help you identify and deal with how you are feeling
- Virtual therapy and psychiatric nurse practitioner can help you develop a treatment plan that fits your needs
- Look for **MHCSN OnlineCare UC** app in Apple and Google stores
    - Register as new member and click on Emotional Wellness
    - Select an option and begin taking a self-assessment
    - Review Self-Care Guide for helpful tips

Dearborn Resources

Available for all employees and family members covered by Dearborn Life or Disability

- 3 free face-to-face sessions in your area
- Unlimited telephonic counseling 24/7
- Web-based services with tools to help with personal, relational, legal, health, and financial concerns like:
    - Stress or anxiety
    - Job pressures
    - Marital and family conflicts
    - Grief and loss
    - Managing debt
    - Depression
    - Alcohol or drug abuse
    - Tax questions

Disability Resource Services™

In the U.S. and Canada, call
866-899-1363
TDD: 800-697-0353
GuidanceResources.com
Enter Your Company ID: DISRES

Blue Care Network Resources

Available for all employees and family members covered by Blue Care Network (BCN) medical plans

- For up to date information regarding COVID-19, visit www.bcbsm.com/coronavirus
- Talk with a registered nurse 24/7 about symptoms or health-related questions at 855-624-5214 (24 Hour Nurse Hotline)
- Reach out to a behavioral health therapist at:
    - COVID-19 Crisis Hotline: 833-848-1764
    - BCN Mental Health Support: 800-482-5982
    - Blue Cross Online Visits: 844-606-1608 or bcbsmonlinevisits.com
- Access Blue Cross Health & Well-being digital programs through your member account (www.bcbsm.com) or the Blue Cross mobile app
- Watch short informational webinars at Bluecrossvirtualwellbeing.com

Your Share

2021 Cafeteria Benefit Credits

***Subtract your Cafeteria Benefit Credit (CBC) from your total benefit cost to determine your true out of pocket cost for benefits.*

Hours per Week & Years of Service	< 1 Year		1 - 4.99 Years		5 - 9.99 Years		+10 Years	
	Per Year	Per Pay Period	Per Year	Per Pay Period	Per Year	Per Pay Period	Per Year	Per Pay Period
36 or more	$ 3,485.00	$134.04	$ 3,834.00	$147.46	$ 4,182.00	$160.85	$ 4,531.00	$174.27
32 - 35.99	$ 2,614.00	$100.54	$ 2,875.00	$110.58	$ 3,137.00	$120.66	$ 3,398.00	$130.69
30 - 31.99	$ 1,986.00	$76.38	$ 2,185.00	$84.04	$ 2,384.00	$91.69	$ 2,582.00	$99.31
24 – 29.99	$ 70.00	$2.69	$ 77.00	$2.96	$ 84.00	$3.23	$ 91.00	$3.50

2021 Medical Plan Costs

	Single		2 Person		Family	
	Per Year	Per Pay	Per Year	Per Pay	Per Year	Per Pay
Low Plan	$3,415.80	$131.38	$6,744.84	$259.42	$8,551.80	$328.92
Middle Plan	$4,416.12	$169.85	$7,313.28	$281.28	$9,226.68	$354.87
High Plan	$6,412.56	$246.64	$11,518.08	$443.00	$14,152.08	$544.31

2021 Dental Plan Costs

	Single		2 Person		Family	
	Per Year	Per Pay	Per Year	Per Pay	Per Year	Per Pay
Basic	$346.56	$13.33	$677.52	$26.06	$945.36	$36.36
Enhanced	$541.20	$20.82	$1,050.36	$40.40	$1,480.08	$56.93

2021 Vision Plan Costs

	Single		2 Person		Family	
	Per Year	Per Pay	Per Year	Per Pay	Per Year	Per Pay
Vision	$90.00	$3.46	$180.12	$6.93	$298.92	$11.50

Flexible Spending Accounts (FSA)

Health Care Flexible Spending Account

Your FSA is administered by **Health Equity.** Whether or not you are enrolled in Holland Home's medical plans, this account offers you an opportunity to save money by allowing you to pay for out-of-pocket health care expenses with tax-free dollars. You can:

- **Save up to $2,750 for qualified medical, dental, and vision expenses**

General Purpose FSAs are subject to the "use-it or lose-it" rule. Any unused funds remaining in your General Purpose FSA as of December 31 will stay active through the grace period, which ends on March 15. You have until March 31 to submit for reimbursement.

Health Care Flexible Spending Account (FSA)
You can use the monies in your General Purpose Flexible Spending Account for a wide range of medical, dental, and vision expenses. These expenses can be for you or anyone who is considered your dependent – *even those not enrolled in your health insurance plan.* Expenses are considered *incurred* when the health care services are provided. You cannot be reimbursed for expenses incurred before the plan effective date, before your enrollment date, after you terminate from the plan, or for expenses incurred after the close of the plan year.

For a detailed list of what's covered, file claims, upload receipts, and see your claims in real time, access the HealthEquity FSA self-service website: https://my.healthequity.com/Login.aspx

You can also access your account on the mobile app. Search for "HealthEquity" in the App Store or Google Play store.

Dependent Care Flexible Spending Account

Your Dependent Care FSA is administered by **Health Equity**. The Dependent Care Flexible Spending Account (DCFSA) allows you to pay for out-of-pocket work-related dependent/child care costs on a *pre-tax* basis. You may participate in this plan regardless of your marital status; however, keep in mind that the plan is in place to allow you to pay for your dependent/child care expenses if you are *gainfully employed*.

- **You may contribute up to $5,000 if you're married and file a joint tax return, provided both you and your spouse each earn more than $5,000 annually. By IRS rules, married individuals who file separate tax returns are limited to $2,500 contribution annually.**

Dependent Care FSAs are subject to the "use-it or lose-it" rule. Any unused funds remaining in your Dependent Care FSA as of December 31st will be forfeited.

Any unused amounts left in your account after the close of the plan year will be forfeited. If your employment ends with Holland Home, any unused amounts left in your account will be forfeited.

Remember, you must re-enroll each year if you would like to continue participating in the plan.

This is intended as an easy-to-read summary, not a certificate of coverage or proof of eligibility. For additional information, refer to the carrier benefit summaries.

Dental Coverage

Holland Home offers dental coverage through Blue Cross Blue Shield of Michigan. You may use any dental provider you choose, but you'll get the best discounted price with dentists and specialists who participate with Blue Dental PPO network. However, when you receive services from a non-participating dentist, the non-participating dentist fee may be less than what the dentist charges or Delta Dental approves, and you are responsible for the difference. This is sometimes referred to as "balance billing".

	Basic Plan	Enhanced Plan
Deductible		
Annual deductible per person Does not apply to Diagnostic & Preventive, or Orthodontia	$50 per person $150 per family	$50 per person $150 per family
Maximums		
Annual maximum per person per benefit year	$800	$1,000
Lifetime orthodontia maximum per person	Not covered	$1,000
Class 1—Diagnostic & Preventative		
Exams, cleanings, fluoride, & space maintainers Emergency Palliative Treatment— to temporarily relieve pain Sealants - to prevent decay of permanent teeth Brush Biopsy - to detect oral cancer Radiographs - X-rays	75%	100%
Class 2—Basic Services		
Periodontal Services—to treat gum disease Endodontic Services—root canals Major Restorative Services—crowns Minor Restorative Services - fillings and crown repair Oral Surgery Services—extractions and dental surgery Relines & Repairs - to bridges and dentures Other Basic Services - misc. services	50% after deductible	75% after deductible
Class 3—Major Services		
Prosthodontic Services - bridges, implants, and dentures	50% after deductible	50% after deductible
Class 4—Orthodontia		
Orthodontics—for children up to 19	Not covered	50%

Visit www.mibluedentist.com to find participating providers

If you choose to waive the dental coverage, you will not be able to elect either dental plan for 2 years.

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Vision Coverage

Holland Home offers vision coverage through Blue Cross Blue Shield using the VSP network. You'll receive the best discount by using a participating provider. Below is a summary of the in-network Vision benefits.

Benefit	Description	Copay
Your Coverage within the VSP Signature Network		
Well Vision Exam	• Focuses on your eyes & overall wellness • Every 12 months	$20
Materials		$20
Frames	• $130 Allowance for Frames • $150 Allowance for Featured Frame Brands • 20% off amount over your allowance • Every 12 months	Included in Prescription Glasses
Lenses	• Single vision, lined bifocal, and lined trifocal lenses • Polycarbonate lenses for dependent children • One pair of Lenses every 12 months	Included in Prescription Glasses
Contacts (Instead of Glasses)	• $130 Allowance for Contacts; copay does not apply • Contact Lens Exam (Fitting & Evaluation) • Every 12 months	Up to $60
Extra Savings	• Discounts on prescription sunglasses, additional pairs of glasses and frames, lens options, and LASIK	

Additional information regarding the BCBSM VSP Vision plan, including the out-of-network/non-participating provider coverage, can be obtained upon request from your HR Department.

Visit www.VSP.com to find participating providers

Make sure to present your BCBS Blue Vision ID card at the time of service. The doctor needs this ID number to verify eligibility.

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Life and AD&D Insurance

Holland Home provides eligible employees with $10,000 basic life and accidental death & dismemberment (AD&D) insurance. This coverage is paid for by Holland Home. Please update your beneficiary information on your Kronos profile.

Voluntary Term Life/AD&D Insurance

Employees who want to supplement their group life insurance benefits may purchase additional coverage for themselves and for their eligible dependents. **You pay 100% of the cost of voluntary term life insurance through payroll deductions.** Please refer to Kronos for age-related rates and additional information.

	Voluntary Term Life /AD&D Plan Details
Benefit Amounts	Employees can elect up to $150,000, in $25,000 increments
	Spouses can elect up to $75,000, in $12,500 increments, not to exceed 50% of employee's benefit amount **
	Child(ren) can elect $5,000 **
Guaranteed Issue for new hires (Evidence of Insurability EOI **not** required)*	Employee = $150,000 Spouse = $25,000 Children = $10,000
Annual Enrollment Changes	Employee – can increase by $25,000 without medical questions; any additional increases require medical questions Spouse – any benefit over $25,000 requires medical questions Children – not subject to medical questions
Benefit Reduction by Age	Benefit will reduce to 65% at age 65 and to 50% at age 70

*Evidence of Insurability must be completed and approved by Dearborn to elect amounts over the Guaranteed Issue amount.
**In order to purchase this benefit for your dependents you must purchase coverage for yourself.

If you end employment with Holland Home, you may request a conversion or portability policy within 31 days of your last day of employment. Please contact Human Resources for more information.

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Disability Insurance

Holland Home offers eligible employees the option to enroll in **short term disability** insurance to help you continue your income in the event you are unable to work.

	$250 STD Plan	$500 STD Plan
Benefits begin	1st day for accident 8th day for sickness	1st day for accident 8th day for sickness
Benefits payable	60% of weekly earnings to a maximum weekly benefit of **$250**	60% of weekly earnings to a maximum weekly benefit of **$500**
Duration of benefit	26 weeks or until LTD begins	26 weeks or until LTD begins
Pre-existing condition limitation	3/12 - A Pre-existing Condition is a sickness or injury for which you have received treatment within 3 months prior to your effective date. A disability contributed to or caused by a Pre-existing Condition within the first 12 months of your effective date will not be covered.	

Long Term Disability insurance provides you with some monthly income in the event that your disability lasts longer than 6 months. You may choose between 2 long term disability income plan options, but you must be enrolled in 1 of the options.*

	Core LTD Plan	Buy-up LTD Plan
Benefits begin	180 days elimination period	180 days elimination period
Benefits payable	**40%** of monthly earnings to a maximum monthly benefit of **$1,000**	**60%** of monthly earnings to a maximum monthly benefit of **$6,000**
Duration of benefit	Social Security Normal Retirement Age	Social Security Normal Retirement Age
Pre-existing condition limitation	3/12 - A Pre-existing Condition is a sickness or injury for which you have received treatment within 3 months prior to your effective date. A disability contributed to or caused by a Pre-existing Condition within the first 12 months of your effective date will not be covered.	

Evidence of Insurability (EOI) is required if you move from the Core to the Buy-up LTD plan. Coverage will not be approved and payroll deductions will not be taken until your EOI form has been approved by the carrier.

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Voluntary Accident

After you experience any type of accident, things like lost wages, out-of-pocket expenses, and the cost for help can add up. Accident coverage provides cash benefits regardless of any other insurance you have.

The annual **Benefit Bank** represents the total dollar amount available for covered services in a calendar year. Choose between $5,000, $10,000, or $15,000 for your annual benefit bank. You will be responsible for the first $100 (maximum of $200 per family) before benefits are payable.

If you suffer an accidental injury and receive care within 72 hours, you must submit the proof of claim for the dollar amount of the actual medical and recovery expenses. To determine actual expenses to be reimbursed, Life Secure will take into account the adjustments or discounts which may be negotiated between the health insurance plan and providers for services received.

Group Accident benefits from this coverage will pay in addition to the BCN medical coverage, minus any deductible applicable under this coverage. All benefits are paid directly to the certificate holder.

Covered Expenses	Details
Ambulance	Once per accident, per covered person
Initial services	Initial care must begin within 72 hours of the accident
Drugs	Drugs administered in a hospital, urgent care center or physician's office
Physician follow-up services, including chiropractic services	Up to one visit per day, with a maximum of three visits per accident*
Major diagnostic exams: CT, MRI, EEG	Covered up to $750 per exam, limit two exams per calendar year, one per accident*
Tests, X-rays, blood tests echocardiography, electrocardiography ultrasound	One test or one set of X-rays per accident*
Surgery	Up to two surgeries per accident, per covered person, must be performed within 90 days of accident
Physical, occupational and speech therapy	One visit per day, with a maximum of 10 visits per accident, per covered person. Visits must begin within 90 days of accident and must be completed within six months of accident
Durable medical equipment	Rental or purchase of qualified equipment prescribed within 30 days of accident
Prosthetic devices	Must be received within one year of accident
Hospitalization	Includes intensive care unit stay

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Important Notices

Employers must provide disclosures to employees regarding certain legal requirements; including the Health Insurance Portability and Accountability Act (HIPAA) and the Patient Protection and Affordable Care Act (PPACA). This document provides you with certain required disclosures related to our employee benefits plan (the "Plan"). If you have any questions or need further assistance please contact your Plan Administrator as follows:

Holland Home
Human Resources
2100 Raybrook Ave. SE Suite 300
Grand Rapids MI 49546

This Document Is For Information Purposes Only

This communication is intended for illustrative and information purposes only. The plan documents, summary plan descriptions, insurance certificates, and policies serve as the governing documents to determine plan eligibility, benefits, and payments.

If you have Medicare or will become eligible for Medicare in the next 12 months, federal law gives you more choices about your prescription drug coverage. See page 16 & 17 for details.

Limitations And Exclusions

Insurance and benefit plans always contain exclusions and limitations. Please see benefit booklets and/or contracts for complete details of coverage and eligibility.

Future Of The Plan

Holland Home reserves the right to amend, modify, or terminate its benefit plan at any time, including during treatment.

Notice Regarding Special Enrollment Rights

If you do not timely or properly complete the enrollment process, you and your eligible dependents generally will not be covered under the Plan, upon your initial eligibility date. Also, if you fail to specifically enroll your eligible dependents on the enrollment form, your eligible dependents will not be covered under the Plan upon the dependent's initial eligibility date. If enrollment does not occur on an individual's initial eligibility date, coverage may not be applied for until the next annual open enrollment period. However, if an employee or dependent experiences a special enrollment rights circumstance, coverage may begin mid-year, before the next annual open enrollment. This section explains the special enrollment rights rules.

If an individual experiences a loss of health coverage, if an employee has a new dependent, or an individual loses or gains eligibility with respect to Medicaid or a State Children's Health Insurance Program ("CHIP"), an eligible employee and/or a dependent may have special enrollment rights to participate in coverage under the group health plan mid-year without being required to wait until the next annual open enrollment period.

- A loss of other coverage may occur when COBRA has been exhausted, an individual becomes ineligible for coverage (for example, due to a change in status), employer contributions for the coverage have been terminated, the other coverage is an HMO and the individual no longer lives or works in the HMO service area, coverage is lost because the other plan no longer offers any benefits to a class of similarly-situated individuals (such as part-time employees), or a benefit package option is terminated unless the individual is provided a current right to enroll in alternative coverage. A loss of other coverage for this purpose does not include, however, termination due to the nonpayment of required contributions, for cause due to the filing of a fraudulent application or claim, or where the individual voluntarily terminates other coverage.
- The addition of a new dependent may occur due to marriage, birth, adoption or placement for adoption.
- If an individual's Medicaid or CHIP coverage is terminated as a result of a loss of eligibility or if the individual becomes eligible for a premium assistance subsidy under Medicaid or a CHIP, the individual has special enrollment rights.

Enrollment must generally be requested in a special enrollment rights situation within 30 days after the loss of other coverage or the addition of the new dependent, whichever is applicable. However, in the case of loss or gain of Medicaid or CHIP eligibility, a health plan must allow mid-year enrollment if the individual submits a request within 60 days after the loss of eligibility or gain of premium assistance.

Notice Regarding Women's Health And Cancer Rights Act

The Women's Health and Cancer Rights Act requires group health plans and insurers offering mastectomy coverage to also provide coverage for:

- Reconstruction of the breast on which the mastectomy was performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance; and
- Prostheses and treatment of physical complications at all stages of the mastectomy, including lymph edemas

These services are payable to a patient who is receiving benefits in connection with a mastectomy and elects reconstruction. The physician and patient determine the manner in which these services are performed.

The plan may apply deductibles and copayments consistent with other coverage within the plan. This notice serves as the official annual notice and disclosure of the fact that employer's health plan has been amended to comply with this law.

Important Notices

Notice Regarding Newborns And Mothers Health Protection Act

Group health plans and health insurance issuers offering group health insurance may not, under federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child for less than 48 hours following normal vaginal delivery, or less than 96 hours following a cesarean section, or require that a provider obtain authorization from the plan or insurance issuer to prescribe a length of stay not in excess of the above periods.

Notice Regarding GINA

The Genetic Information Nondiscrimination Act of 2008 (GINA) states that group health plans and insurance issuers may not:

- Adjust group premium or contribution amounts on the basis of genetic information.
- Request or require individuals to undergo a genetic test
- Request, require or purchase genetic information prior to or in connection with enrollment, or at any time for underwriting purposes.

Notice Regarding Patient Protections

The following paragraphs outline certain protections under the PPACA and only apply when the Plan requires the designation of a Primary Care Physician.

One of the provisions in the PPACA is for plans and insurers that require or allow for the designation of primary care providers by participants to inform the participants of their rights.

You will have the right to designate any primary care provider who participates in the Plan's network and who is available to accept you and/or your eligible dependents. For children, you may designate a pediatrician as the primary care provider. You also 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 in the Plan's network. The health care professional, however, 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 or notifying primary care provider or Plan of treatment decisions.

If you do not make a provider designation, the Plan may make one for you. For information on how to select or change a primary care provider, and for a list of the participating primary care providers, pediatricians, or obstetrics or gynecology health care professionals, please contact the insurer.

Other PPACA Protections

Other PPACA requirements include allowing eligible dependent children to continue health coverage until age 26, not retroactively rescinding coverage except as permitted by law and issuing eligible individuals a summary of benefits and coverage (SBC) describing the terms of the group health plan. You will be provided with an SBC as required by law.

Medicare Notice

You must notify Holland Home when you or your dependents become Medicare eligible. Holland Home is required to contact the insurer to inform them of your Medicare status. Federal law determines whether Medicare or the group health plan is the primary payer. You must also notify Medicare directly that you have group health insurance coverage. Privacy laws prohibit Medicare from discussing coverage with anyone other than the Medicare beneficiary or their legal guardian. The toll free number to Medicare Coordination of Benefits is 1-800-999-1118.

Important Information About Your Prescription Drug Coverage And Medicare

Please note that the following notice only applies to individuals who are eligible for Medicare.

Medicare eligible individuals may include employees, spouses or dependent children who are Medicare eligible for one of the following reasons.

- Due to the attainment of age 65
- Due to certain disabilities as determined by the Social Security Administration
- Due to End Stage Renal Disease (ESRD)

If you are covered by Medicare, please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with Holland Home and about your options under Medicare's prescription drug coverage. This information can help you decide whether or not you want to join a Medicare drug plan. If you are considering joining, you should compare your current coverage, including which drugs are covered at what cost, with the coverage and costs of the plans offering Medicare prescription drug coverage in your area. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice.

There are two important things you need to know about your current coverage and Medicare's prescription drug coverage:

1. Medicare prescription drug coverage became available in 2006 to everyone eligible for Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.

2. Blue Care Network has determined that the prescription drug coverage offered by the Holland Home Plan are, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and are therefore considered Creditable Coverage. If your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

Important Notices

When Can You Join A Medicare Drug Plan?

You can join a Medicare drug plan when you first become eligible for Medicare and each year from October 15th through December 7th. This may mean that you may have to wait to join a Medicare Prescription Drug Plan and that you may pay a higher premium (a penalty) if you join later, unless you maintain creditable coverage. You may pay that higher premium (a penalty) as long as you have Medicare prescription drug coverage. In addition, if you lose creditable prescription drug coverage, through no fault of your own, you will be eligible for a sixty (60) day Special Enrollment Period because you lost creditable coverage to join a Part D plan. In addition, if you lose or decide to leave employer-sponsored coverage, you will be eligible to join a Part D plan at that time using an Employer Group Special Enrollment Period. You should compare your current prescription drug coverage, including which drugs are covered at what cost, with the coverage and costs of the plans offering Medicare prescription drug coverage in your area.

What Happens To Your Current Coverage If You Decide to Join A Medicare Drug Plan?

If you decide to join a Medicare drug plan, your current plan coverage will not be affected. You can keep your existing coverage or join a Medicare drug plan as a supplement to, or in lieu of, your coverage under your employer's plan. If you do decide to join a Medicare drug plan and drop your current plan's coverage, be aware that you and your dependents may not be able to get this coverage back until the plan's next open enrollment (or if you experience a special enrollment event).

When Will You Pay A Higher Premium (Penalty) To Join A Medicare Drug Plan?

You should also know that if you drop or lose your current coverage and don't join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later. If you go 63 continuous days or longer without creditable prescription drug coverage, your monthly premium may go up by at least 1% of the Medicare base beneficiary premium per month for every month that you did not have that coverage. For example, if you go 19 months without creditable coverage, your premium may consistently be at least 19% higher than the Medicare base beneficiary premium. You may have to pay this higher premium (a penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following October to join.

For More Information About This Notice or Your Current Prescription Drug Coverage…

Contact your HR Representative. You'll get this notice each year. You will also get it before the next period you can join a Medicare drug plan, and if this coverage through your company changes. You also may request a copy of this notice at any time.

For More Information About Your Options Under Medicare Prescription Drug Coverage…

More detailed information about Medicare plans that offer prescription drug coverage is in the "Medicare & You" handbook.

You'll get a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare drug plans. For more information about Medicare prescription drug coverage:

- Visit www.medicare.gov
- Call your State Health Insurance Assistance Program (see the inside back cover of your copy of the "Medicare & You" handbook for their telephone number) for personalized help
- Call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

If you have limited income and resources, extra help paying for Medicare prescription drug coverage is available. For information, visit Social Security at www.socialsecurity.gov , or call 1-800-772-1213 (TTY 1-800-325-0778).

Remember: Keep this Creditable Coverage notice. If you decide to join one of the Medicare drug plans, you may be required to provide a copy of this notice when you join to show whether or not you have maintained creditable coverage and, therefore, whether or not you are required to pay a higher premium (penalty).

HIPAA Privacy And Security

Holland Home and any health insurance issuer in connection with employer's group health plan are committed to complying with the privacy and security requirements of HIPAA as modified by the HIPAA/ HITECH Omnibus Final Rule. Participants will receive a notice of privacy practices in connection with the Plan. You will also receive a new copy in the event the notice is modified. If you would like to receive another copy of the notice of privacy practices, you may do so at any time, by contacting the plan administrator. Duplicate copies are provided free of charge.

Nondiscrimination

The Plan complies with applicable federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability or sex. The Plan does not exclude people or treat them differently because of race, color, national origin, age, disability or sex.

Important Notices

ERISA Rights

As a participant in the Plan, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974, as amended (ERISA). ERISA provides that all plan participants shall be entitled to the following:

Receive Information About Your Plan and Benefits

You can examine, without charge, at the Plan Administrator's office and at other specified locations, such as worksites all documents governing the Plan, including insurance contracts and a copy of the latest annual report (Form 5500 Series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefit Security Administration.

You can obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the Plan, including insurance contracts and copies of the latest annual report (Form 5500 Series) and an updated summary plan description. The administrator may make a reasonable charge for the copies.

Continue Group Health Plan Coverage

You can continue health care coverage for yourself, spouse, or dependents if there is a loss of coverage under the Plan as a result of a qualifying event. Your or your dependents may have to pay for such coverage. Review your summary plan description and the documents governing the Plan on the rules governing your COBRA continuation coverage rights.

Prudent Actions by Plan Fiduciaries

In addition to creating rights for participants, ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plan. The people who operate your Plan, called "fiduciaries" of the Plan, have a duty to do so in the interest of you and other Plan participants and beneficiaries. No one, including your Employer, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a benefit or exercising your rights under ERISA.

Enforce Your Rights

If your claim for a welfare benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules.

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of Plan documents or the latest annual report from the Plan and do not receive them within 30 days, you may file suit in a Federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to $110 a day ($147 a day for penalties assessed after August 1 2016, as adjusted for inflation) until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Plan Administrator.

If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in state or Federal court. In addition, if you disagree with the Plan's decision or lack thereof concerning the qualified status of a domestic relations order or a medical child support order, you may file suit in Federal court. If it should happen that Plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

Plan Administrator Contact Information

For more information about any of the notices contained herein, or any of your rights under the Plan, please contact the Plan Administrator at:

Holland Home
Human Resources
2100 Raybrook Ave. SE Suite 300
Grand Rapids MI 49546
616-235-5026

Notice of Eligibility for Healthcare Related to Military Leave

If you take a military leave, federal law under the Uniformed Services Employment and Reemployment Rights Act (USERRA) provides the following rights:

- 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.
- If you don't elect to continue employer-based health plan coverage during your military services, you have the right to be reinstated in your employer's health plan when you are reemployed, generally without any waiting period or exclusions (e.g., pre-existing condition exclusions) except for service-connected illnesses or injuries.

The Plan Administrator can provide you with additional information about how to elect continuation coverage under USERRA.

Important Notices

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 w**ww.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, 2020. Contact your State for more information on eligibility -

ALABAMA – Medicaid
Website: http://www.myalhipp.com
Phone: 1-855-692-5447
ALASKA – Medicaid
The AK Health Insurance Premium Payment Program Website: http://myakhipp.com
Phone: 1-866-251-4861
Email: customerservice@myakhipp.com
Medicaid Eligibility: https://dhss.alaska.gov/dpa/pages/mediciad/default.aspx
ARKANSAS – Medicaid
Website: http://myarhipp.com
Phone: 1-855-MyARHIPP (855-692-7447)
CALIFORNIA - Medicaid
Website: https://www.dhcs.ca.gov/services/Pages/TPLRD_CAU_cont.aspx
Phone: 916-440-5676
COLORADO – Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)
Health First Colorado Website: https://www.healthfirstcolorado.com/
Health First Colorado Member Contact Center: 1-800-221-3943/State Relay 711
CHP+: Colorado.gov/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
FLORIDA – Medicaid
Website: https://www.flmedicaidtplrecovery.com/flmedicaidtplrecovery.com/hipp/index.html
Phone: 1-877-357-3268
GEORGIA – Medicaid
Website: https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp
Phone: 678-564-1162 ext 2131
Phone 1-800-457-4584

INDIANA – 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: http://www.indianamedicaid.com
IOWA – Medicaid and CHIP (Hawki)
Medicaid Website: https://dhs.iowa.gove/ime/members
Medicaid Phone: 1-800-338-8366
Hawki Website: http://dhs.iowa.gov/Hawki
Phone: 1-800-257-8563
KANSAS – Medicaid
Website: http://www.kdheks.gov/hcf/default.htm
Phone: 1-800-792-4884
KENTUCKY – 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
LOUISIANA – Medicaid
Website: www.medicaid.la.gov or www.ldh.la.gov/lahipp
Phone: 1-888-342-6207 (Medicaid or 1-855-618-5488 (LaHIPP)
MAINE – Medicaid
Website: http://www.maine.gov/dhhs/ofi/public-assistance/index.html
Phone: 1-800-442-6003
TTY Maine relay 711
Private Health Insurance Premium Webpage:
https://www.maine.gov/dhhs/ofi/applications-forms
Phone: -800-977-6740.
MASSACHUSETTS – Medicaid and CHIP
Website: http://www.mass.gov/eohhs/gov/departments/masshealth/
Phone: 1-800-862-4840

Important Notices

MINNESOTA – Medicaid
Website: https://mn.gov/dhs/people-we-serve/seniors/health-care/health-care-programs/programs-and-services/other-insurance.jsp
Phone: 1-800-657-3739

MISSOURI – Medicaid
Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm
Phone: 573-751-2005

MONTANA – Medicaid
Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP
Phone: 1-800-694-3084

NEBRASKA - Medicaid
Website: http://www.ACCESSNebraska.ne.gov
Phone: 1-855-632-7633
Lincoln: 1-402-473-7000
Omaha: 1-402-595-1178

NEVADA – Medicaid
Medicaid Website: http://dwss.nv.gov/
Medicaid Phone: 1-800-992-0900

NEW HAMPSHIRE – Medicaid
Website: https://www.dhhs.nh.gov/ombp/nhhpp/
Phone: 603-271-5218
Toll free number for the HIPP program: 1-800-852-3345, ext 5218

NEW JERSEY – Medicaid and CHIP
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

NEW YORK – Medicaid
Website: http://www.nyhealth.gov/health_care/medicaid/
Phone: 1-800-541-2831

NORTH CAROLINA – Medicaid
Website: https://medicaid.ncdhhs.gov/
Phone: 919-855-4100

NORTH DAKOTA – Medicaid
Website: http://www.nd.gov/dhs/services/medicalserv/medicaid/
Phone: 1-844-854-4825

OKLAHOMA – Medicaid and CHIP
Website: http://www.insureoklahoma.org
Phone: 1-888-365-3742

OREGON – Medicaid
Website: http://healthcare.oregon.gov/Pages/index.aspx
http://www.oregonhealthcare.gov/index-es.html
Phone: 1-800-699-9075

PENNSYLVANIA – Medicaid
Website: https://www.dhs.pa.gov/providers/Providers/Pages/Medical/HIPP-Program.aspx
Phone: 1-800-692-7462

RHODE ISLAND – Medicaid and CHIP
Website: www.eohhs.ri.gov
Phone: 855-697-4347, or 401-462-0311 (Direct RIte Share Line)

SOUTH CAROLINA - Medicaid
Website: http://www.scdhhs.gov
Phone: 1-888-549-0820

SOUTH DAKOTA - Medicaid
Website: http://dss.sd.gov
Phone: 1-888-828-0059

TEXAS – Medicaid
Website: https://www.gethipptexas.com/
Phone: 1-800-440-0493

UTAH – Medicaid and CHIP
Medicaid: https://medicaid.utah.gov/
CHIP: http://health.utah.gov/chip
Phone: 1-877-543-7669

VERMONT– Medicaid
Website: http://www.greenmountaincare.org/
Phone: 1-800-250-8427

VIRGINIA – Medicaid and CHIP
Website: https://www.coverva.org/hipp/
Medicaid Phone: 1-800-432-5924
CHIP Phone: 1-855-242-8282

WASHINGTON – Medicaid
Website: https://www.hca.wa.gov/
Phone: 1-800-562-3022

WEST VIRGINIA – Medicaid
Website: http://mywvhipp.com/
Phone: 1-855-MyWVHIPP (1-855-699-8447)

WISCONSIN – Medicaid and CHIP
Website: https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm
Phone: 1-800-362-3002

WYOMING – Medicaid
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, 2020, or for more information on special enrollment rights, contact either:

U.S. Department of Labor	U.S. Department of Health and Human Services
Employee Benefits Security Administration	Centers for Medicare & Medicaid Services
www.dol.gov/ebsa	www.cms.hhs.gov
1-866-444-EBSA (3272)	1-877-267-2323, Menu Option 4, Ext. 61565

Healthcare Terms

- This glossary defines many commonly used terms, but isn't a full list. These glossary terms and definitions are intended to be educational and may be different from the terms and definitions in your plan or health insurance policy. Some of these terms also might not have exactly the same meaning when used in your policy or plan, and in any case, the policy or plan governs. (See your Summary of Benefits and Coverage for information on how to get a copy of your policy or plan document.)
- See below for an example showing how deductibles, coinsurance and out-of-pocket limits work together in a real life situation.

Allowed Amount

This is the maximum payment the plan will pay for a covered health care service. May also be called "eligible expense", "payment allowance", or "negotiated rate".

Balance Billing

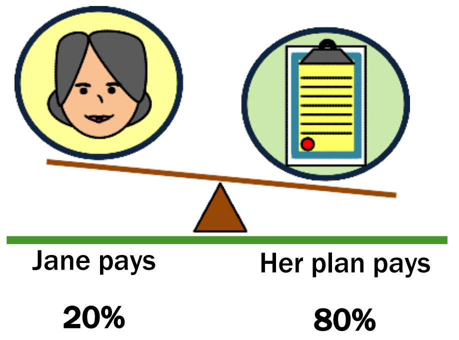
When a provider bills you for the balance remaining on the bill that your plan doesn't cover. This amount is the difference between the actual billed amount and the allowed amount. For example, if the provider's charge is $200 and the allowed amount is $110, the provider may bill you for the remaining $90. This happens most often when you see an out-of-network provider (non-preferred provider). A network provider (preferred provider) may not bill you for covered services.

Claim

A request for a benefit (including reimbursement of a healthcare expense) made by you or your health care provider to your health insurer or plan for items or services you think are covered.

Coinsurance

Your share of the costs of a covered health care service, calculated as a percentage (for example, 20%) of the allowed amount for the service. You generally pay coinsurance *plus* any deductibles you owe. (For example, if the health insurance or plan's allowed amount for an office visit is $100 and you've met your deductible, your coinsurance payment of 20% would be $20. The health insurance or plan pays the rest of the allowed amount.)



Complications of Pregnancy

Conditions due to pregnancy, labor, and delivery that require medical care to prevent serious harm to the health of the mother or fetus. Morning sickness and non-emergency caesarean section generally are NOT complications of pregnancy.

Copayment

A fixed amount (for example, $15) you pay for a covered health care service, usually when you receive the service. The amount can vary by the type of covered health care service.

Cost Sharing

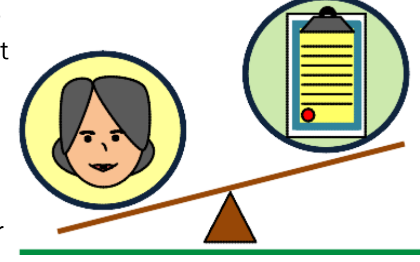
Your share of costs for services that a plan covers that you must pay out of your own pocket (sometimes called "out-of-pocket costs"). Some examples of cost sharing are copayments, deductibles, and coinsurance. Family cost sharing is the share of cost for deductibles and out-of-pocket costs you and your spouse and/or child(ren) must pay out of your own pocket. Other costs, including your premiums, penalties you may have to pay, or the cost of care a plan doesn't cover usually aren't considered cost-sharing.

Cost-sharing Reductions

Discounts that reduce the amount you pay for certain services covered by an individual plan you buy through the Marketplace. You may get a discount if your income is below a certain level, and you choose a Silver level health plan or if you're a member of a federally -recognized tribe, which includes being a shareholder in an Alaska Native Claims Settlement Act corporation.

Deductible

An amount you could owe during a coverage period (usually one year) for covered health care services before your plan begins to pay. An overall deductible applies to all or almost all covered items and services. A plan with an overall deductible may also have separate deductibles that apply to specific services or groups of services. A plan may also have only separate deductibles. (For example, if your deductible is $1000, your Plan won't pay anything until you've met your $1000 deductible for covered health care services subject to the deductible.)



Healthcare Terms

Diagnostic Test
Tests to figure out what your health problem is. For example, an x-ray can be a diagnostic test to see if you have a broken bone.

Durable Medical Equipment (DME)
Equipment and supplies ordered by a health care provider for everyday or extended use. DME may include: oxygen equipment, wheelchairs, and crutches.

Emergency Medical Condition
An illness, injury, symptom (including severe pain), or condition severe enough to risk serious danger to your health if you didn't get medical attention right away. If you didn't get immediate medical attention you could reasonably expect one of the following: 1) Your health would be put in serious danger; or 2) You would have serious problems with your bodily functions; or 3) You would have serious damage to any part or organ of your body.

Emergency Medical Transportation
Ambulance services for an emergency medical condition. Types of emergency medical transportation may include transportation by air, land, or sea. Your plan may not cover all types of emergency medical transportation, or may pay less for certain types.

Emergency Room Care/Emergency Services
Services to check for an emergency medical condition and treat you to keep an emergency medical condition from getting worse. These services may be provided in a licensed hospital's emergency room or other place that provides care for emergency medical conditions.

Excluded Services
Health care services that your plan doesn't pay for or cover.

Formulary
A list of drugs your plan covers. A formulary may include how much your share of the cost is for each drug. Your plan may put drugs in different cost sharing levels or tiers. For example, a formulary may include generic drug and brand name drug tiers and different cost sharing amounts will apply to each tier.

Grievance
A complaint that you communicate to your health insurer or plan.

Habilitation Services
Health care services that help a person keep, learn or improve skills and functioning for daily living. Examples include therapy for a child who isn't walking or talking at the expected age. These services may include physical and occupational therapy, speech-language pathology, and other services for people with disabilities in a variety of inpatient and or outpatient settings.

Health Insurance
A contract that requires a health insurer to pay some or all of your health care costs in exchange for a premium. A health insurance contract may also be called a "policy" or "plan".

Home Health Care
Health care services and supplies you get in your home under your doctor's orders. Services may be provided by nurses, therapists, social workers, or other licensed health care providers. Home health care usually doesn't include help with non-medical tasks, such as cooking, cleaning, or driving.

Hospice Services
Services to provide comfort and support for persons in the last stages of a terminal illness and their families.

Hospitalization
Care in a hospital that requires admission as an inpatient and usually requires an overnight stay. Some plans may consider an overnight stay for observation as outpatient care instead of inpatient care.

Hospital Outpatient Care
Care in a hospital that usually doesn't require an overnight stay.

Individual Responsibility Requirement
Sometimes called the "Individual Mandate", the duty you may have to be enrolled in health coverage that provides minimum essential coverage. If you don't have minimum essential coverage, you may have to pay a penalty when you file your federal income tax return unless you qualify for health coverage exemption.

In-network Coinsurance
Your share (for example, 20%) of the allowed amount for covered healthcare services. Your share is usually lower for in-network covered services.

In-network Copayment
A fixed amount (for example, $15) you pay for covered health care services to providers who contract with your health insurance or plan. In-network copayments usually are less than out-of-network copayments.

Healthcare Terms

Marketplace
A marketplace for health insurance where individuals, families and small businesses can learn about their plan options; compare plans based on costs, benefits and other important features; apply for and receive financial help with premiums and cost sharing based on income; and choose a plan and enroll in coverage. Also known as an "Exchange". The Marketplace is run by the state in some states and by the federal government in others. In some states, the Marketplace also helps eligible consumers enroll in other programs, including Medicaid and the Children's Health Insurance Program (CHIP). Available online, by phone, and in-person.

Maximum Out-of-pocket Limit
Yearly amount the federal government sets as the most each individual or family can be required to pay in cost sharing during the plan year for covered, in-network services. Applies to most types of health plans and insurance. This amount may be higher than the out of pocket limits stated for your plan.

Medically Necessary
Health care services or supplies needed to prevent, diagnose, or treat an illness, injury, condition, disease, or its symptoms, including habilitation, and that meet accepted standards of medicine.

Minimum Essential Coverage
Health coverage that will meet the individual responsibility requirement. Minimum essential coverage generally includes plans, health insurance available through the Marketplace or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage.

Minimum Value Standard
A basic standard to measure the percent of permitted costs the plan covers. If you're offered an employer plan that pays for at least 60% of the total allowed costs of benefits, the plan offers minimum value and you may not qualify for premium tax credits and cost sharing reductions to buy a plan from the Marketplace.

Network
The facilities, providers and suppliers your health insurer or plan has contracted with to provide health care services.

Network Provider (Preferred Provider)
A provider who has a contract with your health insurer or plan who has agreed to provide services to members of a plan. You will pay less if you see a provider in the network. Also called "preferred provider" or "participating provider."

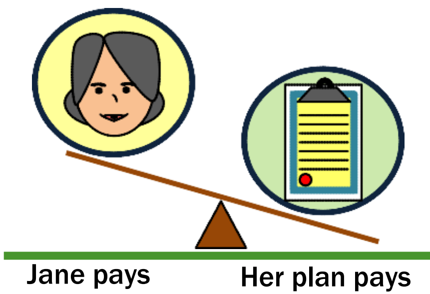
Orthotics and Prosthetics
Leg, arm, back and neck braces, artificial legs, arms, and eyes, and external breast prostheses after a mastectomy. These services include: adjustment, repairs, and replacements required because of breakage, wear, loss, or a change in the patient's physical condition.

Out-of-network Coinsurance
Your share (for example, 40%) of the allowed amount for covered health care services to providers who don't contract with your health insurance or plan. Out-of-network coinsurance usually costs you more than in-network coinsurance.

Out-of-network Copayment
A fixed amount (for example, $30) you pay for covered health care services from providers who do not contract with your health insurance or plan. Out-of-network copayments usually are more than in-network copayments.

Out-of-network Provider (Non-Preferred Provider)
A provider who doesn't have a contract with your plan to provide services. If your plan covers out-of-network services, you'll usually pay more to see an out-of-network provider than a preferred provider. Your policy will explain what those costs may be. May also be called a "non-preferred" or "non-participating" instead of "out-of-network provider".

Out-of-pocket Limit
The most you ***could*** pay during a coverage period (usually one year) for your share of the costs of covered services. After you meet this limit the plan will usually pay 100% of the allowed amount. This limit helps you plan for health care costs. This limit never includes your premium, balance-billed charges or health care your plan doesn't cover. Some plans don't count all of your copayments, deductibles, and coinsurance payments, out-of-network payment, or other expenses toward this limit.



Physician Services
Health care services a licensed medical physician including an M.D. (Medical Doctor, or D.O. (Doctor of Osteopathic Medicine), providers or coordinates.

Plan
Health coverage issued to you directly (individual plan) or through an employer, union or other group sponsor (employer group plan) that provides coverage for certain health care costs. Also called "health insurance plan", "policy", "health insurance policy" or "health insurance".

Preauthorization
A decision by your health insurer or plan that a health care service, treatment plan, prescription drug or durable medical equipment (DME) is medically necessary. Sometimes called prior authorization, prior approval or precertification. Your health insurance or plan may require preauthorization for certain services before you receive them, except in an emergency. Preauthorization isn't a promise your health insurance or plan will cover the cost.

Healthcare Terms

Premium
The amount that must be paid for your health insurance or plan. You and or your employer usually pay it monthly, quarterly, or yearly.

Premium Tax Credits
Financial help that lowers your taxes to help you and your family pay for private health insurance. You can get this help if you get health insurance through the Marketplace and your income is below a certain level. Advance payments of the tax credit can be used right away to lower your monthly premium costs.

Prescription Drug Coverage
Coverage under a plan that helps pay for prescription drugs. If the plan's formulary uses "tiers" (levels) prescription drugs are grouped together by type or cost. The amount you'll pay in cost sharing will be different for each "tier" of covered prescription drugs.

Prescription Drugs
Drugs and medications that by law require a prescription.

Preventive Care (Preventive Service)
Routine health care, including screenings, check-ups, and patient counseling, to prevent or discover illness, disease, or other health problems.

Primary Care Physician
A physician, including an M.D. (Medical Doctor) or D.O. (Doctor of Osteopathic Medicine), who provides or coordinates a range of health care services for you.

Primary Care Provider
A physician, including an M.D. (Medical Doctor) or D.O. (Doctor of Osteopathic Medicine), nurse practitioner, clinical nurse specialist, or physician assistant, as allowed under state law and the terms of the plan, who provides, coordinates, or helps you access a range of health care services.

Provider
An individual or facility that provides health care services. Some examples of a provider include a doctor, nurse, chiropractor, physician assistant, hospital, surgical center, skilled nursing facility, and rehabilitation center. The plan may require the provider to be licensed, certified, or accredited as required by state law.

Reconstructive Surgery
Surgery and follow-up treatment needed to correct or improve a part of the body because of birth defects, accidents, injuries, or medical conditions.

Referral
A written order from your primary care provider for you to see a specialist or get certain health care services. In many health maintenance organizations (HMOs), you need to get a referral before you can get health care services from anyone except your primary care provider. If you don't get a referral first, the plan may not pay for the services.

Rehabilitation Services
Health care services that help a person keep, get back, or improve skills and functioning for daily living that have been lost or impaired because a person was sick, hurt, or disabled. These services may include physical and occupational therapy, speech- language pathology, and psychiatric rehabilitation services in a variety of inpatient and or outpatient settings.

Screening
A type of preventive care that includes tests or exams to detect the presence of something, usually performed when you have no symptoms, signs, or prevailing medical history of a disease or condition.

Skilled Nursing Care
Services performed or supervised by licensed nurses in your home or in a nursing home. Skilled nursing care is not the same as "skilled care services", which are services performed by therapists or technicians (rather than licensed nurses) in your home or in a nursing home.

Specialist
A provider focusing on a specific area of medicine or a group of patients to diagnose, manage, prevent, or treat certain types of symptoms and conditions.

Specialty Drug
A type of prescription drug that, in general, requires special handling or ongoing monitoring and assessment by a health care professional, or is relatively difficult to dispense. Generally, specialty drugs are the most expensive drugs on a formulary.

UCR (Usual, Customary and Reasonable)
The amount paid for a medical service in a geographic area based on what providers in the area usually charge for the same or similar medical service. The UCR amount sometimes is used to determine the allowed amount.

Urgent Care
Care for an illness, injury, or condition serious enough that a reasonable person would seek care right away, but not to severe as to require emergency room care.

How your insurance works

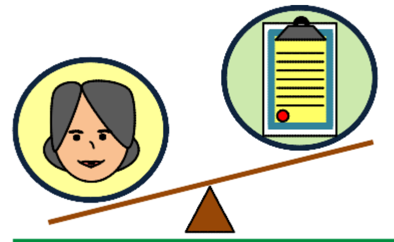
Jane's Plan Deductible: $1,250 **Coinsurance:** 20% **Out-of-Pocket Limit:** $3,500

January 1st

Beginning of Coverage Period

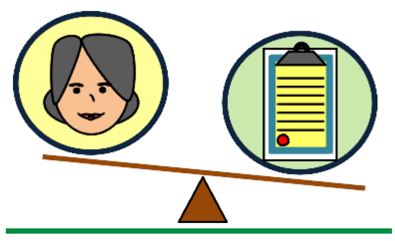
December 31st

End of Coverage Period



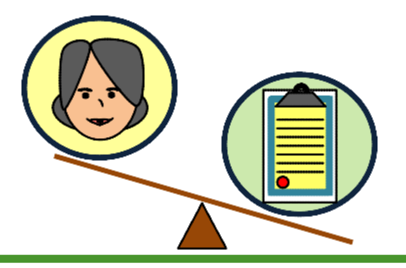
Jane pays 100% Her plan pays 0%

Jane hasn't reached her $1,250 deductible yet
Her plan doesn't pay any of the costs.
MRI: $1,000
Jane pays: $1,000
Her plan pays: $0



Jane pays 20% Her plan pays 80%

Jane reaches her $1,250 deductible, coinsurance begins
Jane has had several imaging services and paid $1,250 in total, reaching her deductible. So her plan pays some of the costs for her next visit.
Inpatient Hospital Stay: $1,700
Jane pays: 20% of $1,700 = $340
Her plan pays: 80% of $1,700 = $1,360



Jane pays 0% Her plan pays 100%

Jane reaches her $3,500 out-of-pocket limit
Jane has seen the doctor often and paid $3,500 in total. Her plan pays the full cost of her covered health care services for the rest of the year.
Office visit costs: $125
Jane pays: $0
Her plan pays: $125

Contact List

Plan	Company	Phone Number / Website	Reasons to contact
General Information	Holland Home	Human Resources benefits@hollandhome.org or 616-235-5026	Enrollment Human Resources
Medical / Pharmacy	Blue Care Network	www.bcbsm.com 800-662-6667	• Find participating physicians • Inquiries about eligibility • Confirm benefits • Questions about a bill or EOB (explanation of benefits) • Obtain claim forms • File a claim • Problems with eligibility • Problems with resolving claims through your carrier • Problems with obtaining benefit information through your carrier
Flexible Spending Account (FSA)	Health Equity	www.healthequity.com 866-346-5800	
Dental	BCBSM	www.mibluedentist.com 888-826-8152	
Vision	BCBSM	www.vsp.com 800-877-7195	
Life & Disability	Dearborn	www.mydearborngroup.com 800-721-7987	
Accident	Life Secure	www.yourlifesecure.com	
403(b) Savings Plan	Blueway Financial	Jeff Vander Weele 616-974-3003 or jeff.vanderweele@raymondjames.com	
Insurance Agency	Buiten & Associates	Lisa DeBoer, Senior Account Manager lisa.deboer@buiteninsurance.com 616-284-3029 Kevin Cumings, VP of Group Benefits kevin.cumings@buiteninsurance.com 616-956-0040 Ally Flinski, Individual/Medicare ally.flinski@buiteninsurance.com 616-284-3039	
Personal Insurance Agency	Buiten & Associates	www.buiteninsurance.com 800-530-9221	

The information in this Employee Benefits Guide is presented for illustrative purposes and is based on information provided by the employer. The text contained in this Guide was taken from various summary plan descriptions and benefit information. While every effort was taken to accurately report your benefits, discrepancies or errors are always possible. In case of discrepancy between the Guide and the actual plan documents the actual plan documents will prevail. All information is confidential, pursuant to the Health Insurance Portability and Accountability Act of 1996. If you have any questions about your Guide, contact Human Resources.

Discrimination is Against the Law

Holland Home complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Holland Home does not exclude people or treat them differently because of race, color, national origin, age, disability or sex.

Holland Home:

Provides free aids and services to people with disabilities to communicate effectively with us, such as:

- Qualified sign language interpreters
- Written information in other formats (large print, audio, accessible electronic formats, other formats)

Provides free language services to people whose primary language is not English, such as:

- Qualified interpreters
- Information written in other languages

If you need these services, contact Kim Motter at 616-956-9440.

If you believe that Holland Home has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with Kim Motter, 2100 Raybrook, Suite #203, Grand Rapids, MI 49546; phone 616-956-9440; toll free 800-447-3007; fax 616-954-1520; e-mail info@RelianceCCP.org

You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, Kim Motter is available to help you.
You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf or by mail or phone at:
U.S. Department of Health and Human Services
200 Independence Avenue SW
Room 509F, HHH Building
Washington, D.C. 20201
1-800-368-1019, 800-537-7697 (TDD)
Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-800-656-0310 (TTY 7-1-1).

CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-800-656-0310 (TTY 7-1-1).

注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-800-656-0310 (TTY 7-1-1).

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-800-656-0310번으로 전화해 주십시오. (TTY 7-1-1).

PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-800-656-0310. (TTY 7-1-1).

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-800-656-0310 (TTY 7-1-1).

ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1 -800-656-0310)
- :هاتف الصم والبكم(TTY 7-1-1).

ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-800-656-0310 ‘(TTY 7-1-1).

UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 1-800-656-0310 (TTY 7-1-1).

ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 1-800-656-0310 (TTY 7-1-1).

ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-800-656-0310 (TTY 7-1-1).

注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。1-800-656-0310まで、お電話にてご連絡ください。(TTY 7-1-1).

KUJDES: Nëse flitni shqip, për ju ka në dispozicion shërbime të asistencës gjuhësore, pa pagesë. Telefononi në 1-800-656-0310 (TTY 7-1-1).

OBAVJEŠTENJE: Ako govorite srpsko-hrvatski, usluge jezičke pomoći dostupne su vam besplatno. Nazovite 1-800-656-0310 (TTY 7-1-1).

ΠΡΟΣΟΧΗ: Αν μιλάτε ελληνικά, στη διάθεσή σας βρίσκονται υπηρεσίες γλωσσικής υποστήριξης, οι οποίες παρέχονται δωρεάν. Καλέστε 1-800-656-0310 (TTY 7-1-1).

Benefit Open Enrollment Process

Kronos Workforce Dimensions

- **To access via Computer:** Enter the URL https://hollandhome.prd.mykronos.com in **Chrome** browser. Then enter your user name and password on the logon page.
- **To access via Mobile:** Download the "Workforce Dimensions" app from the app store and you will have to enter the URL https://hollandhome.prd.mykronos.com when prompted in the app. (You will only have to do this once).

Username: Badge Number
Password: Password Created by You

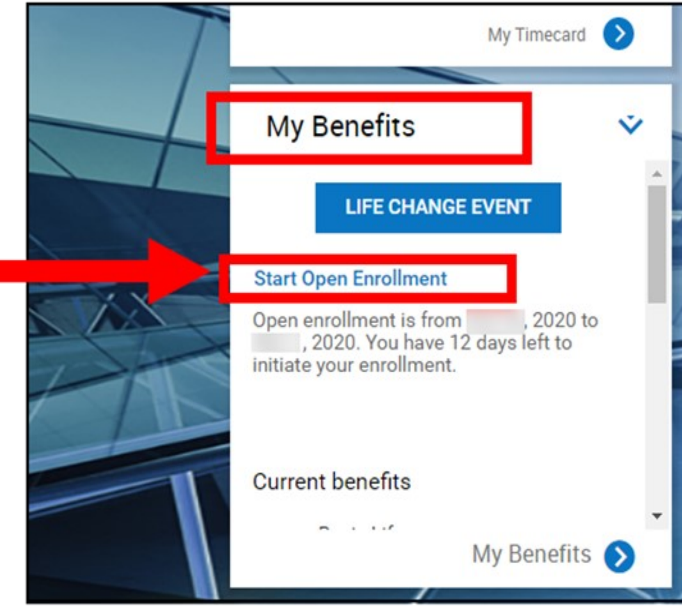
Trouble logging in? Click 'Forgot Password' and follow the prompts. Next, check your primary email account listed in Kronos. Click the link within the email from 'DimensionsIDP@mykronos.com'.

You will be prompted *twice* to reset your password. One the second prompt, the 'Old Password' is the one just previously created. Then return to the Workforce Dimensions page to log in.

Password Requirements:
- **Minimum of ten characters in length**
- **Must contain *both* uppercase and lowercase letters**
- **Must contain at least one number**
- **Must contain at least one special character i.e. !@#$%=+&^*()/**

If you need assistance with logging in please contact:
Information Services Kronos Hotline: 616-228-6969

Click 'Start Open Enrollment' located under 'Benefits' on the Kronos homepage dashboard



Benefit Open Enrollment Process

Kronos Workforce Dimensions

Track enrollment progress

KRONOS My Benefits

Enrollment | Benefit Plans

← Open Enrollment

70%

CONTINUE

Items to be completed. Green check mark is completed. If you are not selecting a benefit, you must waive it for a check mark to appear. Once every item has a check mark, you can then submit.

- ✔ Instructions
- ✔ Cafeteria Benefit Credit
- ✔ Dental
- ✔ Vision
- FSA
- Dependent Care FSA
- ✔ Core Plans
- ✔ Disability
- ✔ LTD Buy Up
- Life Insurance
- ✔ Accident
- Confirm & Submit

Instructions

As you proceed through the benefit categories (Medical, Dental, etc.), review the provider, pricing and coverage type that best meets your family's needs. Note that there are options to compare plan pricing and features to assist you with your selections.

Once you have decided on a plan, click on the "select" checkbox next to the plan. Note that you do have the option to waive plan coverage and can modify your selections up to final submit on confirm selections tab.

After you have selected your plan, if you have chosen a plan that requires a dependent (e.g. Employee plus Family) you will need to define those dependents. In most cases your dependents have already been added to the options for you. If not, you will want to have your dependent(s) contact, SSN and birthday information available as you complete this section.

NOTE: You must complete the Confirmation Selection tab and submit prior to your selections to be considered for activation.

Your information will be forwarded to HR for review and approval. You can always return to view your status of current benefits as needed or prompt a request for change should you experience a "Life Change Event" outside of the open enrollment period.

Dental

Compare Plans

☐ Waive all Dental

☐ Basic Dental

Coverage Name
-

To make changes to already selected benefits, uncheck the box, then check it again, and make your changes.

☑ Enhanced Dental — *Passive Enrollment - Plan Previously Selected*

Coverage Name Enhanced - Double	
Coverage -	Employee Contribution $40.40
Taxable Income -	Company Contribution -
Employee Frequency Every Scheduled Pay	Company Frequency -

CONTINUE

DETAILS

Benefit Open Enrollment Process
Kronos Workforce Dimensions

After re-checking the box, a new window will open. Choose the coverage type from the drop down list.

Fill in Required Info for Selected Plan

Coverage Level

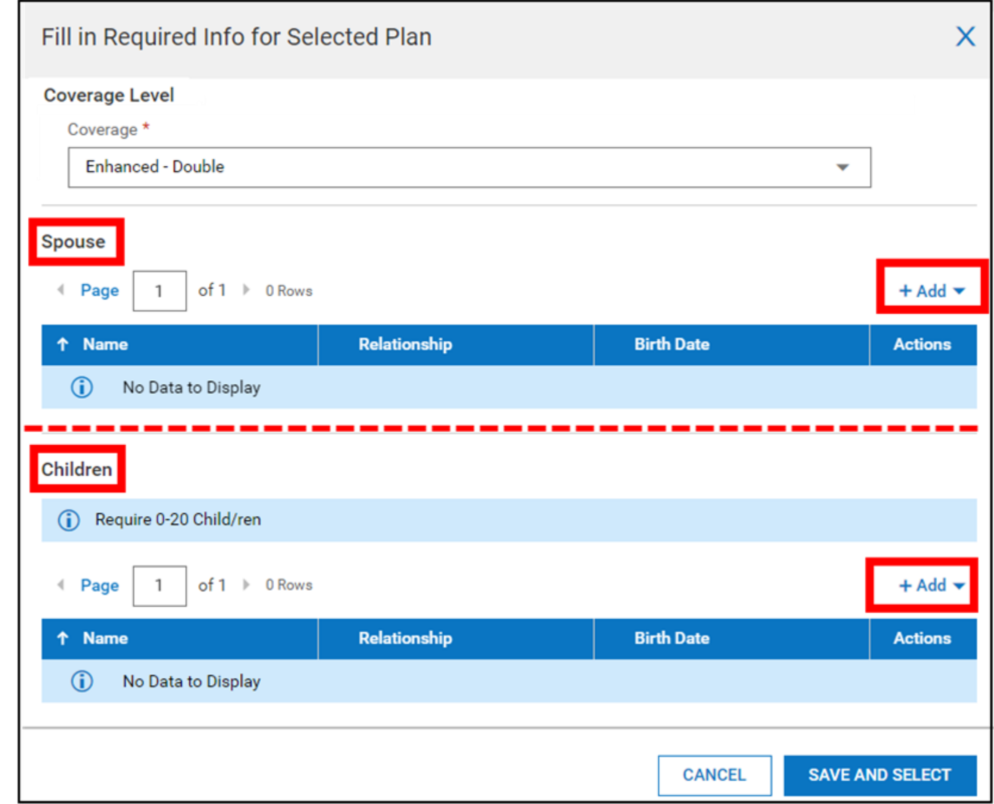
Coverage *

Enhanced - Single
Enhanced - Double
Enhanced - Family

CANCEL SAVE AND SELECT

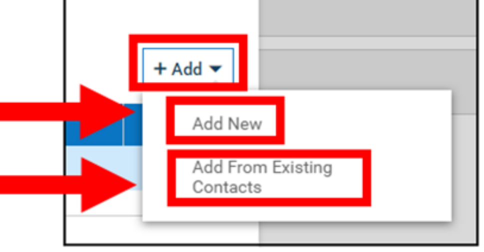
Next, add dependents. Be sure to add your spouse under 'Spouse' and children under 'Children'.

To add a dependent, click 'Add' under the applicable section.



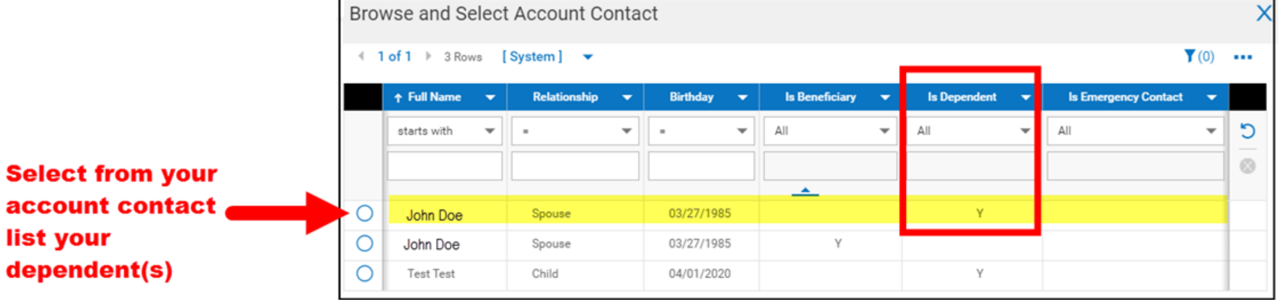
Select 'Add New' to create a new contact/ dependent profile

Select 'Add From Existing Contacts' to select from contacts/ dependents already on file



Benefit Open Enrollment Process

Kronos Workforce Dimensions

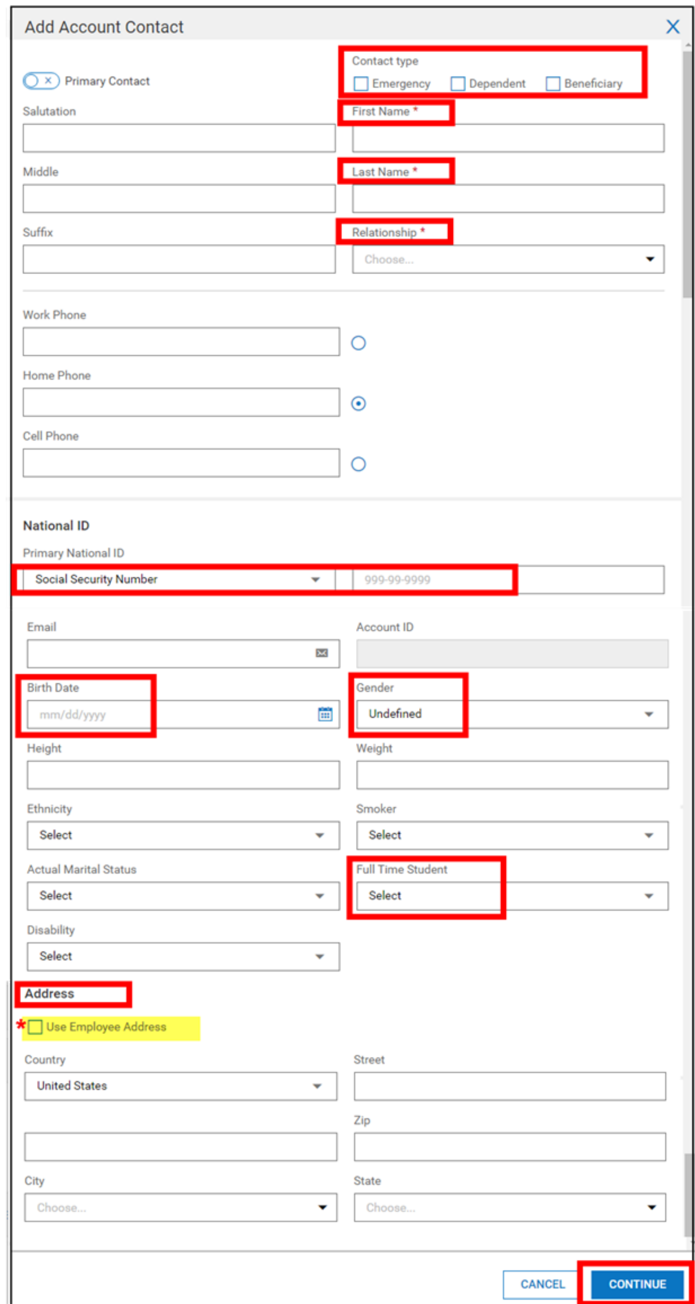


When adding a new contact, designate that they are a dependent, beneficiary, and/or emergency contact.

Required fields include:

- **First & Last Name**
- **Social Security Number**
- **Birth Date**
- **Gender**
- **Full Time Student**
- **Address***

***If address is the same as your own, choose 'Use Employee Address'.**



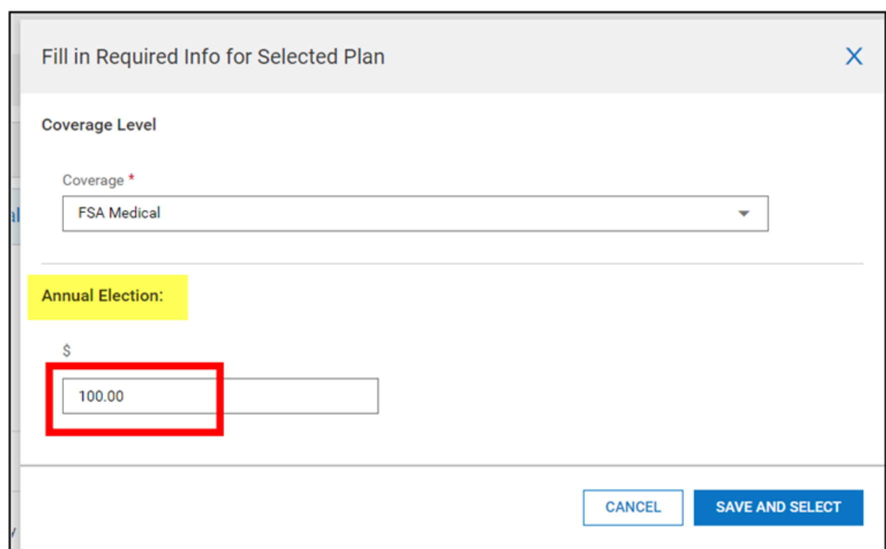
Benefit Open Enrollment Process

Kronos Workforce Dimensions

If electing FSA and/or Dependent Care FSA enter the *annual* amount.

If you have an amount in mind for each paycheck, multiply that amount by 26 to determine the annual amount.

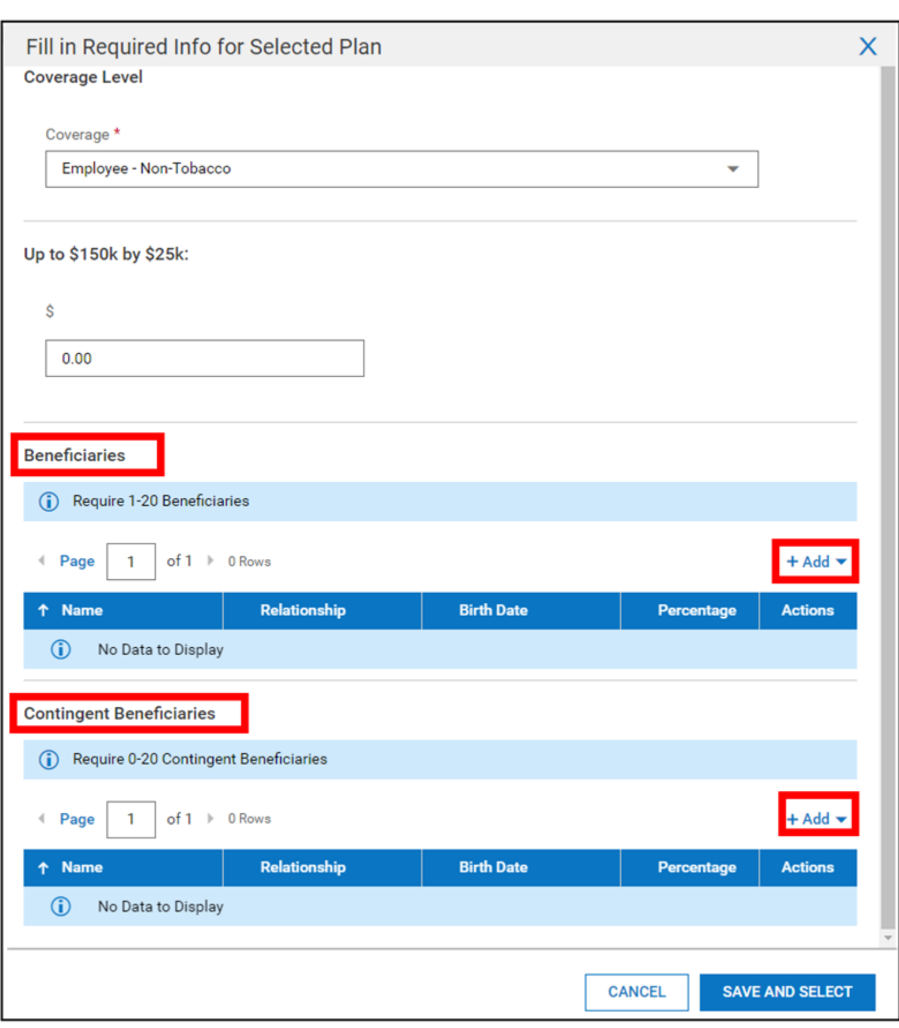
Example = $20 every pay check X 26 = $520 annual amount



If electing Voluntary Life Insurance, you must assign at least one beneficiary.

To add a beneficiary, click 'Add' then enter a percentage amount. The total percentage must equal 100%. If adding one beneficiary, they would be 100%; if adding 2 beneficiaries, they would each be assigned any percentage combination to equal 100%.

A contingent beneficiary is voluntary.



Benefit Open Enrollment Process
Kronos Workforce Dimensions

IMPORTANT—MUST READ—EVIDENCE OF INSURABILITY (EOI) FORM

Long Term Disability (LTD) Buy Up:

⇒ If not previously enrolled in Buy-up LTD and adding Buy-up LTD for the new benefit year, an Evidence of Insurability (EOI) Form **must** be completed and returned to Dearborn before the coverage will be approved.

Voluntary Life Insurance:

CURRENTLY ENROLLED:

⇒ Employees enrolled – can increase coverage by **1 level of $25,000** at annual enrollment up to Guaranteed Insured amount of $150,000 *without* EOI. If total is more than $25,000, must submit EOI for additional amount over $25,000.

⇒ Spouse enrolled – can increase coverage by **1 level of $12,500** at annual enrollment up to Guaranteed Insured amount of $25,000 *without* EOI. If total is more than $12,500, must submit EOI for additional amount over $12,500.

NOT CURRENTLY ENROLLED:

⇒ Employees - require EOI for any amount

⇒ Spouse - require EOI for any amount

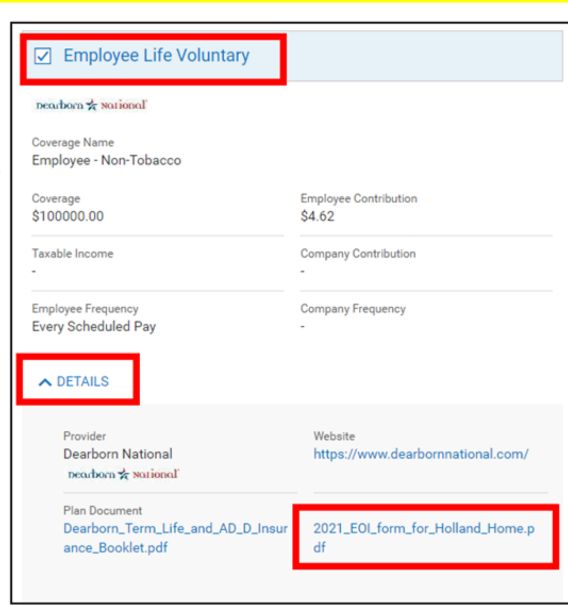
⇒ Children – No EOI needed

How to obtain EOI form

After electing LTD Buy Up and/or Life Insurance coverage, expand 'Details' then click 2021_EOI_form.pdf to download.

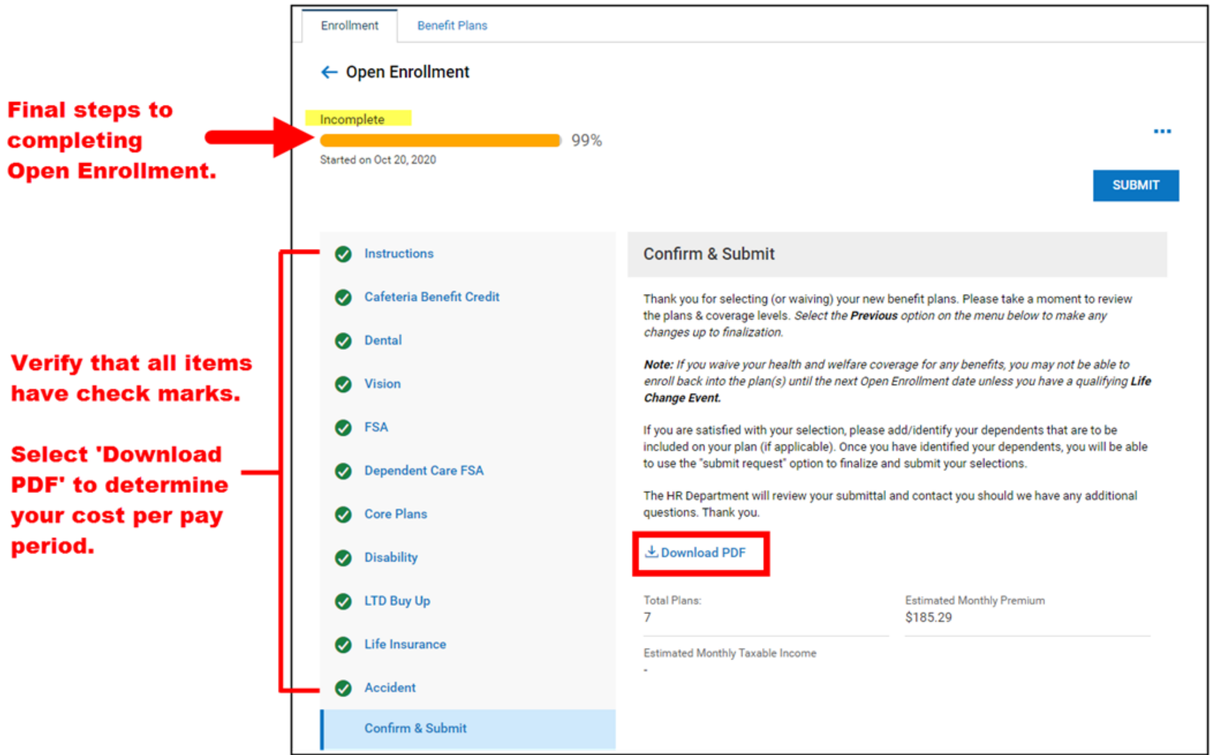
Print the form, complete it, and return to Dearborn.

Instructions on how to submit to Dearborn are included with the EOI Form.



Benefit Open Enrollment Process

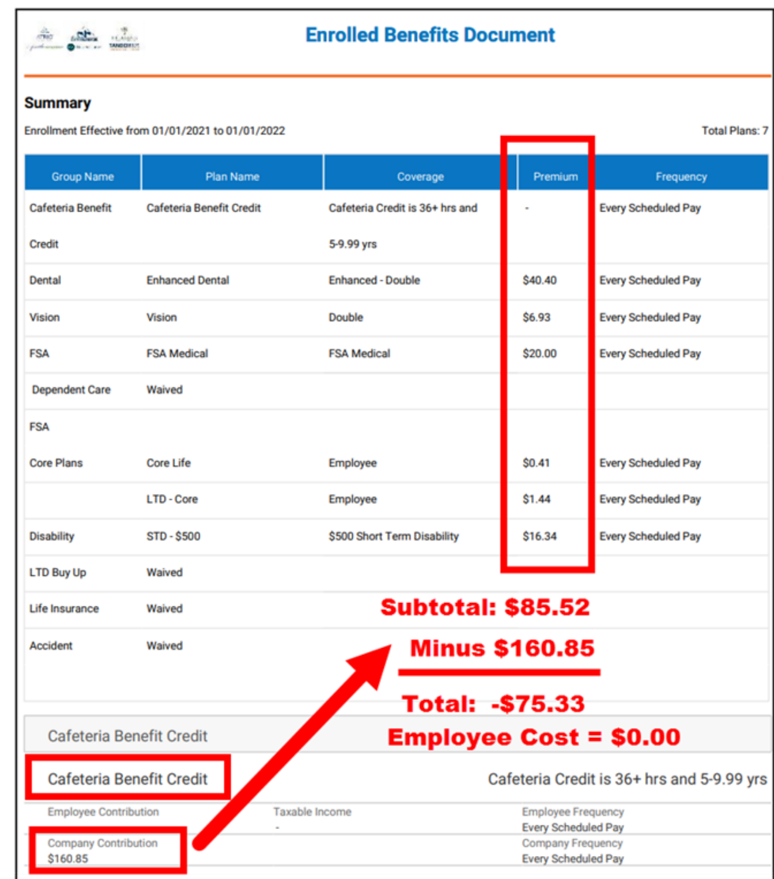
Kronos Workforce Dimensions



To find your cost per pay check, add the items in the 'Premium' column.

Then subtract the Cafeteria Benefit Credit Company Contribution.

If the Total is a negative number, you have a $0.00 out of pocket cost for benefits. You can then return to elections and make changes (such as increase FSA) or submit as is.



Enrolled Benefits Document

Summary

Enrollment Effective from 01/01/2021 to 01/01/2022 | Total Plans: 7

Group Name	Plan Name	Coverage	Premium	Frequency
Cafeteria Benefit Credit	Cafeteria Benefit Credit	Cafeteria Credit is 36+ hrs and 5-9.99 yrs	-	Every Scheduled Pay
Dental	Enhanced Dental	Enhanced - Double	$40.40	Every Scheduled Pay
Vision	Vision	Double	$6.93	Every Scheduled Pay
FSA	FSA Medical	FSA Medical	$20.00	Every Scheduled Pay
Dependent Care FSA	Waived			
Core Plans	Core Life	Employee	$0.41	Every Scheduled Pay
	LTD - Core	Employee	$1.44	Every Scheduled Pay
Disability	STD - $500	$500 Short Term Disability	$16.34	Every Scheduled Pay
LTD Buy Up	Waived			
Life Insurance	Waived			
Accident	Waived			

Subtotal: $85.52

Minus $160.85

Total: -$75.33

Employee Cost = $0.00

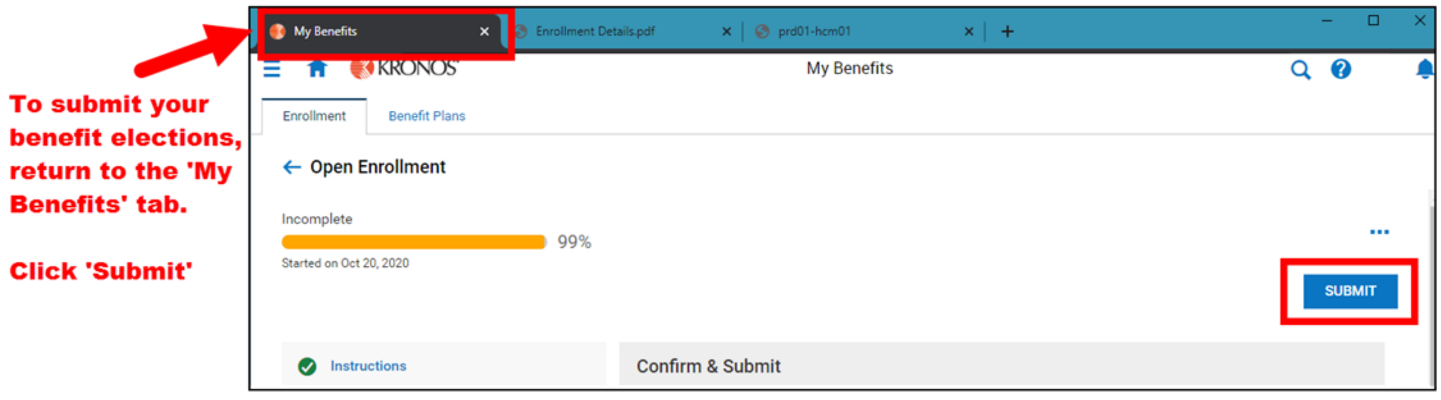
Cafeteria Benefit Credit

Cafeteria Benefit Credit — Cafeteria Credit is 36+ hrs and 5-9.99 yrs

Employee Contribution	Taxable Income	Employee Frequency
	-	Every Scheduled Pay
Company Contribution		**Company Frequency**
$160.85		Every Scheduled Pay

Benefit Open Enrollment Process

Kronos Workforce Dimensions



Enter the last 4 digits of your Social Security Number

Then click 'Accept'

Enrollment Acknowledgement

Please type your (Sarah Radler) SSN to confirm.

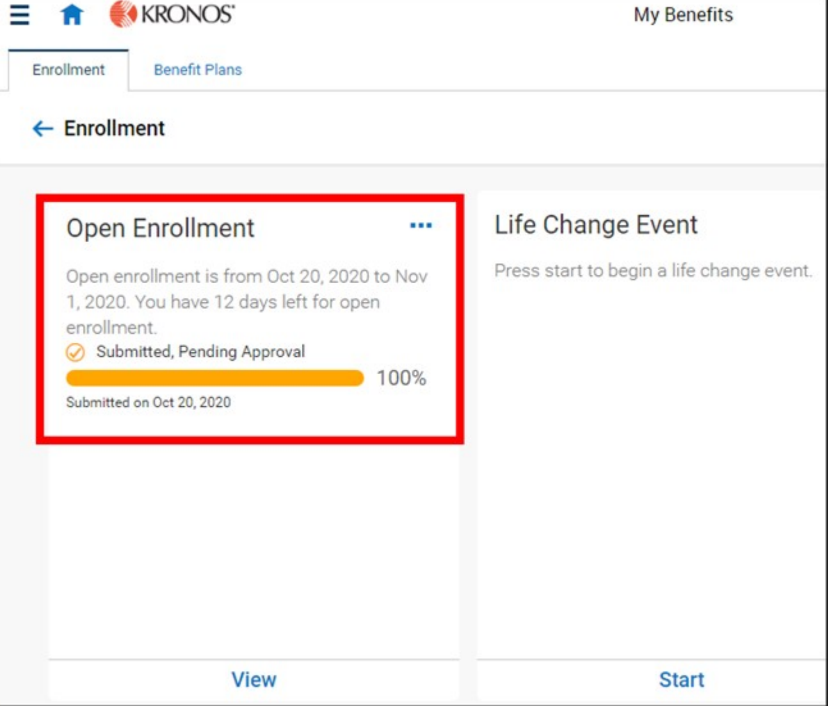
Last 4 of SSN *

If you wish to make additional changes, click on "**decline**" and you will return to the option menu.

Click on "**accept**" if you are satisfied with your selections and wish to proceed with the submittal process.

DECLINE ACCEPT

The Open Enrollment will show 100% completed once successfully submitted.



Benefit Open Enrollment Process

Kronos Workforce Dimensions

After submitting your Open Enrollment, if you need to make changes follow the steps below.

Return to 'My Benefits'.

Click the three dots next to 'Open Enrollment' then choose 'Delete'.

This will erase your elections and then you will need to start over again from scratch.

KRONOS | My Benefits

Enrollment | Benefit Plans

← Enrollment

Open Enrollment ···

Print

Delete

Open enrollment is from Oct 20, 2020 to N 1, 2020. You have 12 days left for open enrollment.

Submitted, Pending Approval

100%

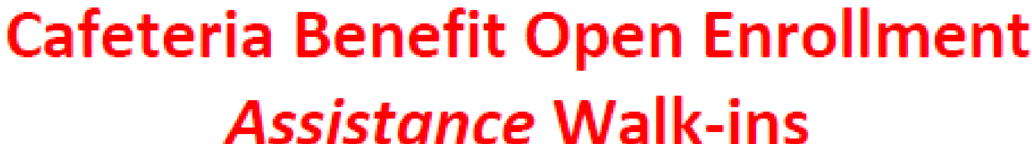
Submitted on Oct 20, 2020

View

Life Change Event

start to begin a life change event.

Start



Walk-in time frames for help enrolling in benefits through Kronos Workforce Dimensions for the 2021 benefit year.

Open Enrollment Begins: Monday 10/26
Open Enrollment Deadline: Wednesday 11/18

WHEN	WHERE	TIME
Tuesday 10/27	Breton Rehab – Lobby	10:00AM – 12:00PM
Tuesday 10/27	Raybrook – Chapel	1:30PM – 3:00PM
Wednesday 10/28	Care Resources	12:00PM – 2:00PM
Thursday 10/29	Corporate – HR	9:00AM – 11:00AM
Friday 10/30	Trillium Woods – Chapel	9:00AM – 11:00AM
Monday 11/2	Breton Rehab – Lobby	1:00PM – 3:00PM
Tuesday 11/3	Raybrook – Chapel	9:00AM – 12:00PM