VanDyk Mortgage Corporation
Est. 1987

2019 ENROLLMENT
BENEFITS GUIDE

If you (and/or) your dependents have Medicare or will become eligible for Medicare in the next 12 months, a Federal law gives you more choices about your prescription drug coverage. Please see page 29 for more details.

WHAT'S INSIDE

We've created a benefit package that helps you protect you and your family. We know the health care decisions you make are very important. You deserve all the information you need to make the right choices for you and your family.

The purpose of this guide is to give you a high level overview of our health, dental, and life benefit programs. Refer to the summary plan documents available from Human Resources.

Thank you for your hard work.

VOLUNTARY BENEFITS

The following are voluntary benefits outside of VanDyk's benefit package. Unum determine the benefits and terms. Please contact them directly with any questions.

CONTACT INFORMATION

BENEFIT CONSULTANT

HYLANT

General Claims and Benefit Information

Customer Service Helpline: In order to help you with your benefit questions, claim issues, and general inquiries, you and your dependents may contact Hylant. Please call the number listed below, Monday-Friday during normal business hours, 8 a.m.- 4:30 p.m., and speak to a customer service specialist who can assist you with your benefit questions.

Hylant Client Advocate
800-609-9614
benefithelp@hylant.com
www.hylant.com

Benefits Contact Brenna Toland	VanDyk Mortgage	616-974-9277	btoland@vandykmortgage.com
Medical	Blue Cross Blue Shield	877-671-2583	www.bcbsm.com
Dental	Blue Dental	888-826-8152	www.mibluedentist.com
Vision	Blue Vision / VSP	800-877-7195	www.vsp.com
Life/AD&D	Dearborn National	800-778-2281	www.dearbornnational.com
Disability	Dearborn National	877-348-0487	www.dearbornnational.com
Flexible Spending Account	Infinisource	866-370-3040	www.infinisource.com

How to enroll?

Log into your Paylocity account and select “Enterprise Web Benefits”. Contact Brenna Toland with any issues.

VOLUNTARY BENEFITS

The following are voluntary benefits outside of VanDyk’s benefit package. The carriers determine the benefits and terms. Please contact Unum directly with any questions.
Benefits elected during open enrollment will be effective January 1.

Accident & Critical Illness	Unum	800-635-5597	www.unum.com

When contacting any of the companies above, it is important to have the insurance card or ID number(s) of the subscriber for the coverage you are calling about as well as any appropriate paperwork, such as an explanation of benefits, a denial letter, receipts, etc.

BENEFITS ELIGIBILITY OVERVIEW

ELIGIBILITY

We are pleased to offer you health and welfare benefits that are designed to protect you and your family while you are employed with our organization.

DEPENDENT ELIGIBILITY

Your dependents may also be covered under the benefit plans as described below.

Benefits	Legal Spouse	Dependent Children
Medical / Rx	☑	Up to age 26
Dental	☑	Up to age 26
Vision	☑	Up to age 26
Life and AD&D	☑	Up to age 19

You may be asked to provide Human Resources with proof of dependent eligibility in the form of:

- Your most recent Federal Income Tax Return,
- Court Order specifying your responsibility to provide "group health care coverage" to your dependent children, and/or
- Copy of their birth certificate.

NEW HIRE COVERAGE

As a new employee, it is important you review the benefit information and enroll in benefits during your initial new hire eligibility period. If you do not enroll by that deadline, you will not be eligible for coverage until the following annual open enrollment period or if you experience a qualifying event.

Waiting Period: **First of month following 30** days for medical, dental, vision, life and AD&D, STD insurance. Other voluntary benefits are only available during open enrollment.

Benefits Effective: First day of month after 30 days.

QUALIFYING EVENT

If you experience a family status change during the year, you are able to make a mid-year benefit election change within 30 days of the event. A family status change includes:

- Marriage
- Divorce
- Birth or adoption
- Death of a dependent
- Change in your spouse's employment or
- Loss of coverage by a spouse

YOU MUST NOTIFY HUMAN RESOURCES WITHIN 30 DAYS OF THE QUALIFYING EVENT WITH YOUR REQUEST TO CHANGE YOUR BENEFITS, OR YOU WILL NEED TO WAIT UNTIL THE NEXT ANNUAL OPEN ENROLLMENT PERIOD.

TERMINATION OF COVERAGE

If employment is terminated, benefits will end last day worked.

COBRA CONTINUATION COVERAGE

When you or any of your dependents no longer meet the eligibility requirements for a health plan, you may be eligible for continued coverage as required by the Consolidated Omnibus Budget Reconciliation Act (COBRA) of 1986.

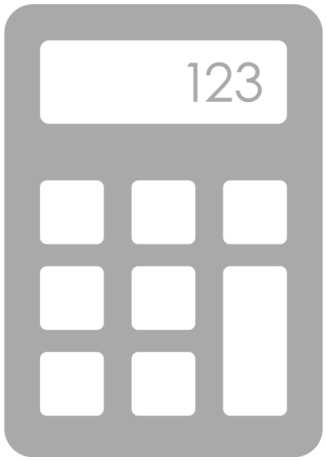
COST OF COVERAGE OVERVIEW

2019 PAYROLL DEDUCTIONS (PER PAY PERIOD)

	Employee Only	Employee + Spouse	Employee + Family
MEDICAL			
Simply Blue $1,000	$144.73	$557.35	$734.19
Simply Blue $2,500	$118.10	$493.43	$654.28
HSA $3,000	$92.00	$430.80	$575.99
Routine Care $4,000	$87.50	$420.00	$562.50
DENTAL			
BCBS Dental	$16.36	$32.72	$57.25
VISION			
Vision Service Plan (VSP)	$2.75	$5.49	$9.12
SHORT TERM DISABILITY			
	Based on age		
VOLUNTARY LIFE INSURANCE			
	Rates based on age and coverage level. Refer to page 19 for more information.		

UNDERSTANDING YOUR PRE-TAX BENEFIT PAYROLL DEDUCTIONS

The Section 125 Cafeteria Plan allows you to contribute “before-tax” dollars to pay for your coverage under a portion of the company’s benefit plans (e.g., medical, dental and vision coverage). By paying your premiums with “before-tax” dollars, you generally may reduce the amount of income and Social Security taxes that you otherwise would be required to pay. The elections you make during the Cafeteria Plan enrollment period are effective for the entire 12-month plan year. You generally cannot change your elections during the year unless you experience a change-in-status event (refer to your benefits booklet for the definition of a “change in status”). The circumstances that permit a change of election vary from one benefit to another. If you believe you have experienced a change-in-status event and you wish to change your elections, notify HR within 30 days of the change.



MEDICAL BENEFITS OVERVIEW

Plan Administrator Blue Cross Blue Shield of Michigan (BCBSM)

See page 3 for contact information

The following is a summary of your **In Network medical benefits only**. For a more detailed explanation of benefits and details regarding the Out of Network benefits, please refer to your certificate of coverage or SBC. You may access a list of participating providers through the carrier's website.

	Simply Blue $1,000*	Simply Blue $2,500*	SB HSA $3,000*	SB Routine Care $4,000*
	In-Network	In-Network	In-Network	In-Network
DEDUCTIBLES	Calendar Year	Calendar Year	Calendar Year	Calendar Year
Individual	$1,000	$2,500	$3,000	$4,000
Family	$2,000	$5,000	$6,000	$8,000
COINSURANCE				
Plan Pays	80%	80%	80%	70%
You Pay	20%	20%	20%	30%
OUT OF POCKET MAXIMUM				
Individual	$6,350	$6,350	$4,000	$6,600
Family	$12,700	$12,700	$8,000	$13,200
COMMONLY USED SERVICES				
Physician Visit or Virtual Visit	$30 copay	$30 copay	80% after deductible	$40 copay
Specialist Visit	$50 copay	$50 copay	80% after deductible	70% after deductible
Preventive Care Services	100% coverage	100% coverage	100% coverage	100% coverage
Urgent Care Visit	$60 copay	$60 copay	80% after deductible	70% after deductible
Emergency Room	$150 copay	$150 copay	80% after deductible	70% after deductible
Diagnostic Labs & X-Rays	80% after deductible	80% after deductible	80% after deductible	70% after deductible
Hospitalization	80% after deductible	80% after deductible	80% after deductible	70% after deductible
Mental Health & Substance Abuse*	80% after deductible	80% after deductible	80% after deductible	70% after deductible

PHARMACY			Rx after Deductible	Rx after Deductible Tier 2 & 3
Generic	$15	$15	$15	$10
Preferred Brand	$50	$50	$50	$40
Non Preferred Brand	$70 or 50%	$70 or 50%	$70 or 50%	$80
Mail Order (90 day supply)	2x	2x	2x	2x

** In Network Benefits list above. See Summary Plan Document for additional details and Out of Network Benefits. You may also contact the plan administrator with questions regarding benefits.*

UNDERSTANDING THE DIFFERENCE

HIGH DEDUCTIBLE HEALTH PLAN (HDHP) VS PPO

Having two health plans to choose from (or more if you have a spouse who also has access to health insurance) can create confusion when it comes time to decide which plan is best for you and your family.

	HDHP SB HSA $3000	PPO Plan All other plans
Annual Deductible	☑ Applies to all expenses (medical and prescriptions)	☑ Applies to hospital services, radiology and lab services performed outside of a doctor's office; does not include copays
Annual Out-of-pocket (OOP) Maximum	☑ Includes all deductible expenses; once OOP reached, the plan pays all eligible expenses at 100% (medical and prescriptions)	☑ Includes all medical deductible and copay expenses; once OOP reached, the plan pays all eligible medical expenses at 100%
Rx Out-of-pocket (OOP) Maximum	Not Applicable	☑ Includes all pharmacy copay expenses once OOP reached, the plan pays all eligible pharmacy expenses at 100%
Set Copayment Amounts	No copays	☑ Copays apply for doctor's office visits and prescription drugs
PPO Network	Blue Cross Blue Shield	Blue Cross Blue Shield
Out-of-network Coverage	☑	☑
Preventive Care Coverage	☑ Covered in full at network providers	☑ Covered in full at network providers
Health Savings Account (HSA)	☑ Payroll deductions can be set up to be deposited your account	Not eligible per IRS guidelines
Flexible Spending Account (FSA)	Not offered with HDHP	☑ No eligibility limitations
Premium Amount	☑ Lower paycheck cost; higher out of pocket at time of service	☑ Higher paycheck cost; lower out of pocket at time of service

BCBS Online Health Care

Blue Cross

Online Visits

Getting health care online:

What you need to know

When you use Blue Cross Online Visits (previously called 24/7 online health care), you'll have access to online medical behavioral health services anywhere in the U.S.

You can rest assured knowing you and your covered family members can see and talk to:

- A doctor for minor illnesses such as a cold, flu, or sore throat when their primary care doctor isn't available
- A behavioral health clinician or psychiatrist to help work through different challenges such as anxiety, depression and grief.

After Jan. 1, 2018, here's what you need to do to use online visits:

- **Mobile—**Download the BCBSM Online Visits app
- **Web—**Visit bcbsmonlinevisits.com
- **Phone—**Call **1-844-606-1608**

Create a Blue Cross Online Visits account to get started

1.Download the BCBSM Online Visits app from your smartphone or tablet using the App Store® or Google Play™. From your desktop, access a doctor via the web.

2.Add your Blue Cross or Blue Care Network health care plan information.

When to use the service

You can use it for minor illnesses such as:

- Sinus and respiratory infections
- Colds, flu and seasonal allergies
- Eye irritation or redness
- Strains and sprains

You can even get a prescription from your online doctor if you need it.

Save time and money

Your primary doctor is still your best option for treatment. Many have evening, weekend or online appointments.

But Blue Cross Online Visits can be helpful when you're sick and your own doctor isn't available. Online Visits are:

- Convenient. You don't have to leave your home to get medical care. If you're traveling, you can access an online doctor almost anywhere in the U.S.
- Affordable. If it's covered by your Blue Cross plan, these visits cost the same or less than a regular office visit.
- Quick. The average wait time is about 3 minutes and the average call is about 10 minutes, although a doctor will spend as much time as necessary.
- Easy. Once you've used the service, you can use your account at bcbsm.com to track all of your claims information.

bcbsmonlinevisits.com

BCBSM Online Visits

1-844-606-1608

FLEXIBLE SPENDING ACCOUNTS (FSA)

WHAT IS A FLEXIBLE SPENDING ACCOUNT?

A Flexible Spending Account allows you to set aside money from your paycheck before income taxes (Federal, Social Security, Medicare, state and local taxes, if applicable) are withheld. This money is available to pay for eligible expenses, such as copayments, deductibles, eyeglasses, contact lenses, prescriptions and other health-related expenses that are not reimbursed by insurance or dependent care expenses, such as child care.

HOW DOES IT WORK?

You decide how much to contribute to your Healthcare FSA on a plan year basis to the maximum allowable amount. Your annual election will be divided by the number of pay periods and deducted evenly on a pre-tax basis from each paycheck throughout the plan year.

DEBIT CARD AND CLAIM FILING

You will be issued a debit card to access the Healthcare FSA (transactions are to be processed like a credit card; a PIN will not be issued). Simply swipe your card at the provider's office, pharmacy, etc. It is important when utilizing the debit card to still request and keep an itemized receipt. You may receive a letter asking for a copy of the receipt. If you fail to submit the information requested, your debit card may be deactivated. Please contact Infinisource if this occurs.

If you do not use the debit card and you have an eligible expense that needs to be reimbursed, simply complete a claim form, include a bill or itemized receipt from the provider, and submit this information for reimbursement via fax, mail, online or mobile app.

NOTE: The debit card issued is valid for three years or until the expiration date noted on the card.

SAMPLE ELIGIBLE EXPENSES

- Unreimbursed medical expenses (deductibles, coinsurance, copay, etc.)
- Dental services (excluding cosmetic services)
- Orthodontia
- Glasses, contacts, and eye exams
- Lasik eye surgery

Annual FSA Maximum 2019 Contribution Limits

Healthcare FSA	$2,650
Dependent Care FSA	$2,500 per person or $5,000 married couple filing jointly

THINGS TO CONSIDER BEFORE YOU CONTRIBUTE TO AN FSA

- Be sure to fund the account wisely as the funds are "use it or lose it". Any unused funds at the end of the year will automatically be forfeited.
- You cannot take income tax deductions for expenses you pay with your Healthcare &/or Dependent Care FSA.
- You cannot stop or change contributions to your FSA during the year unless you have a change in family status consistent with your change in contributions.
- You may have a Health Savings Account and a Dependent Care FSA.
- You are not able to enroll in a Health Care FSA if you are enrolled in the HSA $3,000 plan. You can only contribute to a Health Savings Account.

DEPENDENT CARE FSA OVERVIEW

WHAT IS A DEPENDENT CARE FSA ACCOUNT?

This is a pre-tax benefit account used to pay for eligible expenses for dependents under age 13 or care for disabled spouse or dependent that allows you - or you and your spouse - to work.

Below are some examples of eligible expenses:

In-Home Babysitting Fees*

Before and After School Care

Day Care Facility Fees

DEPENDENT CARE FSA CONTRIBUTION LIMITS

Under the Dependent Care FSA, if you are married and file a joint return, or if you file a single or head of household return, the annual IRS limit is $5,000. If you are married and file separate returns, you can each elect $2,500 for the plan year. You and your spouse must be employed or your spouse must be a full-time student to be eligible to participate in the Dependent Care FSA.

CLAIMS REIMBURSEMENT

You may fax, mail or submit your dependent care claim to the carrier for reimbursement online or via the mobile app.

Note: You can only be reimbursed for the money you put into the account. For example: if you have contributed $200 into your Dependent Care FSA, but your after school care was $300 for the month, you can only be reimbursed for $200.

THINGS TO CONSIDER BEFORE YOU CONTRIBUTE TO A DEPENDENT CARE FSA

- Be sure to fund the account wisely as the funds are "use it or lose it". Any unused funds at the end of the year will automatically be forfeited.
- You must enroll in the dependent care FSA prior to the start of the plan year or during open enrollment (*unless you experience certain life events, called Permitted Election Change Events that allow a special mid-year enrollment.)*
- Save your receipts for each eligible expense you submit for reimbursement. Receipts should include:
  - Name (who received service)
  - Provider name (provider that delivered service)
  - Date of Service
  - Type of service
  - Cost of service

SAMPLE ELIGIBLE EXPENSES

- Fees for licensed day care or adult care facilities
- Before and after school care programs for dependents under age 13
- Amounts paid for services (including babysitters or nursery school) provided in or outside of your home
- Nanny expenses attributed to dependent care
- Nursery school (preschool) fees
- Summer Day Camp – primary purpose must be custodial care and not educational in nature

For a full list of eligible expenses, visit www.irs.gov/publications and refer to Publication 503.

**In order to receive reimbursement for in-home babysitting fees, income must be recorded by the provider.*

HEALTH SAVINGS ACCOUNT (HSA)

WHAT IS A HEALTH SAVINGS ACCOUNT?

A Health Savings Account, commonly known as an "HSA," is an individual account you can open, add money to, and spend on eligible health care expenses. If you elected the high deductible health plan, you are eligible for an HSA.

SETTING UP YOUR HSA

Once you are covered by a qualified health plan you may set up your HSA.

Once you set up your HSA, any payroll deductions you have elected may begin. It is important to get your HSA set up as quickly as possible because you cannot turn in expenses incurred before the account was set up.

ADDING MONEY

The government sets the annual dollar maximum that can be contributed to an HSA depending on the level of coverage you have under your health insurance. Coverage of two or more people is considered family coverage. People who are age 55 or older can make additional catch-up contributions.

HSA Maximum 2019 Contribution Limits	
Employee only	$3,500
Employee + dependents	$7,000
55+ CatchUp	$1,000

NOTE: PLEASE SEE IRS REGULATIONS OR HR FOR HSA ENROLLMENT ELIGIBILITY

USING HSA MONEY

You decide when to spend money from your HSA. If you pay out of pocket for an eligible medical expense, you can choose to not reimburse yourself and let the money in your HSA build up or you can reimburse yourself for the expense from your HSA.

If you use your HSA money for expenses that are not eligible, you will pay a 20% penalty plus income tax on the amount. Once you turn age 65, you may use your HSA money for any expense, medical or not, but you will pay income taxes on those non-medical expenses. To view the full list of eligible expenses, visit www.irs.gov/publications and refer to Publication 969.

Note: It is your responsibility to familiarize yourself with IRS regulations on HSAs and maintain records of all transactions pertaining to your HSA for audit purposes.

ELIGIBLE EXPENSES

The money in your HSA must be used for eligible medical, dental, vision, and prescription drug expenses. In general, eligible health care expenses are those that qualify toward the deductibles, copays, and coinsurance with your health insurance. If you use money for a dental, vision or medical expense that is not covered by the medical plan, it is important you understand your medical plan deductible still needs to be met if an expense is incurred.

PORTABILITY

- You own 100% of the deposited funds, meaning if you change employers or retire, you do not lose the money in the account regardless of whether you contributed the money or it was an employer contribution.

FLEXIBILITY

- You can choose whether to spend the money on current medical expenses or you can save your money for future use.
- Any unused funds will automatically roll over to the following year as there is no "use it or lose it" provision.

TAX SAVINGS

- Contributions are tax free (pre-tax through payroll deductions or tax deductible)
- Earnings are tax free
- Funds withdrawn for eligible medical expenses are tax free

PREMIUM SAVINGS

- By choosing the HDHP available, your payroll premium cost is lower than the traditional PPO plan.

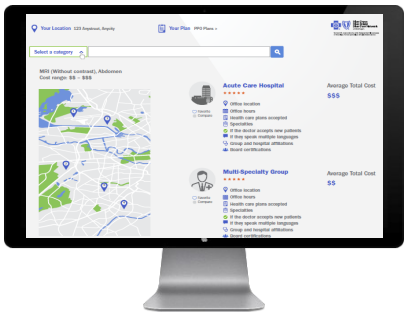
ONLINE TOOLS AND RESOURCES

LOG ON TO WWW.BCBSM.COM

- Check claim status and history
- View explanation of benefits and health statements
- View claim documents
- View account balances
- View benefits and eligibility
- Find a network doctor
- Refill a prescription
- Estimate treatment costs
- Chat with a nurse
- Search for information in the palm of your hand
- Learn about health conditions, symptoms and the latest treatment options

COST ESTIMATOR TOOL

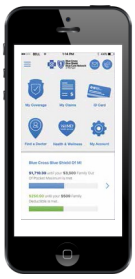
- Your personalized online tool to make MORE informed health care decisions
- Gives you the knowledge to better understand your choices and have better control of your health care



- **Compare costs**
- **Renew provider**
- **Provider quality**
- **Shop for generic brands**

BCBSM MOBILE APP

- Provides access to you and your family's health information anytime/anywhere
- Whether you want to find physicians near you, check the status of a claim or speak directly with a nurse
- Available for Apple and Android operating systems



PHARMACY RESOURCES

HYLANT SCRIPT NAVIGATOR

Is your copay for generic drugs $4 or less?

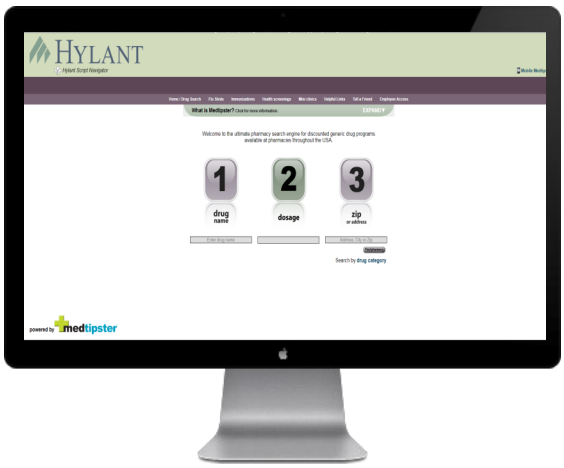
It could be. Hylant Script Navigator assists in identifying discounted generic drug programs available at pharmacies throughout the USA.

How does it work?

1. Visit **hylantscriptnavigator.com**
2. Enter in the name of the drug
3. Dosage amount
4. Your zip code

What will I receive?

- Access to a database containing thousands of discounted generics at over 60,000 pharmacies
- Information for the nearest pharmacy that caries your discounted generic medication in your neighborhood, often for $4 or less.



GENERIC AND FREE, OR LOW COPAY

Many pharmacies now offer discount prescriptions —often even lower than your copay. Check this list to see if discounts are available in your area:

- **Meijer:** a variety of oral antibiotics for FREE
- **Publix:** 90-day supply for select generic medications for only $7.50
- **Wal-Mart**: $4 for a 30-day supply and $10 for a 90-day supply of some generic medications
- **Kroger**: long list of low-cost generic drugs offered on an ongoing basis with free program card
- **Giant Eagle**: wide range of generic drugs at $4 or $10 per prescription as well as a 90-day supply for qualified drugs
- **Walgreens:** over 50 medications for as little as $5 for up to a 30-day supply, and can also receive discounts on vitamins, birth control, diabetic supplies, and lifestyle medications with membership
- **Rite Aid:** selection of generic medications at $9.99 for a 30-day supply and $15.99 for a 90-day supply with membership
- **Sam's Club**: hundreds of generic medications at $4 or $10 for a 30-day supply, and five select prescriptions for free with membership

COST SAVINGS TIPS AND HEALTH TIPS

1

CHOOSE A PRIMARY CARE PHYSICIAN

Selecting a primary care physician is one of the best things you can do for your health. This person knows your health history and schedules routine screening tests that frequently help prevent and detect diseases, such as heart disease, cancer, and diabetes. A visit to your primary care physician is usually less expensive compared to an urgent care or emergency room visit.

GO TO IN-NETWORK VERSUS OUT-OF-NETWORK

In-network providers have a contract with the health insurance company to provide services at reduced rates. In most cases, if you visit a physician or other provider within the network, the amount you will be responsible for paying will be less than if you go to an out-of-network provider.

2

3

SAVE ON PRESCRIPTION COSTS

Prescription costs can add up throughout the year. To save money, you can order your medications in bulk (90-day supply) through mail order, search for the least expensive pharmacy option near you (Walmart vs CVS), or check to ensure medications are listed on the plan's formulary list. If not, check with your doctor to see if there is a generic alternative.

KEEP YOURSELF AND YOUR FAMILY HEALTHY

Exercising, eating right, managing stress and not smoking are just some of the ways to prevent health problems from developing. Take advantage of preventive health services covered by your insurance plan. It is less costly to prevent illness than to treat a disease.

4

PRESCRIPTION OPIOID AWARENESS

A NATIONAL CRISIS

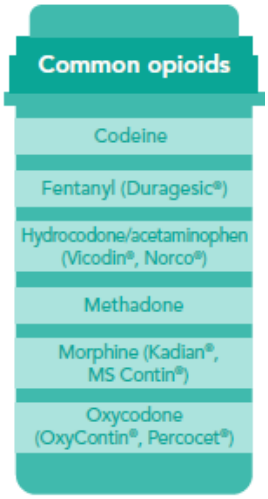
You've no doubt heard that there's a national opioid epidemic, affecting people of all ages and income levels. Someone you know – a friend, a family member or even a coworker – might be misusing, abusing or addicted to prescription painkillers.

WHAT'S AN OPIOID

Prescription opioids can be used to help relieve moderate-to-severe pain and are often prescribed following a surgery or injury, or for certain health conditions. These medications can be an important part of treatment but also come with serious risks. It is important to work with your health care provider to make sure you are getting the safest, most effective care.

KNOW YOUR OPTIONS

Before accepting a prescription, talk to your doctor:



· Make the most informed decision.

· Work with your doctor to create a plan on how to manage your pain.

· Know your options and consider ways to manage your pain that do not include opioids.

· Talk to your doctor about any and all side effects and concerns.

· Follow up regularly with your doctor.

IF YOU ARE PRESCRIBED OPIOIDS

Make sure you know the name of your medication, how much and how often to take it, and its potential risks & side effects.

Never take opioids in greater amounts or more often than prescribed.

Avoid taking opioids with alcohol and other substances or medications you have not discussed with your doctor.

Store prescription opioids in a secure place and out of reach of others (this may include visitors, children, friends, and family).

Safely dispose of unused prescription opioids.

SIDE EFFECTS

Prescription opioids carry serious risks of addiction and overdose, especially with prolonged use. An opioid overdose, often marked by slowed breathing, can cause sudden death. The use of prescription opioids can have a number of side effects as well, even when taken as directed:

Tolerance	Sleepiness / dizziness
Physical dependence	Confusion
Increased sensitivity to pain	Depression
Constipation	Itching and sweating
Low levels of testosterone	
Nausea, vomiting, and dry mouth	

ALTERNATIVES FOR PAIN MANAGEMENT

Talk with your doctor about the benefits of using one of the below methods if you suffer from chronic pain. Some of the options may even work more effectively than opioids, depending on the type of pain. Here are some of the alternative solutions proposed by the CDC:

- Acetaminophen (Tylenol) or ibuprofen (Advil)
- Cognitive behavioral therapy—a psychological, goal-directed approach in which patients learn how to modify physical, behavioral, and emotional triggers of pain and stress
- Exercise therapy, including physical therapy
- Medications for depression or for seizures
- Interventional therapies (injections)
- Exercise and weight loss
- Other therapies such as acupuncture and massage

HOW TO GET HELP

If you believe you or a loved one may be struggling with addiction, tell your health care provider and ask for guidance or call the Substance Abuse and Mental Health Services Administration (SAMHSA) National Helpline at 1-800-662-HELP (4357). Be Informed!

DENTAL BENEFITS OVERVIEW

Plan Administrator Blue Cross Blue Shield

You have access to an extensive network of dentists. You may access a list of participating providers through the carrier's website.

See page 3 for contact information

	Dental
	Coverage
Look for a participating provider in Blue Dental PPO Network: www.mibluedentist.com	
Type I—Preventive Services: Cleanings, Fluoride Treatment for Children, Space Maintainers, Topical Sealants	100% coverage
Type II—Basic Services: Restorative, Endodontics, Periodontics, Fillings, Oral Surgery	75% after deductible
Type III—Major Services: Crowns, Bridges, Dentures, Implants	50% after deductible
Type IV—Orthodontics Up to age 19	50% after deductible
DEDUCTIBLE *Waived for Preventive Services*	Plan Year Deductible
Individual	$50
Family	$100
MAXIMUM BENEFIT LIMITS	
Annual Limit: Basic and Major Services	$1,000
Lifetime Limit: Orthodontics	$1,000

Benefits of choosing In-Network providers:

- No balance billing
- Discounted pricing
- Doctors have been thoroughly screened

VISION BENEFITS OVERVIEW

Plan Administrator BCBS / VSP

The vision care network consists of private practicing optometrists, ophthalmologists, opticians and optical retailers. You may access a list of participating providers through the carrier's website.

See page 3 for contact information

	Vision (VSP)	
	In-Network	**Out-of-Network**
Look for a participating provider in the following network: Vision Service Plan (VSP) / www.vsp.com		
Office Visit Copay	$10 copay	Up to $45 reimbursement
Eye Exams Covered Once Every 12 Months	$10 copay	$10 copay applies to charge
Frames Covered Once Every 24 Months	$25 copay (one copay apples to both lenses and frames)	Up to $70 reimbursement
Lenses Covered Once Every 12 Months	$25 copay (one copay applies to both lenses and frames)	Reimbursement up to approved amount based on lens type less $25 copay (member responsible for any difference)
Contact Lenses (Medically Necessary) Covered Once Every 12 Months	$25 copay	Up to $210 reimbursement
Contact Lenses (Elective) Covered Once Every 12 Months	$130 allowance	Up to $105 reimbursement

HOW TO GET THE MOST OUT OF YOUR VISION INSURANCE

- Use it! If you purchase vision insurance, but never use it then you have wasted your money. Make sure you get your annual eye exam
- Choose in-network versus out-of-network providers
- Check to see if your provider offers discounts on additional eyewear

LIFE AND AD&D INSURANCE OVERVIEW

LIFE AND ACCIDENTAL DEATH & DISMEMBERMENT (AD&D) INSURANCE

See page 3 for contact information

Life insurance provides a monetary benefit to your beneficiary in the event of your death while you are employed at the company. AD&D insurance is equal to your life insurance benefit amount and is payable to your beneficiary in the event of your death as a result of an accident and may also pay benefits in certain injury instances. It is important to keep your beneficiary information up to date.

Administrator	Dearborn National
Cost of Coverage	Provided at no cost

Life Insurance	$50,000
Accidental Death and Dismemberment	$50,000
Benefit Reduction Schedule	35% at age 65 50% at age 70

VOLUNTARY LIFE AND AD&D INSURANCE

You have the opportunity to elect Voluntary Life Insurance. This will provide an additional life insurance benefit for you, your spouse and/or your dependent child(ren). Contributions for these premiums are 100% employee paid.

See page 3 for contact information

Administrator	Dearborn National
Cost of Coverage	Rates based on elected coverage amount and your age

	Voluntary Life and AD&D Coverage		
	Employee	**Spouse**	**Dependent Child(ren)**
Increments	$25,000 increments to $100,000	$5,000 increments to $15,000 or $25,000	$5,000 increments to $10,000
Guarantee Issue Amounts*	$100,000	$25,000	$10,000
Maximum	$25,000 increments to $100,000	$5,000 increments to $15,000 or $25,000	$5,000 increments to $10,000
Benefit Reduction Schedule	35% at age 65 50% at age 70		
Spouse rates based on Employee age.			

**If you waive voluntary life coverage when you are initially eligible you will be required to provide Evidence of Insurability (EOI) when enrolling at a later date. EOI is the documentation of good health in order to be approved for coverage. The carrier will review and determine approval based on EOI documentation. Benefits may be limited and/or denied based on EOI results.* Claims incurred prior to the approval of your coverage will not be covered. It is important to keep your beneficiary information up to date.

Rates for Voluntary Life Insurance can be found on page 19 of this booklet.

VOLUNTARY LIFE INSURANCE RATES

Age Band	Employee & Spouse Rates Per $1,000 Monthly
Below 20	$0.05
20-24	$0.05
25-29	$0.05
30-34	$0.06
35-39	$0.09
40-44	$0.13
45-49	$0.21
50-54	$0.33
55-59	$0.51
60-64	$0.69
65-69	$1.11
70-74	$1.87
75-79	$5.54
80-84	$5.54
85-89	$5.54
90-94	$5.54
95-99	$5.54
100 and above	$5.54

	Employee & Spouse Supplemental AD&D
All Ages	$0.02

Dependent Child(ren) Rates per $1,000	
Life	$0.15
AD&D	$0.02

How to calculate your per pay premium:

Amount of coverage/1,000 x rate = Monthly cost x 12/24 = Per Pay Cost

Example: An employee age 40 electing $50,000 voluntary life insurance

Life Benefit	$50,000
Age Rate	$0.130
(Life Benefit /1000) x Rate	$6.50

Per Pay Calculation = Monthly Rate ($6.50) x 12 months / 24 pay periods

Per Pay Rate: $3.25

**If you waive voluntary life coverage when you are initially eligible you will be required to provide Evidence of Insurability (EOI) when enrolling at a later date. EOI is the documentation of good health in order to be approved for coverage. The carrier will review and determine approval based on EOI documentation. Benefits may be limited and/or denied based on EOI results.* Claims incurred prior to the approval of your coverage will not be covered. It is important to keep your beneficiary information up to date.

DISABILITY PLAN OVERVIEW

VOLUNTARY SHORT TERM DISABILITY INSURANCE

Short Term Disability Insurance provides income protection in the event you become disabled and are unable to work due to sickness or non-occupational injury, including pregnancy, for a short period of time.*

See page 3 for contact information

This benefit is available first of the month following 30 days of employment.

Administrator	Dearborn National
Cost of Coverage	Rates based on age

Benefit Amount	60% of weekly earnings
Benefit Maximum	$2,000
Benefits Begin After	7 days for accident 7 days for illness
Maximum Benefit Period	12 weeks

Age Band	Rates per $10 Weekly Benefit Monthly
Below 20	$0.450
20-24	$0.450
25-29	$0.600
30-34	$0.600
35-39	$0.600
40-44	$0.600
45-49	$0.600
50-54	$0.645
55-59	$0.645
60-64	$0.655
65-69	$0.785
70-74	$0.785
75-79	$0.785
80-84	$0.785
85-89	$0.785
90-94	$0.785
95-99	$0.785
100 and above	$0.785

How to calculate your per pay premium:

Weekly wage x .60 /10 x rate = Monthly cost

Example: An employee age 40 earning $1200 weekly wage

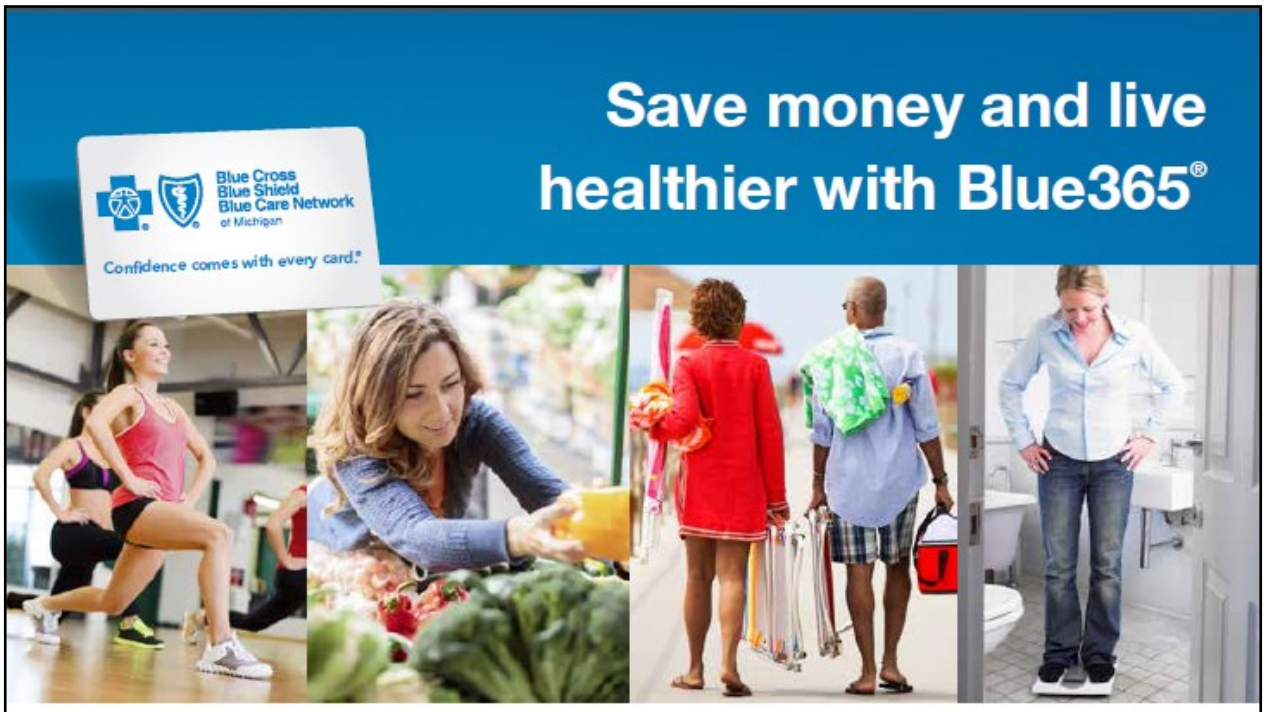
Benefit	$1200 x 0.60 = $720
Age Rate	$0.60
Benefit/10 x Rate	$43.20

Per Pay Calculation = Monthly Rate ($43.20) x 12 months / 24 pay periods

Per Pay Rate: $21.60

**If you waive voluntary disability coverage when you are initially eligible, you will be required to provide Evidence of Insurability (EOI) when enrolling at a later date. Please allow 4 to 6 weeks for underwriting review. Claims incurred prior to the approval of your coverage will not be covered. Benefits may be limited and/or denied based on the EOI results.*

EMPLOYEE DISCOUNT PROGRAMS



Save money and live healthier with Blue365®

Membership has its benefits

Blue Cross Blue Shield of Michigan and Blue Care Network members can score big savings on a variety of healthy products and services from businesses in Michigan and across the United States.

We've got plenty of deals to keep you and your family healthy.

Member discounts with Blue365 offers exclusive deals on things like:

- **Fitness and wellness:** Health magazines, fitness gear and gym memberships
- **Healthy eating:** Cookbooks, cooking classes and weight-loss programs
- **Lifestyle:** Travel and recreation
- **Personal care:** Lasik and eye care services, dental care and hearing aids

Cash in on discounts

Start saving today! Show your Blue Cross or Blue Care Network ID card at participating local retailers or use an offer code online to take advantage of these savings. For a full list of discount offers, log in or register at **bcbsm.com** and click *Member Discounts with Blue365®* on the right side of your home page. You can also conveniently access discounts on the go with the Blue Cross mobile app. Search **BCBSM** in Google Play™ or the App Store® to download our mobile app.

Blue Cross Blue Shield Blue Care Network of Michigan | Blue365®
Because health is a big deal™

EMPLOYEE DISCOUNT PROGRAMS

Member discounts with Blue365

Take advantage of discounts from the businesses listed below and many more.

Get monthly updates and details about new offers delivered directly to your email inbox. Just log in to your member account at bcbsm.com and opt-in to receive emails through *Paperless Options* under *Account Settings*.

You can conveniently access discounts from any device — anytime, anywhere.

Blue Cross Blue Shield Blue Care Network of Michigan

Nonprofit corporations and independent licensees of the Blue Cross and Blue Shield Association

Program information valid as of June 2017.

The Blue365 program is brought to you by the Blue Cross and Blue Shield Association. The Blue Cross and Blue Shield Association is an association of independent, locally operated Blue Cross and Blue Shield plans. Blue365 offers access to savings on items that members may purchase directly from independent vendors, which are different from items that are covered under health care plan policies with Blue Cross Blue Shield of Michigan or Blue Care Network, its contracts with Medicare or any other applicable federal health care program. Neither Blue Cross Blue Shield of Michigan, Blue Care Network nor the Blue Cross and Blue Shield Association recommends, endorses, warrants or guarantees any specific vendor or item.

ADDITIONAL VOLUNTARY BENEFITS

ACCIDENT INSURANCE—Unum

This voluntary benefit is outside of VanDyk's benefit package. Unum determines the benefits and terms.

See page 3 for contact information

unum
Better benefits at work.

Van Dyk Mortgage Corp

Group Accident Insurance with wellness benefit

If you have an accident, will it hurt your bank account too?

Unum's accident insurance gives you something to fall back on.

Life can take a tumble.

With a full-time job and three active kids, Marsha has a lot of demands on her time — and her pocketbook. So if her kids break something other than a window, she doesn't want an injury to break her bank account as well.

Benefits that pay for covered accidents while you are on the road to recovery

Unum's coverage provides a lump sum benefit based on the type of injury (or covered incident) you sustain or the type of treatment you need.

Examples of covered injuries include:

- broken bones
- burns
- torn ligaments
- lacerations
- coma due to a covered injury
- eye injuries
- ruptured discs
- concussion

Some covered expenses include:

- emergency room treatment
- outpatient surgery facility
- doctor office visit
- hospitalization
- occupational therapy
- speech therapy
- chiropractic visit
- physical therapy

See the schedule of benefits for a full list of covered injuries and expenses.

Who's at risk?

- Every 10 minutes, over 750 Americans suffer an injury severe enough to seek medical help.[1]
- Most injuries are not work-related and therefore not covered by workers' compensation.[2]

An illustrative example of how accident coverage can help you with your expenses

40-year-old claimant
Accident: Fall at home
Injury: Anterior Cruciate Ligament (ACL) tear (knee ligament injury)

Out-of-pocket expenses incurred:	
Emergency room copay	$150
Deductible	1,500
Coinsurance for surgery ($3,500 x 30%)	1,050
Copay for six physical therapy visits	120
Total out-of-pocket expenses:	**$2,820**

Benefits paid:	
Emergency room visit	$150
Appliance (knee brace)	200
Outpatient surgery facility service	500
Surgical ligament tear repair	1,000
Physical therapy sessions (6)	210
Total benefit paid under policy:	**$2,060**

Costs of treatment and benefit amounts may vary.
Example is based on the level 3 schedule of benefits.

How to apply To learn more, watch for information from your employer.

ADDITIONAL VOLUNTARY BENEFITS

ACCIDENT INSURANCE—Unum

This voluntary benefit is outside of VanDyk's benefit package. Unum determines the benefits and terms.

See page 3 for contact information

Get the coverage you need.

Choose the coverage that's right for you. Your accident insurance plan can provide benefits for covered accidents that occur off the job. Accident insurance is offered to all eligible employees who are actively at work.* You decide if it's right for you and your family.

The following benefits are automatically included in your plan:

Wellness Benefit

Based on the plan selected by your employer, this benefit can pay $50 per calendar year per insured individual if a covered health screening test is performed, including:

- Blood tests
- Stress tests
- Colonoscopies
- Chest X-rays
- Mammograms

A full list of covered tests will be provided in your certificate.

Four reasons to buy this coverage at work:

1. No health questions to answer. If you apply, you automatically receive this base plan.
2. This plan is portable. You may take the coverage with you if you leave the company or retire without having to answer new health questions. Unum will bill you directly.
3. Coverage becomes effective on the first day of the month in which payroll deductions begin.
4. Premiums are conveniently deducted from your paycheck.

Available family coverage

Who can have it?	
Spouse coverage	Ages 17 to 64
Child coverage	Dependent children newborn until their 26th birthday, regardless of marital or student status.

Employees must be U.S. citizens or legally authorized to work in the U.S. to receive coverage. Spouses and dependents must reside in the U.S. to receive coverage.

My accident coverage

Coverage plan chosen: _____

Cost per pay period: $ _____

Date deductions begin: ___/___/____

(For your records — complete during your enrollment)

THIS IS A LIMITED POLICY.

IMPORTANT NOTICE – THE BASE POLICY DOES NOT PROVIDE COVERAGE FOR SICKNESS

* Being "actively at work" means that on the day the employee applies for coverage, he/she must be working at one of his/her company's business locations, or at a location where he/she is required to represent the company. If applying for coverage on a day that is not a scheduled workday, the employee will be considered actively at work as of his/her last scheduled workday. Employees are not considered actively at work if they are on a leave of absence

Some states may require individuals to have comprehensive medical coverage before purchasing Accident Insurance.

1,2 National Safety Council, *Injury Facts* (2015).

Underwritten by:
Unum Life Insurance Company of America, Portland, Maine

The policy or its provisions may vary or be unavailable in some states. The policy has exclusions and limitations that may affect any benefits payable. See the actual policy or your Unum representative for specific provisions and details of availability.

Unum complies with all state civil union and domestic partner laws when applicable.

unum.com

EN-1779 (7-16) FOR EMPLOYEES OFF JOB PLAN

ADDITIONAL VOLUNTARY BENEFITS

CRITICAL ILLNESS INSURANCE—Unum

This voluntary benefit is outside of VanDyk's benefit package. Unum determines the benefits and terms.

See page 3 for contact information

unum
Better benefits at work.

Van Dyk Mortgage Corp

Group Critical Illness Insurance with Wellness Benefit

Could your bank account survive a serious illness?

Get protected with Group Critical Illness Insurance from Unum.

Lisa's story

Lisa was planning her daughter's wedding when a stroke disrupted her plans. Thanks to her Critical Illness coverage, Lisa was able to afford the treatment her medical insurance didn't cover. So she was able to focus on her goal for recovery: to dance at her daughter's wedding.

Who's at risk?

- The odds of developing cancer during a lifetime are one in two for men and one in three for women.[1]
- Every 34 seconds someone in America will have a coronary event.[2]

Key advantage

You can use this coverage more than once. If you receive a full benefit payout for a covered illness, your coverage can be continued for the remaining covered conditions.

How to apply To learn more, watch for information from your employer.

Three reasons to buy this coverage at work

1. You get affordable rates when you buy this coverage through your employer, and the premiums are conveniently deducted from your paycheck.
2. Coverage is portable. You may take the coverage with you if you leave the company or retire without having to answer new health questions. Unum will bill you directly.
3. Coverage becomes effective on the first day of the month in which payroll deductions begin.

How can Critical Illness insurance help?

Critical Illness insurance can pay a lump sum benefit at the diagnosis of a critical illness. You can choose to purchase $5,000 to $50,000 of coverage — and you can use the money any way you see fit.

Covered conditions	
Heart attack	Blindness
Major organ failure	End-stage renal (kidney) failure
Occupational HIV	Coronary artery bypass surgery; pays 25% of lump sum benefit
Benign brain tumor	
Covered conditions with time limitations	
Stroke	Evidence of persistent neurological deficits confirmed by a neurologist at least 30 days after the event
Coma	Coma resulting from severe traumatic brain injury lasting for a period of 14 or more consecutive days
Permanent paralysis	Complete and permanent loss of the use of two or more limbs for continuous 90 days as a result of a covered accident
Optional cancer conditions	
If selected by your employer, you may choose to select this benefit for an additional premium.	
Cancer	Carcinoma in situ;[3] pays 25% of lump sum benefit

Please see policy definitions for complete details about these covered conditions.

ADDITIONAL VOLUNTARY BENEFITS

CRITICAL ILLNESS INSURANCE—Unum

This voluntary benefit is outside of VanDyk's benefit package. Unum determines the benefits and terms.

See page 3 for contact information

Group Critical Illness Insurance

The following benefit is automatically included in your plan:

Wellness Benefit

Based on the plan selected by your employer, this benefit can pay $50 per calendar year per insured individual if a covered health screening test is performed, including:

- Blood tests
- Stress tests
- Colonoscopies
- Chest X-rays
- Mammograms

A full list of covered tests will be provided in your certificate.

Available family coverage

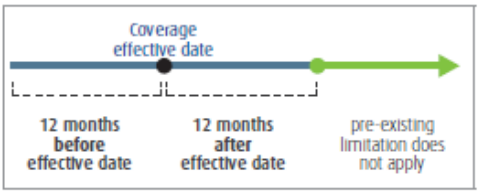
Who can have it?	Benefit
Employees who are actively at work	$5,000 to $50,000 in $1,000 increments
Dependent children newborn until their 26th birthday, regardless of marital or student status All eligible children are automatically covered at 25% of the employee benefit amount (no additional cost)	Eligible children are covered for the same conditions as employee and the following specific childhood conditions: cerebral palsy, cleft lip or palate, cystic fibrosis, Down syndrome and spina bifida. Diagnosis must occur after the child's coverage effective date.
Spouse ages 17 through 64 with purchase of employee coverage[4]	From $5,000 to $30,000 in $1,000 increments

Employees must be a U.S. citizen or legally authorized to work in the United States and actively at work at a U.S. location to receive coverage. Spouses and dependents must reside in the United States to receive coverage.

Provisions

Pre-existing condition limitation

Unum will not pay benefits for a claim that is caused by, contributed to or occurs as a result of a pre-existing condition for which the date of diagnosis is in the first 12 months following the Insured's coverage effective date.



Pre-existing condition means a sickness or injury or symptoms of a sickness or injury, whether diagnosed or not, for which the insured received medical treatment, consultation, care or services, including diagnostic measures, took prescribed drugs or medicine or had been prescribed drugs or medicine to be taken during the 12 months just prior to the insured's coverage effective date or effective date of a change in coverage.

Reduction of benefits

The benefit amount for the employee and spouse reduces by 50% on the first policy anniversary date after the insured individual's 70th birthday. Premiums will not be reduced. For coverage purchased after age 70, benefit amounts will not be reduced.

My Critical Illness coverage

Amount I applied for: $ _____

Cost per pay period: $ _____

Date deductions begin: ___/___/____

(For your records — complete during your enrollment)

THIS INSURANCE PROVIDES LIMITED BENEFITS.

1 American Cancer Society, "Cancer Facts & Figures 2015" (2015).
2 American Heart Association, "Heart Disease and Stroke Statistics — 2013 Update: A Report from the American Heart Association," Circulation (Jan. 1/8, 2013).
3 Carcinoma in situ is defined as cancer that involves only cells in the tissue in which it began and that has not spread to nearby tissues.
4 Spouses who work for the same employer can only be covered as either an employee or spouse, but not both.

EN-1775 (4-16) FOR EMPLOYEES

Underwritten by: Unum Life Insurance Company of America, Portland, Maine
The policy or its provisions may vary or be unavailable in some states. The policy has exclusions and limitations which may affect any benefits payable. See the actual policy or your Unum representative for specific provisions and details of availability.

unum.com

BASE PLAN WITH WELLNESS

IMPORTANT DISCLOSURES

Note to All Employees

Certain Federal Regulations require employers to provide disclosures of these regulations to all employees. The remainder of this document provides you with the required disclosures related to our employee benefits plan. If you have any questions or need further assistance please contact your Plan Administrator as follows:

VanDyk Mortgage

Margarita Hays

2449 Camelot Court SE

616-974-9214

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 applicable Plan for the remainder of the Plan Year, except as described below. Also, if you fail to specifically enroll your Eligible Dependents on the enrollment form, your Eligible Dependents will not be covered under the applicable Plan for the remainder of the Plan Year, except as otherwise provided below.

(a.) If you decline enrollment for yourself or your dependents because you or your dependent had other health insurance or group health plan coverage, either through COBRA or otherwise, you may enroll yourself and Eligible Dependents in the Health Program within **30 days** of the loss of that coverage. For this purpose, “loss of coverage” will occur if the other group health plan coverage terminates as a result of: (i) termination of employer contributions for the other coverage; (ii) exhaustion of the maximum COBRA period; (iii) legal separation or divorce; (iv) death; (v) termination of employment; (vi) reduction in hours of employment; or (vii) failure to elect COBRA coverage.

However, a loss of coverage will not be deemed to occur if the other coverage terminates due to a failure to pay premiums or termination for cause. At the time you enroll in the Employer’s Plan, you must provide a written statement from the administrator of the other health plan that you no longer have that coverage.

(b.) You are eligible to enroll yourself and your Eligible Dependent in the Health Program within **30 days** of the date you acquire a new Eligible Dependent through marriage, birth, adoption or placement for adoption. Your enrollment will become effective on the date of marriage, birth, adoption or placement for adoption. (Note pre-tax payments may not be made for retroactive coverage due to marriage.)

(c.) You are eligible to enroll yourself and your Eligible Dependent in the Plan within **60 days** after either:

(1.) You or your Eligible Dependent’s Medicaid coverage under title XIX of the Social Security Act or CHIP coverage through a State child health plan under title XXI of the Social Security Act is terminated as a result of loss of eligibility for such coverage; or

(2.) You or your Eligible Dependent is determined to be eligible for employment assistance under Medicaid or CHIP to help pay for coverage under the Plan.

IMPORTANT DISCLOSURES

Notice Regarding Women's Health and Cancer Rights Act (Janet's Law)

On October 21, 1998, Congress passed a Federal Law known as the Women's Health and Cancer Rights Act. The law includes important new protections for breast cancer patients who elect breast reconstruction in connection with a mastectomy. For individuals receiving mastectomy-related benefits, coverage will be provided in a manner determined in consultation with the attending physician and patient, 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 benefits will be provided subject to the same deductible and coinsurance applicable to other medical and surgical benefits provided under this plan.

If you would like more information on WHCRA benefits, please call your plan administrator.

Notice Regarding Michelle's Law

On Thursday, October 9, 2008, President Bush signed into law H.R. 2851, known as Michelle's Law. This law requires employer health plans to continue coverage for employees' dependent children who are college students and need a medically necessary leave of absence. This law applies to both fully insured and self-insured medical plans.

The dependent child's change in college enrollment must meet the following requirements:

The dependent is suffering from a serious illness or injury.

The leave is medically necessary.

The dependent loses student status for purposes of coverage under the terms of the plan or coverage.

Coverage for the dependent child must remain in force until the earlier of:

- One year after the medically necessary leave of absence began.
- The date the coverage would otherwise terminate under the terms of the plan.

A written certification by the treating physician is required. The certification must state that the dependent child is suffering from a serious illness or injury and that the leave is medically necessary. Provisions under this law became effective for plan years beginning on or after October 9, 2009.

Medicare Notice

You must notify VanDyk Mortgage when you or your dependents become Medicare eligible. VanDyk Mortgage 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.

If you have Medicare or will become eligible for Medicare in the next 12 months, a federal law gives you more choices in your prescription drug plan. Please see the complete Medicare Part D Coverage Notice(s) below.

Medicare Part D Coverage Notice – Important Information About Your Prescription Drug Coverage and Medicare

Please note that the following notice only applies to individuals who are or will become eligible for Medicare in the next 12 months.

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)

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with VanDyk Mortgage 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:

Medicare prescription drug coverage became available in 2006 to everyone with 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.

VanDyk Mortgage has determined that the prescription drug coverage offered by your company plan, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is 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.

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 15 through December 7. However, if you lose your current creditable prescription drug coverage, through no fault of your own, you will also be eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare drug plan.

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 coverage will not be affected. Your current coverage pays for other health expenses in addition to prescription drugs. The prescription drug coverage is part of the Group Health Plan and cannot be separated from the medical coverage. If you enroll in a Medicare prescription drug plan, you and your eligible dependents will still be eligible to receive all of your current health and prescription drug benefits. You have the option to waive the coverage provided under the Group Health Plan due to your eligibility for Medicare. If you decide to waive coverage under the Group Health Plan due to your Medicare eligibility, you will be entitled to re-enroll in the plan during the next open enrollment period.

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 will receive this notice each year and again, 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 U.S. Social Security Administration's 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

The Plan complies with the privacy requirements of the Health Insurance Portability and Accountability Act of 1996 (HIPAA). These requirements are described in a Notice of Privacy Practices that was previously given to you. A copy of this notice is available upon request.

Health Insurance Marketplace Coverage Options and Your Health Coverage

There is an additional 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.

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.

IMPORTANT DISCLOSURES

Each year, the open enrollment period for health insurance coverage through the Marketplace runs from Nov. 1 through Dec. 15 of the previous year. After Dec. 15, you can get coverage through the Marketplace only if you qualify for a special enrollment period or are applying for Medicaid or the Children's Health Insurance Program (CHIP).

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 9.86 percent of your household income for 2019, 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. (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.)

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 Human Resources. 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, as well as an online application for health insurance coverage and contact information for a Health Insurance Marketplace in your area.

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 January 31, 2018. Contact your State for more information on eligibility –

ALABAMA– Medicaid	COLORADO – Health First Colorado (Colorado's Medicaid Program)
Website: http://myalhipp.com/ Phone: 1-855-692-5447	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/
ALASKA – Medicaid	**FLORIDA – Medicaid**
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	Website: http://flmedicaidtplrecovery.com/hipp/ Phone: 1-877-357-3268
ARKANSAS – Medicaid	**GEORGIA – Medicaid**
Website: http://myarhipp.com/ Phone: 1-855-MyARHIPP (855-692-7447)	Website: http://dch.georgia.gov/medicaid - Click on Health Insurance Premium Payment (HIPP) Phone: 404-656-4507

IMPORTANT DISCLOSURES

INDIANA – Medicaid	NEBRASKA – 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 Phone 1-800-403-0864	Website: http://www.ACCESSNebraska.ne.gov Phone: (855) 632-7633 Lincoln: (402) 473-7000 Omaha: (402) 595-1178
IOWA – Medicaid	**NEVADA – Medicaid**
Website: http://dhs.iowa.gov/hawk-i Phone: 1-800-257-8563	Medicaid Website: https://dhcfp.nv.gov Medicaid Phone: 1-800-992-0900
KANSAS – Medicaid	**NEW HAMPSHIRE – Medicaid**
Website: http://www.kdheks.gov/hcf/ Phone: 1-785-296-3512	Website: https://www.dhhs.nh.gov/ombp/nhhpp/ Phone: 603-271-5218 Hotline: NH Medicaid Service Center at 1-888-901-4999
KENTUCKY – Medicaid	**NEW JERSEY – Medicaid and CHIP**
Website: https://chfs.ky.gov Phone: 1-800-635-2570	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
LOUISIANA – Medicaid	**NEW YORK – Medicaid**
Website: http://dhh.louisiana.gov/index.cfm/subhome/1/n/331 Phone: 1-888-695-2447	Website: https://www.health.ny.gov/health_care/medicaid/ Phone: 1-800-541-2831
MAINE – Medicaid	**NORTH CAROLINA – Medicaid**
Website: http://www.maine.gov/dhhs/ofi/public-assistance/index.html Phone: 1-800-442-6003 TTY: Maine relay 711	Website: https://dma.ncdhhs.gov/ Phone: 919-855-4100
MASSACHUSETTS – Medicaid and CHIP	**NORTH DAKOTA – Medicaid**
Website: http://www.mass.gov/eohhs/gov/departments/masshealth/ Phone: 1-800-862-4840	Website: http://www.nd.gov/dhs/services/medicalserv/medicaid/ Phone: 1-844-854-4825
MINNESOTA – Medicaid	**OKLAHOMA – Medicaid and CHIP**
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	Website: http://www.insureoklahoma.org Phone: 1-888-365-3742
MISSOURI – Medicaid	**OREGON – Medicaid**
Website: https://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005	Website: http://healthcare.oregon.gov/Pages/index.aspx http://www.oregonhealthcare.gov/index-es.html Phone: 1-800-699-9075
MONTANA – Medicaid	**PENNSYLVANIA – Medicaid**
Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084	Website: http://www.dhs.pa.gov/provider/medicalassistance/healthinsurancepremiumpaymenthippprogram/index.htm Phone: 1-800-692-7462

IMPORTANT DISCLOSURES

RHODE ISLAND – Medicaid	VIRGINIA – Medicaid and CHIP
Website: http://www.eohhs.ri.gov/ Phone: 855-697-4347	Medicaid Website: http://www.coverva.org/programs_premium_assistance.cfm Medicaid Phone: 1-800-432-5924 CHIP Website: http://www.coverva.org/programs_premium_assistance.cfm
SOUTH CAROLINA – Medicaid	**WASHINGTON – Medicaid**
Website: https://www.scdhhs.gov Phone: 1-888-549-0820	Website: http://www.hca.wa.gov/free-or-low-cost-health-care/program-administration/premium-payment-program Phone: 1-800-562-3022 ext. 15473
SOUTH DAKOTA - Medicaid	**WEST VIRGINIA – Medicaid**
Website: http://dss.sd.gov Phone: 1-888-828-0059	Website: http://mywvhipp.com/ Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)
TEXAS – Medicaid	**WISCONSIN – Medicaid and CHIP**
Website: http://gethipptexas.com/ Phone: 1-800-440-0493	Website: https://www.dhs.wisconsin.gov/publications/p1/p10095.pdf Phone: 1-800-362-3002
UTAH – Medicaid and CHIP	**WYOMING – Medicaid**
Medicaid Website: https://medicaid.utah.gov/ CHIP Website: http://health.utah.gov/chip Phone: 1-877-543-7669	Website: https://wyequalitycare.acs-inc.com/ Phone: 307-777-7531
VERMONT– Medicaid	
Website: http://www.greenmountaincare.org/ Phone: 1-800-250-8427	

To see if any other states have added a premium assistance program since July 31, 2018, 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

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BENEFITS GUIDE