

## Brown's Superstores

### 2024 Associate Benefit Enrollment

### Associate Plan Menu and Contributions



☐ New Hire ☐ Life Event ☐ Open Enrollment

Associate Name:  #300 Number:   
Social Security Number:  Date of Birth:   
Home Address:   
City:  State:  Zip:   
Signature:  Date:

## ACO Network

### Aetna Whole Health

#### Basic Managed Choice Plan (Bronze)

Associate Contributions (Weekly)

- ☐ Associate Only: **\$19.01**  
☐ Associate + Family: **\$32.68**

#### Managed Choice Plan (Silver Plus)

Associate Contributions (Weekly)

- ☐ Associate Only: **\$56.44**  
☐ Associate + Family: **\$132.33**

#### HCRA Plan (Aetna Healthfund)

Associate Contributions (Weekly)

- ☐ Associate Only: **\$32.08**  
☐ Associate + Family: **\$67.25**

## Broad Network

#### Basic Managed Choice Plan (Bronze)

Associate Contributions (Weekly)

- ☐ Associate Only: **\$20.91**  
☐ Associate + Family: **\$35.95**

#### Managed Choice Plan (Silver Plus)

Associate Contributions (Weekly)

- ☐ Associate Only: **\$62.09**  
☐ Associate + Family: **\$145.56**

#### HCRA Plan (Aetna Healthfund)

Associate Contributions (Weekly)

- ☐ Associate Only: **\$35.29**  
☐ Associate + Family: **\$73.97**

- ☐ **Medical Waiver:** Since I have refused the insurance, I understand that I may not enroll in my employer's plan until the next open enrollment period unless I have a qualifying life event, such as marriage, death of a spouse, birth, adoption, a court has ordered coverage to be provided for a spouse or minor child or lose my coverage elsewhere. If I experience a qualifying life event, I understand that I must request enrollment in the plan within thirty (30) days of the qualifying life event.

## Brown's Superstores

### 2024 Associate Benefit Enrollment Associate Plan Menu and Contributions



Associate Name:

#### Vision: EyeMed

##### EyeMed Vision Plan: Option 1

Associate Contributions (Weekly)

- ☐ Associate Only: **\$0.00**
- ☐ Associate + One Eligible Dependent: **\$0.00**
- ☐ Associate + Family: **\$0.00**

##### EyeMed Vision Plan: Option 2

Associate Contributions (Weekly)

- ☐ Associate Only: **\$0.55**
- ☐ Associate + One Eligible Dependent : **\$1.21**
- ☐ Associate + Family: **\$2.17**

- ☐ **Vision Waiver:** Since I have refused the insurance, I understand that I may not enroll in my employer's plan until the next open enrollment period unless I have a qualifying life event, such as marriage, death of a spouse, birth, adoption, a court has ordered coverage to be provided for a spouse or minor child or lose my coverage elsewhere. If I experience a qualifying life event, I understand that I must request enrollment in the plan within thirty (30) days of the qualifying life event.

#### Flexible Spending Account (FSA) Health Care

☐ Elect Coverage \$

#### Dependent Care

☐ Elect Coverage \$

- ☐ **FSA Waiver:** Since I have refused the insurance, I understand that I may not enroll in my employer's plan until the next open enrollment period unless I have a qualifying life event, such as marriage, death of a spouse, birth, adoption, a court has ordered coverage to be provided for a spouse or minor child or lose my coverage elsewhere. If I experience a qualifying life event, I understand that I must request enrollment in the plan within thirty (30) days of the qualifying life event.

#### For administration use only.

Associate Hire Date:

Effective Date:

Effective Date Notes:

Billing Store:

Additional Notes:

Associate Name: 

## Dependent Enrollment

Please attach applicable Marriage Certificate/Birth Certificate for anyone you are adding.

Name:  Date of Birth:  Relationship:  SSN: **Medical** ☐ Add ☐ Drop**Dental** ☐ Add ☐ Drop**Vision** ☐ Add ☐ DropName:  Date of Birth:  Relationship:  SSN: **Medical** ☐ Add ☐ Drop**Dental** ☐ Add ☐ Drop**Vision** ☐ Add ☐ DropName:  Date of Birth:  Relationship:  SSN: **Medical** ☐ Add ☐ Drop**Dental** ☐ Add ☐ Drop**Vision** ☐ Add ☐ DropName:  Date of Birth:  Relationship:  SSN: **Medical** ☐ Add ☐ Drop**Dental** ☐ Add ☐ Drop**Vision** ☐ Add ☐ DropName:  Date of Birth:  Relationship:  SSN: **Medical** ☐ Add ☐ Drop**Dental** ☐ Add ☐ Drop**Vision** ☐ Add ☐ DropName:  Date of Birth:  Relationship:  SSN: **Medical** ☐ Add ☐ Drop**Dental** ☐ Add ☐ Drop**Vision** ☐ Add ☐ DropName:  Date of Birth:  Relationship:  SSN: **Medical** ☐ Add ☐ Drop**Dental** ☐ Add ☐ Drop**Vision** ☐ Add ☐ DropName:  Date of Birth:  Relationship:  SSN: **Medical** ☐ Add ☐ Drop**Dental** ☐ Add ☐ Drop**Vision** ☐ Add ☐ DropName:  Date of Birth:  Relationship:  SSN: **Medical** ☐ Add ☐ Drop**Dental** ☐ Add ☐ Drop**Vision** ☐ Add ☐ DropName:  Date of Birth:  Relationship:  SSN: **Medical** ☐ Add ☐ Drop**Dental** ☐ Add ☐ Drop**Vision** ☐ Add ☐ Drop