Plan Year 2017-2018
Effective May 1, 2017 to April 30, 2018

JL Properties, Inc.

EMPLOYEE BENEFITS GUIDE

Welcome

We are committed to providing employees with a benefits program that is both comprehensive and competitive, with a range of plan options to meet the needs of our diverse workforce. This program is designed to assist you in providing for the health, well-being and financial security of you and your covered dependents. We know that your benefits are important to you and your family. Helping you understand the benefits **JL Properties, Inc.** offers is important to us. That is why we have created this Employee Benefits Guide.

Benefits can be overwhelming – you usually don't think about them unless it is time to enroll, or until you need them. This guide can help you in both situations. Your benefits are here to protect your health and financial security, and help you prepare for the future. We give you many options, so be sure to evaluate the package available to you and choose the benefits and coverage levels that make the most sense.

Benefits Guide Overview

This guide provides a general overview of your benefit choices to help you select the coverage that is right for you. Be sure to make choices that work to your best advantage. Of course with choice comes responsibility and planning. Please take time to read about and understand the benefit plan thoroughly, and enroll on time. Included in this guide are summary explanations of the benefits and costs as well as contact information for each provider. It is important to remember that only those benefit programs for which you are eligible and have enrolled in apply to you. We encourage you to review each section and to discuss your benefits with your family members. Be sure to pay close attention to applicable co-payments and deductibles, how to file claims, networks and services that may be limited or not covered (exclusions).

This guide is not an employee/employer contract. It is not intended to cover all provisions of all plans but rather is a quick reference to help answer most of your questions. Please see your Summary Plan Description for complete details.

We hope this guide will give you a clear explanation of your benefits and help you be better prepared for the enrollment process. Making educated decisions about your benefits – when you choose them and when you use them – can help save money.

Are you eligible for benefits?

Before you get started, be sure to understand who may be covered on the benefit plan.

To determine the benefits for which you may be eligible, please refer to the chart below. You are eligible to participate in these plans upon meeting each plan's eligibility requirements. You also have the option to enroll your eligible dependents in some of these plans.

Eligible dependents may include:

- ❑ Lawful spouse or domestic partner
- ❑ Children:
  - Child under 26 years of age
  - Natural or legally adopted
  - Minor or foster child for whom you or your spouse has legal guardianship

You must sign up your eligible dependents for insurance coverage—their enrollment is not automatic.

Benefit Plan	Eligibility	Probationary
	You are eligible to enroll if you are an Employee working	You are eligible to enroll on the
Medical	at least 30 hours per week	First of the month after 60 days
Cafeteria Plan	at least 30 hours per week	First of the month after 60 days
Group Life/AD&D	at least 30 hours per week	First of the month after 60 days
Voluntary Principal Benefits (Dental, Vision, Life/AD&D, STD and LTD)	at least 30 hours per week	First of the month after 60 days

Documentation, such as birth and marriage certificates may be required as proof of dependent eligibility. If you change your elections during the year due to a qualified change in status, you will be required to provide specific information applicable to your event.

When Can I Make Benefit Elections?

There are three enrollment opportunities for benefits:

- ❑ When you are hired as a new employee.
- ❑ When you experience a qualifying event.
- ❑ During annual open enrollment.

1. **When you are initially eligible for coverage.** You have a certain number of days from the date you are eligible for coverage to submit your enrollment.
2. **Special enrollment opportunity**. This is a limited enrollment period that opens if you have lost other coverage due to a reason beyond your control, or you have a qualified family status change.

   Examples of qualified family status changes that allow you to change some of your benefits during the year include:

   - Marriage or divorce
   - Death of your dependent child or spouse
   - Change in your or your spouse's employment status that results in loss or gain of coverage
   - Birth, adoption, or change in the custody of your child
3. **Annual open enrollment**. JL Properties, Inc. open enrollment is **April 1st – April 30th**. This is the time of year to add or delete coverage for any eligible dependents. If you do not enroll an eligible spouse or child now, you may only add that person on the JL Properties, Inc.'s plan during next year's open enrollment period or a special enrollment opportunity.

Your employer will tell you the date you must have your paperwork completed and turned in.

What's Changing?

❑ **New this year! Voluntary Vision Moving to Principal VSP!**

If you would like to add or change coverage you will need to complete an enrollment form. If you had coverage with Ameritas VSP it is automatically transferred to Principal VSP. Benefits reset effective 5/01/2017.

Carrier: Aetna **Plan**: Open Choice PPO

MEDICAL BENEFITS	In-Network Designated Provider	In-Network Non-Designated Provider	Out-of-Network
Individual Annual Deductible PCY	$2,500	$2,500	$5,000
Family Annual Deductible PCY	$7,500	$7,500	$15,000
Individual Out-of-Pocket PCY (includes deductible)	$5,500	$5,500	$11,000
Family Out-of-Pocket PCY (includes deductible)	$11,000	$11,000	$22,000
Preventive Office Visit	Covered in Full	Covered in Full	50% after deductible
Office Visit	$25 copay deductible waived	$45 copay deductible waived	50% after deductible
Specialist Visit	$25 copay deductible waived	$45 copay deductible waived	50% after deductible
Urgent Care Provider	$50 copay deductible waived	$50 copay deductible waived	50% after deductible
Emergency Care	$100 copayment after deductible, then 20%	$100 copayment after deductible, then 20%	$100 copayment after deductible, then 20%
Inpatient Coverage	20% after deductible	40% after deductible	50% after deductible
Outpatient Diagnostic Laboratory	20% after deductible	40% after deductible	50% after deductible
Outpatient Diagnostic X-ray for Complex Imaging (MRI, MRA, PET, CT scans)	20% after deductible	40% after deductible	50% after deductible
Outpatient Mental Health / Chemical Dependency	$25 copay deductible waived	$45 copay deductible waived	50% after deductible

Carrier: Aetna **Plan**: Open Choice PPO

MEDICAL BENEFITS	In-Network Designated Provider	In-Network Non-Designated Provider	Out-of-Network
Outpatient Rehabilitation Includes speech, physical & occupational therapy (25 PCY)	$25 copay deductible waived	$45 copay deductible waived	50% after deductible
Outpatient Chiropractic (12 visits PCY)	$25 copay deductible waived	$45 copay deductible waived	50% after deductible
Routine Eye Exams	Covered 100%; deductible waived	Covered 100%; deductible waived	50%; after deductible
Vision Eyewear	Covered 100% up to $200 every 12 months	Covered 100% up to $200 every 12 months	Covered 100% up to $200 every 12 months
Routine Hearing Screening	Covered 100%; deductible waived	Covered 100%; deductible waived	50%; after deductible

To help you save money on prescription drugs, talk with your pharmacist. Check with your pharmacist about special programs or discount cards. Pharmacists will also know if drug companies are running promotions.

RX BENEFITS	Retail		Mail Order	
	In-Network	**Out-of-Network**	**In-Network**	**Out-of-network**
Generic	$15 copay	50% after applicable copay	$30 copay	Not Covered
Preferred Brand Name	$30 copay	50% of submitted cost; after applicable copay	$60 copay	Not Covered
Non Preferred Generic and Brand Name	Generic & Brand: $50 copay	50% of submitted cost; after applicable copay	Generic & Brand: $100 copay	Not covered
Specialty Drugs	Preferred Specialty: $30 copay Non-Preferred Specialty: $50 copay	Not covered	Not covered	Not covered
Supply Limit per Fill	Retail: 90 Days; Mail: 90 Days; Specialty: 30 Days			

Aetna's Informed Health Line

As a member of an Aetna health insurance plan, you have instant access to information that can help you make informed choices about health care. You can quickly search these credible resources:

- Call toll free anytime, day or night – Available 24 hours a day, 7 days a week
- Talk to a registered nurse who can provide information on more than 5,000 health and wellness topics
- Listen to the Audio Health Library, a recorded collection of more than 2,000 health topics. Transfer easily to a registered nurse at any time during the call
- Using your secure Aetna Navigator member website, www.aetna.com, browse one of the most advanced online health databases available today.
- Language translation services available.

Visit online at www.aetna.com or call 1-800-556-1555.

Teladoc – Virtual Care

Teladoc allows you to resolve your routine medical issues anytime you need care from wherever you happen to be. Teladoc is a national network of board-certified physicians who provide quality health care through the convenience of phone or online video consultations for members of any age. Teladoc physicians can diagnose, treat, and write prescriptions, when necessary, for routine medical conditions, including:

- Sore throat and stuffy nose
- Sinus infection
- Bronchitis
- Allergies
- Pink eye

For more information, visit the Teladoc website at www.teladoc.com/aetna or call 1-855-835-2362.

Most health plans must cover a set of preventive services — like shots and screening tests — at no cost to you.

What is preventive care?

Preventive care includes health services like screenings, check-ups, and patient counseling that are used to prevent illnesses, disease, and other health problems, or to detect illness at an early stage when treatment is likely to work best. Getting recommended preventive services and making healthy lifestyle choices are key steps to good health and well-being.

What types of services does this include?

ALL MEMBERS

- Yearly preventive health exams (more frequent visits covered for children under 3)
- Standard immunizations (including flu shots)
- Screenings for cholesterol, blood pressure, diabetes, obesity & depression

WOMEN

- Cervical cancer screening
- Mammography screening (age 40 and older)
- Osteoporosis screening (age 60 and older)
- Contraceptives & sterilization for women covered on the medical plan (prescription generic oral and injectable contraceptives, vaginal ring & hormone patch). Brand name contraceptives are still subject to preventive copays.
- Lactation consultant visit
- Manual breast pump
- HPV testing once every 3 years (age 30 and older)

MEN

- Prostate cancer screening (age 50 and older)
- Abdominal aortic aneurysm screening for men who have ever smoked (at ages 65-75)

CHILDREN

- Newborn screening for hearing, thyroid disease, sickle cell anemia, and cystic fibrosis
- Developmental delays and autism screening
- Vision screening

This is not an exhaustive list. Please verify services with your provider.

Emergency Care vs. Urgent Care

When you're sick or injured, deciding where to get care is the last thing you want to worry about. Understanding your options now will make decisions easier when you need immediate care.

Doctor, urgent and emergency care

Your primary care is the best place to start when you're sick or hurt. They know your health history, including any underlying conditions you may have. when you visit your doctor for an illness injury, they can make informed choices about your treatment and necessary tests. And many primary care doctors have evening and weekend hours to accommodate busy schedules.

But what if you get sick or injured when your doctor's office is closed? If your condition isn't life-threating but needs to be taken care of right away, then urgent care may be the right choice for you. Your in-network Urgent care centers are usually open after normal business hours, including evenings and weekends. Many offer on-site diagnostic tests. And, in most situations, you'll find that you save time and money by going to urgent care instead of an emergency room.

Emergency rooms are the best place for treating severe and life-threatening conditions. They're open 24 hours, seven days a week. They have the widest range of services for emergency after-hours care, including diagnostic tests and access to specialists. That specialized care also makes it the most expensive type of care. And you'll probably have to wait a long time to get treated.

The important thing to remember is to use your best judgment when choosing your Facility when determining where to seek care. If you visit an Urgent Care Facility that is Out-of-Network, you could be faced with a Balance Bill situation.

Be prepared

Building a relationship with your primary doctor who knows you and your health history is important, especially in those moments when you need help making the best decision on where to get immediate care. It's a good idea to know where the closest emergency room and in-network urgent care centers are. So when you need immediate care, you'll already know where to go.

Go to Urgent Care

- Moderate fever
- Colds, cough or flu
- Bruises and abrasions
- Cuts and minor lacerations
- Minor burns and skin irritations
- Eye, ear, or skin infections
- Sprains or strains
- Possible fractures
- Urinary tract infections
- Respiratory infections

OR

Go to the Emergency Room

- Heart attack or stroke
- Chest pain
- Shortness of breath
- Severe abdominal pain
- Loss of consciousness
- Head injury or other major trauma
- Major burns
- One-sided weakness or numbness
- Open fractures
- Severe bleeding
- Intense pain
- Poisoning or suspected overdose

Some medical situations could be life-threatening, such as chest pain or severe bleeding – seconds count. In those circumstances you should call 911 or the local Emergency Medical Services for immediate assistance. For more information on when to call 911 in a medical emergency, please see these guidelines developed by the American College of Emergency Physicians. http://www.emergencycareforyou.org/Emergency-101/When-To-Call-911/

Carrier: Principal Financial **Plan**: Dental PPO

DENTAL BENEFITS	
Individual / Family Deductible PCY	$50 / $150
Deductible Waived for	Preventive Services
Type 1 – Preventive*	0%
Type 2 – Basic	20%
Type 3 - Major	50%
Annual Benefit Maximum	$1,000

SERVICES & LIMITATIONS	
Type 1 - Preventive	
▪ Routine exams (one per six months) ▪ Routine cleanings (one per six months) ▪ X-rays Bitewing (one set every calendar year) ▪ X-rays Full Mouth (one every 60 months)	▪ Fluoride (one treatment each calendar year; only for dependent children under age 14) ▪ Space maintainers (only for dependent children under age 14) ▪ Sealants (only for dependent children under age 14; one each tooth each 36 months)
Type 2 - Basic	
▪ Emergency exams (subject to routine exam frequency limit) ▪ Fillings and stainless steel crowns ▪ General anesthesia (covered for specific procedures) / IV Sedation ▪ Periodontal surgical procedures	▪ Simple oral surgery ▪ Complex oral surgical procedures ▪ Simple endodontics (root canal therapy for anterior teeth) ▪ Complex endodontics (root canal therapy for molar teeth)
Type 3 - Major	
▪ Repairs to partial denture, bridge, crown, relines, rebasing, tissue conditioning and adjustment to bridge/denture ▪ Dentures (initial placement/replacement)	▪ Crowns (each 120 months per tooth) ▪ Inlays, onlays, cast post and core, core buildup (each 120 months per tooth) ▪ Bridges (initial placement/replacement of bridges 120 months old)

Dental health means much more than healthy teeth – it is integral to your health and well-being. Oral diseases and conditions are often a sign of other health problems, so taking preventive measures today means a healthier tomorrow. It is important to schedule regular dental visits to prevent and treat dental disease.

Carrier: Principal Financial **Network**: VSP Choice Network

VISION BENEFITS	Description	Frequency	Copay
Exam	▪ Focuses on your eyes and overall wellness	One exam every 12 months	$10 copay
Prescription Glasses			$25 copay
Frame	▪ $150 allowance for a wide selection of frames ▪ 20% off amount over allowance	One set every 12 months	Combined with prescription glasses
Lenses	▪ Single vision, lined bifocal, and lined trifocal lenses ▪ Polycarbonate lenses for dependent children	Two lenses (one pair) every 12 months	Combined with prescription glasses
Elective Contacts	▪ Elective contact lens exam (fitting and evaluation) ▪ $150 allowance for elective contacts	Once every 12 months	Up to $60 copay
Necessary Contacts *	▪ Covered in full for members who have specific conditions ▪ Contacts are instead of frames and lenses	Once every 12 months	$25 copay

** Necessary contact lenses are prescribed to correct extreme visual problems that cannot be corrected with regular lenses.*

Although they are more expensive than traditional **sunglasses**, **polarized sunglasses** effectively reduce glare from surfaces other than water, such as snow and glass. Drivers can also benefit from **polarization**, as the special **lenses** help reduce glare and reflections from the surface of the road.

Extra Savings and Discounts

Glasses and Sunglasses

- Lens enhancements are covered after a copay, saving members an average of 20-25% off additional glasses and sunglasses, including lens options from any VSP doctor within 12 months of last covered vision exam.

Contacts

- 15% off cost of contact lens exam (fitting and evaluation)

Laser Vision Correction

- Average 15% off the regular price or 5% off the promotional price; discounts only available from contracted facilities.

Life insurance, while it's not a popular topic, is a valuable benefit that can provide financial protection for your family. The basic premise is that if you should die, your survivors will receive money to help fill the financial gap you leave. The life insurance benefit can replace your income, or cover basic needs such as clothing, food, child care, and education. While it is not pleasant to think about, defining your life insurance needs is important and can provide peace of mind for you and your loved ones.

Group LIFE/AD&D Carrier: Aetna	
Benefit Amount	$10,000
Reduction Schedule	Reduces at age 65
Cost	JL Properties, Inc. pays the cost of this benefit
Voluntary LIFE/AD&D Carrier: Principal	
Employee Life Benefit	$500,000 (increments of $10,000) Guarantee Issue Amount: $130,000
Spouse Life Benefit	Not to exceed 100% of Employee amount or $100,000 (increments of $5,000) Guarantee Issue Amount: $30,000
Dependent Life Benefit	14 days of age and up: you may choose a benefit of $2,500, $5,000 or $10,000 Birth to 14 days: $1,000
Reduction Schedule	Reduces to at age 65
Cost	You pay the cost of this benefit

A Life Insurance MUST: Naming a Beneficiary

Your beneficiary is the person (or people) you choose to receive the death benefit when you die. It's very important to name a beneficiary.

- ❑ If your wishes are not known when you die, your money may not go where you intend it to go.
- ❑ If you do not have a beneficiary on file with your employer or life insurance provider, the money may not be paid to your loved ones—even if you've paid premiums. Read your policy for details.
- ❑ Without clear direction on file, your family could end up fighting for your death benefit in court. This can take time and money, and it's the last thing your loved ones will want to deal with after your death.

Make sure your beneficiary information is up-to-date.

Voluntary Short Term Disability (STD)

STD insurance provides income protection in the case of a short-term illness. Once you meet the eligibility waiting period, you will be automatically enrolled in the employer-provided basic STD coverage.

STD Carrier: Principal
Elimination Period
1st day for disability due to an injury 8th day for disability due to a sickness Benefits begin the day after the elimination period is completed
Weekly Benefit
60% of weekly earnings
Maximum Benefit Available
$1,800 per week
Maximum Payment Period
13 weeks
Cost
You pay the cost of this benefit

Voluntary Long Term Disability (LTD)

LTD provides income protection in case of a long-term illness or injury. Once you meet the eligibility waiting period, you will be automatically enrolled in the employer-provided basic LTD coverage. Benefits will be payable after the elimination period; during this period, you can use your Paid-Time Off (PTO) or sick leave and STD benefits (if applicable).

LTD Carrier: Principal
Elimination Period
The later of 90 days or the date your insured Short Term Disability payments end, if applicable Benefits begin the day after the elimination period is completed
Monthly Benefit
60% of monthly earnings
Maximum Benefit Available
$8,000 per month
Maximum Payment Period
To age 65
Cost
You pay the cost of this benefit

Enrolled in Group Medical Plan
$200 per month / $2,400 per year ($100 semi-monthly)
Not Enrolled on the Group Medical Plan*
$310 per month / $3,720 per year ($155 semi-monthly)

*Must show proof of other coverage

You may use your cafeteria plan towards the following:

- ❑ Balance of your Medical Coverage (only if covered under JL Properties Health Plan)
- ❑ Voluntary Dental
- ❑ Voluntary Vision
- ❑ Voluntary Term Life/AD&D
- ❑ Voluntary Short Term Disability
- ❑ Voluntary Long Term Disability
- ❑ Medical FSA (Maximum annual Employer contribution towards Medical FSA is $500)
- ❑ Dependent Daycare FSA
- ❑ Employee Funds / Balance

Annual Limits for Flexible Spending Accounts (FSA)
Health Care FSA
$2,600 maximum annual contribution per household
Dependent Care FSA
$5,000 maximum annual contribution per household

Eligible Expenses – FSA
Deductibles/Co-payments
Acupuncture
Alcoholism & Drug Abuse Treatments
Childbirth Classes
Chiropractor
Contact Lenses & Solutions
Dental Expenses
Eye Exams & Eye Glasses
Hearing Aides & Batteries
Medical Related Transit Expenses
Orthodontia
Prescription Sunglasses
Psychiatric Care
Smoking Cessation Programs

Important considerations before enrolling into a FSA:

- ❑ You have to re-enroll each year if you want to contribute to an FSA, even if you do not change your annual election amount.
- ❑ Use it or lose it – all funds deducted from your paycheck and placed in an FSA must be used during the plan year or they will be forfeited.
- ❑ Your elections cannot be changed or revoked unless you experience a qualified family status change.
- ❑ Funds cannot be moved from your healthcare to your dependent care account or vice versa.
- ❑ If you enroll in the Healthcare Flexible Spending Account, you will not be eligible to contribute to a Health Savings Account (HSA).

In-Network vs. Out-of-Network

Using the network will save you money

A network is a group of health care providers, including doctors, specialists, dentists, hospitals, labs and other facilities. These health care providers have agreed to provide medical services to health insurance members—you and your covered dependents—at discounted costs. When you join a health plan, you become a member of the club (so to speak). You get access to the same services you would receive from any other provider, but as a member of the network using a provider in the network, you pay less.

The amount you pay, also known as the contract rate, is lower than what the doctor or facility would charge if you were not a member of the network. All you pay when you visit a network provider is your copay, coinsurance or deductible, depending on the service you receive. You get the care you need at a discounted cost, while visiting providers you know and trust.

Using out-of-network providers

There may be times when you decide to visit a provider that is *not* in the network. You will pay more for care because out-of-network providers have not contracted with your insurance company; therefore, they will charge higher fees. The fees may be reimbursed at a lower rate, and you could be responsible for paying charges above what your health plan considers "reasonable" for similar services in your area.

There are also more steps to take when using an out-of-network provider. You may have to get a referral from a network doctor in order for your care to be covered at all. You may also have to pay the full cost of the visit, and then file your own claim forms to be reimbursed for a portion of what you spent.

Your action plan: don't get surprised by the bill

There are times when going outside your network for care may be unavoidable—like getting sick or injured on vacation. But going outside the network for planned care, especially for something major like a surgery, can be quite costly. To avoid higher out-of-network fees, ask the provider's staff how much he or she will charge for your visit. Or, call around to different providers in your area so you can choose a provider with more reasonable rates.

Remember, you are your own best advocate. No matter what kind of care you are seeking, speak up and ask questions up front to get the best care *and* avoid being surprised when you get the bill.

Get The Most From Your Health Plan

Make sure you're getting the most value for your health care dollar with these helpful tips.

1. **Use doctors in your network**

   Pay the lowest cost for care by using doctors, clinics, hospitals, and pharmacies in your health plan's network. When you go out-of-network, your insurer covers less of the cost.

2. **Use your preventive care benefits**

   Many health plans pay for preventive care visits. Getting regular exams, screenings, and immunizations can save you a lot of money in the long run by catching problems early or preventing them altogether.

3. **Shop for high-value care**

   More expensive care isn't necessarily better, and the cheapest option is not always the best. If you're considering your health care options for a specific procedure, there are resources to help you shop based on cost and quality.

4. **Choose the right type of care**

   Urgent care, an online doctor visit, or call to a nurse line might help – saving you a trip to the emergency room. When you need care, knowing your options can save you time.

5. **Ask your doctor for generic drugs**

   Generic drugs are safe and effective. They're FDA-approved and contain the same active ingredients as the brand-name versions. Generics cost much less and work just the same.

6. **Use your health plan's support programs**

   Check to see if your health plan includes programs like help to quit smoking, fitness discounts, health assessments and other ways to be healthier or save money.

7. **Take care of yourself**

   A healthy lifestyle is in your control. You'll feel better and have lower health care costs if you:

   - Eat well
   - Get enough sleep
   - Get moving
   - Quit smoking and avoid secondhand smoke
   - Keep your weight under control

The following table shows the semi-monthly amounts you will pay for coverage under each plan.

Aetna MEDICAL & RX	Employee	Employee & Spouse	Employee & Child(ren)	Employee & Family
Employee Pays	$36.75	$328.87	$295.81	$590.68
Employer Pays	$330.69	$428.07	$417.05	$515.34

Principal (VSP) Voluntary Vision	Employee	Employee & Spouse	Employee & Child(ren)	Employee & Family
Employee Pays	$5.50	$8.63	$9.13	$14.00

Principal Voluntary Dental	Employee	Employee & 1 Dependent	Employee & Family
Employee Pays	$21.13	$41.85	$71.57

Aetna Group Life	Employee	Employer
Life/AD&D	0%	100%

Aetna
Start your search at www.aetna.com (or, if you are already a member, log in to Aetna Navigator). Click on Find a Doctor. Use the simple online instructions to perform a general search. You also may search for a particular physician by name, specialty or other options.

Principal (Vision)
Use the Provider Directory on www.vsp.com to locate nearby VSP providers or to see if your current eye care professional participates in the VSP network. To speak to a representative by phone, please call 800-877-7195.

Principal (Dental)
Locate a Dentist near you or see if a dentist you know participate in your network. Go to this page and follow the prompts. http://c3.go2dental.com/member/dental_search/provsel.cgi

Medical, Rx and Group Life	Voluntary Benefits	Cafeteria Plan
Aetna **1-800-872-3862** www.aetna.com *M-F: 7 am – 7 pm (ET)*	**Principal Financial Group** 1-800-986-3343 www.principal.com	**Professional Benefits Services, Inc.** 1-800-982-2012 cafeteria@profben.com www.profben.com

- **Copay**: A fixed fee that members must pay for their use of specific medical services covered by the plan.

- **Deductible**: The amount you pay out of your own pocket each year before your insurance begins picking up most costs of health care.

- **Coinsurance**: An insurance policy provision under which the carrier and the member share costs incurred after the deductible is met according to a certain formula.

  Example: Members pay an in-network coinsurance of 20% and carrier pays 80%, after deductible is met.

- **Out-of-Pocket Maximum**: The highest or total amount your health insurance requires you to pay towards the cost of your health care during the benefit year, including copays, deductibles and coinsurance. Once met, claims are paid at 100% of usual and customary charges for the rest of the benefit year.

- **Usual, Customary and Reasonable Charges (UCR):** The calculation by a health care plan of what they determine is the appropriate fee to pay for a specific health care service.

- **Balance Billed**: Defined as the difference between what the carrier will cover as determined by Usual, Customary and Reasonable Charges, and what your Provider charges. You may be responsible for paying this difference if you do not use a preferred provider.

- **Preferred Provider**: The physicians, hospitals, and other health care providers who have contracted with the carrier and provide care at negotiated prices. Due to the agreement in the contract, you will receive discounts and are not responsible for amounts above the allowable charges (UCR).

Enrollment Checklist

- ❑ Review enrollment materials
- ❑ Review all available plans and options to see which is best for you
- ❑ Consider the coverage you may be eligible for
- ❑ Review contributions
- ❑ Make sure you have all required information available
- ❑ Review accuracy of enrollment information
- ❑ Updated your beneficiary information
- ❑ Submit information before deadline

*Remember that the choices you make during open enrollment will take effect on **May 1st, 2017** and remain in effect until **April 30th, 2018**. Only qualifying events will allow you to make a change before that date.*