JTL Carriers, LLC

Effective 11/1/2017 - 10/31/2018

Employee Election Form - Medical / Dental / Vision / Life Insurance

Medical - United Health Care
Dental & Vision - United Health Care

Medical Options - Select one of these three plans, or waive coverage

	Co-Pay Plan 1	Co-Pay Plan 2	HSA Plan 3
	AQ-Z3, OI	AQ-Z4, OI	AQ-1R, OI HSA
In Network Benefits:			
Preventive Care Services	No Ded - 100%	No Ded - 100%	No Ded - 100%
Deductible: Single/Family	$2,500/$5,000	$5,000/$10,000	$3,500/$7,000
Family Deductible	Embedded*	Embedded*	Embedded*
Co-insurance	20%	20%	0%
Out of Pocket: Single/Family	$5,000 / $10,000	$6,350 / $12,700	$6,350 / $12,700
Office Co-Pay - Primary / Specialist	$30 / $60	$30 / $60	Deductible + $30/$60
Urgent Care	$100 Co-pay	$100 Co-pay	Deductible + $100 Co-pay
Emergency Room	$350 Co-pay	$250 Co-pay	Deductible + $350 Co-pay
Hospital Admissions	Deductible + 20%	Deductible + 20%	Deductible + 0%
RX Co-pay (Tier 1 / 2 / 3)	$10 / $35 / $70	$10 / $35 / $70	Deductible + $10 / $35 / $70
Out of Network Benefits:			
Deductible: Single/Family	$5000 / $10,000	$10,000 / $20,000	$7,500/$15,000
Co-insurance	40%	40%	20%
Out of Pocket: Single/Family	$10,000 / $20,000	$12,700 / $25,400	$12,700 / $25,400
Office Co-pay	n/a	n/a	n/a
Urgent Care	Deductible + 40%	Deductible + 40%	Deductible + 20%
Emergency Room	$350 Co-pay	$350 Co-pay	Deductible + $350 Co-pay
Hospital Admissions	Deductible + 40%	Deductible + 40%	Deductible + 20%
RX Co-pay (Tier 1 / 2 / 3)	$10 / $35 / $70	$10 / $35 / $70	Deductible + $10 / $35 / $60

**Embedded deductible means that no individual family member is required to contribute more to the family deductible than their individual deductible amount.*

Employee Contribution (Weekly Pay Period):

	Plan 1	Plan 2	Plan 3
Employee	$68.46	$62.33	$52.62
Employee + Spouse	$143.66	$130.80	$110.42
Employee + Child(ren)	$123.31	$112.23	$94.75
Family	$198.54	$180.77	$152.60

All eligible employees are covered by $25,000 of Company paid Life and Accidental Death & Dismemberment insurance.

Dental Plan - Select or Waive coverage

UHC Dental Plan (P4216)
PPO (myUHCdental.com)

	In-network	Out of network
PPO Network	yes	no
Deductible (EE/Family)	$50/$150*	$50/$150*
*Deductible waived for Preventive Care		
Preventive Care	100%	100%
Basic Services	90%	80%
Endodontics/Periodontics	90%	80%
Major Serices	60%	50%
Annual Maximum	$2,000	$2,000
Rollover of Annual Maximum*	$0 to $600	$0 to $500
Orthodontia	none	none
Usual & Customary %		85%

Employee Contribution (Weekly Pay Period):

Employee only	$4.27
Employee + Spouse	$8.43
Employee + Child(ren)	$8.58
Family	$13.38

*If your total dental claims paid for you in one benefit year is less than $1000, then you qualify for an annual rollover of $500, or $600 if all your claims are from in-network providers.

Vision Plan - Select or Waive coverage

UHC Vision Plan (VH009)
PPO (myUHCvision.com)

	In-network	Out of network
Exam Co-pay / Materials Co-pay	$10 / $10	$40 max
Frequency - Exam / Lenses / Frames	12 months	$40 max
Standard Lenses	Covered	$40 - $80 max
Frame Allowance	$150	$45 max
Contact Lenses (in lieu of glasses)	$105	$105
Lasik Benefits / Hearing Aids	Discount Avail	Discount Avail

Employee Contribution (Weekly Pay Period):

Employee only	$0.00
Employee + Spouse	$1.55
Employee + Child(ren)	$1.81
Family	$2.55

Important!
Return your forms by
10/13/2017
if you wish to make a Change!

If you wish to change your medical Plan for the period 11/1/2017 - 10/31/2018, please check the plan you would like to have, and select who you wish to cover:
Employees not returning a form will remain in their current Co-pay Plan 1 or 2. If you are currently in a HSA plan you will be moved to HSA Plan 3 (unless you select a different Plan below).

Plan 1 _______ Plan 2 _______ Plan 3 _______

Employee only _______
Employee + Spouse _______
Employee + Child(ren) _______
Family _______
Waive _______

Check if you want to add Dental coverage for you and your dependents, and/or if you want to add Vision coverage for your dependents:
(If you are currently enrolled in Dental and/or Vision you will remain covered (unless you "Waive").

	Dental:	Vision:
Employee only:	_______	Included
Employee + Spouse:	_______	_______
Employee + Child(ren):	_______	_______
Family:	_______	_______
Waive:	_______	n/a

Note: This Summary of Benefits is intended only to highlight the Benefits available to you and should not be relied upon to fully determine coverage. Please refer to the UHC Summary Of Benefits (SBC) for a complete listing of services, limitations, and exclusions. The Certificate of Coverage prevails in all description conflicts.

Employee Name: ______________________________

Employee Signature: ______________________________ **Date:** ____________________

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