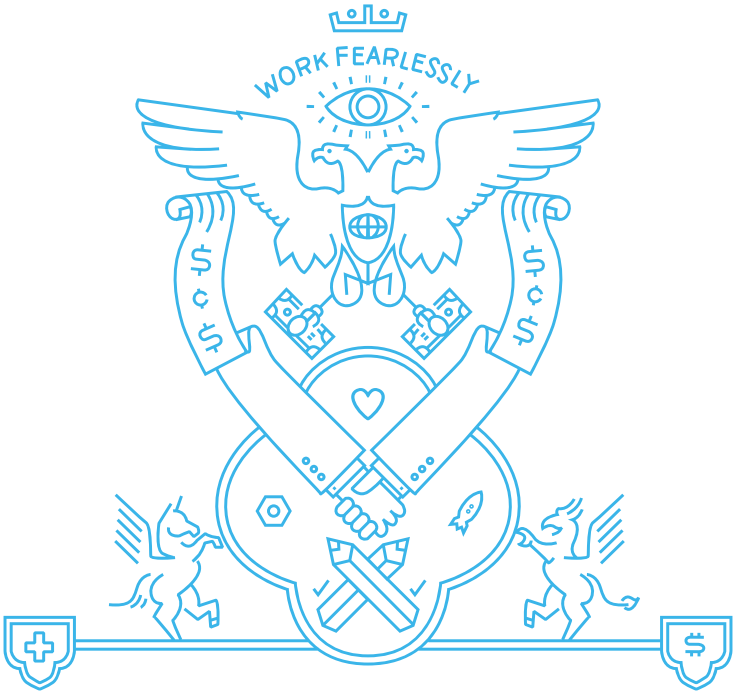


2018-2019 PLAN YEAR

Understanding Open Enrollment

JUSTWORKS.

CERTIFIED PEO

PART ONE

Introduction to Open Enrollment

It is that time of year again... Time to pick your health coverage plans for the new plan year! Take care of yourself and your family by choosing a plan that best fits your needs and budget.

Please note these relevant dates:

Open Enrollment Period:
September 24, 2018 to October 3, 2018

Start of new plan year:
November 1, 2018

Getting Started

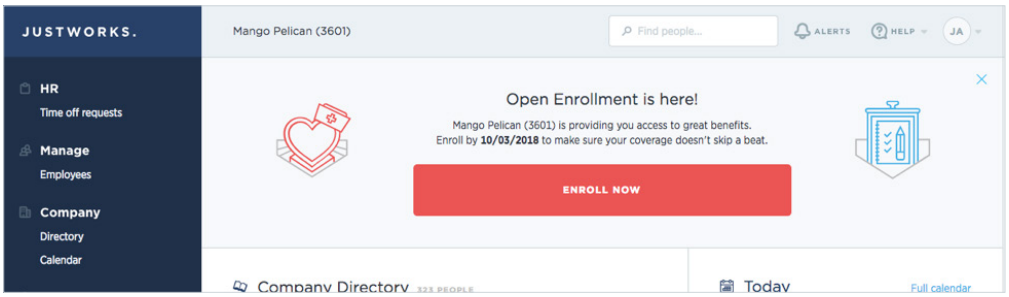
Your life may have changed since you last signed up for health insurance. The open enrollment period is your opportunity to reset your coverage, pick new plans, and even add or drop dependents. It's the only time to make these sorts of changes during the plan year, unless you have a Qualifying Life Event (QLE), such as marriage or the birth of a child. Otherwise, you're locked into the options you select until the next open enrollment period for the following plan year.

If you're happy with your current plans, you may choose to simply renew them, if they're still available to you. There may be changes to your plans or what your employer has chosen to provide access to, so it's important to review your options closely.

Justworks makes open enrollment easy with an online-only process. Once you sign in:

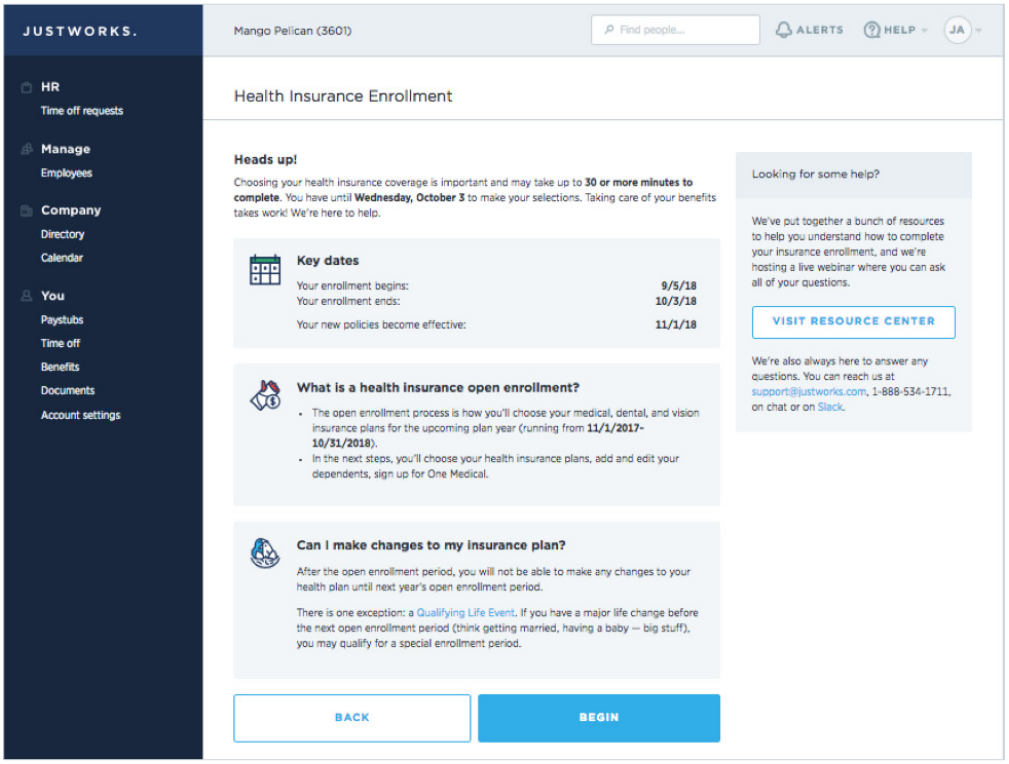
Step One

You will see this handy banner where you can click and start the process right away.



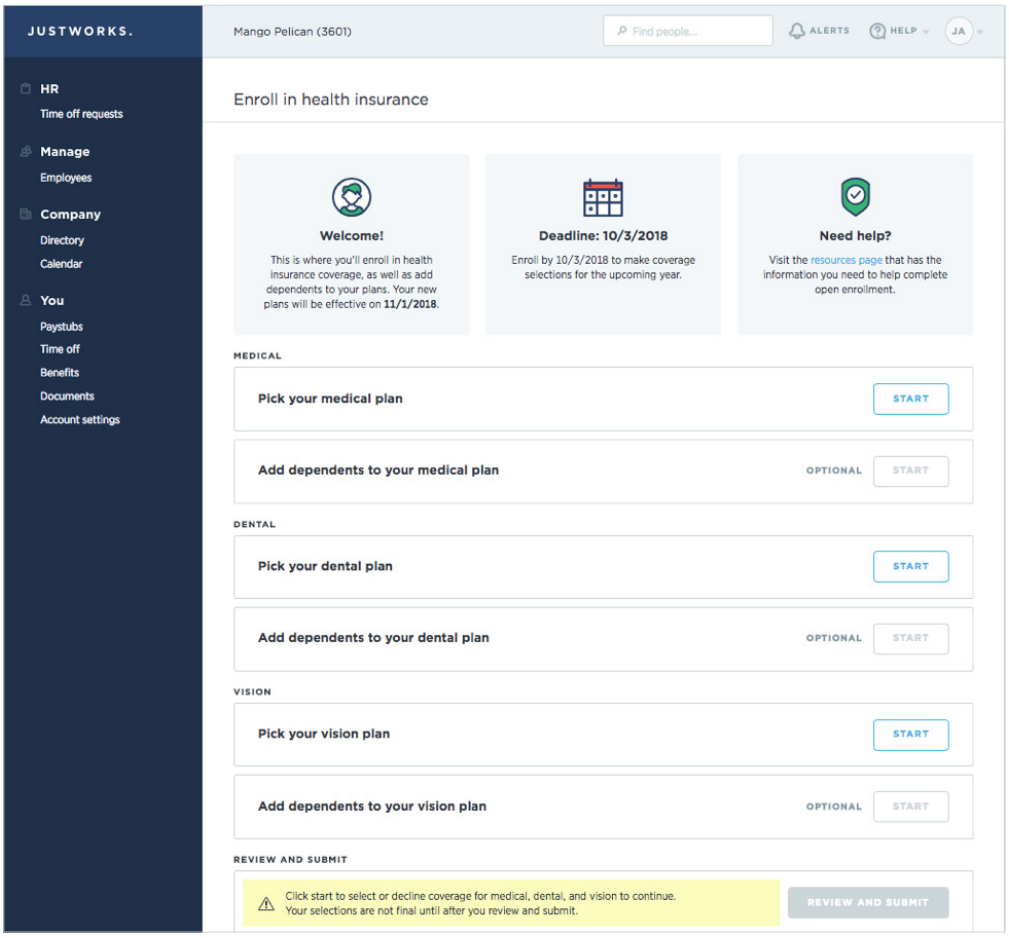
Step Two

Once you click Enroll Now you will be taken to the Open Enrollment Learn Page. You can visit our Resource Center, located on the right or begin enrollment right away.



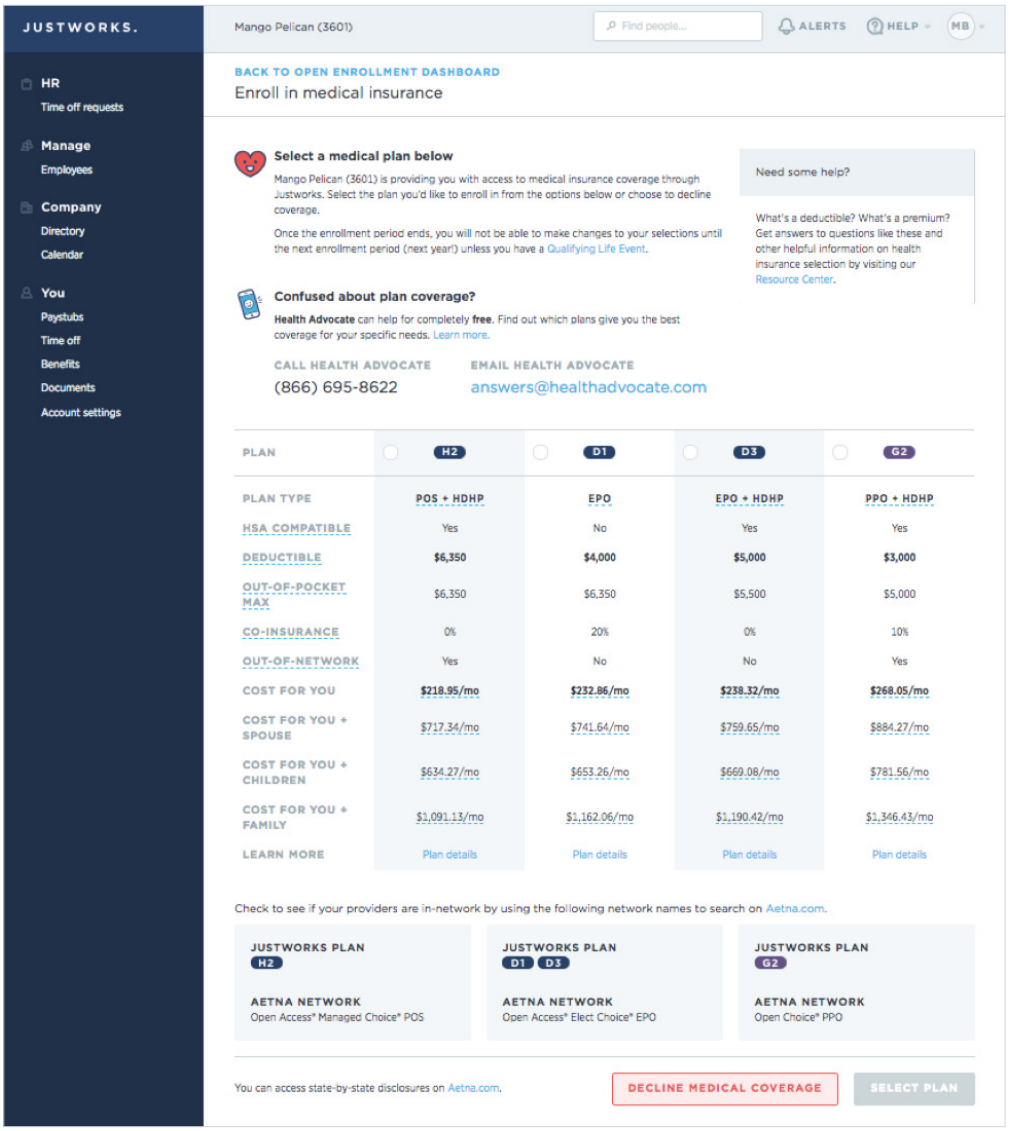
Step Three

Once you begin, you will be prompted to pick your plans. You can start by clicking Start on any section.



Step Four

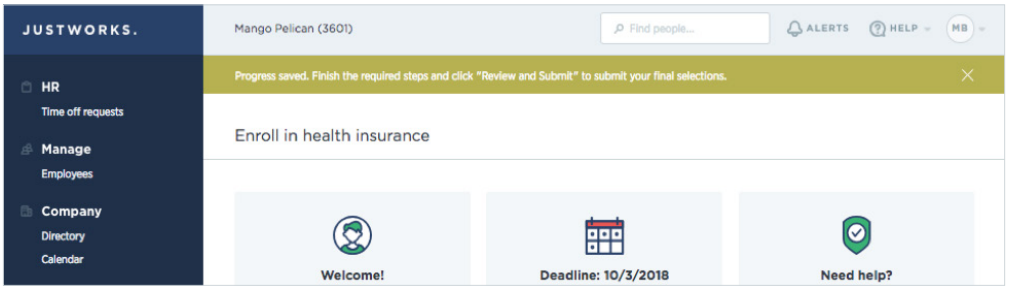
You can review plans on the page and Decline Medical Coverage or Select Plan.



Note that these prices are for display only.

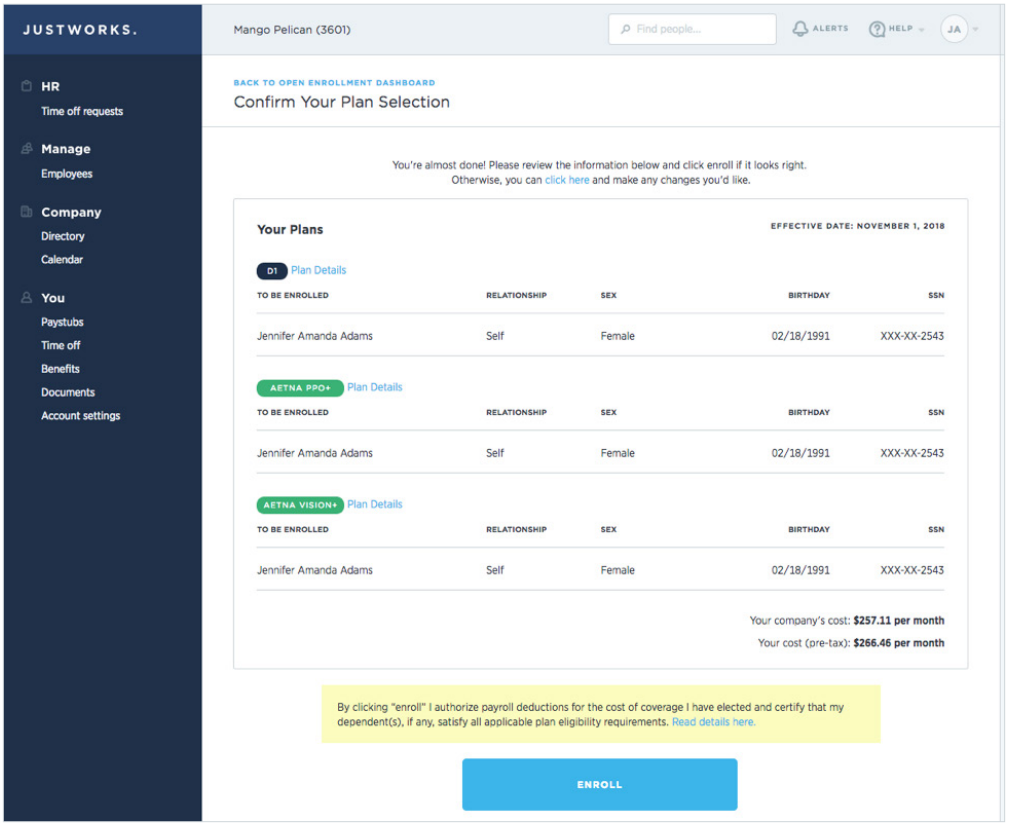
Step Five

Once you have selected all your plans you can review your options. Once you're done, click the Review and Submit button. If you are not ready to submit, don't worry. Your selections are saved and you can go back and make changes until October 3.



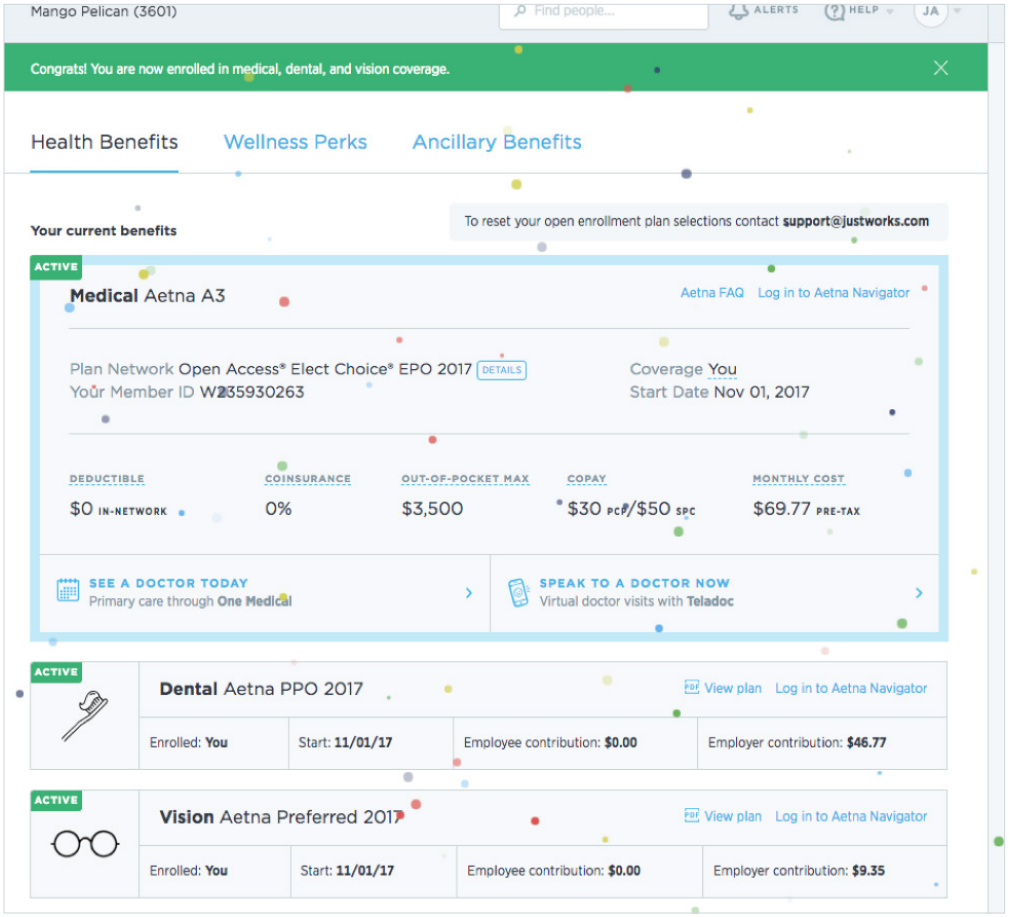
Step Six

Once you submit, you will have one more chance to review and confirm your selection. When you're all set with your options, go ahead and click Enroll.



Step Seven

Last thing - don't stop until the confetti drops! You'll know you've successfully enrolled when you see confetti on the screen.



PART TWO

Glossary of Terms and What They Mean for You

Plan Types

EPO

Exclusive Provider Organization; provides in-network coverage only (except in life or death emergencies) without pre-authorization.

What it means for you EPO plans do not require you to elect primary care physicians or require referrals in order to see specialists. It's a best practice to search for your preferred providers to see if they're in-network when you're exploring EPO options.

HDHP

High Deductible Health Plan; According to IRS rules, plans this year have a deductible of at least $1,350 and an out-of-pocket maximum on in-network expenses of $6,650 for the employee-only tier of coverage. With the exception of preventative care, the coinsurance and all cost sharing will not apply to any services before the deductible has been met. Please refer to the plan document or contact Aetna to determine which services have the deductible requirement waived.

What it means for you If you anticipate lower plan utilization or might like to save on premiums, this could be a good pick for you. If your company also provides access to HSA, you may elect to contribute to an HSA if enrolled in a HDHP. This would allow you to save pre-tax dollars to put toward future healthcare costs.

POS

Point of Service; provides in- and out-of-network coverage. Traditionally speaking, POS plans are "gated," meaning a member must choose a primary care provider (PCP) who is the "point of service." All Aetna POS plans accessed through Justworks are "open access," meaning participants do not need a referral from a PCP to see a specialist.

What it means for you As with Preferred Provider Organizations (PPOs) or any other plans covering both in- and out-of-network services, if you choose to access healthcare services outside of your network, you may pay higher out-of-pocket costs relative to those of services provided by in-network providers.

Please note that not all companies will offer access to all types of plans.

Other Common Health Insurance Terms

Coinsurance

This is the percentage of the cost of a service or fee the insurance carrier will cover after the deductible (if any) is met. For example, if a plan has 80% coinsurance, Aetna will cover 80% of the service and the remaining 20% will be paid for by the member. Typically, the coinsurance coverage for out-of-network services will be lower than for in-network services, which will result in reimbursement that is less than the cost for out-of-network services in general.

What it means for you You will pay coinsurance amount up to your out-of-pocket maximum.

Copay

This is the pre-set dollar amount you have to pay for a specific type of service or visit regardless of its cost before the deductible is met for all plans, except HDHPs. Copays count toward the out-of-pocket maximum but not the deductible.

What it means for you This the amount you have to pay at your actual appointment. This amount counts toward the out-of-pocket maximum but not your deductible.

Deductible

This is the amount of money you must pay out-of-pocket for covered health services before the carrier begins to pay. After you pay your deductible, you usually pay your copay or coinsurance, up to the out-of-pocket maximum. Typically copays will not apply toward your deductible. Health insurance plans will have a deductible for each individual on a plan, and a combined family deductible.

One thing to note is that all plans accessible through Justworks have embedded deductibles. This means that no individual is responsible for meeting more than their individual deductible, even if they are on a family plan.

Deductibles reset each calendar year on January 1.

What it means for you The amount you have to spend before your health insurance starts to pay portions of your bills.

FSA

Flexible Spending Account; this allow employees to use pre-tax dollars to pay for out-of-pocket health care or dependent care expenses. These funds are only available during the calendar year, January 1 through December 31, and expire at the end of the year. Any funds that are not used by the end of the year are forfeited.

What it means for you Think of an FSA as a pre-tax piggy bank for healthcare needs that you can use to pay for anything health-related, from inhalers to lip balm. An FSA lives with the employer, so if you lose your job, you will lose unused funds on the day of termination.

HSA

Health Savings Account; allows you to contribute pre-tax earnings to pay for eligible medical expenses. Funds contributed towards your HSA do not expire, even if you decide to change medical plans or if your employment is terminated. Unlike an FSA, an HSA belongs to the employee. Employees set up a pre-tax account that is specific for their health savings. In order to be eligible to enroll in and contribute to an HSA, you are required to be enrolled in a HDHP medical plan.

What it means for you Think of an HSA as a pre-tax piggy bank for healthcare needs that you can use to pay for anything health-related, from inhalers to lip balm — well into retirement! Unlike an FSA, the HSA lives with you so even if you lose your job, you can keep the funds.

Out-of-pocket Maximum/ Payment Limit:

This is the most you would have to pay for qualifying services in a calendar year. The carrier covers 100% of the cost for qualifying claims after this amount is exceeded. Once you've met this amount, the carrier will generally cover 100% of subsequent procedures and charges. The plans accessible through Justworks have embedded out-of-pocket maximums. This means that no individual is responsible for meeting more than the amount of the individual out-of-pocket maximum, even if they are on a family plan and the family out-of-pocket maximum is not met. Please note that the out-of-pocket maximum resets each year on January 1.

What it means for you Once you hit this amount, you are generally not responsible for any further costs for treatment from covered providers. There are some stipulations on what will be covered as listed in the plan documents, so we always recommend checking with Aetna Member Services to clarify costs related to specific services.

Premium

This is the monthly cost of your health insurance plan. Employees pay their portion of the premium on a monthly, pre-tax basis. Your employer may or may not contribute an amount towards your premium. Premiums are based on four tiers:

- Employee only/individual
- Employees + spouse/domestic partner
- Employee + child(ren)
- Family (employee + spouse/domestic partner + child(ren)

Information about monthly cost to you for each plan and tier will be available during open enrollment.

What it means for you This is the amount that will be deducted from your paychecks over the course of each month.

PART THREE

What to Consider When Choosing a Plan

Selecting the right health insurance plan can seem daunting. You might feel like you need a crystal ball to look into the future to get a clear picture of what you'll need in the year to come. While that's not possible, there are some steps you can take.

To help you make the best decision, here are some questions to ask yourself:

- Did the plan I selected for the past year adequately meet my needs?
- Are my regular providers covered by my plan?
- What is more important: a broader network of providers or lower monthly costs?
- Do I anticipate using more or less medical services in the year to come?
- How has my family changed in the past year? Do I have additional dependents?
- Did my family or I go through any big medical changes?
- Will anyone in my family be turning 26 and moving off of dependent coverage?

PART FOUR

FAQs

Below, find some frequently asked questions about open enrollment, sourced from Justworks customers like you!

What happens to my deductible this year?

Plan deductibles are based on the calendar year, so they won't reset until January 1, 2019. Aetna will automatically carry over credit for what you've paid toward your deductible balance to your new plan, so you'll continue to pay toward the deductible through December 31, 2019 — unless the balance carried over exceeds your new plan's deductible amount. On January 1, 2019, what you've paid towards the deductible will reset to zero for the new calendar year.

Will I receive a new medical/dental/vision card?

Yes. Employees will maintain their same Aetna Member ID, however, you will be sent a new card. You may continue to use your existing card, but any updates to your policy will not be reflected in the old card. If you need a replacement card, you can always download and print a copy through your Aetna Navigator account (aetnanavigator.com), or request a new card by reaching out to Aetna.

Physical dental cards are not provided by the carrier, but you can access a digital copy in your Aetna Navigator account.

Note: You can also find your Member ID number in the "Benefits" section of your Justworks account!

How can I tell if my doctor is in-network?

Use Aetna's Directory of Health Care Professionals. When you log into the secure site, you can search for providers within your "plan" or "network".

Your current plan network is listed in the "Benefits" section of your Justworks' account. You can also find your plan network information by clicking the "Details" button next to your plan network and downloading the PDF.

Note: All medical plans offered through Justworks are "open access," meaning a referral isn't required to see a specialist. Aetna can also change their network at any time, so it's best to confirm coverage with your doctor before any appointments.

When can I enroll in an HSA or FSA?

FSAs are based on the calendar year. Open enrollment for that account will be in December for the new plan year beginning January 1, 2019. If you have an HDHP, you can add an HSA at any time.

I have questions about specific medical services, procedures, claims, or costs. Who can help me?

For specific questions related to these topics, reach out to Aetna or Health Advocate directly. Medical services, procedures, claims, and costs are all considered to be "Protected Health Information" and can only be discussed with a HIPAA-compliant resource.

Health Advocate is a third-party resource that's automatically available to all employees and can help answer questions about plans and claims, and provide help for finding specialists who accept your insurance.

Aetna Member Services: (888) 982-3862
Health Advocate: (866) 695-8622 or answers@healthadvocate.com

I’m having trouble making my new plan selections in Justworks. Who can help me?

Please contact Justworks Support at support@justworks.com or (888) 534-1711 and we’ll be happy to help you navigate our platform.

PART FIVE

Who to Call

When you have questions about open enrollment, the last thing you want to do is spend time tracking down phone numbers. Here, we've rounded up some common questions, who to contact to get the answers, and how to reach them.

JUSTWORKS.

Contact Justworks for:

- Eligibility questions, for example:
  - What is my effective date?
  - What is my termination date?
  - I've had a qualifying life event; what do I do now?
  - Which plans are available to me?
  - What will my employee contribution be?
- Having trouble making plan selections in my Justworks account
- Updating demographic information for you and your dependents, for example:
  - Spelling of name, address, date of birth, etc.
- If you're still not sure who to contact. We can help point you in the right direction!

Contact Info

1 (888) 534-1711

support@justworks.com

(959) 247-0005

slack.justworks.com

Available 24/7!

HealthAdvocate

Contact Health Advocate for:

- Questions related to Health Advocate services, for example:
  - How do I choose the best plan for me?
  - What procedures are covered?
- Questions about specific medical services, procedures, claims, or costs
- Questions about In Vitro Fertilization (IVF)
- Medical Bill Saver

Health Advocate is a third-party resource that's available to all benefits-eligible employees. They can help answer questions about plans and claims, and provide help for finding specialists who accept your insurance.

Contact Info

1-866-695-8622

answers@healthadvocate.com

aetna

Contact Aetna for:

- Coverage questions, for example:
  - Is a procedure covered under my plan?
  - Is a doctor or facility in my network?
  - What should I expect to pay for a certain service or procedure?
  - What does this section of my plan document mean?
- Claims questions
- Deductible credits
- Accessing Loss of Coverage Letter or Proof of Coverage

Medical, Dental, and Vision Coverage

Contact Info

Medical, Vision, Dental, and Pharmacy

1 (866) 208-5994

MetLife

Contact MetLife for:

- Coverage questions, for example:
  - Is a procedure covered under my plan?
  - Is a doctor or facility in my network?
- Claims questions
- Deductible credits
- Accessing Loss of Coverage Letter or Proof of Coverage

Dental and Vision Coverage

Contact Info

Dental: 1 (800) 942-0854

Vision: 1 (855) 638-3931