JDC Group
Exceptional Technology Talent

Internal Team

2016

Summary of Employee Benefits

JDC Group Exceptional Technology Talent

To our Employees and their Families:

JDC Group recognizes the important role employee benefits play as a critical component of your overall compensation. As such, we make every effort to target the best quality benefit plans for our employees and their families.

Our program offers a range of plan options to meet the needs of our diverse workforce. We know that your benefits are important to you and your family.

This program is designed to assist you in providing for the health, wellbeing and financial security of you and your covered dependents. Helping you understand the benefits JDC Group offers is important to us.

This Benefit guide, along with your Benefit Summaries, provides an explanation of the benefits available to you and your family.

This is your enrollment opportunity. At this time, you may elect to enroll in the benefit programs offered.

Options selected during this enrollment period will become effective March, 1, 2016 and remain in place until February 28, 2017 unless you or your dependents experience a qualified life event.

JDC Group

Medical Coverage - United Healthcare		
Type of Plan	**Choice Plus Mid Plan OA9**	
	In-Network	**Out-of-Network**
Overview	May use both In-Network and Out-of-Network providers Use Network providers and receive the In-Network level of benefits Use Non-Network providers receive a lower level of benefits and you may be subject to Balance Billing.	
Deductible		
Individual	$2,000	$4,000
Family	$4,000	$8,000
Coinsurance	Plan pays 100% after Deductible	Plan pays 80% after Deductible
Out of Pocket Maximum	Includes Deductible/Coinsurance/Copays	
Individual	$4,000	$8,000
Family	$8,000	$16,000
Lifetime Maximum	Unlimited	
Office Visits		
Primary Care Physician	$25 Copay	Plan pays 80% after Deductible
Specialist	$50 Copay	
Preventive Care Services	Plan pays 100%	Plan pays 80% after Deductible
Inpatient	Plan pays 100% after Deductible	Plan pays 60% after Deductible
Outpatient Surgery	Plan pays 100% after Deductible	Plan pays 80% after Deductible
Emergency Room	$200 Copay	$200 Copay
Urgent Care	$100 Copay	Plan pays 80% after Deductible
Prescription Drugs		
Retail Pharmacy (31 days)		
Tier 1	$10 Copay	$10 Copay
Tier 2	$35 Copay	$35 Copay
Tier 3	$60 Copay	$60 Copay
Tier 4	$100 Copay	$100 Copay
Mail Order Pharmacy (90 days)		
Tier 1	$30 Copay	Not Covered
Tier 2	$105 Copay	Not Covered
Tier 3	$180 Copay	Not Covered
Tier 4	$300 Copay	Not Covered
Specialty Drugs	*T1 $10 - T2 $100 - T3 $200 - T4 $300*	

Option 1 $2000 100% (OA-9)							
	Medical	**Dental**	**Vision**		**JDC**	**EE**	Per Pay Period
EE	$504.51	$ 38.96	$ 7.72	$551.19	$ 496.07	$55.12	**$25.44**
EE+SP	$1,059.48	$ 77.90	$ 14.64	$1,152.02	$ 496.07	$655.95	**$302.75**
EE+CH	$958.56	$ 76.01	$ 17.17	$1,051.74	$ 496.07	$555.67	**$256.46**
FAMILY	$1,513.53	$ 119.91	$ 24.16	$1,657.60	$ 496.07	$1,161.53	**$536.09**

Medical Coverage - United Healthcare		
Type of Plan	**Choice Plus High Plan OB2**	
	In-Network	**Out-of-Network**
Overview	May use both In-Network and Out-of-Network providers Use Network providers and receive the In-Network level of benefits Use Non-Network providers receive a lower level of benefits and you may be subject to Balance Billing.	
Deductible		
Individual	$2,000	$4,000
Family Embedded	$4,000	$8,000
Coinsurance	Plan pays 90% after Deductible	Plan pays 70% after Deductible
Out of Pocket Maximum	Includes Deductible/Coinsurance/Copays	
Individual	$4,000	$8,000
Family	$8,000	$16,000
Lifetime Maximum	Unlimited	
Office Visits		
Primary Care Physician	$40 Copay	Plan pays 70% after Deductible
Specialist	$80 Copay	
Preventive Care Services	Plan pays 100%	Plan pays 70% after Deductible
Inpatient	Plan pays 90% after deductible	Plan pays 70% after Deductible
Outpatient Surgery	Plan pays 90% after Deductible	Plan pays 70% after Deductible
Emergency Room	$250 Copay	$250 Copay
Urgent Care	$100 Copay	Plan pays 70% after Deductible
Prescription Drugs		
Retail Pharmacy (31 days)		
Tier 1	$10 Copay	$10 Copay
Tier 2	$35 Copay	$35 Copay
Tier 3	$60 Copay	$60 Copay
Tier 4	$100 Copay	$100 Copay
Mail Order Pharmacy (90 days)		
Tier 1	$30 Copay	Not Covered
Tier 2	$105 Copay	Not Covered
Tier 3	$180 Copay	Not Covered
Tier 4	$300 Copay	Not Covered
Specialty Drugs	*T1 $10 - T2 $100 - T3 $200 - T4 $300*	

Option 2 $2000 90% (OB-2)

	Medical	Dental	Vision		JDC	EE	Per Pay Period
EE	$475.43	$ 38.96	$ 7.72	$522.11	$ 469.90	$52.21	**$24.10**
EE+SP	$998.41	$ 77.90	$ 14.64	$1,090.95	$ 469.90	$621.05	**$286.64**
EE+CH	$903.31	$ 76.01	$ 17.17	$996.49	$ 469.90	$526.59	**$243.04**
FAMILY	$1,426.29	$ 119.91	$ 24.16	$1,570.36	$ 469.90	$1,100.46	**$507.91**

Medical Coverage - United Healthcare		
Type of Plan	**Choice Plus High Plan 8BF**	
	In-Network	**Out-of-Network**
Overview	May use both In-Network and Out-of-Network providers Use Network providers and receive the In-Network level of benefits Use Non-Network providers receive a lower level of benefits and you may be subject to Balance Billing.	
Deductible		
Individual	$2,000	$4,000
Family	$4,000	$8,000
Coinsurance	Plan pays 70% after Deductible	Plan pays 60% after Deductible
Out of Pocket Maximum	Includes Deductible/Coinsurance/Copays	
Individual	$6,600	$12,000
Family	$13,200	$24,000
Lifetime Maximum	Unlimited	
Office Visits		
Primary Care Physician	$35 Copay	Plan pays 60% after Deductible
Specialist	$70 Copay	Plan pays 60% after Deductible
Preventive Care Services	Plan pays 100%	Plan pays 60% after Deductible
Inpatient	Plan pays 70% after deductible	Plan pays 60% after Deductible
Outpatient Surgery	Plan pays 70% after deductible	Plan pays 60% after Deductible
Emergency Room	$500 Copay	$500 Copay
Urgent Care	$100 Copay	Plan pays 60% after Deductible
Prescription Drugs		
Retail Pharmacy (31 days)		
Tier 1	$10 Copay	$10 Copay
Tier 2	$35 Copay	$35 Copay
Tier 3	$60 Copay	$60 Copay
Tier 4	$100 Copay	$100 Copay
Mail Order Pharmacy (90 days)		
Tier 1	$30 Copay	Not Covered
Tier 2	$105 Copay	Not Covered
Tier 3	$180 Copay	Not Covered
Tier 4	$300 Copay	Not Covered
Specialty Drugs	*T1 $10 - T2 $100 - T3 $200 - T4 $300*	

Option 3 $2000 70% (8B-F)							
	Medical	**Dental**	**Vision**		**JDC**	**EE**	Per Pay Period
EE	$438.36	$ 38.96	$ 7.72	$485.04	$ 436.54	$48.50	**$22.39**
EE+SP	$920.55	$ 77.90	$ 14.64	$1,013.09	$ 436.54	$576.55	**$266.10**
EE+CH	$832.89	$ 76.01	$ 17.17	$926.07	$ 436.54	$489.53	**$225.94**
FAMILY	$1,315.08	$ 119.91	$ 24.16	$1,459.15	$ 436.54	$1,022.61	**$471.98**

Medical Coverage - United Healthcare		
Type of Plan	**HSA High Deductible Health Plan 8B5**	
	In-Network	**Out-of-Network**
Overview	May use both In-Network and Out-of-Network providers Use Network providers and receive the In-Network level of benefits Use Non-Network providers receive a lower level of benefits and you may be subject to Balance Billing.	
Deductible		
Individual	$4,000	$8,000
Family	$8,000	$16,000
Coinsurance	Plan pays 100% after Deductible	Plan Pays 80% after Deductible
Out of Pocket Maximum	Includes Deductible/Coinsurance/Copays	
Individual	$6,400	$12,800
Family	$12,800	$25,600
Lifetime Maximum	Unlimited	
Physician's Office Visit	PCP $35 Copay after Deductible Specialist $50 Copay after Deductible	Plan Pays 80% after Deductible
Preventive Care Services	Plan pays 100%; Deductible waived	Plan Pays 80% after Deductible
Inpatient	$500 Copay after Deductible	Plan Pays 80% after Deductible
Outpatient Surgery	$300 Copay after Deductible	Plan Pays 80% after Deductible
Emergency Room	$250 Copay after Deductible	$250 Copay after Network Deductible
Urgent Care	$100 Copay after Deductible	Plan Pays 80% after Deductible
Prescription Drugs		
Retail Pharmacy (31 days)		
Tier 1	$15 Copay after Deductible	$15 Copay after Deductible
Tier 2	$45 Copay after Deductible	$45 Copay after Deductible
Tier 3	$85 Copay after Deductible	$85 Copay after Deductible
Tier 4	$125 Copay after Deductible	$125 Copay after Deductible
Mail Order Pharmacy (90 days)		
Tier 1	$45 Copay after Deductible	Not Covered
Tier 2	$135 Copay after Deductible	Not Covered
Tier 3	$255 Copay after Deductible	Not Covered
Tier 4	$375 Copay after Deductible	Not Covered
Health Savings Account	Election of the High Deductible Health Plan entitles you to open a Health Savings Account (HSA) through HSA Bank. More information to follow.	

Option 4 $4000 HDHP (8B-5)							
	Medical	**Dental**	**Vision**		**JDC**	**EE**	Per Pay Period
EE	$347.94	$ 36.75	$ 7.72	$392.41	$ 353.17	$39.24	**$18.11**
EE+SP	$730.67	$ 73.49	$ 14.64	$818.80	$ 353.17	$465.63	**$214.91**
EE+CH	$661.09	$ 71.71	$ 17.17	$749.97	$ 353.17	$396.80	**$183.14**
FAMILY	$1,043.82	$ 113.12	$ 24.16	$1,181.10	$ 353.17	$827.93	**$382.12**

Helpful Hints for United HealthCare - 2016

From time to time, we will send out information about your healthcare company – United HealthCare (UHC) to better ensure that you are using the benefits to their maximum potential and that you don't have to incur any unnecessary or unexpected expenses.

Hospital Visits

If you should have a hospital visit please be sure that the hospital calls in to do a pre certification for your stay. Failure to do so will result in a penalty.

Most members use an in network hospital and know that their surgeon/doctor is an in network provider. Most of us do not know, however, if the providers in the hospital that are used without our say so are in or out of network. These providers are referred to as the ERAP doctors (Emergency Medicine, Radiologists, Anesthesiologists and Pathologists) UHC will **not** cover these doctors as in network unless they are a part of the UHC Choice Plus network. Typically you cannot choose who these doctors are so it is imperative that you communicate to your doctor/surgeon and the hospital that they must use one of UHC's in network doctors for any Emergency Medicine, Radiology, Anesthesiology and Pathology Services.

Directions on finding in network ERAP providers:

You are able to go onto the UHC website and look up these doctor's

Directions to find ERAP providers:

Go to www.myuhc.com

Under Links and Tool in the Right hand column – click on Find a Physician

Select a Plan – Click United HealthCare Choice Plus

Click change address and type in the zip code of the provider or hospital

Type in provider or hospital name

This is what you will see

Northside Hospital
Specialty:
General Hospital

More about this hospital

Compare with other providers

Add to List

In Network

Estimated Distance: **3 miles**
1000 Johnson Ferry Rd NE
Atlanta, GA 30342-1606
404-851-8000
Map|Add Contact|Text Me
ID: 00000628152 010
Additional Information Available:

- Click here for details on facility based physician contract status that may help you to avoid additional out-of-pocket expenses

NOTE – You should click on the word **here** above and it will take you to a screen that will verify if the hospital has ERAP doctors that are in network at their hospital.

IMPORTANT: If a member has a procedure in an in network hospital and one of the ERAP providers is "not" in-network then the claim will proceed as follows:

- UHC will contact the doctor's office and will try to get the doctor's office to agree to "shared savings". Shared savings is a negotiated rate paid to the doctor which is not as much as an in-network MD would be reimbursed but it is a lot better than the alternative which is 110% of Medicare.
- If the doctor agrees to shared savings then they are agreeing to NOT balance bill the patient.
- If the doctor refuses to be in-network and refuses shared savings then the doctor will be paid 110% of Medicare and they can balance bill the patient.

Virtual Medicine
See flyer on the following page regarding benefits to speak with a doctor anytime online

Please know we at CBIZ are committed to providing you excellent customer service and are here if you have any questions regarding your benefits. You can reach me, Elyse Kellert, Account Manager at 770-858-4802 or ekellert@cbiz.com.

UnitedHealthcare® dental plan

Consumer MaxMultiplier Options PPO 30/covered dental services P4883 /U90

	NETWORK	NON-NETWORK
Individual Annual Deductible	$50	$50
Family Annual Deductible	$150	$150
Annual Maximum Benefit* *(The total benefit payable by the plan will not exceed the highest listed maximum amount for either Network or Non-Network services.)*	$1500 per person per calendar year	$1500 per person per calendar year
Annual Deductible Applies to Preventive and Diagnostic Services	No	
Waiting Period	No waiting period	

COVERED SERVICES**	NETWORK PLAN PAYS***	NON-NETWORK PLAN PAYS****	BENEFIT GUIDELINES
DIAGNOSTIC SERVICES			
Periodic Oral Evaluation	100%	100%	Limited to 2 times per consecutive 12 months.
Radiographs	100%	100%	Bitewing: Limited to 1 series of films per calendar year. Complete/Panorex: Limited to 1 time per consecutive 36 months.
Lab and Other Diagnostic Tests	100%	100%	
PREVENTIVE SERVICES			
Dental Prophylaxis (Cleanings)	100%	100%	Limited to 2 times per consecutive 12 months.
Fluoride Treatments	100%	100%	Limited to covered persons under the age of 16 years and limited to 2 times per consecutive 12 months.
Sealants	100%	100%	Limited to covered persons under the age of 16 years and once per first or second permanent molar every consecutive 36 months.
Space Maintainers	100%	100%	For covered persons under the age of 16 years, limit 1 per consecutive 60 months.
BASIC DENTAL SERVICES			
Restorations *(Amalgam or Anterior Composite)***	80%	80%	Multiple restorations on one surface will be treated as a single filling.
General Services *(including Emergency Treatment)*	80%	80%	Palliative Treatment: Covered as a separate benefit only if no other service was done during the visit other than X-rays. General Anesthesia: when clinically necessary. Occlusal Guard: Limited to 1 guard every consecutive 36 months.
Simple Extractions	80%	80%	Limited to 1 time per tooth per lifetime.
Oral Surgery *(includes surgical extractions)*	80%	80%	
Periodontics	80%	80%	Perio Surgery: Limited to 1 quadrant or site per consecutive 36 months per surgical area. Scaling and Root Planing: Limited to 1 time per quadrant per consecutive 24 months. Periodontal Maintenance: Limited to 2 times per consecutive 12 months following active and adjunctive periodontal therapy, exclusive of gross debridement.
Endodontics	80%	80%	Root Canal Therapy: Limited to 1 time per tooth per lifetime.
MAJOR DENTAL SERVICES			
Inlays/Onlays/Crowns**	50%	50%	Limited to 1 time per tooth per consecutive 60 months.
Dentures and other Removable Prosthetics	50%	50%	Full Denture/Partial Denture: Limited to 1 per consecutive 60 months. No additional allowances for precision or semi-precision attachments.
Fixed Partial Dentures (Bridges)**	50%	50%	Limited to 1 time per tooth per consecutive 60 months.

Dental		
	EE	Per Pay Period
EE	$ 38.96	**$1.80**
EE+SP	$ 77.90	**$19.77**
EE+CH	$ 76.01	**$18.90**
FAMILY	$ 119.91	**$39.16**

UnitedHealthcare/dental exclusions and limitations

Dental Services described in this section are covered when such services are:

A. Necessary;

B. Proviced by or under the direction of a Dentist or other appropriate provider as specifically described;

C. The least costly, clinically accepted treatment; and

D. Not excluded as described in the Section entitled, General Exclusions.

GENERAL LIMITATIONS

PERIODIC ORAL EVALUATION Limited to 2 times per consecutive 12 months.

COMPLETE SERIES OR PANOREX RADIOGRAPHS Limited to 1 time per consecutive 36 months.

BITEWING RADIOGRAPHS Limited to 1 series of films per calendar year.

EXTRAORAL RADIOGRAPHS Limited to 2 films per calendar year.

DENTAL PROPHYLAXIS Limited to 2 times per consecutive 12 months.

FLUORIDE TREATMENTS Limited to covered persons under the age of 16 years, and limited to 2 times per consecutive 12 months.

SPACE MAINTAINERS Limited to covered persons under the age of 16 years, limited to 1 per consecutive 60 months. Benefit includes all adjustments within 6 months of installation.

SEALANTS Limited to covered persons under the age of 16 years, and once per first or second permanent molar every consecutive 36 months.

RESTORATIONS Multiple restorations on one surface will be treated as a single filling.

PIN RETENTION Limited to 2 pins per tooth; not covered in addition to cast restoration.

INLAYS AND ONLAYS Limited to 1 time per tooth per consecutive 60 months. Covered only when a filling cannot restore the tooth.

CROWNS Limited to 1 time per tooth per consecutive 60 months. Covered only when a filling cannot restore the tooth.

POST AND CORES Covered only for teeth that have had root canal therapy.

SEDATIVE FILLINGS Covered as a separate benefit only if no other service, other than x-rays and exam, were performed on the same tooth during the visit.

SCALING AND ROOT PLANING Limited to 1 time per quadrant per consecutive 24 months.

ROOT CANAL THERAPY Limited to 1 time per tooth per lifetime.

PERIODONTAL MAINTENANCE Limited to 2 times per consecutive 12 months following active or adjunctive periodontal therapy, exclusive of gross debridement.

FULL DENTURES Limited to 1 time every consecutive 60 months. No additional allowances for precision or semi-precision attachments.

PARTIAL DENTURES Limited to 1 time every consecutive 60 months. No additional allowances for precision or semi-precision attachments.

RELINING AND REBASING DENTURES Limited to relining/rebasing performed more than 6 months after the initial insertion. Limited to 1 time per consecutive 12 months.

REPAIRS TO FULL DENTURES, PARTIAL DENTURES, BRIDGES Limited to repairs or adjustments performed more than 12 months after the initial insertion. Limited to 1 per consecutive 6 months.

PALLIATIVE TREATMENT Covered as a separate benefit only if no other service, other than the exam and radiographs, were performed on the same tooth during the visit.

OCCLUSAL GUARDS Limited to 1 guard every consecutive 36 months and only covered if prescribed to control habitual grinding.

FULL MOUTH DEBRIDEMENT Limited to 1 time every consecutive 36 months.

GENERAL ANESTHESIA Covered only when clinically necessary.

OSSEOUS GRAFTS Limited to 1 per quadrant or site per consecutive 36 months.

PERIODONTAL SURGERY Hard tissue and soft tissue periodontal surgery are limited to 1 quadrant or site per consecutive 36 months per surgical area.

REPLACEMENT OF COMPLETE DENTURES, FIXED OR REMOVABLE PARTIAL DENTURES, CROWNS, INLAYS OR ONLAYS Replacement of complete dentures, fixed or removable partial dentures, crowns, inlays or onlays previously submitted for payment under the plan is limited to 1 time per consecutive 60 months from initial or supplemental placement. This includes retainers, habit appliances, and any fixed or removable interceptive orthodontic appliances.

GENERAL EXCLUSIONS

The following are not covered:

1. Dental Services that are not necessary.
2. Hospitalization or other facility charges.
3. Any dental procedure performed solely for cosmetic/aesthetic reasons. (Cosmetic procedures are those procedures that improve physical appearance.)
4. Reconstructive Surgery regardless of whether or not the surgery is incidental to a dental disease, injury, or Congenital Anomaly when the primary purpose is to improve physiological functioning of the involved part of the body.
5. Any dental procedure not directly associated with dental disease.
6. Any dental procedure not performed in a dental setting.
7. Procedures that are considered to be Experimental, Investigational or Unproven. This includes pharmacological regimens not accepted by the American Dental Association (ADA) Council on Dental Therapeutics. The fact that an Experimental, Investigational or Unproven Service, treatment, device or pharmacological regimen is the only available treatment for a particular condition will not result in coverage if the procedure is considered to be Experimental, Investigational or Unproven in the treatment of that particular condition.
8. Services for injuries or conditions covered by Worker's Compensation or employer liability laws, and services that are provided without cost to the covered person by any municipality, county, or other political subdivision. This exclusion does not apply to any services covered by Medicaid or Medicare.
9. Expenses for dental procedures begun prior to the covered person becoming enrolled under the Policy.
10. Dental Services otherwise covered under the Policy, but rendered after the date individual coverage under the Policy terminates, including Dental Services for dental conditions arising prior to the date individual coverage under the Policy terminates.
11. Services rendered by a provider with the same legal residence as a covered person or who is a member of a covered person's family, including spouse, brother, sister, parent or child.
12. Foreign Services are not covered unless required as an Emergency.
13. Replacement of complete dentures, fixed and removable partial dentures, or crowns, if damage or breakage was directly related to provider error. This type of replacement is the responsibility of the Dentist. If replacement is necessary because of patient non-compliance, the patient is liable for the cost of replacement.
14. Fixed or removable prosthodontic restoration procedures for complete oral rehabilitation or reconstruction.
15. Attachments to conventional removable prostheses or fixed bridgework. This includes semi-precision or precision attachments associated with partial dentures, crown or bridge abutments, full or partial overdentures, any internal attachment associated with an implant prosthesis, and any elective endodontic procedure related to a tooth or root involved in the construction of a prosthesis of this nature.
16. Procedures related to the reconstruction of a patient's correct vertical dimension of occlusion (VDO).
17. Placement of dental implants, implant-supported abutments and prostheses
18. Placement of fixed partial dentures solely for the purpose of achieving periodontal stability.
19. Treatment of benign neoplasms, cysts, or other pathology involving benign lesions, except excisional removal. Treatment of malignant neoplasms or Congenital Anomalies of hard or soft tissue, including excision.
20. Setting of facial bony fractures and any treatment associated with the dislocation of facial skeletal hard tissue.
21. Services related to the temporomandibular joint (TMJ), either bilateral or unilateral. Upper and lower jaw bone surgery (including that related to the temporomandibular joint). No coverage is provided for orthognathic surgery, jaw alignment, or treatment for the temporomandibular joint.
22. Acupuncture; acupressure and other forms of alternative treatment, whether or not used as anesthesia.
23. Drugs/medications, obtainable with or without a prescription, unless they are dispensed and utilized in the dental office during the patient visit.
24. Charges for failure to keep a scheduled appointment without giving the dental office 24 hours notice.
25. Occlusal guards used as safety items or to affect performance primarily in sports-related activities.
26. Dental Services received as a result of war or any act of war, whether declared or undeclared or caused during service in the armed forces of any country.

UnitedHealthcare®

Vision Benefit Summary
www.myuhcvision.com
Customer Service: (800) 638-3120
Provider Locator: (800) 839-3242

Plan V1368

	NETWORK	NON-NETWORK
Comprehensive Vision Exam	$10 Copay	Up to $40
Materials - Eyeglass Lenses/Eyeglass Frames or Contact Lenses	$25 Copay[1]	See below
Frequencies - Based on last date of service	Exam Once every 12 months Lenses Once every 12 months Frames Once every 24 months	

COVERED SERVICES	NETWORK	NON-NETWORK
Pair of Lenses (for Eyewear)		
• Standard single vision lenses • Standard lined bifocal lenses • Standard lined trifocal lenses • Standard lenticular lenses Lens options such as progressive lenses, tints, UV, and anti-reflective coating may be available at a discount at participating providers.	Covered in full after applicable copay[1] Includes standard scratch-resistant coating and polycarbonate lenses	Up to $40 Up to $60 Up to $80 Up to $80
Frames		
You will receive a retail frame allowance toward the purchase of any frame at a network provider. For frames that exceed your allowance, you may receive an additional 30% discount on the overage (available only at participating providers and may exclude certain frame manufacturers).	$130 Retail Frame Allowance (after applicable copay [1])	Up to $45
Contact Lenses[2]		
• Covered contact lens selection It is important to note the covered contact lens selection may vary by provider but does include the most popular brands on the market today.[3] A complete list can be found by visiting our website www.myuhcvision.com.	Up to 4 boxes of contact lenses plus the fitting/evaluation fees and up to two follow-up visits are covered-in-full (after applicable copay [1])	Up to $125
• Non-selection contacts You receive an allowance which is applied toward the fitting/evaluation fees and purchase of contact lenses outside the covered contact lens selection.	Up to $125 (material copay is waived)	Up to $125
• Necessary contact lenses[4]	Covered in full after applicable copay[1]	Up to $210

Vision		
	EE	Per Pay Period
EE	$ 7.72	**$0.36**
EE+SP	$ 14.64	**$3.53**
EE+CH	$ 17.17	**$4.69**
FAMILY	$ 24.16	**$7.92**

Vision Plan

UnitedHealthcare®

Vision Benefit Summary

www.myuhcvision.com
Customer Service: (800) 638-3120
Provider Locator: (800) 839-3242

Plan V1368

Important to Remember:

Network

- Always identify yourself as a UnitedHealthcare customer when making your appointment. This will assist your provider in obtaining a claim authorization before your visit.
- Your participating provider will help you determine which contact lenses are available in the UnitedHealthcare selection.
- Your contact lens allowance is applied to the fitting/evaluation fees, as well as the purchase of non-covered selection contact lenses. For example, if your allowance is $125 and the fitting fee and evaluation is $35, you will have $90 toward the purchase of non-selection contact lenses. Evaluation and fitting fees may vary among providers and type of fitting required. Your material copay is waived when purchasing non-selection contacts.
- Patient options, such as UV coating, progressive lenses, etc., which are not covered-in-full, may be available at a discount at participating providers.

Choice and Access of Vision Care Providers

UnitedHealthcare offers its vision program through a national network including both private practice and retail chain providers. To access the Provider Locator service, visit our Web site at www.myuhcvision.com or call 1-800-839-3242, 24 hours a day, seven days a week. You may also view your benefits, search for a provider or print an ID card online at www.myuhcvision.com.

Retain this UnitedHealthcare vision benefit summary which includes detailed benefit information and instructions on how to use the program. Please refer to your Certificate of Coverage for a full explanation of benefits.

Network Provider - Copays and non-covered patient options are paid to provider by program participant at the time of service.

Non-Network Provider - Participant pays full fee to the provider, and UnitedHealthcare reimburses the participant for services rendered up to the maximum allowance. Copays do not apply to non-network benefits. All receipts must be submitted at the same time. Written proof of loss should be given to the Company within 90 days after the date of the loss. If it was not reasonably possible to give written proof in the time required, the Company will not reduce or deny the claim for this reason. However, proof must be filed as soon as reasonably possible, but no later than 1 year after the date of service unless the Covered Person was legally incapacitated.

Additional Materials Benefit

UnitedHealthcare offers an additional Materials Discount Program. At a participating network provider you will receive a 20% discount on an additional pair of eyeglasses or contact lenses. This program is available after your vision benefits have been exhausted. Please note that this discount shall not be considered insurance, and that UnitedHealthcare shall neither pay nor reimburse the provider or member for any funds owed or spent. Not all providers may offer this discount. Please contact your provider to see if they participate. Discounts on contact lenses may vary by provider. Additional materials do not have to be purchased at the time of initial material purchase. Additional materials can be purchased at a discount any time after the insured benefit has been used.

Customer Service is available toll-free at 1-800-638-3120 from 8:00 a.m. to 11:00 p.m. Eastern Time Monday through Friday; and 9:00 a.m. to 6:30 p.m. Eastern Time on Saturday.

This Benefit Summary is intended only to highlight your benefits and should not be relied upon to fully determine coverage. This benefit plan may not cover all of your healthcare expenses. More complete descriptions of benefits and the terms under which they are provided are contained in the certificate of coverage that you will receive upon enrolling in the plan. If this Benefit Summary conflicts in any way with the Policy issued to your employer, the Policy shall prevail.

UnitedHealthcare Vision® coverage provided by or through UnitedHealthcare Insurance Company, located in Hartford, Connecticut, or its affiliates. Administrative services provided by Spectera, Inc., United HealthCare Services, Inc. or their affiliates. Plans sold in Texas use policy form number VPOL.06.TX and associated COC form number VCOC.INT.06.TX.

STD, LTD, Basic Life/AD&D

Benefit Highlights*

JDC provides this coverage at no cost to employees.

The benefit pays 60% of your **weekly** earnings to maximum of $1,000 / week

0/7 Day Elimination Period for Sickness or Accident

13 week benefit duration

Maternity benefits included

JDC provides this coverage at no cost to employees.

The benefit pays 60% of your **monthly** earnings to maximum of $10,000 / month

90 Day Elimination Period

Definition of Disability: 2 Year Own Occupation / Residual to Retirement

Pays to retirement age: ADEA (age 65 normal retirement age)

24 month Mental & Nervous / Self-reported symptoms limitation

3/12 Pre-existing Condition Exclusion (if enrolled in the plan for less than one year)

Work-Life Balance Employee Assistance Program

Worldwide Emergency Travel Assistance

JDC provides this coverage at no cost to employees.

$15,000 Life and AD&D benefit

Accidental Death & Dismemberment Benefits Included

Age Reduction: 65% at Age 65; 50% at Age 70

Accelerated Death Benefit is 100% of the Life Amount to a maximum of $250,000

Coverage is Portable

2016 Annual Health Plan Notices

Women's Health and Cancer Rights Act of 1998

Did you know that your plan, as required by the Women's Health and Cancer Rights Act of 1998, provides benefits for mastectomy – related services, including reconstruction and surgery to achieve symmetry between the breasts, prosthesis, and complications resulting from a mastectomy (including lymphedema). Please call your plan administrator for more information.

The Genetic Information Nondiscrimination Act (GINA)

The Genetic Information Nondiscrimination Act of 2008, also referred to as GINA, is a new federal law that protects Americans from being treated unfairly because of differences in their DNA that may affect their health. The new law prevents discrimination from health insurers and employers. The President signed the act into federal law on May 21, 2008. The parts of the law relating to health insurers will take effect by May 2009, and those relating to employers will take effect by November 2009.

Who needs protection from genetic discrimination?

Everyone should care about the potential for genetic discrimination. Every person has dozens of DNA differences that could increase or decrease his or her chance of getting a disease such as diabetes, heart disease, cancer or Alzheimer's. It's important to remember that these DNA differences don't always mean someone will develop a disease, just that the risk to get the disease may be greater.

More and more tests are being developed to find DNA differences that affect our health. These tests (called genetic tests) will become a routine part of health care in the future. Health care providers will use information about each person's DNA to develop more individualized ways of detecting, treating and preventing disease. But unless this DNA information is protected, it could be used to discriminate against people.

Why was the law needed?

The law was needed to help ease concerns about discrimination that might keep some people from getting genetic tests that could benefit their health. The law also enables people to take part in research studies without fear that their DNA information might be used against them in health insurance or the workplace.

Newborn's Act Disclosure

Group health plans and health insurance issuers generally may not, under Federal law, restrict benefits for any hospital length of stay with connection to childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, Federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother and her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under Federal law, require that a provider obtain authorization from the plan or the insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

MANDATED NOTICES

HIPAA Notice of Privacy Practices

This rule required health plans to send participants an initial notice of privacy practices and then reminders must be given once every three years. This memo is a reminder that if you would like to see or obtain another copy of the health plan's HIPAA Privacy Notice, please contact your HR Department.

Michelle's Law: Notice of Extended Coverage to Participants Covered Under a Group Health Plan

Federal legislation known as "Michelle's Law" generally extends eligibility for group health benefit plan coverage to a dependent child who is enrolled in an institution of higher education at the beginning of a medically necessary leave of absence if the leave normally would cause the dependent child to lose eligibility for coverage under the plan due to loss of student status. The extension of eligibility protects eligibility of a sick or injured dependent child for up to one year.

The Plan currently permits an employee to continue a child's coverage if that child is enrolled at an accredited institution of learning on a full-time basis, with full-time defined by the accredited institution's registration and/or attendance policies. Michelle's Law requires the Plan to allow extended eligibility in some cases for a dependent child who would lose eligibility for Plan coverage due to loss of full-time student status.

There are two definitions that are important for purposes of determining whether the Michelle's Law extension of eligibility applies to a particular child:

- *Dependent child* means a child of a plan participant who is eligible under the terms of a group health benefit plan based on his or her student status and who was enrolled at a post-secondary educational institution immediately before the first day of a medically necessary leave of absence.

- *Medically necessary leave of absence* means a leave of absence or any other change in enrollment:

⇒ of a dependent child from a post-secondary educational institution that begins while the child is suffering from a serious illness or injury

⇒ which is medically necessary

⇒ and which causes the dependent child to lose student status under the terms of the Plan

For the Michelle's Law extension of eligibility to apply, a dependent child's treating physician must provide written certification of medical necessity (i.e., certification that the dependent child suffers from a serious illness or injury that necessitates the leave of absence or other enrollment change that would otherwise cause loss of eligibility).

If a dependent child qualifies for the Michelle's Law extension of eligibility, the Plan will treat the dependent child as eligible for coverage until the earlier of:

⇒ One year after the first day of the leave of absence

⇒ The date that Plan coverage would otherwise terminate (for reasons other than failure to be a full-time student)

A dependent child on a medically necessary leave of absence is entitled to receive the same Plan benefits as other dependent children covered under the Plan. Further, any change to Plan coverage that occurs during the Michelle's Law extension of eligibility will apply to the dependent child to the same extent as it applies to other dependent children covered under the Plan.

MANDATED NOTICES

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 July 31, 2015. Contact your State for more information on eligibility –

ALABAMA – Medicaid	GEORGIA – Medicaid
Website: www.myalhipp.com Phone: 1-855-692-5447	Website: http://dch.georgia.gov/ - Click on Programs, then Medicaid, then Health Insurance Premium Payment (HIPP) Phone: 404-656-4507
ALASKA – Medicaid	**INDIANA – Medicaid**
Website: http://health.hss.state.ak.us/dpa/programs/medicaid/ Phone (Outside of Anchorage): 1-888-318-8890 Phone (Anchorage): 907-269-6529	Website: http://www.in.gov/fssa Phone: 1-800-889-9949
COLORADO – Medicaid	**IOWA – Medicaid**
Medicaid Website: http://www.colorado.gov/hcpf Medicaid Customer Contact Center: 1-800-221-3943	Website: www.dhs.state.ia.us/hipp/ Phone: 1-888-346-9562
FLORIDA – Medicaid	**KANSAS – Medicaid**
Website: https://www.flmedicaidtplrecovery.com/ Phone: 1-877-357-3268	Website: http://www.kdheks.gov/hcf/ Phone: 1-800-792-4884

MANDATED NOTICES

KENTUCKY – Medicaid	NEW HAMPSHIRE – Medicaid
Website: http://chfs.ky.gov/dms/default.htm Phone: 1-800-635-2570	Website: http://www.dhhs.nh.gov/oii/documents/hippapp.pdf Phone: 603-271-5218
LOUISIANA – Medicaid	**NEW JERSEY – Medicaid and CHIP**
Website: http://dhh.louisiana.gov/index.cfm/subhome/1/n/331 Phone: 1-888-695-2447	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
MAINE – Medicaid	**NEW YORK – Medicaid**
Website: http://www.maine.gov/dhhs/ofi/public-assistance/index.html Phone: 1-800-977-6740 TTY 1-800-977-6741	Website: http://www.nyhealth.gov/health_care/medicaid/ Phone: 1-800-541-2831
MASSACHUSETTS – Medicaid and CHIP	**NORTH CAROLINA – Medicaid**
Website: http://www.mass.gov/MassHealth Phone: 1-800-462-1120	Website: http://www.ncdhhs.gov/dma Phone: 919-855-4100
MINNESOTA – Medicaid	**NORTH DAKOTA – Medicaid**
Website: http://www.dhs.state.mn.us/id_006254 Click on Health Care, then Medical Assistance Phone: 1-800-657-3739	Website: http://www.nd.gov/dhs/services/medicalserv/medicaid/ Phone: 1-800-755-2604
MISSOURI – Medicaid	**OKLAHOMA – Medicaid and CHIP**
Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005	Website: http://www.insureoklahoma.org Phone: 1-888-365-3742
MONTANA – Medicaid	**OREGON – Medicaid**
Website: http://medicaid.mt.gov/member Phone: 1-800-694-3084	Website: http://www.oregonhealthykids.gov http://www.hijossaludablesoregon.gov Phone: 1-800-699-9075
NEBRASKA – Medicaid	**PENNSYLVANIA – Medicaid**
Website: www.ACCESSNebraska.ne.gov Phone: 1-855-632-7633	Website: http://www.dhs.state.pa.us/hipp Phone: 1-800-692-7462
NEVADA – Medicaid	**RHODE ISLAND – Medicaid**
Medicaid Website: http://dwss.nv.gov/ Medicaid Phone: 1-800-992-0900	Website: http://www.eohhs.ri.gov/ Phone: 401-462-5300

MANDATED NOTICES

SOUTH CAROLINA – Medicaid	VIRGINIA – Medicaid and CHIP
Website: http://www.scdhhs.gov Phone: 1-888-549-0820	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 CHIP Phone: 1-855-242-8282
SOUTH DAKOTA - Medicaid	**WASHINGTON – Medicaid**
Website: http://dss.sd.gov Phone: 1-888-828-0059	Website: http://www.hca.wa.gov/medicaid/premiumpymt/pages/ index.aspx Phone: 1-800-562-3022 ext. 15473
TEXAS – Medicaid	**WEST VIRGINIA – Medicaid**
Website: http://gethipptexas.com/ Phone: 1-800-440-0493	Website: http://www.dhhr.wv.gov/bms/Medicaid%20Expansion/Pages/default.aspx
UTAH – Medicaid and CHIP	**WISCONSIN – Medicaid and CHIP**
Website: Medicaid: http://health.utah.gov/medicaid CHIP: http://health.utah.gov/chip	Website: https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm Phone: 1-800-362-3002
VERMONT– Medicaid	**WYOMING – Medicaid**
Website: http://www.greenmountaincare.org/ Phone: 1-800-250-8427	Website: https://wyequalitycare.acs-inc.com/ Phone: 307-777-7531

To see if any other states have added a premium assistance program since July 31, 2015, or for more information on special enrollment rights, contact either:

U.S. Department of Labor
Employee Benefits Security Administration
www.dol.gov/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

OMB Control Number 1210-0137 (expires 10/31/2016)

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Disclaimer: This Benefit Guide provides only the briefest of summaries of the benefits available under JDC Group. In the event of any discrepancy between this summary and any Plan Document, the Plan Document will prevail. JDC Group retains the right to modify or eliminate these or any benefits at any time and for any reason.

CBIZ Benefits & Insurance Services