New Hire Benefits and Enrollment Guide

July 1, 2016 to June 30, 2017

HYLANT

Health | FSA | Dental | Vision | Disability | Life | Retirement | Identity Theft | Legal Shield
Colonial Voluntary Plans

2016-2017 Benefits Overview

CDS Family & Behavioral Health Services offers eligible employees a variety of benefits that can provide you and your family with health care coverage, financial protection and more, tailored to best fit your needs. Our benefits program is an important part of your overall compensation and with the assistance of Hylant, we are regularly assessing the quality and cost of the benefits to ensure we offer the most competitive package possible. An overview of our plans are described below, however, we encourage you to review this guide in its entirety before making your elections.

Contents

This booklet is intended for illustrative and information purposes only. The plan documents, insurance certificates and policies will serve as the governing documents. In the case of conflict between the information in this booklet and the official plan documents, the plan documents will always govern. ***CDS Family & Behavioral Health Services*** *reserves the right to change or terminate at any time, in whole or in part, the employee benefit package, with respect to all or any class of employees, or former employees.*

- **Open Enrollment: Open enrollment is your opportunity to make changes to your benefit elections.** Open enrollment takes place in June each year. Once your selections are completed, you will be locked into the plan selections until our next Open Enrollment, unless there is a qualifying event (marriage, divorce, birth, adoption or change in custody of a child, death of a dependent, change in employment status). All changes must be made within 30 days of the qualifying event.
- **Healthcare:** Our medical plans are with AvMed. You have a choice between the Silver and Bronze plans. CDS pays a portion of your health insurance premium for you. Please refer to the medical section of this guide for complete details.
- **Dental and Vision:** Our dental and vision insurance plans are with Guardian. You pay the cost of these coverages.
- **Life**: We provide Base Life insurance at no cost to you. We offer a Voluntary Supplemental Life insurance plan with Reliance Standard.
- **Disability:** Reliance Standard administers our Long Term and Short Term Disability plans. CDS pays 100% of the premium for the Long Term Disability insurance coverage and you have the option to purchase Short Term Disability insurance.
- **Flexible Spending Account:** You have the option to participate in the Medical Care and/or Dependent Care Account.
- **Voluntary Benefits:** We offer voluntary benefits through Colonial Life. Please refer to the plan information in this guide.
- **Pre-Paid Legal and Identity Theft Protection:** We offer these benefits with LegalShield.
- **Retirement Plan:** We offer a retirement plan through VALIC.
- **Online Enrollment:** You will enroll for your benefits on our online enrollment system, Employee Navigator. Instructions for enrolling are included in this guide.

Health Insurance Marketplace Coverage & Mandate Penalties

As a result of the Affordable Care Act (ACA), commonly referred to as "health care reform", the benefits landscape is changing. **Please carefully read the following as it contains important information regarding your healthcare plan and the Affordable Care Act.**

There is a new way to buy health insurance: the **Health Insurance Marketplace**. ***The Marketplace Open Enrollment begins in November 1, 2016 and ends in January 31, 2017.*** To assist you as you evaluate options for you and your family, this notice provides some basic information about the Marketplace.

What is the Health Insurance Marketplace: The Marketplace is designed to help you find health insurance that meets your needs and fits your budget. The Marketplace offers "one-stop shopping" to find and compare private health insurance options.

Does Employer Health Coverage Affect Eligibility for Premium Savings through the Marketplace: Yes. If you have an offer of health coverage from your employer that meets certain standards (minimum value and affordability), you will not be eligible for a tax credit through the Marketplace and may wish to enroll in your employer's health plan.

Do the Plans Offered by CDS Family & Behavioral Health Services Meet the Minimum Value Standard Set by the Affordable Care Act (ACA): Yes, both plans meet the minimum value requirement.

Do any of the CDS Family & Behavioral Health Services plans meet the cost requirements (affordability) of the Affordable Care Act (ACA): Yes, the CDS Family & Behavioral Health Services plan meets the cost requirements for most if not all employees.

Will any CDS Family & Behavioral Health Services employees be eligible for subsidies through the Marketplace: Because at least one of our plans meets the minimum value and the cost (affordability) standards of the Affordable Care Act, **CDS Family & Behavioral Health Services** employees who are eligible for benefits are not expected to be eligible for Marketplace subsidies.

Note: If you purchase a health plan through the Marketplace instead of accepting health coverage offered by your employer, then you may lose the employer contribution to the employer-offered coverage. Also, this employer contribution (as well as your employee contribution to employer-offered coverage) is excluded from income for federal and state income tax purposes. Your payments for coverage through the Marketplace are made on an after-tax basis.

What is the penalty for noncompliance of the individual mandate: As of January 1, 2014, all American citizens are required to have health insurance, including their dependents. Adults who do not have health insurance will be subject to a fine of the greater of **2.5% of income or $695 per person. After 2016, it's adjusted for inflation.**

If you're uninsured for just part of the year, 1/12 of the yearly penalty applies to each month you're uninsured. If you're uninsured for less than 3 months, you don't have to make a payment.

Who will be exempt from the mandate: Individuals who have a religious exemption, those not lawfully present in the United States, and incarcerated individuals are exempt from some requirements. **You are also exempt from the penalty if you have minimum essential health coverage.** You are considered to have minimum essential coverage if you have Medicare, Medicaid, CHIP, any job-based plan (i.e. CDS Family & Behavioral Health Services medical plan or your Spouse's medical plan through his/her place of employment), any medical plan you bought through the Marketplace, COBRA, retiree medical coverage, Tricare, VA health coverage. If you are uninsured, you will be subject to the fee . **In order to avoid the fee, you should enroll in the company medical plan.**

If you drop our group medical plan can you get immediate coverage with a Marketplace plan: No, dropping/cancelling employer coverage does not qualify as a special event for the Marketplace. You would have to wait until Marketplace Open Enrollment.

If you get a Marketplace plan and then drop it, can you get back on the CDS Family & Behavioral Health Services plan: Dropping/cancelling a Marketplace plan is not a qualifying event to elect group coverage. You would need to wait until the next Open Enrollment to elect group coverage.

How Can I Get More Information: For more information about your coverage offered by your employer, please review this benefit guide or contact Human Resources.

The Marketplace can help you evaluate your coverage options, including your eligibility for coverage through the Marketplace and its cost. Please visit **HealthCare.gov** for more information, as well as an online application for health insurance coverage and contact information for a Health Insurance Marketplace in your area.

Health Care Reform information is changing almost daily. As a result, this information is subject to change at any time. For more information on Health Care Reform, please visit www.healthcare.gov or call 1-800-318-2596 for the most current information.

Eligibility

CDS Family & Behavioral Health Services is pleased to offer its employees an excellent benefit program.

Eligibility: Health and welfare plans are available to all employees who work **30** or more hours per week.

Dependent Eligibility: If you wish, your dependents may also be covered. Eligible dependents include:

- Legal spouse, as defined by Federal Law; and
- MEDICAL - Your children up to the end of the month in which they turn **26** regardless of marital status, financial dependency, residency with the Eligible Employee, student status, employment status, or eligibility for other coverage. In the state of Florida dependent coverage is available up to age **30** if the dependent is unmarried, a Florida resident , or a full-time student and uninsured. The dependent must maintain continuous coverage.
- DENTAL - Children up to the end of the month in which they turn **26** as long as they are dependent upon you for support and is: (i) living in your household; or (ii) a full-time or part-time student.
- VISION - Children up to the end of the month in which they turn **26** as long as they are dependent upon you for support and is: (i) living in your household; or (ii) a full-time or part-time student.
- VOLUNTARY LIFE - Children up to the day they reach age **20** if they reside in the employee's home and are financially dependent on the employee, or age **26** as long as they are a full time student and financially dependent on the employee.
- It is your responsibility to provide the Human Resources Department with proof of your dependents' eligibility, in the form of: (a) your most recent Federal Income Tax Return, (b) Court Order specifying your responsibility to provide "group health care coverage" to your dependent children, or (c) Copy of birth or marriage certificate. **It is also your responsibility to notify Human Resources when your dependents no longer meet eligibility criteria.**

New Hire Coverage: As a new hire, your plan eligibility date is the **first day of the month following 60 calendar days of service.** New employees have up to 30 days after their eligibility date to enroll. If you do not enroll by that deadline, you will not be eligible for coverage until the following annual open enrollment period.

Annual Elections: You have the opportunity to pay for medical, dental, vision and FSA coverage on a pre-tax basis. IRS rules stipulate that once you have made your elections for the plan year, you may not change them until the next annual enrollment unless a qualifying event occurs. It is important that you make your choices carefully. Exceptions will be made for changes in family status during the year, allowing you to make a mid-year benefit change. A family status change includes:

- Marriage
- Divorce
- Birth or adoption
- Death of a dependent
- Change in your spouse's employment or
- Loss of coverage by a spouse
- Marketplace Open Enrollment/Special Enrollment

If you have a family status change, you must notify Human Resources to change your benefit elections within 30 days of the qualifying event, or you will need to wait until the next annual open enrollment period.

COBRA Continuation Coverage: When you or any of your dependents no longer meet the eligibility requirements for health and welfare plans, you may be eligible for continued coverage as required by the Consolidated Omnibus Budget Reconciliation Act (COBRA) of 1986.

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Online Enrollment System

CDS Family & Behavioral Health Services conducts benefits enrollment through an on-line enrollment system called Employee Navigator.

You will receive an email that includes a registration link. This link will direct you to the Employee Navigator registration page, which prompts you to verify the last 4 digits of your Social Security Number and then setup a username and password. We recommend that you use your email address as the username.

If you don't receive the email, or you don't have an email address, you may go on-line to *https://www.employeenavigator.com/benefits/Account/Register* click on the *register as a new user* link from the EN login screen. This link will direct you to the registration page, which will prompt you to input the following information:

- First name
- Last name
- Company ID (CDSFBHS)
- Last 4 of SSN
- Date of birth

Note: By default, the system automatically populates employee emails as the username when an email is on file for the employee. Employees can keep this username, or remove and create their own.

Once you have logged into the system, you will be looking at your home page; please click on the Profile tab and update any information that is incorrect under the employee profile tab. You will then need to review the employee benefits brochure which is listed under the employee home page, under compliance documents.

Once you have reviewed the employee benefits brochure, please click on the Update Benefits begin your enrollment in your benefit plans. Please note: you must either accept or decline each benefit before your election can be completed.

Once all benefits have been reviewed and accepted or declined, you will be asked to assign beneficiaries for your employer-sponsored life insurance benefit. Lastly, you will be taken to the Summary page where you will be asked to acknowledge your elections by pressing the Agree button. You will also need to click to submit elections to the Benefit Administrator. Be sure to complete both steps to finalize your benefit elections.

You will then have the opportunity to print your election form and keep a copy for your records. Please remember your user name and password as you can review your benefits at any time through the year by visiting this system.

Please do not hesitate to contact your benefits administrator if you have any questions or concerns, or if you would prefer to enroll through a method other than the on-line enrollment system.

Healthcare Benefits At-a-Glance

Healthcare is one of the most important and necessary parts of your benefit package. The following is a summary of your benefits offered through **AvMed.** For a more detailed explanation of benefits, please refer to your Certificate of Coverage. You may access a list of participating providers at http://www.avmed.org.

	Summary of Network Medical Benefits	
	Silver Plan	**Bronze Plan**
Doctors Office Visits		
Primary Care Physician/Specialist	$35/$50 Copay	$60/$70 Copay After Deductible
Preventive Care Services	100% Coverage In Network	100% Coverage In Network
Urgent Care*	$100 Copay	$120 Copay After Deductible
Emergency Room	$200 Copay	$300 Copay After Deductible
Prescription Drugs		After Deductible
(Tier 1/2/3/Specialty)		
Pharmacy Filled (up to 30 day supply)	$20/$40/$60/$75 Copay	$25/$50/$75 Copay/30%
Mail Order (up to 90 day supply)	2x Retail Copay	N/A
Deductible (Individual/Family)	$5,000/$10,000	$5,000/$10,000
Coinsurance	Plan Pays 70%, You pay 30% After Deductible	Plan Pays 70%, You pay 30% After Deductible
Out of Pocket Maximum	Includes Deductible, Coinsurance and all Copays	
(Individual/Family)	$6,350/$12,700	$6,350/$12,700
Outpatient Surgery	Deductible + 30% Coinsurance	Deductible + 30% Coinsurance
Inpatient Hospital	Deductible + 30% Coinsurance	Deductible + 30% Coinsurance
Lab (no charge at Quest)	Deductible + 30% Coinsurance	Deductible + 30% Coinsurance
X-Rays	Deductible + 30% Coinsurance	Deductible + 30% Coinsurance
Major Diagnostics (CT, PET, MRI, MRA)	Deductible + 30% Coinsurance	Deductible + 30% Coinsurance
Lifetime Maximum Benefit	Unlimited	

Non urgent use of Urgent Care provider will not be covered.

NOTE: **Deductibles and out-of-pocket maximums start over on January 1st each year.**

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Your Healthcare Cost

Your Cost per Bi-weekly Pay Period		
Annual Pay of $26,000 or Less	Silver Plan	Bronze Plan
Employee	$18.44	$0.00
Employee and Spouse	$239.61	$175.57
Employee and Children	$184.13	$131.53
Family	$406.03	$307.68
Annual Pay of >$26,000 and <$40,000		
Employee	$31.35	$7.32
Employee and Spouse	$252.52	$182.88
Employee and Children	$197.04	$138.85
Family	$418.94	$315.00
Annual Pay of >$40,000		
Employee	$44.26	$14.64
Employee and Spouse	$265.43	$190.21
Employee and Children	$209.95	$146.17
Family	$431.85	$322.32

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AvMed Emergency Care/Urgent Care

When is it an Emergency?

Urgent Care, Emergency Care

Which one, when?

Accidents happen. Understanding what choices you have and creating a personal emergency care plan are the keys to getting the most appropriate treatment, in the best setting, with the least hassle.

Knowing when to go to an urgent care center or an emergency room can save you time, money and stress.

Levels of Care

1 LEVEL 1 - Self-Care
Use a home remedy or first-aid kit, or get help from family members.
Examples: bee sting; minor cut; upset stomach; head cold

2 LEVEL 2 - Doctor
Have your doctor's phone numbers on hand.
Examples: fever; non-life-threatening illnesses; vomiting; skin rash; diarrhea; dehydration

3 LEVEL 3 - Urgent Care Center
Know where they are located.
Examples (if your doctor is unavailable): ear infection; bronchitis; allergic reaction; sprain or suspected fracture; general wound care

4 LEVEL 4 - Emergency Room
Know how to get there fast.
Examples: reasonable belief that your condition is life threatening; sudden, sharp abdominal pain; uncontrolled bleeding; complicated fracture

5 LEVEL 5 - Ambulance
Call 911.
Examples: chest pain; difficulty breathing; suspected heart attack or stroke; extended loss of consciousness

To find a listing of Urgent Care Centers look in your AvMed Provider Directory, call AvMed's Member Services or go to AvMed's Web Site at **www.avmed.org**. At the Web site, select *"Urgent Care Centers"* to the right of the home page.

Important Phone Numbers

- Member Services: Call the number listed on your AvMed ID card.
- TTY assistance is available: (TTY 711)
  In Miami 1-305-671-4948 All other areas 1-877-442-8633
- AvMed's Nurse On Call: 1-888-866-5432, 24 hours a day, 7 days a week.

AvMed
Embrace better health.

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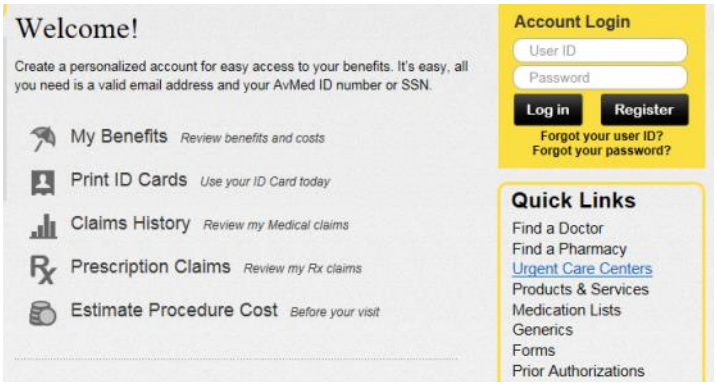
AvMed Resources

AvMed makes tough decisions easy for their members by supplying them with the resources they need to become educated, cost-conscious health care consumers. By registering online at www.AvMed.org you will gain access to your own member portal where you will have the ability to:

- View your plan benefits and costs
- Print and order a new ID Card
- Find network providers
- Review your medical and pharmacy claims
- Estimate the cost of treatments in your area



Preventive Care Services

AvMed is dedicated to helping people live healthier lives, and encourage members to receive age and gender appropriate Preventive health services.

Preventive Care Services include, but are not limited to:

Well-woman exam, including Pap smears
Annual physical exams
Well-child care and immunizations
Colorectal cancer screening, including colonoscopies
Mammograms
Blood pressure, diabetes and cholesterol testing
Obesity screenings
Counseling on quitting smoking
Osteoporosis screening
Depression screening
Tests to screen for HIV and other sexually transmitted diseases

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AvMed Smart Shopper Program

SMARTSHOPPER ROADMAP

Your guide to healthcare savings and **cash incentives**

AvMed Smart Shopper

Same doctor.
Same quality.
Same procedure.

MRI cost: **$2,400**
No cash incentive

MRI cost: **$450**
$150 SmartShopper cash incentive

DIFFERENT LOCATION. VERY DIFFERENT PRICE.

Prices for the exact same quality medical services, such as MRIs and surgical procedures, can vary significantly, even within the same zip code. Since they're rarely published, smart shopping can be a tough task. AvMed SmartShopper is a game changer!

- Go to **www.AvMed.org/SmartShopper** and click SmartShopper to shop inpatient and outpatient healthcare services in your area.
- Save hundreds-even thousands-of dollars when you choose a cost-effective healthcare provider.
- When you help lower healthcare costs, you earn cash incentives!

★★★★★

Cash back: $100

"I wanted to find the best value without compromising the quality of my care. The SmartShopper customer service expert helped me make the right choice quickly. I received excellent care, saved on my deductible and got a $100 cash incentive!"

- Amy L.

SAVE MONEY & EARN CASH BACK

PARTIAL INCENTIVE LIST

Procedure	Your Incentive
Bone Density Study	up to $50
Breast Biopsy	up to $150
Bunionectomy	up to $150
Cardiac Echocardiogram	up to $75
Carpal Tunnel Surgery	up to $150
Colonoscopy	up to $150
CT Scans	up to $150
Ear, Nose & Throat (select procedures)	up to $150
Gall Bladder Surgery	up to $150
Hernia Repair Surgery	up to $150
Hip Replacement	up to $500
Hysterectomy	up to $500
Knee Surgery (arthroscopic)	up to $150
Mammograms	up to $50
MRIs	up to $150
Ultrasounds	up to $50

Go to **www.AvMed.org/SmartShopper** for a full list of services.

AvMed Smart Shopper

Invites you to **SEE HEALTHCARE DIFFERENTLY.**

Simple. Powerful. Rewarding. **AvMed SmartShopper is a Game Changer.**

www.AvMed.org/SmartShopper
1-855-869-2133

1. CREATE A SECURE ACCOUNT

Visit AvMed.VitalsSmartShopper.com and click on the "First Time Users" tab.

2. GET SHOPPING

You can shop online or by phone. Online shoppers should be sure to enter their AvMed Member I.D. exactly as it appears on their AvMed insurance card. Follow the prompts to fill in the rest and click "Log in."

3. NEXT STOP: CASH BACK

When your doctor recommends any of the eligible procedures, SmartShopper lets you price-shop top providers in your area. Better yet, when you choose one of the most cost-effective options, you'll also get cash back!

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Hylant Script Navigator (Pharmacy Search Engine)

The ultimate pharmacy search engine for discounted generic drug programs available at pharmacies throughout the USA.

http://www.hylantscriptnavigator.com

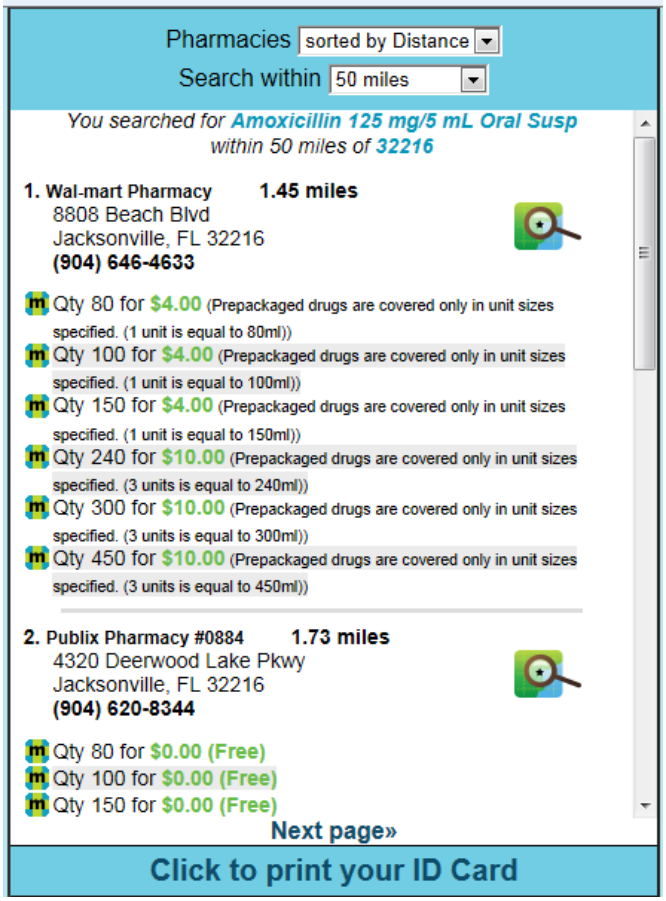
Enter the drug name, dosage and your zip code and find the best deal for your generic prescription. You can also find therapeutic alternatives, search at a specific pharmacy or suggest a pharmacy.

Other search types include Flu Shots, Immunizations, Health Screenings, Mini clinics.

Today, pharmacies all across the U.S. have implemented **$4 generic drugs programs**. The question many people ask themselves is, "which pharmacy has my prescription on their **$4 generic drugs program?**" Medtipster.com was designed to answer that question, without sending users through a multiple step process to obtain the answer.

Cheap prescription drugs are available for more than 70% of written prescriptions. Generic drugs are distributed as the bioequivalent to the brand name, and today are more commonly distributed to consumers when and where available. Talk to your doctor if you have specific questions about your prescription and the alternative of a generic equivalent.

Finding the **cheapest prescriptions** is as easy as 1-2-3 with Medtipster.com's proprietary technology. You will never again have to wonder which pharmacy's generic program has your prescription drug. Have your healthcare and afford it, too.



pharmasueann™ ask PharmaSueAnn™ LIVE

The world of healthcare is both confusing and expensive. Hylant Script Navigator provides access to Pharmasueann at **http://www.hylant.medtipster.com/pharmasueann.php**

You will get some very concrete advice. Discover steps you can take to avoid the Medicare donut hole. Get tips for managing your care in the hospital. Learn about the background on some of the issues in drug trials. Every little bit of knowledge helps! PharmaSueAnn is here to serve you.

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Voluntary Dental

Our dental coverage is with **Guardian**. You have the choice between two dental plans: the Value Plan or the Network Access Plan. Both plans give you the freedom to visit any provider, however, by choosing network providers you'll receive the highest level of benefit and save on out of pocket costs.

When utilizing ***out-of-network providers,*** benefits will be reimbursed based on Guardian's fee schedule shown below. These providers can balance bill you for amounts in excess of the amount paid by Guardian causing you higher out of pocket costs.

- **Value MAC Plan**—at the in-network discounted reimbursement level
- **Network Access PPO Plan**—based on the approved Reasonable and Customary fee

Guardian maintains a large network of participating dental providers. To see a list of participating providers go to: **www.GuardianLife.com. (click "Find a Provider" and choose the DentalGuard Preferred Network).**

This is an open enrollment opportunity for our dental plan. If you enroll now, you and eligible dependents that you elect to cover will have full benefits.

	Summary of Dental Plan Benefits			
	Value Plan		Network Access Plan	
	In-Network	Out-Of-Network	In-Network	Out-Of-Network
Preventive Services: Cleanings, exams, fluoride treatments (to age 19), sealants (to age 16)	100% of Network Fee	100% of Network Fee	100% of Network Fee	100% of R&C*
Basic Services: Fillings, x-rays, extractions, anesthesia, periodontics, endodontics	80% of Network Fee	80% of Network Fee	50% of Network Fee	50% of R&C*
Major Services: Bridges, Dentures, Single Crowns, Inlays, Onlays & Veneers	50% of Network Fee	50% of Network Fee	25% of Network Fee	25% R&C*
Deductible (Waived for Preventive)	Calendar Year Deductible		Calendar Year Deductible	
Individual	$50		$50	
Family	$150		$150	
Maximum Annual Benefit per person	$1,000 plus Maximum Rollover		$1,000 plus Maximum Rollover	

*Reasonable and Customary

Employee Contributions Per Pay Period (26 pay periods)

Employee	*Employee + Spouse*	*Employee + Children*	*Employee + Family*
$9.16	**$19.48**	**$21.06**	**$30.36**

Rates are the same for both plans.

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Dental Maximum Rollover Benefit

Both dental plans come with Guardian's Maximum Rollover Benefit.

Guardian's Maximum Rollover Benefit rewards careful utilization of this coverage. The annual benefit maximum per insured member ($1,000) may be increased each calendar year as follows:

- If an insured member receives dental services during a calendar year and has total claims of less than $500, the annual benefit maximum for that insured member will increase for the next calendar year.
- The increase will be $250, or $350 if an In-Network dentist is used.
- This increase will occur each year the above conditions are met to a maximum total increase of $1,000.

In this way, prudent users of this benefit can accumulate additional coverage that will be available in future years.

Please note: Maximum Rollover for new entrants joining with 3 months or less remaining in the benefit year, will not begin until the start of the next full benefit year.

You can view your annual Maximum Rollover Account statement detailing your account and those of your dependents on **http://www.GuardianAnyTime.com**

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College Tuition Benefit

The list of participating schools is growing and they have added several more this year to bring their total to over 335 participating schools. This means more than 1/3 of the NAICU Accredited colleges and universities are participating schools in the program. The current participating schools in Florida include:

- Ave Maria
- Eckerd College
- Embry-Riddle Aeronautical University
- Florida Institute of Technology
- University of Tampa
- Florida Southern College
- Lynn University
- Rollins College
- Saint Leo University

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Voluntary Vision

The vision coverage is provided by Guardian, utilizing the DAVIS network. You have the option of visiting any provider; however, by choosing a network provider you'll receive the highest level of benefit and save on out-of-pocket costs.

To see a list of participating providers go to: www.GuardianAnyTime.com

Click on "Find A Provider" and look for providers in the **DAVIS Vision Network** (includes WalMart, JCPenney, Sears, Target, Sam's Club, and Pearle Vision)

	In-Network Benefits	Out-of-Network Benefits After Copay
Eye Exam Copay (every calendar year)	$10 Copay	$50 Allowance
Lenses (every calendar year)	$25 Copay	Single $48 Allowance Bifocal $67 Allowance Trifocal $86 allowance Lenticular $126 allowance
Frames (every other calendar year)	$130 Retail Allowance plus 20% off balance The 20% discount is not valid at Walmart and Sam's Club locations due to the lower prices available at those stores.	$48 retail allowance
Contact Lenses in lieu of glasses (every calendar year)	Elective (conventional and disposable): $130 Allowance, Copay waived Medically Necessary: Paid in Full after Copay	Elective (conventional and disposable): $105 Allowance, Copay waived Medically Necessary: $210 Allowance
	Contact lenses purchased from the Davis Collection are covered in full after the copay, if any, and the contact lens fitting and evaluations are included at no additional charge. The Davis Collection is available at most participating independent provider offices but not in retail locations.	

Employee Contributions Per Pay Period (26 pay periods)

Employee	*Employee + Spouse*	*Employee + Children*	*Employee + Family*
$3.00	**$5.24**	**$5.35**	**$8.64**

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Voluntary Short Term Disability

Our Short Term Disability Insurance is provided by **Reliance Standard.** The plan provides financial protection by paying a portion of your income while you are disabled and unable to work. The benefit you receive is based on your pre-disability earnings - the amount you earned before your disability began.

A sudden loss or interruption of income due to a disabling illness or injury is a great financial risk, and one that many of us cannot afford to take. We recognize the importance of safeguarding your ability to earn income.

This a valuable guarantee issue opportunity for this coverage. You can enroll in this coverage during your initial eligibility period without answering medical questions, the coverage is guaranteed. If you choose not to enroll now, and later elect this coverage during open enrollment, you must complete an Evidence of Insurability form (EOI) and submit it to Reliance Standard for approval.

	Short Term Disability Benefit Summary
Benefit Amount	60% of your Weekly Earnings
Benefit Maximum	$500 per week
Benefit Duration	Up to 90 days while disabled
Elimination Period	Benefits begin on the 15th day of accident or the 15th day of sickness
Preexisting Condition Limitation	Any condition for which you received treatment, or for which a prudent person would have sought treatment, during the three months prior to your coverage effective date, will not be covered until 12 months of continuous coverage in this plan. This restriction only applies to new employees in their first 12 months of coverage
Definition of Disability	You are unable to do the material duties of your job and you are under the regular care of a physician.

Your cost per pay period is $0.1085 per $10.00 of bi-weekly benefit. See calculation examples on the next page.

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Voluntary Short Term Disability

Cost Calculations for Short Term Disability Insurance

Multiply biweekly pay by 60% (x 0.6). The result is your biweekly benefit (not to exceed $1,000.00).

Divide your biweekly benefit by 10, and multiply by $0.1085. This is your biweekly cost.

e.g. $750.00 biweekly pay X 0.6 = $450.00 benefit
$450.00 benefit ÷ 10 = 45 X $0.1085 = $4.88 biweekly cost

Sample Costs for Short Term Disability Insurance:

Biweekly Pay	Biweekly Benefit	Biweekly Cost
$ 700.00	$ 420.00	$ 4.56
$ 800.00	$ 480.00	$ 5.21
$ 900.00	$ 540.00	$ 5.86
$1,000.00	$ 600.00	$ 6.51
$1,100.00	$ 660.00	$ 7.16
$1,200.00	$ 720.00	$ 7.81
$1,300.00	$ 780.00	$ 8.46
$1,400.00	$ 840.00	$ 9.11
$1,500.00	$ 900.00	$ 9.76
$1,600.00	$ 960.00	$10.41
$1,666.00	$1,000.00	$10.85
Maximum benefit is $1,000.00 biweekly		

We deduct your biweekly cost on an after tax basis. This ensures that your benefit payments will be tax free.

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Long Term Disability

Statistics show that nearly *one-third* of Americans between the ages of 35 and 65 will suffer a serious disability at one point in their life. Long Term Disability (LTD) insurance is designed to provide you with income in the event you cannot work for an extended period of time due to a disabling illness or accident.

We offer Long Term Disability Insurance through **Reliance Standard -** the cost of this benefit is paid in full by CDS Family & Behavioral Health Services. The plan provides financial protection by paying a portion of your income while you are disabled. The benefit you receive is based on your pre-disability earnings - the amount you earned before your disability began. The coverage starts after it has been medically determined that you meet the plan's definition of disability*.

***Note:** While you are on disability leave, Reliance Standard may require you to be examined by doctors, other medical practitioners or vocational experts of their choice. They can require examinations as often as it is reasonable to do so. They may also require you to be interviewed by an authorized Reliance Standard Representative. Refusal to be examined or interviewed may result in denial or termination of your claim.*

Long Term Disability Benefit Summary	
Benefit Amount	60% of Monthly Income
Benefit Maximum	$5,000 Per Month
Benefit Begins	After 90 Days of Disability or until the end of the STD Max benefit period
Definition of Disability	The inability to perform the material and substantial duties of your regular occupation as defined by the contract - Two years Own Occupation
Benefit Limitations	24 months for Mental Illness and Substance Abuse
Preexisting Condition Limitation	3/12 Exclusion (3 month treatment look-back period/12 months waiting period beginning with the effective date of coverage, before the pre-existing condition is covered)
Survivor Benefit	If the employee dies while they are Disabled, a single sum payment equal to 3 times the employee's last net Monthly Benefit is made.
Maximum Benefit Period	24 months if you are unable to perform duties of your job, and to Social Security Retirement age if unable to perform the duties of any job.

Life and Accidental Death & Dismemberment (AD&D)

Life and Accidental Death & Dismemberment (AD&D) insurance is provided by **Reliance Standard no cost to the employee.** Life insurance provides a monetary benefit to your beneficiary in the event of your death while you are employed at **CDS Family & Behavioral Health Services.**

AD&D insurance is equal to your Life insurance benefit amount and is payable to your beneficiary in the event of your death as a result of an accident and may also pay benefits in certain injury instances. It is important to keep your beneficiary information up-to-date.

Plan Features	Benefit Amount
Life Insurance	$15,000
Accidental Death and Dismemberment	Benefit up to 100% of the Life amount due to certain injuries or death from an accident.
Benefit Reduction Schedule	Employee and Spouse benefit reduces by 35% at age 65, by 60% at age 70 and by 80% at age 75.
Accelerated Death Benefit	A percentage of this benefit may be withdrawn when diagnosed with a terminal illness.
Conversion	If employment terminates, coverage may be converted to a individual policy on a guaranteed basis. To purchase a conversion policy, application and the first premium payment must be made within the time period specified in the policy.

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Supplemental Life Insurance

Though our Life/AD&D program provides valuable protection, it may not be enough for you; therefore, we offer a Supplemental Life program through Reliance Standard where you can purchase additional coverage for yourself and your dependents. **Employees are responsible for 100% of the cost of this additional life insurance.**

Plan Features	Benefit Amount
Employee Life Insurance	Increments of $10,000 up to $500,000
Spouse Life Insurance	Increments of $10,000 up to $500,000 You do not need to be covered for your spouse to have coverage
Dependent Child(ren) Life Insurance	$2,500, $5,000, $7,500 or $10,000 for each child You or your spouse must be covered in order to cover dependent children
Benefit Reduction Schedule	40% at age 75, 65% at age 80, 72.5% at age 85
Maximum Benefit	$500,000 for Employees, $500,000 for Spouses and $10,000 for Children
Guarantee Issue	$100,000 for Employees ($10,000 for those age 60-69) $20,000 for Spouses under the age of 60 All amounts for Children **Guarantee Issue (GI) means the maximum amount of coverage available during the initial enrollment period with no medical information required. For amounts higher than the Guarantee Issue, Evidence of Insurability (EOI) is required. Coverage is subject to carrier's approval.**

	Supplemental Life Enrollment Options
New Hires	You can elect up to the Guarantee Issue amount shown above with no medical questions asked. Amounts elected over these GI amounts will be subject to Evidence of Insurability (EOI). **Please note – A Reliance form needs to be completed.** **If you waive supplemental life coverage when you are initially eligible, you will be required to provide Evidence of Insurability when enrolling at a later date.**

If you are submitting Evidence Of Insurability (EOI), please allow 4 to 6 weeks for underwriting approval. Claims incurred prior to the approval of your coverage will not be covered. Benefits may be limited and/or denied based on the EOI results.

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Supplemental Life Insurance

Your costs per pay period are illustrated below:

Age	Cost per $10,000 Coverage on Yourself and Spouse
Under 30:	$0.23
30-34:	$0.32
35-39:	$0.46
40-44:	$0.74
45-49:	$1.15
50-54:	$1.99
55-59:	$3.09
60-64:	$4.11
65-69:	$6.69

Child Coverage	Cost of $2,500 of coverage
All eligible children are covered for this cost	$0.23

Cost for spouse coverage is based on spouse's age.

Per IRS rules, your cost for this coverage will not be pre-taxed.

Flexible Spending Account

WHAT IS IT USED FOR?

The IRS permits you to pay certain health and work related expenses with earnings that are not taxed. The benefit of this is quite substantial. If you are in the 28% tax bracket, for example, your earnings are reduced by nearly 36% in Federal taxes (28% income tax and 7.65% FICA tax). If you make use of our Flexible Spending Accounts, there will be no reductions made for taxes to that portion of your earnings used to pay eligible expenses.

There are two Flexible Spending Accounts: a Medical Care Account and a Dependent Care Account. If you or your family have predictable medical, dental or eye care costs that are not fully reimbursed by insurance, you could benefit from our Medical Care Account. Eligible expenses include your deductibles, copays and coinsurance under our health insurance plans, dental expenses, orthodontics, eye exams, glasses and contact lenses, hearing aids, etc.

Under Health Care Reform over-the-counter medications are not considered eligible expenses for the Medical Care Account without a prescription from your physician. The Dependent Care Account allows you to pay for daycare expenses for children under age 13, or for a disabled dependent of any age living in your home, if such daycare is necessary to enable you to work.

HOW DOES IT WORK FOR ME?

You must submit your receipts for your expenses to receive reimbursement from your account. You choose the dollar amount you want to contribute to each account based on your estimated expenses for the upcoming year. This amount is deposited into your account on your benefits effective date. Your contributions will be deducted in equal amounts from each paycheck pre-tax throughout the plan year. The important thing is that the deposits to your account are not taxed and are used by you tax-free. The result is a direct saving to you equal to the taxes you would otherwise pay on this income.

RULES AND CONTRIBUTIONS

There are important rules which you must understand before electing to participate. For example, once you have elected to have a specified amount deducted from each paycheck, you cannot change your election until the end of the plan year unless you experience a qualified change in status. You can roll over a balance of up to $500 into the next plan year. Any balance over $500 left in your Medical Care account at the end of the plan year is forfeited. It cannot be refunded to you. If you currently pay daycare in order to work, you may receive a tax credit on your tax return. In lower tax brackets the tax credit may be more valuable than the benefits of the Dependent Care Account. For these reasons, it is important that you consult your tax advisor.

The maximum contribution allowed to the Medical Care Account is $2,500 ($96.15 per bi-weekly pay period). You may also roll over up to $500 from the current plan year. The maximum for the Dependent Care Account is $5,000 ($192.31 per bi-weekly pay period) or $2,500 to the Dependent Care Account if you are married and you and your spouse file separate returns.

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Retirement Plan

VALIC

VALIC is the largest provider of TSA programs nationally, and we have selected them for the superiority of their products and services. As an employee of CDS, you have the benefit of a Tax Sheltered Annuity (TSA) plan, underwritten and serviced by VALIC (Variable Annuity Life Insurance Company).

With this program, you may defer a percentage of each paycheck into a personal tax-sheltered investment account. Your deposits will be sheltered from personal income tax and your account will grow tax free until you withdraw the funds. Your deposits may be invested in a guaranteed account and/or in a variety of funds invested in stocks, bonds and other securities.

CDS contributes from 0-10% annually to each employee eligible for retirement benefits. Employees hired on or after January 1, 1995 must have 2 years of continuous employment and 500 hours of service in the 3rd year to vest in the retirement plan. Employees hired on or after July 1, 2011 must be at least 21 years of age and have worked at least 1000 hours in at least 3 years of continuous employment to vest in the retirement plan. Employees must work 1000 hours each Plan year and be employed on the last day of the Plan year to be entitled to a distribution.

Representatives from VALIC will be available to meet with you personally to explain the program further, and to assist you in enrolling.

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Colonial Voluntary Plans

Group Accident

- Pays cash directly to you in the event of an on or off the job injury
- Hospital admission and hospital confinement benefit
- Accidental death benefit
- $75 - $7,500 for fractures or dislocations
- Much more

Cancer

- $5000 first initial diagnosis benefit
- Annual wellness benefit upon completion of a cancer screening
- Benefit per day for chemo & radiation treatment
- Up to $3,000 for surgical procedures
- Experimental Treatment benefit
- Much more

Medical Bridge

- Hospital admission payment per admittance
- Pays $500 or $1,000 for outpatient surgery
- Emergency Room and doctor's office benefits
- Rate based on your age and benefit amount you choose to receive

Critical Illness

- Coverage amounts range from $5,000 to $75,000 for employees
- Rates based on age and coverage amount
- Covered illnesses include heart attack, stroke, major organ failure, end stage renal disease, blindness and others

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Pre-Paid Legal Plan & Identity Theft Protection

Pre-Paid Legal Plan

Our Pre-Paid Legal Plan is provided by LegalShield. Our pre-paid legal plan enables you, for a small fee deducted from each paycheck, to have immediate access to the advice and services of attorneys whenever a question or problem arises.

The following list of questions will suggest the broad scope of services available to you.

Have you ever. . .

- thought about writing or revising your will?
- purchased a home?
- had a problem with child support or visitation rights?
- signed a lease you'd like to change?
- wanted advice on a credit matter?
- had difficulty collecting an insurance claim?
- had questions about guardianship?
- had an income tax question?
- had a property dispute?
- received a traffic ticket you thought was unjustified?
- been involved in a separation or divorce?
- worried about being audited by the IRS?
- needed assistance in dealing with the purchase of a new car?

The cost to you and your family is **$7.36** per biweekly pay period. You will receive a presentation at our annual meeting and a brochure presenting your benefits in detail.

Identity Theft Protection

Our Identity Theft Protection is provided by LegalShield. The Federal Trade Commission estimates that as many as 9 million U.S. residents have their identities stolen every year. Many consumers might not even realize this has happened to them. You can spend months or years – and thousands of dollars – cleaning up the mess the thieves have made of your good name and credit record.

Some things to think about when it comes to protecting yourself from identity theft:

Do you hand your credit card to servers at restaurants?

Do you sign your credit cards?

Do you supply personal information over the internet?

Do you keep your Social Security number in your wallet or purse?

Do you leave mail at your home or business for the postal carrier to collect?

Do you shred unwanted mail with personal information?

Do other people ever run your credit report?

Can you be sure data security is good at companies that have your information?

Your Identity Theft Shield membership includes:

- **Privacy and Security monitoring including internet**
- **Continuous monitoring through TransUnion**
- **Identity Restoration in case you are a victim**

Cost per biweekly pay period:

Single :	$4.13
Family:	$8.75
Single w/ Legal Plan:	$11.49
Family w/Legal Plan:	$14.26

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Sick Leave Pool

The purpose of the sick leave pool is simple. It is designed to help ourselves and each other when facing a financial crisis due to serious/extended illness or injury.

Eligibility Criteria

- Employees must be off of probation prior to being eligible to join the sick leave pool.
- An employee must have a minimum of 20 hours of sick leave to join the sick leave pool at open enrollment each year.
- An annual contribution of 2 hours of sick leave is required to remain in the sick leave pool.
- Employees may contribute up to 40 hours to the pool annually.

Withdrawal Procedures

- Any employee who has exhausted all sick, vacation, and personal days may make a written request for one to ten days of additional leave when the leave is needed to assure the employees contracted hours for the pay period are met to the Human Resource Specialist. The employee must also provide verification from a physician supporting their inability to work with their letter of request.
- The employee's supervisor must endorse the request.
- When the pool has sufficient resources it is the intent that the maximum withdrawal shall not exceed $2,500 in any fiscal year per employee.
- No employee can withdraw more than $5,000 during the course of their employment with CDS.

Procedures

- Requests for withdrawals will be considered by the sick leave pool committee.
- The committee shall consist of four CDS employees and one CDS Board Member.
- The committee shall be chaired by the Human Resources Specialist.
- Three members must be present for the committee to conduct business.

Formula

- Hours contributed to the sick leave pool are valued at the contributor's hourly rate at the time of contribution.
- Withdrawals are valued at the hourly rate of the employee requesting assistance.
- If the sick leave pool lacks sufficient resources, CDS, Inc. will guarantee the return of an employee's minimum contribution within the past year based upon the sick leave pool committee recommendation.
- Individuals interested must make at least a two hour contribution

If you wish to participate in the Sick Leave Pool, please complete an Enrollment Form.

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Important Disclosures

NOTE TO ALL EMPLOYEES:

Certain State and Federal Regulations require employers to provide disclosures of these regulations to all employees. The remainder of this document provides you with all of the required disclosures related to our employee benefits plan. If you have any questions or need further assistance please contact your Plan Administrator as follows:

CDS Family & Behavioral Health Services, Inc.
Human Resources
3615 SW 13th Street, Suite 2
Gainesville, FL 32608
Phone: (352) 244-0628 Ext. 3812

THIS DOCUMENT IS FOR INFORMATION PURPOSES ONLY

This communication is intended for illustrative and information purposes only. The plan documents, insurance certificates, and policies will serve as the governing documents to determine plan eligibility, benefits, and payments.

LIMITATIONS AND EXCLUSIONS

Insurance and benefit plans always contain exclusions and limitations. Please see benefit booklets and/or contracts for complete details of coverage and eligibility.

ALL RIGHTS RESERVED

CDS Family & Behavioral Health Services reserves the right to amend, modify, or terminate its insurance and benefit plans at any time, including during treatment.

NOTICE REGARDING SPECIAL ENROLLMENT RIGHTS

If you do not timely or properly complete the enrollment process, you and your Eligible Dependents generally will not be covered under the applicable Plan, except as described below. Also, if you fail to specifically enroll your Eligible Dependents on the enrollment form, your Eligible Dependents will not be covered under the applicable Plan, except as otherwise provided below.

(a.) If you decline enrollment because you or your dependent had other group health plan coverage, either through COBRA or otherwise, you may enroll yourself and Eligible Dependents in the Medical Program within **30 days** of the loss of that coverage. Your enrollment will become effective on the date you enroll in the Medical Program. For this purpose, "loss of coverage" will occur if the other group health plan coverage terminates as a result of: (i) termination of employer contributions for the other coverage; (ii) exhaustion of the maximum COBRA period; (iii) legal separation or divorce; (iv) death; (v) termination of employment; (vi) reduction in hours of employment; or (vii) failure to elect COBRA coverage.

However, a loss of coverage will not be deemed to occur if the other coverage terminates due to a failure to pay premiums or termination for cause. At the time you enroll in the Employer's Plan, you must provide a written statement from the administrator of the other medical plan that you no longer have that coverage.

(b.) You are eligible to enroll yourself and your Eligible Dependent in the Medical Program within **30 days** of the date you acquire a new Eligible Dependent through marriage, birth, adoption or placement for adoption. Your enrollment will become effective on the date of marriage, birth, adoption or placement for adoption.

(c.) You are eligible to enroll yourself and your Eligible Dependent in the Plan within **60 days** after either:

> (1.) Your or your Eligible Dependent's Medicaid coverage under title XIX of the Social Security Act or CHIP coverage through a State child health plan under title XXI of the Social Security Act is terminated as a result of loss of eligibility for such coverage; or
>
> (2.) You or your Eligible Dependent is determined to be eligible for employment assistance under Medicaid or CHIP to help pay for coverage under the Plan.

(d.) You are eligible to enroll yourself and your Eligible Dependents in the Plan during an Open Enrollment Period. Your enrollment will become effective on the 1st day of the Plan Year following the Open Enrollment Period.

(e.) You may enroll in the Plan an Eligible Dependent child for whom you are required to provide medical coverage pursuant to a Qualified Medical Child Support Order (as defined under ERISA Section 609). This enrollment of an Eligible Dependent will become effective as of the Plan Administrator's qualification and acceptance of the Qualified Medical Child Support Order.

(f.) You are eligible to enroll yourself and your Eligible Dependents in the Plan under any other special circumstances permitted under the applicable Benefits Guide (and subject to the Cafeteria Plan rules outlined in Section 125 of the Internal Revenue Code).

NOTE: You will not be allowed to enroll yourself and/or Eligible Dependents for coverage in the Plan for a Plan Year unless you timely and affirmatively complete the enrollment process by the deadlines set forth above (i.e. within 30 days for loss of coverage or new dependents; within 60 days for Medicaid or CHIP circumstances; within 30 days of receipt of this notice for a dependent under the age of 26; or within the deadline established by the Plan Administrator for Open Enrollment Period).

Should you have any questions regarding this information or require additional details, please contact the Plan Administrator at the address or phone number below.

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Human Resources
3615 SW 13th Street, Suite 2
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Phone: (352) 244-0628 Ext. 3812

Important Disclosures

HOW TO REQUEST A CERTIFICATION OF CREDITABLE COVERAGE FROM THIS PLAN:

HIPAA also requires any medical program offered by the Employer to provide certificates of creditable coverage to you after you lose coverage under such medical program. This certificate allows you to use your coverage under the medical program to reduce or eliminate any pre-existing condition exclusion period that might otherwise apply to you when you change health care plans. You also may request a certificate of creditable coverage for periods of coverage on and after July 1, 1996, within 24 months of your loss of coverage. To request a HIPAA Certificate of Creditable Coverage, please contact the insurance company customer service department by calling the phone number on your healthcare identification card. If you are unable to obtain the certificate of coverage through the carrier, or have other questions regarding Pre-existing Conditions, please contact the Plan Administrator for assistance at the address or phone number below.

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NOTICE REGARDING WOMEN'S HEALTH AND CANCER RIGHTS ACT (JANET'S LAW)

On October 21, 1998, Congress passed a Federal Law known as the Women's Health and Cancer Rights Act. Under the Women's Health and Cancer Rights Act, group health plans and insurers offering mastectomy coverage must also provide coverage for:

- Reconstruction of the breast on which the mastectomy was performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance; and
- Prostheses and treatment of physical complications at all stages of the mastectomy, including lymph edemas

These services are payable to a patient who is receiving benefits in connection with a mastectomy and elects reconstruction. The physician and patient determine the manner in which these services are performed.

The plan may apply deductibles and copayments consistent with other coverage within the plan. This notice serves as the official annual notice and disclosure of that the fact that the company's health and welfare plan has been designed to comply with this law. This notification is a requirement of the act.

The Women's Health and Cancer Rights Act (Women's Health Act) was signed into law on October 21, 1998. The law includes important new protections for breast cancer patients who elect breast reconstruction in connection with a mastectomy. The Women's Health Act amended the Employee Retirement Income Security Act of 1974 (ERISA) and the Public Health Services Act (PHS Act) and is administered by the Departments of Labor and Health and Human Services.

NOTICE REGARDING MICHELLE'S LAW

On Thursday, October 9, 2008, President Bush signed into law H.R. 2851, known as Michelle's Law. This law requires employer health plans to continue coverage for employees' dependent children who are college students and need a medically necessary leave of absence. This law applies to both fully insured and self-insured medical plans.

The dependent child's change in college enrollment must meet the following requirements:

- The dependent is suffering from a serious illness or injury.
- The leave is medically necessary.
- The dependent loses student status for purposes of coverage under the terms of the plan or coverage.

Coverage for the dependent child must remain in force until the earlier of:

- One year after the medically necessary leave of absence began.
- The date the coverage would otherwise terminate under the terms of the plan.

A written certification by the treating physician is required. The certification must state that the dependent child is suffering from a serious illness or injury and that the leave is medically necessary. Provisions under this law become effective for plan years beginning on or after October 9, 2009.

NOTICE REGARDING NEWBORNS AND MOTHERS HEALTH PROTECTION ACT

Group health plans and health insurance issuers offering group health insurance may not, under federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child for less than 48 hours following normal vaginal delivery, or less than 96 hours following a cesarean section, or require that a provider obtain authorization from the plan or insurance issuer to prescribe a length of stay not in excess of the above periods.

MEDICARE NOTICE

You must notify **CDS Family & Behavioral Health Services** when you or your dependents become Medicare eligible. **CDS Family & Behavioral Health Services** is required to contact the insurer to inform them of your Medicare status. Federal law determines whether Medicare or the group health plan is the primary payer. You must also notify Medicare directly that you have group health insurance coverage. Privacy laws prohibit Medicare from discussing coverage with anyone other then the Medicare beneficiary or their legal guardian. The toll free number to Medicare Coordination of Benefits is 1 -800-999-1118.

Important Disclosures

If you have Medicare or will become eligible for Medicare in the next 12 months, a Federal law gives you more choices in your prescription drug plan. Please see the complete Medicare Part D Non-Creditable Coverage Notice. Should you have any questions regarding this information or require additional details, please contact the Plan Administrator at the address or phone number below.

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NOTICE REGARDING PATIENT PROTECTION RIGHTS
The **CDS Family & Behavioral Health Services** group health plan **does not** require members to designate a Primary Care Physician. The following paragraphs outline certain protections under the PPACA and only apply when the Plan requires the designation of a Primary Care Physician.

One of the provisions in the PPACA of 2010 is for plans and insurers that require or allow for the designation of primary care providers by participants to inform the participants of their rights beginning on the first day of the first plan year on or after September 23, 2010.

You will have the right to designate any primary care provider who participates in the Plan's network and who is available to accept you and/or your Eligible Dependents. For children, you may designate a pediatrician as the primary care provider. You also do not need prior authorization from the Plan or from any other person (including your primary care provider) in order to obtain access to obstetrical or gynecological care from a health care professional in the Plan's network. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan or procedures for making referrals or notifying primary care provider or Plan of treatment decisions.

If you do not make a provider designation, the Plan may make one for you. For information on how to select or change a primary care provider, and for a list of the participating primary care providers, pediatricians, or obstetrics or gynecology health care professionals, please contact the insurer.

Should you have any questions regarding this information or require additional details, please contact the Plan Administrator at the address or phone number below.

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IMPORTANT INFORMATION ABOUT YOUR PRESCRIPTION DRUG COVERAGE AND MEDICARE-Silver Plan Credible Notice

Please note that the following notice only applies to individuals who are eligible for Medicare.

Medicare eligible individuals may include employees, spouses or dependent children who are Medicare eligible for one of the following reasons.

- Due to the attainment of age 65
- Due to certain disabilities as determined by the Social Security Administration
- Due to End Stage Renal Disease (ESRD)

If you are covered by Medicare, please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with **CDS Family & Behavioral Health Services** and about your options under Medicare's prescription drug coverage. This information can help you decide whether or not you want to join a Medicare drug plan. If you are considering joining, you should compare your current coverage, including which drugs are covered at what cost, with the coverage and costs of the plans offering Medicare prescription drug coverage in your area. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice.

There are two important things you need to know about your current coverage and Medicare's prescription drug coverage:

1. Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.
2. **CDS Family & Behavioral Health Services** has determined that the prescription drug coverage offered with the Silver Plan is, on average, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. If your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

When Can You Join A Medicare Drug Plan?

You can join a Medicare drug plan when you first become eligible for Medicare and each year from October 15th through December 7th. However, if you lose your current creditable prescription drug coverage, through no fault of

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your own, you will also be eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare drug plan.

What Happens To Your Current Coverage If You Decide to Join A Medicare Drug Plan? If you decide to join a Medicare drug plan, your current coverage will not be affected. Your current coverage pays for other health expenses in addition to prescription drugs. The prescription drug coverage is part of the Group Health Plan and cannot be separated from the medical coverage. If you enroll in a Medicare prescription drug plan, you and your eligible dependents will still be eligible to receive all of your current health and prescription drug benefits. You have the option to waive the coverage provided under the Group Health plan due to your eligibility for Medicare. If you decide to waive coverage under the Group Health Plan due to your Medicare eligibility, you will be entitled to re-enroll in the plan during the next open enrollment period.

When Will You Pay A Higher Premium (Penalty) To Join A Medicare Drug Plan? You should also know that if you drop or lose your current coverage and don't join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later. If you go 63 continuous days or longer without creditable prescription drug coverage, your monthly premium may go up by at least 1% of the Medicare base beneficiary premium per month for every month that you did not have that coverage. For example, if you go nineteen months without creditable coverage, your premium may consistently be at least 19% higher than the Medicare base beneficiary premium. You may have to pay this higher premium (a penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following October to join.

For More Information About This Notice or Your Current Prescription Drug Coverage…

Contact your HR Representative. You'll get this notice each year. You will also get it before the next period you can join a Medicare drug plan, and if this coverage through your company changes. You also may request a copy of this notice at any time.

For More Information About Your Options Under Medicare Prescription Drug Coverage…

More detailed information about Medicare plans that offer prescription drug coverage is in the "Medicare & You" handbook. You'll get a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare drug plans. For more information about Medicare prescription drug coverage:

- Visit www.medicare.gov
- Call your State Health Insurance Assistance Program (see the inside back cover of your copy of the "Medicare & You" handbook for their telephone number) for personalized help
- Call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

If you have limited income and resources, extra help paying for Medicare prescription drug coverage is available. For information, visit Social Security at www.socialsecurity.gov, or call 1-800-772-1213 (TTY 1-800-325-0778).

Remember: Keep this Creditable Coverage notice. If you decide to join one of the Medicare drug plans, you may be required to provide a coy of this notice when you join to show whether or not you have maintained creditable coverage and, therefore, whether or not you are require to pay a higher premium (penalty).

CDS Family & Behavioral Health Services, Inc.
Human Resources
3615 SW 13th Street, Suite 2
Gainesville, FL 32608
Phone: (352) 244-0628 Ext. 3812

Important Notice from CDS Family & Behavioral Health Services About Your Prescription Drug Coverage and Medicare-Bronze Plan Non-Credible Notice

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with CDS Family & Behavioral Health Services and about your options under Medicare's prescription drug coverage. This information can help you decide whether or not you want to join a Medicare drug plan. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice.

There are three important things you need to know about your current coverage and Medicare's prescription drug coverage:

Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.

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CDS Family & Behavioral Health Services has determined that the prescription drug coverage offered by the Bronze Plan is, on average for all plan participants, NOT expected to pay out as much as standard Medicare prescription drug coverage pays. Therefore, your coverage is considered Non-Creditable Coverage. This is important because, most likely, you will get more help with your drug costs if you join a Medicare drug plan, than if you only have prescription drug coverage from the Bronze Plan. This also is important because it may mean that you may pay a higher premium (a penalty) if you do not join a Medicare drug plan when you first become eligible.

You can keep your current coverage from CDS Family & Behavioral Health Services . However, because your coverage is non-creditable, you have decisions to make about Medicare prescription drug coverage that may affect how much you pay for that coverage, depending on if and when you join a drug plan. When you make your decision, you should compare your current coverage, including what drugs are covered, with the coverage and cost of the plans offering Medicare prescription drug coverage in your area. Read this notice carefully - it explains your options.

When Can You Join A Medicare Drug Plan?

You can join a Medicare drug plan when you first become eligible for Medicare and each year from October 15 to December 7.

However, if you decide to drop your current coverage with CDS Family & Behavioral Health Services , since it is employer sponsored group coverage, you will be eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare drug plan; however you also may pay a higher premium (a penalty) because you did not have creditable coverage under CDS Family & Behavioral Health Services Bronze Plan.

When Will You Pay A Higher Premium (Penalty) To Join A Medicare Drug Plan?

Since the coverage under CDS Family & Behavioral Health Services Bronze Plan is not creditable, depending on how long you go without creditable prescription drug coverage you may pay a penalty to join a Medicare drug plan. Starting with the end of the last month that you were first eligible to join a Medicare drug plan but didn't join, if you go 63 continuous days or longer without prescription drug coverage that's creditable, your monthly premium may go up by at least 1% of the Medicare base beneficiary premium per month for every month that you did not have that coverage. For example, if you go nineteen months without creditable coverage, your premium may consistently be at least 19% higher than the Medicare base beneficiary premium. You may have to pay this higher premium (penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following October to join.

What Happens To Your Current Coverage If You Decide to Join A Medicare Drug Plan?

If you decide to join a Medicare drug plan, your current coverage may be affected. If you do decide to join a Medicare drug plan and drop your current coverage, be aware that you and your dependents may not be able to get this coverage back.

For More Information About This Notice Or Your Current Prescription Drug Coverage…

Contact the person listed below for further information **NOTE:** You'll get this notice each year. You will also get it before the next period you can join a Medicare drug plan and if this coverage through CDS Family & Behavioral Health Services changes. You also may request a copy of this notice at any time.

For More Information About Your Options Under Medicare Prescription Drug Coverage…

More detailed information about Medicare plans that offer prescription drug coverage is in the "Medicare & You" handbook. You'll get a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare drug plans. For more information about Medicare prescription drug coverage: Visit www.medicare.gov

- Call your State Health Insurance Assistance Program (see the inside back cover of your copy of the "Medicare & You" handbook for their telephone number) for personalized help

Call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

If you have limited income and resources, extra help paying for Medicare prescription drug coverage is available. For information about this extra help, visit Social Security on the web at www.socialsecurity.gov, or call them at 1-800-772-1213 (TTY 1-800-325-0778).

CDS Family & Behavioral Health Services, Inc.

Human Resources
3615 SW 13th Street, Suite 2
Gainesville, FL 32608
Phone: (352) 244-0628 Ext. 3812

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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)**.

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: 1-800-869-1150
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
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://www.lahipp.dhh.louisiana.gov 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

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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.dpw.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: www.ohhs.ri.gov Phone: 401-462-5300
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/ in-dex.aspx Phone: 1-800-562-3022 ext. 15473
TEXAS – Medicaid	**WEST VIRGINIA – Medicaid**
Website: https://www.gethipptexas.com/ Phone: 1-800-440-0493	Website: www.dhhr.wv.gov/bms/ Phone: 1-877-598-5820, HMS Third Party Liability
UTAH – Medicaid and CHIP	**WISCONSIN – Medicaid and CHIP**
Website - Medicaid: http://health.utah.gov/medicaid CHIP: http://health.utah.gov/chip Phone: 1-866-435-7414	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: http://health.wyo.gov/healthcarefin/equalitycare Phone: 307-777-7531

To see if any other states have added a premium assistance program since January 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

General Notice of COBRA Continuation Coverage Rights

Introduction

You're getting this notice because you recently gained coverage under a group health plan (the Plan). This notice has important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan. **This notice explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect your right to get it.** When you become eligible for COBRA, you may also become eligible for other coverage options that may cost less than COBRA continuation coverage.

The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage can become available to you and other members of your family when group health coverage would otherwise end. For more information about your rights and obligations under the Plan and under federal law, you should review the Plan's Summary Plan Description or contact the Plan Administrator.

You may have other options available to you when you lose group health coverage. For example, you may be eligible to buy an individual plan through the Health Insurance Marketplace. By enrolling in coverage through the Marketplace, you may qualify for lower costs on your monthly premiums and lower out-of-pocket costs. Additionally, you may qualify for a 30-day special enrollment period for another group health plan for which you are eligible (such as a spouse's plan), even if that plan generally doesn't accept late enrollees.

What is COBRA Continuation Coverage?

COBRA continuation coverage is a continuation of Plan coverage when it would otherwise end because of a life event. This is also called a "qualifying event." Specific qualifying events are listed later in this notice. After a qualifying event, COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." You, your spouse, and your dependent children could become qualified beneficiaries if coverage under the Plan is lost because of the qualifying event. Under the Plan, qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage.

If you're an employee, you'll become a qualified beneficiary if you lose your coverage under the Plan because of the following qualifying events:

Your hours of employment are reduced, or
Your employment ends for any reason other than your gross misconduct.

If you're the spouse of an employee, you'll become a qualified beneficiary if you lose your coverage under the Plan because of the following qualifying events:

Your spouse dies;
Your spouse's hours of employment are reduced;
Your spouse's employment ends for any reason other than his or her gross misconduct;
Your spouse becomes entitled to Medicare benefits (under Part A, Part B, or both); or
You become divorced or legally separated from your spouse.

Your dependent children will become qualified beneficiaries if they lose coverage under the Plan because of the following qualifying events:

The parent-employee dies;
The parent-employee's hours of employment are reduced;
The parent-employee's employment ends for any reason other than his or her gross misconduct;
The parent-employee becomes entitled to Medicare benefits (Part A, Part B, or both);
The parents become divorced or legally separated; or
The child stops being eligible for coverage under the Plan as a "dependent child."

When is COBRA Coverage Available?

The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Plan Administrator has been notified that a qualifying event has occurred. The employer must notify the Plan Administrator of the following qualifying events:

The end of employment or reduction of hours of employment;
Death of the employee;
Commencement of a proceeding in bankruptcy with respect to the employer; or
The employee's becoming entitled to Medicare benefits (under Part A, Part B, or both).

You Must Give Notice of Some Qualifying Events

For all other qualifying events (divorce or legal separation of the employee and spouse or a dependent child's losing eligibility for coverage as a dependent child), you must notify the Plan Administrator within 30 days after the qualifying event occurs. You must provide this notice to:

CDS Family & Behavioral Health Services, Inc.
Human Resources
3615 SW 13th Street, Suite 2
Gainesville, FL 32608
Phone: (352) 244-0628 Ext. 3812
Notification should be in writing and include official documentation of qualifying event (i.e. divorce decree, marriage certificate, birth certificate).

General Notice of COBRA Continuation Coverage Rights

How is COBRA Coverage Provided?
Once the Plan Administrator receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. Covered employees may elect COBRA continuation coverage on behalf of their spouses, and parents may elect COBRA continuation coverage on behalf of their children.

COBRA continuation coverage is a temporary continuation of coverage that generally lasts for 18 months due to employment termination or reduction of hours of work. Certain qualifying events, or a second qualifying event during the initial period of coverage, may permit a beneficiary to receive a maximum of 36 months of coverage.

There are also ways in which this 18-month period of COBRA continuation coverage can be extended:

Disability extension of 18-month period of continuation coverage
If you or anyone in your family covered under the Plan is determined by Social Security to be disabled and you notify the Plan Administrator in a timely fashion, you and your entire family may be entitled to get up to an additional 11 months of COBRA continuation coverage, for a maximum of 29 months. The disability would have to have started at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period of COBRA continuation coverage. Please provide Social Security disability determination confirmation to:

CDS Family & Behavioral Health Services, Inc.
Human Resources
3615 SW 13th Street, Suite 2
Gainesville, FL 32608
Phone: (352) 244-0628 Ext. 3812

Second qualifying event extension of 18-month period of continuation coverage
If your family experiences another qualifying event during the 18 months of COBRA continuation coverage, the spouse and dependent children in your family can get up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months, if the Plan is properly notified about the second qualifying event. This extension may be available to the spouse and any dependent children getting COBRA continuation coverage if the employee or former employee dies; becomes entitled to Medicare benefits (under Part A, Part B, or both); gets divorced or legally separated; or if the dependent child stops being eligible under the Plan as a dependent child. This extension is only available if the second qualifying event would have caused the spouse or dependent child to lose coverage under the Plan had the first qualifying event not occurred.

Are there other coverage options besides COBRA Continuation Coverage?
Yes. Instead of enrolling in COBRA continuation coverage, there may be other coverage options for you and your family through the Health Insurance Marketplace, Medicaid, or other group health plan coverage options (such as a spouse's plan) through what is called a "special enrollment period." Some of these options may cost less than COBRA continuation coverage. You can learn more about many of these options at www.healthcare.gov.

If you have questions
Questions concerning your Plan or your COBRA continuation coverage rights should be addressed to the contact or contacts identified below. For more information about your rights under the Employee Retirement Income Security Act (ERISA), including COBRA, the Patient Protection and Affordable Care Act, and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit www.dol.gov/ebsa. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.) For more information about the Marketplace, visit www.HealthCare.gov.

Keep your Plan informed of address changes
To protect your family's rights, let the Plan Administrator know about any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the Plan Administrator.

Plan Contact Information

CDS Family & Behavioral Health Services, Inc.
Human Resources
3615 SW 13th Street, Suite 2
Gainesville, FL 32608
Phone: (352) 244-0628 Ext. 3812

Contact Information

Coverage	Carrier	Phone Number	Website
Health Insurance	AvMed	1-800-882-8633	www.avmed.org
Dental Insurance	Guardian Member Services College Tuition Benefit	 1-800-541-7846 1-215-839-0119	www.guardiananytime.com Dental Network: DentalGuard Preferred
Vision Insurance	Guardian Member Services	 1-888-600-1600	www.guardiananytime.com Vision Network: Davis Vision
Base Life, Supplemental Life, Disability Insurance	Reliance Standard	1-800-351-7500	www.reliancestandard.com
Voluntary Coverages	Colonial Life	1-888-899-4135	Ken MacDougall
Pre-Paid Legal & Identity Theft Protection	LegalShield	1-813-805-2914	Lewis Key
Retirement Plan	VALIC	1-352-372-3497	Art Nangle
Broker	Hylant	1-904-854-8200 1-888-578-9988	www.hylant.com

If a health care claim you will be incurring or have incurred is denied or if you have a question regarding the benefits, you may contact your insurance company using the contact information above or on the back of your ID card or on your Explanation of Benefits.

In the event that this does not resolve the issue, you may contact Hylant at 1-888-578-9988. When you call please be able to provide the following:

- ☑ ***Name of Patient***
- ☑ ***Date of Service***
- ☑ ***Name of Provider***
- ☑ ***Explanation of Benefits (EOB) from the Insurance Company***
- ☑ ***Invoice from the Provider (if applicable)***

You may also be required to provide a signed HIPAA authorization which gives Hylant permission to speak to your providers about your protected health information, as well as permission for your provider to speak to Hylant about your protected health information.