CDS
Family & Behavioral Health Services

NEW HIRE BENEFITS GUIDE

If you (and/or) your dependents have Medicare or will become eligible for Medicare in the next 12 months, a Federal law gives you more choices about your prescription drug coverage. Please see page 27 for more details.

July 1, 2018—June 30, 2019

CONTACT INFORMATION

BENEFITS CONSULTANT

HYLANT

General Claims and Benefit Information

Customer Service Helpline: In order to help you with your benefit questions, claim issues, and general inquiries, you and your dependents may contact Hylant. Hylant is a one-source helpline for your benefit questions. Please call the toll-free number listed below, Monday-Friday during normal business hours, 8:30 a.m.- 4:30 p.m., and speak to a customer service specialist who can assist you with your benefit questions.

Toll Free: (888) 578-9988

Health Insurance	Page 6	Florida Blue	1-800-352-2583	www.floridablue.com
Dental Insurance	Page 11	Guardian	1-800-541-7846	www.guardiananytime.com
Vision Insurance	Page 14	Advantica	1-866-425-2323	www.advanticabenefits.com
Life Insurance & Disability Insurance	Page 17-18	Reliance Standard	1-800-351-7500	www.reliancestandard.com
Flexible Spending Account	Page 20	CDS Family & Behavioral Health Services	1-352-244-0628	
Voluntary Benefits	Page 21	Colonial Life	1-888-899-4135	Ken MacDougall: Kenneth.MacDougall@ColonialLife.com
Pre-Paid Legal & Identity Theft Protection	Page 22	LegalShield	1-813-805-2914	Lewis Key
Retirement Plan	Page 23	Valic	1-352-372-3497	Art Nangle
Sick Leave Pool	Page 24	CDS Family & Behavioral Health Services	1-352-244-0628	
Important Disclosures	Page 25			

If a 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.

BENEFITS ELIGIBILITY OVERVIEW

CDS Family & Behavioral Health Services is pleased to offer employees an excellent benefits program. These health and welfare benefits are designed to protect you and your family while you are an active employee. Our plan year is July 1 through June 30.

Eligibility

Health and welfare plans are available to all full time employees who work 30 or more hours per week.

New Hire Coverage

As a new hire, your plan eligibility date is the first day of the month following 60 days of employment.

If you do not enroll by the deadline, you will not be eligible for coverage until the following annual open enrollment period unless you experience a qualifying event.

Annual Elections

You have the opportunity to pay medical, dental and vision insurance premiums and FSA contributions with pre-tax dollars. It is important that you make your choices carefully, since changes to those elections can generally only be made during the annual open enrollment period. 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 one or more of the following:

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

If you have a family status change, you must notify Human Resources to change your benefit elections within 30 days of the qualifying event. Otherwise, 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 1985.

DEPENDENT ELIGIBILITY

If you wish, your dependents may also be covered under the medical, dental, vision and voluntary life insurance plans. **It is your responsibility to notify Human Resources when your dependents no longer meet the eligibility criteria.**

Eligible dependents include:

- Legal spouse, as defined by federal law; and
- Children

Medical – Your children up to the end of the year in which they reach age 26 regardless of marital status, financial dependency, residency with the eligible employee, student status, employment status, or eligibility for other coverage.

Dental – Your children up to the end of the month in which they reach age 26 if they are living in your household or a full or part-time student.

Vision – Your children up to the end of the year in which they reach age 26.

Voluntary Life – Your 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. If you do not provide the required documentation your dependents will not be covered. A list of acceptable documentation is illustrated below:

Relationship	Acceptable Documentation
Spouse	Most recent Federal Income Tax Return, Copy of Marriage Certificate
Child *(Biological, Adopted and Stepchild under 26)*	Copy of most recent Federal Tax Return, Copy of Birth/Adoption Certificate, School Class Schedule

OLINE ENROLLMENT SYSTEM INSTRUCTIONS

CDS Family & Behavioral Health Services will conduct benefits enrollment through our online enrollment system Employee Navigator.

Use the link below or from the welcome email to begin. 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.

https://www.employeenavigator.com/benefits/Account/Login

Click the link to Register as a New User. 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 guide which is listed under the employee home page, under compliance documents.

Once you have reviewed the employee benefits guide, please click on the benefits tab to begin your enrollment. 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.

HEALTH CARE BENEFITS OVERVIEW

Healthcare benefits are among the most important and necessary parts of your benefits package. The following is a summary of our medical plans offered through Florida Blue. For a more detailed explanation of benefits, please refer to your Certificate of Coverage or SBC. You may access a list of participating providers through the carrier's website (see page 2 of this guide for more information). Out of network Services are not covered.

Our plans with Florida Blue require the selection of a Primary Care Physician (PCP), however, a referral is not required to see a Specialist. You will input this information when enrolling for your benefits in Employee Navigator. To add or change your PCP, you can call Florida Blue at 1-800-352-2583 or make the change online by accessing your member account at **www.floridablue.com**. We use the Blue Care Network of providers.

	Bronze Plan Summary (HSA) Blue Care 128/129	Silver Plan Summary Blue Care 53
	In Network	**In Network**
DEDUCTIBLE	Calendar Year	Calendar Year
Individual	$2,500	$3,500 per person
Family	$5,000	$5,000 maximum
COINSURANCE		
Plan Pays	80%	70%
You Pay	20%	30%
OUT OF POCKET MAXIMUM	Ded, Coins & Rx Copays Included	Ded, Coins & Copays Included
Individual	$5,000	$6,350 per person
Family	$10,000	$12,700 maximum
DOCTORS OFFICE VISITS		
Preventive Care Services	100% coverage	100% coverage
Primary Care Physician	20% after Deductible	$40 Copay
Specialist Physician	20% after Deductible	$65 Copay
Urgent Care	20% after Deductible	$85 Copay
Emergency Room	20% after Deductible	$300 Copay
Diagnostic X-Ray at Independent Facility*	20% after Deductible	$65 Copay
Diagnostic Lab at Independent Lab*	20% after Deductible	No Charge
Inpatient Hospitalization	20% after Deductible	30% after Deductible
Outpatient Hospital Services	20% after Deductible	30% after Deductible

PRESCRIPTION DRUGS		
Retail (30 day supply)	Copays apply after Deductible is met	
Tier 1	$10 copay	$10 copay
Tier 2	$50 copay	$50 copay
Tier 3	$80 copay	$80 copay
Mail Order (90-day)	2.5x retail copay	2.5x retail copay

See Certificate of Coverage for complete details and limitations. **Services performed at a hospital may have a higher cost share.*

EMPLOYEE CONTRIBUTIONS (PAYROLL DEDUCTIONS)

	Medical Plan	
Annual Pay of $26,000 or Less	Silver Plan	Bronze Plan
Employee	$26.40	$7.50
Employee and Spouse	$275.21	$204.20
Employee and Children	$193.39	$139.17
Family	$432.55	$329.22
Annual Pay of >$26,000 and <$40,000		
Employee	$39.31	$14.82
Employee and Spouse	$288.12	$211.52
Employee and Children	$206.30	$146.49
Family	$445.46	$336.54
Annual Pay of >$40,000		
Employee	$52.22	$22.14
Employee and Spouse	$301.03	$218.84
Employee and Children	$219.21	$153.81
Family	$458.37	$343.86

HEALTH SAVINGS ACCOUNT

Employees who choose the Bronze Health Plan from Florida Blue will have the option to contribute tax-free dollars to a Health Savings Account (HSA). An HSA is a savings account used in conjunction with a high deductible health insurance policy to help individuals save for qualified medical and retiree health expenses on a tax-free basis.

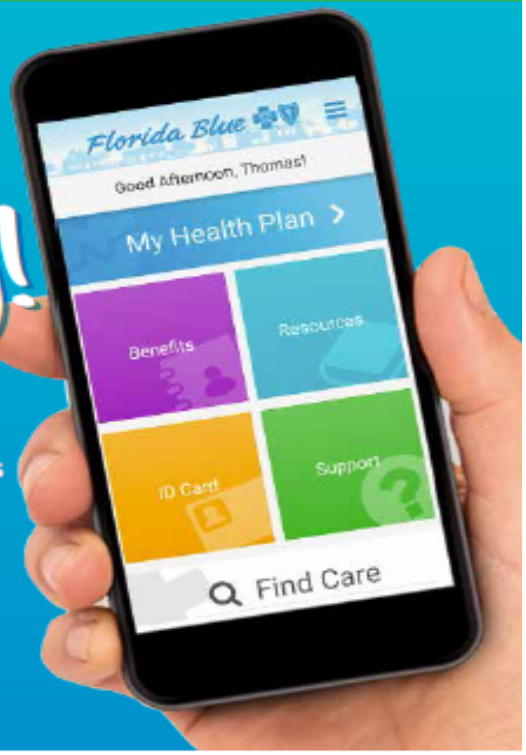
It is your personal savings account that is created with a bank of your choice. All deposits to the HSA belong to you once deposited and cannot be forfeited. Highlights about HSAs are listed below.

- If you elect to make deposits to your HSA, such deposits can be deducted on your tax return. You can start, stop or change your contributions at any time.
- The maximum contributions that may be deposited to your HSA in 2018 is $3,450 for single coverage and $6,900 if dependents are covered. In 2019, these amounts increase to $3,500 for single coverage and $7,000 if dependents are covered. In addition, if you are age 55 or older, you may make an additional tax deductible "catch up" contribution of $1,000 for 2018 and 2019.
- The funds in your account will earn interest. If you maintain a minimum balance, you may invest amounts in excess of this minimum in a broad range of investments including mutual funds. Interest earnings and investment earnings will be exempt from tax.
- Funds can be spent from your HSA tax free on medical, pharmacy, dental and vision expenses not paid by insurance, and on over the counter medical supplies. Over the counter medications are only eligible with a prescription from a physician.
- Your HSA bank may provide a debit card to access funds and pay your providers directly from your account.
- HSA funds may be used to pay for eligible expenses for you and your legal dependents, even if they are not covered under your medical plan. HSA funds can also be spent tax free on COBRA premiums, Medicare premiums and Long-term Care insurance premiums.
- It is important to keep receipts for all HSA expenditures. The IRS can ask for receipts if your account is audited. If you spend HSA funds on ineligible expenses you will be subject to income tax on such expenditures and a tax penalty prior to retirement age.
- If you are over age 65 and covered by Medicare, covered under Tricare or covered under another medical plan that is not an HSA qualified plan including an FSA through your or your spouse's employer, you are not eligible to contribute to a Health Savings Account.

FLORIDA BLUE RESOURCES

Florida Blue
In the pursuit of health®

Download the Florida Blue Mobile App today!



Save Time. Save Money. Stay Healthy.

- Check plan benefits and see the status of your claims
- Find the nearest in-network doctor, Urgent Care Center or pharmacy
- Compare medical costs
- View your member ID card

As Easy as 1, 2, 3…

1. **Download the app** – available through the Apple App Store or Google Play
2. **Get Registered** – log in using your Florida Blue member account User ID and Password
3. **Get Started** – anytime, anywhere with Touch ID*

Stay informed and in control ***24 hours a day, 7 days a week!***

GET IT ON Google Play Download on the App Store

*If available on your mobile device.

Health insurance is offered by Florida Blue. HMO coverage is offered by Florida Blue HMO, an HMO affiliate of Florida Blue. These companies are Independent Licensees of the Blue Cross and Blue Shield Association. We comply with applicable Federal civil rights laws and do not discriminate on the basis of race, color, national origin, age, disability or sex.

ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-800-352-2583 (TTY: 1-877-955-8773).

ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou. Rele 1-800-352-2583 (TTY: 1-800-955-8770).

This booklet is intended for illustrative and informational 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.

Stay **informed** and in **control**
24 hours a day, 7 days a week!

As a Florida Blue member, it's easier than ever to get the health information you need, when you need it! Get immediate access to your health plan information, plus much more by calling our automated assistant or logging in to your member account at floridablue.com.

At your fingertips...	Automated Assistant Call Toll-Free Number on Your ID Card	floridablue.com On your Computer, Smart Phone or Tablet
Deductible status. Total amount and how much has been paid.	✔	✔
Your cost shares. What you'll pay for care from a family doctor, specialist, urgent care facility, hospital or prescription drugs.	✔	✔
Claims status. Find out what was paid and what you may owe.	✔	✔
Benefit materials. ID card, benefit booklet, statements and forms.	✔	✔
Pay your health plan premium. If you buy coverage on your own (not through an employer), you have convenient payment options.	✔	✔
Status of authorizations. When you need approval for coverage.	✔	
Complete benefit details. Plus cost estimates for medical care, quick videos and monthly tips to help you maximize your benefits.		✔
Medication guide. Compare drug prices and use generic drugs or mail order to save on costs.		✔
Monthly statement of claims. Sort by person or type, and print.		✔
Doctors in your plan. Choose qualities that are important to you, see patient ratings and save to "favorites."		✔
Health resources. Take a health assessment. Set health goals and track your progress. It's all part of your online health record, and easy to find.		✔
Member discounts up to 50%. Gym memberships, weight loss programs, fitness wear, contact lenses, glasses and more[1].		✔
Your account preferences. Get online statements, set up your email, select language preferences and send secure messages.		✔

Florida Blue
In the pursuit of health®

85075-1015

[1]Blue365® offers access to savings on items that members may purchase directly from independent vendors. Blue365 does not include items covered under your policies with Florida Blue or any applicable federal or health care program. To find out what is covered under your policies, call Florida Blue. Blue Cross and Blue Shield Association (BCBSA) and local Blue Companies may receive payments from.

DENTAL BENEFITS OVERVIEW

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. If your dentist is out of network, you will have higher coverage in the Network Access Plan.

- **Value Plan**—at the in-network discounted reimbursement level
- **Network Access 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.Guardiananytime.com. (click "Find a Provider" and choose the PPO Dental Plan).**

	Summary of In & Out of Network Benefits	
	Value Plan	**Network Access (NAP) Plan**
Preventive Services: Cleanings, x-rays, exams, fluoride treatments and sealants for children	100% of Network Fee	100% of R&C
Basic Services: Fillings, extractions, periodontics, endodontics	80% of Network Fee	50% of R&C
Major Services: Dentures, bridges, crowns, implants	50% of Network Fee	25% of R&C
Deductible (Waived for Preventive)	Calendar Year Deductible	
Individual	$50	
Family	$150	
Maximum Annual Benefit per person	$1,000 plus Maximum Rollover	

Employee Contributions Per Pay Period (26 pay periods)

Employee	*Employee + Spouse*	*Employee + Children*	*Employee + Family*
$9.00	$18.36	$21.01	$31.06

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DENTAL MAXIMUM ROLLOVER BENEFIT

GUARDIAN DENTAL

Guardian® in sync Dental

Get the "Maximum" from your dental benefits

A solution to reducing costs and allowing employees to get more out of their dental funds.

Guardian will roll over a portion of the unused annual dental maximum into a personal Maximum Rollover Account, which can be used in future years if the plan's annual maximum is reached. As an added advantage, more money is rolled over if in-network dentists are used exclusively during the benefit year.

How Maximum Rollover Works

Depending on the plan's annual maximum, if claims dollars for the year don't exceed a certain threshold, the set Maximum Rollover Amount (pre-determined based on the annual maximum) can be rolled over.

Plan Annual Maximum*	Threshold	Maximum Rollover Amount	In-Network Only Rollover Amount	Maximum Rollover Account Limit
$1,500	$700	$350	$500	$1,250
Maximum Claims Reimbursement	Claims amount that determines rollover eligibility	Additional dollars added to Plan Annual Maximum for future years	Additional dollars added to Plan Annual Maximum for future years if only in-network providers were used during the benefit year	Maximum Rollover Account cannot exceed $1,250

* If a plan has a different annual maximum for PPO benefits vs. non-PPO benefits, ($1500 PPO/$1000 non-PPO for example) the non-PPO maximum determines the Maximum Rollover plan

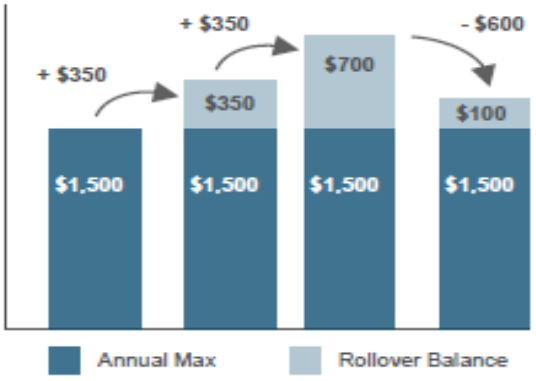
Here's how the benefits work (Sample Plan)

YEAR ONE: Jane starts with a $1,500 Plan Annual Maximum. She submits $150 in dental claims. Since she did not exceed the $700 Threshold, she receives a $350 rollover that will be applied to Year Two.

YEAR TWO: Jane now has an increased Plan Annual Maximum of $1,850. This year, she submits $500 in claims and receives an additional $350 rollover added to her Plan Annual Maximum.

YEAR THREE: Jane now has an increased Plan Annual Maximum of $2,200. This year, she submits $2,100 in claims. All claims are paid due to the Maximum Rollover Amount accumulated.

YEAR FOUR: Jane's Plan Annual Maximum is $1,600 ($1,500 Plan Annual Maximum + $100 remaining Maximum Rollover Amount accumulated)



GUARDIAN | DENTAL | DISABILITY | LIFE | VISION | CRITICAL ILLNESS | CANCER | ACCIDENT | STOP LOSS

GuardianAnytime.com

College Tuition Benefit Self-Registration

Welcome to the College Tuition Benefits Rewards program! You can now create your Rewards account and start accumulating your Tuition Rewards that can be used to pay up to one year's tuition at SAGE Scholar Consortium colleges.

How does it work?
You can use your College Tuition Benefits Rewards at over 330 private colleges and universities across the nation. 80% of SAGE colleges have received an "America's Best" ranking by US News and World Reports.

- Each Tuition Reward point equals a $1 tuition reduction
- You will receive rewards each year you have Guardian Dental Plan benefits
- Tuition Rewards can be given to your relatives including children, nephews, nieces, and grandchildren.
- See how quickly your account can grow!

Policy Year	Subscriber Reward*	Subscriber's Reward Balance (Balance does not accrue interest)
Initial Registration Subscriber and Student Rewards		2,500 (2,000 + 500)
2	2,000	4,500
3	2,000	6,500
4	**4,500 (Bonus Year)**	11,000
5	2,000	13,000
6	2,000	15,000
7	2,000	17,000

*After initial registration, future points credited 30 days after plan anniversary.

To learn more about the program and how to get started, go to: www.Guardian.CollegeTuitionBenefit.com to set up your account. If you have any questions, please feel free to visit the website or contact College Tuition Benefit directly at 215-839-0119.

Guardian's Group Dental Insurance is underwritten by The Guardian Life Insurance Company of America (Guardian) or its subsidiaries. The Tuition Rewards program is provided by College Tuition Benefit. The Guardian Life Insurance Company of America (Guardian) does not provide any services related to this program. College Tuition Benefit is not a subsidiary or an affiliate of Guardian. #2014-15077 Exp. 12/16.

Register Today!

(Print and cut out ID Card)

College Tuition Benefits Rewards – ID Card

Register @
www.Guardian.CollegeTuitionBenefit.com

User ID: Type in your Guardian Dental Plan Number. (Your 'Plan Number' can be found on your Dental ID Card)

Password: Guardian

fold

COLLEGE TUITION BENEFIT.com

The College Tuition Benefit
150 E. Swedesford Road, Suite 100
Wayne, PA 19087
Phone: (215) 839-0119
Fax: (215) 392-3255

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VISION BENEFITS OVERVIEW

The vision coverage is provided by Advantica. 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.advanticabenefits.com** and click on Provider search. Their national network of independent and retail optical providers includes Visionworks, Pearl Vision, Walmart, Eyeglass World and more.

	Vision Plan Summary	
	In Network	**Out of Network**
Eye Exams Covered Once Every 12 Months	$10 copay	Up to $40 reimbursement after $10 Copay
Frames Covered Once Every 24 Months	$150 retail allowance	Up to $60 reimbursement
Lenses Covered Once Every 12 Months	Single: $25 copay Bifocal: $25 copay Trifocal: $25 copay Lenticular: $25 copay Standard Progressive Lenses: $75 Copay	Single Vision: Up to $20 reimbursement Bifocal: Up to $40 reimbursement Trifocal: Up to $60 reimbursement Lenticular: Up to $100 reimbursement
Contact Lenses (Medically Necessary) Covered Once Every 12 Months	$250 retail allowance	Up to $250 reimbursement
Contact Lenses (Elective) Covered Once Every 12 Months	Up to $150 allowance	Up to $80 reimbursement
Contact Lens Fit & Follow Up	$40 allowance	Not covered

Employee Contributions Per Pay Period (26 pay periods)

Employee	*Employee + Spouse*	*Employee + Children*	*Employee + Family*
$2.72	**$5.10**	**$5.79**	**$8.44**

VISION BENEFITS OVERVIEW

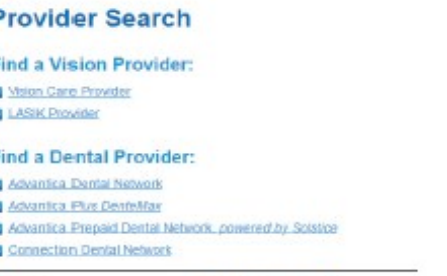
Finding a Provider at AdvanticaBenefits.com

Find a dental or vision provider on AdvanticaBenefits.com in as easy as 3 steps and in under 30 seconds.

1 At **AdvanticaBenefits.com**, click on **Provider Search** in the middle of the page.

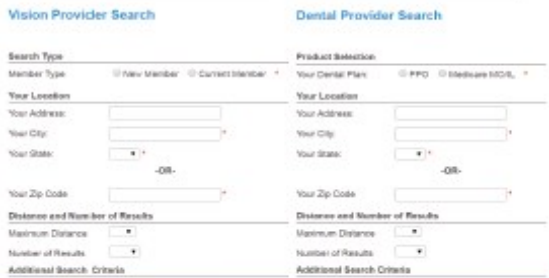
2 Click on the type of provider you are searching for.

- Vision Care Provider
- LASIK Provider
  External website with separate instructions
- Advantica Dental Network
- Advantica Plus DenteMax
- Advantica Prepaid Dental Network, powered by Solstice
  External website with separate instructions
- Connection Dental Network



3 Enter the necessary information and click **Search for a Provider.**

All boxes with a red asterisk are required.



ADVANTICA
See. Smile. Live.

Have Questions or Need Assistance?

Dental Customer Service
Monday-Friday from 7 a.m. to 5 p.m. Central Time
Toll Free: 800.501.3471

Vision Customer Service
Monday-Friday from 7 a.m. to 6 p.m. Central Time
Toll Free: 866.425.2323

ACS-1027-1030

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LIFE AND AD&D INSURANCE OVERVIEW

Life and Accidental Death & Dismemberment (AD&D) Insurance

This coverage is insured through Reliance Standard and is provided by CDS at no cost to the employee. 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.

	Life and AD&D Coverage
Life Insurance	$15,000
Accidental Death and Dismemberment	Benefit up to 100% of the life insurance 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 sent to Reliance Standard within 31 days of termination.

Employee Eligibility Requirements for Life Insurance: You must be actively at work on the day coverage is scheduled to begin. If you are not actively at work on that day, coverage for you and your enrolled dependents will begin once you have returned to work.

LIFE AND AD&D INSURANCE OVERVIEW

Voluntary Life Insurance

Employees have the opportunity to elect Voluntary Life insurance through Reliance Standard. This coverage will provide an additional life insurance benefit for yourself, your spouse and/or your child(ren). This coverage is 100% employee paid. It is important to keep your beneficiary information up to date. You do not need to be covered for your spouse to have coverage. However, you or your spouse must be covered in order to cover dependent children.

	Voluntary Life Coverage
Employee Life Insurance	$10,000 increments to a maximum of $500,000
Guarantee Issue Amounts (newly eligible employees)	$100,000 for Employees ($10,000 for those age 60-69)
Spouse Life Insurance	$10,000 increments to a maximum of $500,000
Guarantee Issue Amounts (newly eligible spouses)	$20,000 for Spouses under the age of 60
Dependent Child(ren) Life Insurance	$2,500, $5,000, $7,500 or $10,000 for each child
Guarantee Issue Amounts (newly eligible children)	$10,000
Employee Coverage Benefit Reduction Schedule	40% at age 75, 65% at age 80, 72.5% at age 85. Spouse coverage terminates at age 75.

	Supplemental Life Enrollment Options
New Hires	You can elect up to the Guarantee Issue amount ($100,000 for Employees, $20,000 for Spouses, $10,000 for Children) with no medical questions asked. Amounts elected over the GI amount will require an Evidence of Insurability form be completed and submitted to Reliance Standard for approval. **Please note – A Reliance New Hire form needs to be completed.** **If you waive supplemental life coverage when you are initially eligible, you will be**

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.

Employee Eligibility Requirements for Life Insurance: You must be actively at work on the day coverage is scheduled to begin. If you are not actively at work on that day, coverage for you and your enrolled dependents will begin once you have returned to work.

Dependent Eligibility Requirement for Life Insurance: A dependent confined to a hospital on the date on which insurance would normally begin will become insured upon discharge from the hospital.

SHORT TERM & LONG TERM DISABILITY

You can purchase Short Term Disability insurance through **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.

This is a guarantee issue opportunity for this coverage. You can enroll in this coverage without answering any medical questions, you are guaranteed the coverage. If you waive this coverage when you are initially eligible and later choose to enroll, you must complete an Evidence of Insurability form (EOI) and submit it to Reliance Standard for approval.

Short Term Disability Insurance

	Benefit Summary
Benefit Amount	60% of weekly earnings
Benefit Maximum	$500 per week
Elimination Period	14 days for accident or illness
Maximum Benefit Period	Up to 90 days while disabled
Pre-existing Condition Limitation	Any condition for which you received treatment, or for which a prudent person would have sought treatment, during the 3 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

We offer Long Term Disability Insurance through Reliance Standard and **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.

Long Term Disability Insurance

	Benefit Summary
Benefit Amount	60% of monthly income
Benefit Maximum	$5,000 per month
Benefit Begins	After 90 days of disability (coordinates with Short Term Disability
Maximum Benefit Period	24 months if you are unable to perform the duties of your job, and to Social Security Retirement age if unable to perform the duties of any job
Pre-existing Condition Limitation	Any condition for which you received treatment, or for which a prudent person would have sought treatment, during the 3 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

Employee Eligibility Requirements for Disability Insurance: You must be actively at work on the day coverage is scheduled to begin. If you are not actively at work on that day, coverage for you will begin once you have returned to work.

EMPLOYEE CONTRIBUTIONS (PAYROLL DEDUCTIONS)

Voluntary Life Insurance Bi-Weekly Cost	
Age	**Cost Per $10,000 Coverage on Yourself and Spouse**
<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

The cost for $2,500 of children's voluntary life insurance coverage is **0.23 per pay period**. All eligible children are covered at this cost (do not multiply by the number of your eligible children).

Sample Voluntary Short Term Disability Bi-Weekly Cost		
Bi-Weekly Pay	**Bi-Weekly Benefit**	**Bi-Weekly Cost**
$700	$420	$4.56
$800	$480	$5.21
$900	$540	$5.86
$1,000	$600	$6.51
$1,100	$660	$7.16
$1,200	$720	$7.81
$1,300	$780	$8.46
$1,400	$840	$9.11
$1,500	$900	$9.76
$1,600	$960	$10.41
$1,666	$1,000	$10.85

FLEXIBLE SPENDING ACCOUNTS (FSA)

WHAT IS IT USED FOR?

The IRS permits you to pay certain expenses with earnings that are not taxed. 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. Visit www.fsastore.com for more information, and easy access to purchase FSA eligible items.

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 July 1st. Your contributions will be deducted in equal amounts from each paycheck pre-tax throughout the plan year.

Rollover Provision

The IRS allows for a rollover of up to $500 of your unused balance of your **Healthcare** FSA election. If at the end of the plan year (June 30th) you have a balance remaining of less than $500, that balance will roll over into the next plan year. Any amount above $500 will be forfeited.

Things to Consider Before You Contribute to an FSA

- Be sure to fund the account wisely so you do not over-contribute
- You cannot take income tax deductions for expenses you pay with you Dependent Care FSA. Consult your tax advisor for more details
- You cannot stop or change contributions to your FSA during the year unless you have a change in family status consistent with your change in contributions

The maximum contribution allowed to the Medical Care Account is $2,650 per plan year. 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.

COLONIAL LIFE 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
- If you enroll in the Florida Blue Bronze Medical Plan, your Medical Bridge benefit will pay only for hospital confinement. No outpatient benefits are available.

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

PRE-PAID LEGAL & ID 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 Experian
- 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

This booklet is intended for illustrative and informational 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.

RETIREMENT PLAN

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.

VALIC

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.

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

This Document Is for Informational Purposes Only

This communication is intended for illustrative and informational 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

HIPAA Privacy

The Plan complies with the privacy requirements of the Health Insurance Portability and Accountability Act of 1996 (HIPAA). These requirements are described in a Notice of Privacy Practices that was previously given to you. A copy of this notice is available upon request.

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 Health Program within **30 days** of the loss of that coverage. 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 health plan that you no longer have that coverage.

(b.) You are eligible to enroll yourself and your Eligible Dependent in the Health 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.) You 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).

IMPORTANT DISCLOSURES

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 below.

CDS Family & Behavioral Health Services, Inc.
Human Resources
3615 SW 13th Street, Suite 2
Gainesville, FL 32608

Notice Regarding Patient Protection Rights The group health plan does 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. 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 below.

CDS Family & Behavioral Health Services, Inc.
Human Resources
3615 SW 13th Street, Suite 2
Gainesville, FL 32608

Medicare Notice

You must notify CDS when you or your dependents become Medicare eligible. CDS 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 than the Medicare beneficiary or their legal guardian. The toll-free number to Medicare Coordination of Benefits is 1-800-999-1118.

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 Notice.

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. The law includes important new protections for breast cancer patients who elect breast reconstruction in connection with a mastectomy. For individuals receiving mastectomy-related benefits, coverage will be provided in a manner determined in consultation with the attending physician and patient, 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 benefits will be provided subject to the same deductible and coinsurance applicable to other medical and surgical benefits provided under this plan. If you would like more information on WHCRA benefits, please call your plan administrator.

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 became 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.

Important Information About Your Prescription Drug Coverage and Medicare

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 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: 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.

CDS has determined that the prescription drug coverage offered by their carrier's Silver Plan is, on average for all plan participants, 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 15 through December 7. However, if you lose your current creditable prescription drug coverage, through no fault of 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 19 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 will receive this notice each year and again, 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 U.S. Social Security Administration's 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 copy of this notice when you join to show whether or not you have maintained creditable coverage and, therefore, whether or not you are required to pay a higher premium (penalty).

CDS Family & Behavioral Health Services, Inc.
Human Resources
3615 SW 13th Street, Suite 2
Gainesville, FL 32608

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.

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).

New Health Insurance Marketplace Coverage Options and Your Health Coverage

Today there is a new way to buy health insurance: the **Health Insurance Marketplace**. To assist you as you evaluate options for you and your family, this notice provides some basic information about the new 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. You may also be eligible for a new kind of tax credit that lowers your monthly premium right away.

The open enrollment period for health insurance coverage through the Marketplace runs from Nov. 1 through Jan. 31. Individuals must enroll or change plans prior to Dec. 15 for coverage starting as early as Jan. 1. After Jan. 31, you can get coverage through the Marketplace only if you qualify for a special enrollment period or are applying for Medicaid or the Children's Health Insurance Program (CHIP).

IMPORTANT DISCLOSURES

Can I Save Money on my Health Insurance Premiums in the Marketplace?

You may qualify to save money and lower your monthly premium, but only if your employer does not offer coverage, or offers coverage that doesn't meet certain standards. The savings on your premium that you're eligible for depends on your household income.

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, you will not be eligible for a tax credit through the Marketplace and may wish to enroll in your employer's health plan. However, you may be eligible for a tax credit that lowers your monthly premium or a reduction in certain cost-sharing if your employer does not offer coverage to you at all or does not offer coverage that meets certain standards.

If the cost of a plan from your employer that would cover you (and not any other members of your family) is more than 9.66 percent of your household income for the year (9.66 percent for 2017), or if the coverage your employer provides does not meet the "minimum value" standard set by the Affordable Care Act, you may be eligible for a tax credit. (An employer-sponsored health plan meets the “minimum value standard” if the plan’s share of the total allowed benefit costs covered by the plan is no less than 60 percent of such costs.)

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 (if any) to the employer-offered coverage. Also, this employer contribution—as well as your employee contribution to employer-offered coverage—is often excluded from income for federal and state income tax purposes. Your payments for coverage through the Marketplace are made on an after-tax basis.

How Can I Get More Information?

For more information about your coverage offered by your employer, please check your summary certificate of coverage or contact:
CDS Family & Behavioral Health Services, Inc.
Human Resources
3615 SW 13th Street, Suite 2
Gainesville, FL 32608

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.

NOTICE OF RESCISSION OF COVERAGE
Under Health Care Reform, your coverage may be rescinded (i.e., retroactively revoked) due to fraud or intentional misrepresentation regarding health benefits or due to failure to pay premiums. A 30 day advance notice will be provided before coverage can be rescinded.

Summary of Benefits & Coverage (SBC) As an employee, the health benefits available to you represent a significant component of your compensation package. They also provide important protection for you and your family in the case of illness or injury.

The Summary of Benefits & Coverage (SBC) is a document intended to help people understand their health coverage and compare health plans when shopping for coverage. The federal government requires all healthcare insurers and group health care sponsors to provide this document to plan participants . SBCs will be created for each medical plan offered. Group health plan sponsors must provide a copy of the SBC to each employee eligible for coverage under the plan. The SBC includes:

- A summary of the services covered by the plan
- A summary of the services not covered by the plan
- A glossary of terms commonly used in health insurance
- The copays and/or deductibles required by the plan, but not the premium
- Information about members’ rights to continue coverage
- Information about members’ appeal rights
- Examples of how the plan will pay for certain services

The SBCs are available electronically on Employee Navigator. A paper copy is also available, free of charge, by calling your benefits administrator at 352-244-0628 x 3812.

IMPORTANT DISCLOSURES

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 associate, 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 associate, 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-associate dies;
The parent-associate's hours of employment are reduced;
The parent-associates employment ends for any reason other than his or her gross misconduct;
The parent-associate 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 associate;
Commencement of a proceeding in bankruptcy with respect to the employer; or
The associate'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 associate 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

Notification should be in writing and include official documentation of qualifying event

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 associates 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:

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 associate or former associate 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.

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

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Premium Assistance Under Medicaid and theChildren'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 January 31, 2018. Contact your State for more information on eligibility –

ALABAMA – Medicaid	**FLORIDA – Medicaid**
Website: http://myalhipp.com/ Phone: 1-855-692-5447	Website: http://flmedicaidtplrecovery.com/hipp/ Phone: 1-877-357-3268
ALASKA – Medicaid	**GEORGIA – Medicaid**
The AK Health Insurance Premium Payment Program Website: http://myakhipp.com/ Phone: 1-866-251-4861 Email: CustomerService@MyAKHIPP.com Medicaid Eligibility: http://dhss.alaska.gov/dpa/Pages/medicaid/	Website: http://dch.georgia.gov/medicaid - Click on Health Insurance Premium Payment (HIPP) Phone: 404-656-4507
ARKANSAS – Medicaid	**INDIANA – Medicaid**
Website: http://myarhipp.com/ Phone: 1-855-MyARHIPP (855-692-7447)	Healthy Indiana Plan for low-income adults 19-64 Website: http://www.in.gov/fssa/hip/ Phone: 1-877-438-4479 All other Medicaid Website: http://www.indianamedicaid.com
COLORADO – Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)	**IOWA – Medicaid**
Health First Colorado Website: https://www.healthfirstcolorado.com/ Health First Colorado Member Contact Center: 1-800-221-3943/ State Relay 711 CHP+: Colorado.gov/HCPF/Child-Health-Plan-Plus CHP+ Customer Service: 1-800-359-1991/ State Relay 711	Website: http://dhs.iowa.gov/ime/members/medicaid-a-to-z/hipp Phone: 1-888-346-9562

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KANSAS – Medicaid	NEW HAMPSHIRE – Medicaid
Website: http://www.kdheks.gov/hcf/ Phone: 1-785-296-3512	Website: https://www.dhhs.nh.gov/ombp/nhhpp/ Phone: 603-271-5218
KENTUCKY – Medicaid	**NEW JERSEY – Medicaid and CHIP**
Website: http://chfs.ky.gov/dms/default.htm Phone: 1-800-635-2570	Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/ Medicaid Phone: 609-631-2392 CHIP Website: http://www.njfamilycare.org/index.html
LOUISIANA – Medicaid	**NEW YORK – Medicaid**
Website: http://dhh.louisiana.gov/index.cfm/subhome/1/n/331 Phone: 1-888-695-2447	Website: https://www.health.ny.gov/health_care/medicaid/ Phone: 1-800-541-2831
MAINE – Medicaid	**NORTH CAROLINA – Medicaid**
Website: http://www.maine.gov/dhhs/ofi/public-assistance/index.html Phone: 1-800-442-6003 TTY: Maine relay 711	Website: https://dma.ncdhhs.gov/ Phone: 919-855-4100
MASSACHUSETTS – Medicaid and CHIP	**NORTH DAKOTA – Medicaid**
Website: http://www.mass.gov/eohhs/gov/departments/masshealth/ Phone: 1-800-862-4840	Website: http://www.nd.gov/dhs/services/medicalserv/medicaid/ Phone: 1-844-854-4825
MINNESOTA – Medicaid	**OKLAHOMA – Medicaid and CHIP**
Website: http://mn.gov/dhs/people-we-serve/seniors/health-care/health-care-programs/programs-and-services/medical-assistance.jsp Phone: 1-800-657-3739	Website: http://www.insureoklahoma.org Phone: 1-888-365-3742
MISSOURI – Medicaid	**OREGON – Medicaid**
Website: https://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005	Website: http://healthcare.oregon.gov/Pages/index.aspx http://www.oregonhealthcare.gov/index-es.html Phone: 1-800-699-9075
MONTANA – Medicaid	**PENNSYLVANIA – Medicaid**
Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084	Website: http://www.dhs.pa.gov/provider/medicalassistance/healthinsurancepremiumpaymenthippprogram/index.htm
NEBRASKA – Medicaid	**RHODE ISLAND – Medicaid**
Website: http://www.ACCESSNebraska.ne.gov Phone: (855) 632-7633 Lincoln: (402) 473-7000 Omaha: (402) 595-1178	Website: http://www.eohhs.ri.gov/ Phone: 855-697-4347
NEVADA – Medicaid	**SOUTH CAROLINA – Medicaid**
Medicaid Website: https://dhcfp.nv.gov Medicaid Phone: 1-800-992-0900	Website: https://www.scdhhs.gov Phone: 1-888-549-0820

SOUTH DAKOTA - Medicaid	WASHINGTON – Medicaid
Website: http://dss.sd.gov Phone: 1-888-828-0059	Website: http://www.hca.wa.gov/free-or-low-cost-health-care/program-administration/premium-payment-program Phone: 1-800-562-3022 ext. 15473
TEXAS – Medicaid	**WEST VIRGINIA – Medicaid**
Website: http://gethipptexas.com/ Phone: 1-800-440-0493	Website: http://mywvhipp.com/ Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)
UTAH – Medicaid and CHIP	**WISCONSIN – Medicaid and CHIP**
Medicaid Website: https://medicaid.utah.gov/ CHIP Website: http://health.utah.gov/chip Phone: 1-877-543-7669	Website: https://www.dhs.wisconsin.gov/publications/p1/p10095.pdf 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
VIRGINIA – Medicaid and CHIP	
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	

To see if any other states have added a premium assistance program since January 31, 2018, or for more information on special enrollment rights, contact either:

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

HIPAA PRIVACY NOTICE

HIPAA Privacy Notice: This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

When it comes to your health information, you have certain rights. This section explains your rights and some of our responsibilities to help you.

Get a copy of your health and claims records	• You can ask to see or get a copy of your health and claims records and other health information we have about you. Ask us how to do this. • We will provide a copy or a summary of your health and claims records, usually within 30 days of your request. We may charge a reasonable, cost-based fee.
Ask us to correct health and claims records	• You can ask us to correct your health and claims records if you think they are incorrect or incomplete. Ask us how to do this. • We may say "no" to your request, but we'll tell you why in writing within 60 days.
Request confidential communications	• You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address. • We will consider all reasonable requests, and must say "yes" if you tell us you would be in danger if we do not.
Ask us to limit what we use or share	You can ask us **not** to use or share certain health information for treatment, payment, or our operations. We are not required to agree to your request, and we may say "no" if it would affect your care.
Get a list of those with whom we've shared information	You can ask for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, who we shared it with, and why. We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.
Get a copy of this privacy notice	You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.
Choose someone to act for you	If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information. We will make sure the person has this authority and can act for you before we take any action.
File a complaint if you feel your rights are violated	You can complain if you feel we have violated your rights by contacting us. You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting **www.hhs.gov/ocr/privacy/hipaa/complaints/.** We will not retaliate against you for filing a complaint.

How else can we use or share your health information? We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see: **www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html.**

Help with public health and safety issues	We can share health information about you for certain situations such as: ■ Preventing disease ■ Helping with product recalls ■ Reporting adverse reactions to medications ■ Reporting suspected abuse, neglect, or domestic violence ■ Preventing or reducing a serious threat to anyone's health or safety
Do research	We can use or share your information for health research.
Comply with the law	We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.
Respond to organ and tissue donation requests and work with a medical examiner or funeral director	We can share health information about you with organ procurement organizations. We can share health information with a coroner, medical examiner, or funeral director when an individual dies.
Address workers' compensation, law enforcement, and other government requests	We can use or share health information about you: ■ For workers' compensation claims ■ For law enforcement purposes or with a law enforcement official ■ With health oversight agencies for activities authorized by law ■ For special government functions such as military, national security, and presidential protective services
Respond to lawsuits and legal actions	We can share health information about you in response to a court or administrative order, or in response to a subpoena.

HIPAA PRIVACY NOTICE

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

In these cases, you have both the right and choice to tell us to:	• Share information with your family, close friends, or others involved in payment for your care • Share information in a disaster relief situation • Contact you for fundraising efforts *If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.*
In these cases we *never* share your information unless you give us written permission:	• Marketing purposes • Sale of your information

How do we typically use or share your health information? We typically use or share your health information in the following ways.

Help manage the health care treatment you receive	We can use your health information and share it with professionals who are treating you.	***Example:*** *A doctor sends us information about your diagnosis and treatment plan so we can arrange additional services.*
Run our organization	We can use and disclose your information to run our organization and contact you when necessary. **We are not allowed to use genetic information to decide whether we will give you coverage and the price of that coverage.** This does not apply to long term care plans.	***Example:*** *We use health information about you to develop better services for you.*
Pay for your health services	We can use and disclose your health information as we pay for your health services.	***Example:*** *We share information about you with your dental plan to coordinate payment for your dental work.*
Administer your plan	We may disclose your health information to your health plan sponsor for plan administration.	***Example:*** *Your company contracts with us to provide a health plan, and we provide your company with certain statistics to explain the premiums we charge.*

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

For more information see: **www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html.**

Changes to the Terms of This Notice: We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, on our web site, and we will mail a copy to you.

NOTES

2018 ENROLLMENT

BENEFITS **ROADMAP**

This booklet is intended for illustrative and informational 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 and former employees.