Benefits-at-a-Glance:

Plan Year November 2017 – October 2018

Bay Laurel Center CDD

Contents and Contact Information

Refer to this list when you need to contact one of your benefit vendors. For general information contact Human Resources.

The information in this Benefits Summary is presented for illustrative purposes and is based on information provided by the employer. The text contained in this Summary was taken from various summary plan, prescriptions and benefit information. While every effort was taken to accurately report your benefits, discrepancies or errors are always possible. In case of discrepancy between the Benefits Summary and the actual plan documents, the actual plan documents will prevail. All information is confidential, pursuant to the Health Insurance Portability and Accountability Act of 1996. If you have any questions about this summary, contact Human Resources.

General Benefit Information

Your Benefit Plans!

Bay Laurel Center CDD offers a variety of benefits allowing you the opportunity to customize a benefit package that meets your personal needs for you and your family.

In the following pages, you'll learn more about the benefits offered. You'll also see how choosing the right combination of benefits can help protect you and your family's health and finances – and your family's future.

CARRIER	BENEFIT
Florida Blue	Medical
Guardian Life Insurance	Dental & Vision
Mutual of Omaha	Life/AD&D, Short and Long Term Disability
Colonial Life Insurance	Hospital Confinement Accident, Cancer, Critical, Illness, Whole/Universal Life for Employees, Spouse, Dependents

When Can You Enroll?

You can sign up for Benefits at any of the following times:

- After completing initial eligibility period;
- During the annual open enrollment period;
- Within 30 days of a qualified family-status change.

If you do not enroll at one of the above times, you must wait for the next annual open enrollment period.

Eligibility

All Regular full-time employees are eligible for Benefit Plans on the First of the Month following 60 days of employment. You may also enroll your dependents in the Benefit Plans when you enroll.

"Regular Full-Time Employees" must be regularly scheduled and working at least 25 hours per week.

Eligible dependents include:

- Your spouse
- Your natural children, step-children living with you, legally adopted children and any other children for whom you have legal guardianship, who are:
  - Under 26 years of age
  - for medical, in some circumstances, up to age 30

DID YOU KNOW?

Beginning in 2014, Individuals (for themselves and dependents) MUST have medical insurance or you may be subject to the following penalty due to the Individual Mandate:

2016:

- ✓ **Greater of $695 (Adults)/ $347.50 (Child) or 2.5% of family income**

2017:

- ✓ **Increased from above by cost of living adjustment**

Penalties are paid in following year as part of tax return.

Medical Insurance

Your Employer offers you health insurance through Florida Blue. Find participating providers on www.floridablue.com Choose Blue Options as your plan.

Plan Name	Blue Options 14003
In Network Deductible (Individual / Family) Out of Network Deductible (Individual / Family)	$500 / $1500 $1000 / $3000
In Network Out-of-Pocket Maximum Out of Network Out-of-Pocket Maximum	$2000 / $6000 $5000 / $10,000
Out-of-Pocket Max Includes	Mental Health/Substance Abuse and out of network covered expenses
Lifetime Major Medical Maximum	Unlimited
Coinsurance – In /Out Network	80% / 50%
ROUTINE PREVENTIVE SERVICES - in Network Wellness, Immunizations, Mammography, Colonoscopy	Covered 100%
Office Visits/Consultations for Illness/Injury	$10 copay
Specialist Visit	$25 copay
Inpatient Hospital	Opt 1- $200 p/d $600 max Opt 2 - $300 p/d $900 max
Outpatient Surgery	Opt 1 - $150; Opt 2 $350
Emergency Room / Urgent Care	$100 / $30 copay
PRESCRIPTIONS RX Copayments (30 day supply) Mail Order (3 month supply)	$10/$30/$50/$150 $20/$60/$100/NA

Election	Monthly Premium	Employer Contributions Per month	Employee Contributions Per Month	Employee Contributions Per Pay (48)
Employee Only	**$672.19**	**$539.15**	**$133.04**	**$33.26**
Employee + Spouse	**$1,344.38**	**$1,144.14**	**$200.24**	**$50.06**
Employee + Child(ren)	**$1,243.55**	**$1,068.51**	**$175.04**	**$43.76**
Family	**$1,915.74**	**$1,572.66**	**$343.08**	**$85.77**

This chart is intended only to highlight the benefits available and should not be relied upon to fully determine your coverage. Should the benefits illustrated conflict in any way with the Summary Plan Description (SPD), the SPD shall prevail. This summary contains highlights only and is subject to change. The specific terms of coverage, exclusions and limitations including legislated benefits are contained in the Summary Plan Description or Insurance Certificates.

Getting more from your Health Care Dollars

Pharmacy Benefits & Consumer Tips

Did you know you can obtain prescription drugs at local retailers at a reduced cost and sometimes even free?

Walgreens, CVS, Publix & Wal-Mart

- ✓ **Wal-Mart** offers generic prescriptions for $4 and a 90 day supply for approximately $10!
- ✓ **Publix** offers a free medications! Just ask for a list.
- ✓ **Walgreens & CVS** have discount clubs you can join for savings – see their websites for details.
- ✓ **New Prescriptions?** Ask your doctor for a generic sample before you spend dollars on a brand name only to find you are allergic or it has an adverse effect on you.
- ✓ **Check Manufacturer** website for coupons/discounts!!!
- ✓ www.goodrx.com – Find out what pharmacy nearest your home zip code charges the least amount for your prescription!

Remember DO NOT show your medical ID card to receive these benefits or you will be charged your medical plans drug rate.

Choose in-network providers for your least expensive option.

Convenience Care Clinics – Don't pay more if you don't have to. Common examples: Pink Eye, school physicals, common infections, flu shots

Urgent Care Centers – for health conditions that aren't life-threatening and your regular doctor isn't available. Common examples: Sprains and Strains, Fever, Minor injuries and Burns, Flu

Emergency Room – use for true emergencies like life threatening illnesses and injuries. Common examples: Chest Pain, Broken Bones, Allergic Reactions, Continuous Bleeding, Head Injury, Deep Wounds

Medical Helpful Hints

- ➢ ASK - Are you a contracted in network provider for MY Florida Blue plan?
- ➢ ASK - Can you provide me a pre-determination (i.e., estimate) of services?
- ➢ NEED LABS? – ensure you and/or your doctor utilizes an IN NETWORK LAB!
- ➢ PREVENTATIVE CARE – have you had your annual checkups? It's FREE!
- ➢ PRE-AUTHORIZATION – Required for ALL in patient stays – coordinated by your In Network Physician. Some Outpatient procedures and diagnostic testing require this too.

REGISTER –Member Private Portal

www.FloridaBlue.com

- ✓ Find an In Network provider, hospital or pharmacy
- ✓ RX Formulary Lists
- ✓ ID Card Replacement
- ✓ View your plan benefits
- ✓ View Claims and Explanation of Benefits
- ✓ Claim/Cost Estimator

Member Resources

24-Hour Nurse helpline - available 24/7/365 for general health and prevention questions or for education and support on medical issues. 877-789-2583.

Florida Blue Member Mobile Solution – Free App for Apple, Kindle Fire, BlackBerry and Google Play. Simply Search for myFlorida Blue Mobile App!

Dental Insurance

GUARDIAN

You have two dental plans to enroll in. Choose the one that best meets your needs.

BENEFITS Mac	Value NA PPO
Deductible	$50/$150- IN $100/$300-Out
Deductible waived for Preventative?	Yes - In No – Out
PREVENTATIVE Oral Examinations; Cleanings; X-Rays; Sealants - children (16)	100/100
BASIC Fillings, General Anesthesia, Scaling & Root Planing, Simple Extractions	80/50
MAJOR Dentures, Fixed Bridges and Crowns	50/25
Endodontics/Periodontics	Basic
Annual Maximum	$1,000

BENEFITS UCR	Buy Up B1 PPO
Deductible – In and Out	$50/$150
Deductible waived for Preventative?	Yes
PREVENTATIVE Oral Examinations; Cleanings; X-Rays; Sealants - children (16)	100/100
BASIC Fillings, General Anesthesia, Scaling & Root Planing, Simple Extractions	100/80
MAJOR Dentures, Fixed Bridges and Crowns	60/50
Endodontics/Periodontics	Basic
Annual Maximum combined $1,000 In and Out, with additional $500 in-network benefit	$1,500/$1,000

Late entrant penalties – both plans – Basic: 6 months; Major: 12 months

Dental Cost Per Pay (48)	Value NA	B1
Employee Only	**$0**	**$3.57**
Employee + Spouse	**$5.39**	**$9.21**
Employee + Child(ren)	**$7.43**	**$12.68**
Family	**$11.62**	**$19.85**

To find a Dental Provider register:
www.GuardianAnyTime.com
Dental Network: PPO-DentalGuard Preferred Dayton/Gainesville

If a member uses a network provider they will pay less out-of-pocket costs. Network providers will not charge more than the allowable fee. **Balance billing will occur** when a member chooses to receive services from an **out-of-network provider.**

Maximum Rollover Feature

Value added feature! Qualifying participants can carryover part of their unused annual max. Earn by submitting at least one claim for dental expenses incurred during the benefit year, While staying at or under the threshold amount. Register on www.GuardianAnyTime.com for details!

Vision Insurance

GUARDIAN

VSP

	VSP Choice Network	
	In-Network	**Out-of-Network Reimbursement**
Benefit Coverage – Includes coverage for glasses OR contact lenses, not both in a plan year.		
Examination for glasses (*once every 12 months*) Contact lens fit and evaluation – max $60 copay	$10	Up to $50
Materials Copay (Waived for elective contacts)	$25	N/A
Frames Retail Allowance (Once every 24 months)	Up to $130 (20% savings on amount over allowance)	Up to $48
Contact Lenses (Evaluation and Fitting)	15% off UCR Available at addl disc charge or sometimes ded from contact lens allowance	N/A
Eyeglass Lenses Allowance (Once every 12 months)		
Single Vision	100% after copay	Up to $48
Bifocal	100% after copay	Up to $67
Trifocal	100% after copay	Up to $86
Lenticular	100% after copay	Up to $126
Contact Lenses: Medically Necessary	Covered 100%	Up to $210
Elective	Up to $130	Up to $120
Lasik	Discount Available	N/A

Vision Cost Per Pay (48)	
Employee Only	**$0**
Employee + Spouse	**$1.16**
Employee + Child(ren)	**$1.23**
Family	**$2.94**

Your Vision Coverage is provided by your employer for you, you can buy up for your dependents. See benefit summary for full details.
To find a VSP Vision Provider register:
www.GuardianAnyTime.com

Mutual of Omaha

Life and AD&D Insurance

Basic Life Insurance

Your Employer provides life insurance to all active full time employees. You also have the option to purchase additional Voluntary Term Life. The chart below provides a brief overview of the plans.

Basic Life/AD&D Insurance General Terms	
Employee Definition	All active full-time employees
Employer Paid Benefit Group Life and AD&D	$15,000 AD&D – Equal to Basic Life
Voluntary Term Life Employee Paid For Employee, Spouse and Children	Employee – up to 5 X's Salary (Max $250k) Guarantee Issue $50,000 Spouse - up to 50% of EE amount (Max $50k) Guarantee Issue $25,000 Children –Up to 50% of EE amount (Max $10,000) Six month old to age 21 (25 if student) 0-14 days old no benefit
Portability / Conversion	Yes, with age and other restrictions for Vol Life. Conversion only on Employer paid life.
Age Reduction	At age 65 reduced by 35%; At age 70 reduced by 50% Spouse terms at 70 or EE retirement if earlier

IMPORTANT

It is the EMPLOYEE's responsibility to complete and submit an Evidence of Insurability (EOI) form. An EOI form is required for coverage elections above the GI or if coverage was previously waived or not elected during the initial eligibility period. Note -Benefit coverage & payroll deductions for newly elected amounts will not take effect until EOI is approved by the carrier. www.mutualofomaha.com/EOI
Don't forget to designate your beneficiary!

Voluntary Life Insurance

Mutual of Omaha

Below is the cost for the Voluntary Life Insurance coverage. The rates/premium are age banded based on the employee's age as of the first day of the plan year for both the employee and spouse.

If the benefit amount you would like to select is over $50,000, select the benefit amount from the first column (Coverage Amount) that when multiplied by another number results in t he benefit amount you want. For Example: If you would like to elect $150,000 in coverage, use the $50,000 row rate which applies to your age band and multiply by 2. Note: Your actual payroll deduction may vary slightly due to rounding.

Employee Weekly Payroll Deduction (Includes AD&D) 48 pay										
AGE	**$10,000**	**$20,000**	**$30,000**	**$40,000**	**$50,000**	**$60,000**	**$70,000**	**$80,000**	**$90,000**	**$100,000**
<30	$0.30	$0.60	$0.90	$1.20	$1.50	$1.80	$2.10	$2.40	$2.70	$3.00
30-34	$0.33	$0.65	$0.98	$1.30	$1.63	$1.95	$2.28	$2.60	$2.93	$3.25
35-39	$0.43	$0.85	$1.28	$1.70	$2.13	$2.55	$2.98	$3.40	$3.83	$4.25
40-44	$0.60	$1.20	$1.80	$2.40	$3.00	$3.60	$4.20	$4.80	$5.40	$6.00
45-49	$0.95	$1.90	$2.85	$3.80	$4.75	$5.70	$6.65	$7.60	$8.55	$9.50
50-54	$1.35	$2.70	$4.05	$5.40	$6.75	$8.10	$9.45	$10.80	$12.15	$13.50
55-59	$1.95	$3.90	$5.85	$7.80	$9.75	$11.70	$13.65	$15.60	$17.55	$19.50
60-64	$3.13	$6.25	$9.38	$12.50	$15.63	$18.75	$21.88	$25.00	$28.13	$31.25
65-69	$5.75	$11.50	$17.25	$23.00	$28.75	$34.50	$40.25	$46.00	$51.75	$57.50

Spouse Weekly Payroll Deduction (Includes AD&D) 48 pay										
AGE	**$5,000**	**$10,000**	**$15,000**	**$20,000**	**$25,000**	**$30,000**	**$35,000**	**$40,000**	**$45,000**	**$50,000**
<30	$0.15	$0.30	$0.45	$0.60	$0.75	$0.90	$1.05	$1.20	$1.35	$1.50
30-34	$0.16	$0.33	$0.49	$0.65	$0.81	$0.98	$1.14	$1.30	$1.46	$1.63
35-39	$0.21	$0.43	$0.64	$0.85	$1.06	$1.28	$1.49	$1.70	$1.91	$2.13
40-44	$0.30	$0.60	$0.90	$1.20	$1.50	$1.80	$2.10	$2.40	$2.70	$3.00
45-49	$0.48	$0.95	$1.43	$1.90	$2.38	$2.85	$3.33	$3.80	$4.28	$4.75
50-54	$0.68	$1.35	$2.03	$2.70	$3.38	$4.05	$4.73	$5.40	$6.08	$6.75
55-59	$0.98	$1.95	$2.93	$3.90	$4.88	$5.85	$6.83	$7.80	$8.78	$9.75
60-64	$1.56	$3.13	$4.69	$6.25	$7.81	$9.38	$10.94	$12.50	$14.06	$15.63
65-69	$2.88	$5.75	$8.63	$11.50	$14.38	$17.25	$20.13	$23.00	$25.88	$28.75

Child(ren) Weekly Payroll Deductions			
$2,500	**$5,000**	**$7,500**	**$10,000**
$0.13	$0.25	$0.38	$0.50

Disability Insurance

Short-Term Disability Insurance

Employer Paid!

Benefit:

60% of
weekly earnings,
not to exceed $1000/week

Benefit Begins:

On the 15th day out of work due to a non-work related disabling injury or illness.

Maximum Benefit Period:

Available for up to 26 weeks

Long-Term Disability Insurance

Employer Paid!

Benefit:

60% of
monthly earnings,
not to exceed $6,000/month

Benefit Begins:

On the 181st day out of work due to a non-work related disabling injury or illness

Maximum Benefit Period:

2 years Own Occupation;
Up to age 65 or Normal Social Security Retirement Age thereafter

Disability income protection insurance provides a benefit for "short or long term" disability resulting from a covered injury or sickness. Benefits begin at the end of the elimination period and continue while you are disabled up to the maximum benefit duration. Pre-Existing Conditions do apply to LTD – see Mutual of Omaha full summaries for details.

Colonial Supplemental Products

Colonial Life℠
Making benefits count.

Accident Insurance – Helps offset the unexpected medical expenses, such as emergency room fees, deductibles and copayments, that can result from a fracture, dislocation or other covered accidental injury.

Cancer Insurance – Helps offset the out-of-pocket medical and indirect, non-medical expenses related to cancer that most medical plans don't cover. This coverage also provides a benefit for specified cancer-screening tests.

Critical Illness Insurance – Complements your major medical coverage by providing a lump-sum benefit that you can use to pay the direct and indirect costs related to a covered critical illness, which can often be expensive and lengthy.

Whole Life / Universal Life Insurance – Enables you to tailor coverage for your individual needs and helps provide financial security for you and your family members.

Medical Bridge/Hospital Confinement - Helps pay for deductible costs for *inpatient* stays! Simplified individual underwriting, pre-x may apply.
Wellness benefit of $50 per year included.

Colonial Life's coverages share important features:

- Coverage is available for your spouse and children with most products.
- Benefits are paid directly to you, unless you specify otherwise.
- With most plans, you can continue coverage when you retire or change jobs, with no increase in premiums.
- With most plans you receive benefits regardless of any other insurance you may have with other companies.

Coverage has exclusions and limitations that may affect benefits payable. Benefits vary by state and may not be available in all states. Contact a Colonial Life benefits representative for more information.

Colonial life products are underwritten by Colonial Life & Accident Insurance Company, for which colonial Life is the marketing brand.

1200 Colonial Life Boulevard, Columbia, SC 29210, www.coloniallife.com
Colonial Life products are not intended as a substitute for medical insurance.

Benefit Information

Choosing Your Benefits

You must actively choose any benefit that you pay for, or share in the cost with your employer.

Your part of the cost is automatically taken out of your paycheck. There are two ways that the money can be taken out:

- **Before your taxes are calculated** – medical and dental, vision, accident, cancer and hospital confinement.
- **After your taxes are calculated** – voluntary life, accidental death & dismemberment and critical illness.

Making Changes

Generally, you can only change your benefit choices during the annual benefits enrollment period. However, you may be able to change your benefit choices at anytime if you have a change in status including:

- Your marriage
- Your divorce or legal separation
- Birth or adoption of an eligible child
- Death of your spouse or covered child
- Change in your spouse's work status that affects his or her benefits
- Change in your work status that affects your benefits
- Change in residence or work site that affects your eligibility for coverage
- Change in your child's eligibility for benefits
- Receiving Qualified Medical Child Support Order (QMCSO)

If you do not notify Human Resources within 30 days of a family status change, you will have to wait until the next annual enrollment period to make benefit changes unless you have another family status change.

Why do I pay for benefits with before-tax money?

There is a definite advantage to paying for some benefits with before-tax money:

Taking the money out before your taxes are calculated lowers the amount of your pay that is taxable. Therefore, you pay less in taxes.

When Coverage Ends

Varies – For medical, dental and vision coverage ends at end of month in which employment with the company ends. Life and disability end on the date of termination.

Colonial polices can be continued by you making premium payments directly to Colonial on an after tax basis only if employment ends with the company.

Key Benefit Terms

Coinsurance – The percentage of the medical or dental charge that you pay after the deductible has been met.

Copayment – A flat fee that you pay for medical services, regardless of the actual amount charged by your doctor or another provider. This generally applies to physicians' office visits and prescription drugs.

Deductible – The amount you pay toward medical and dental expenses each calendar year before the plan begins paying benefits.

Out of Pocket Maximum – The maximum amount you will pay in coinsurance, deductible and copays during the calendar year.

Retiree Health Insurance Policy

Florida Statutes 112.0801

In accordance with Section 112.0801, Florida Statutes, all District personnel who retire from the District with immediate eligibility for normal retirement and their eligible dependents, shall be afforded the option of continuing in the District's group health insurance program as follows:

Retired employees and dependents are eligible for continued health, dental and vision coverage if they agree to pay the full cost of the coverage at the current group rate. The cost of this coverage is subject to periodic review and adjustment by the District.

Health, dental and vision benefits for the retirees shall be provided at the same levels of those provided to the District employees.

Retirees within 30 days of retirement shall have a one-time, irrevocable election to continue participation in the District's insurance program.

If a retiree elects not to continue participating in the District's insurance program at the time of retirement, or discontinues participation in the District insurance program at any time following retirement, or fails to pay the required cost of coverage within 30 days of the invoice date, the retiree shall not thereafter be eligible to participate in the program.

The benefits provided by the District and the cost of coverage may be adjusted when the retiree becomes eligible for Medicare coverage.

The District retains the right to change the insurance program, including, but not limited to, changes in coverage, plans, carriers, benefits, deductibles and co-pays, and to adjust the cost of coverage at any time with appropriate notice to retirees and their dependents.

When a retiree who has elected to continue participating in the District's insurance program reaches age 65, or becomes eligible for Medicare benefits at an earlier age, Medicare shall provide primary health coverage and shall be the primary payer of health benefits, and the District's health benefits shall be secondary to Medicare.

What are my options if I leave the District

What is COBRA?

The Consolidated Omnibus Reconciliation Act (COBRA) of 1985, Title X, contains provisions giving certain former employees, retirees, spouses, former spouses and dependent children the right to temporary continuation of health coverage at group rates. This coverage, however, is only available when coverage is lost due to certain specific events.

Is the District subject to COBRA?

Group health plans for employers with 20 or more employees on more than 50 percent of its typical business days in the previous calendar year are subject to COBRA. At this time, the district is not subject to COBRA as there are less than 20 employees actively employed.

Does this mean that if I separate from the District I am without coverage?

Employees who separate from the District are eligible for State issued COBRA. Continuation of coverage is optional and it is the employee's responsibility to contact Florida Blue directly to apply. There will be no contributions made by the District on behalf of this plan for the former employee or dependent.

Will the COBRA plan be the same as the existing group health plan coverage issued with the District?

No. When you apply, Florida Blue will attempt to provide a plan that is the same or similar to the coverage to the coverage of the existing plan. Any questions in reference to your COBRA issued plan are to be directed to Florida blue.

Does the District accept any payments for State Issued COBRA?

No. Any payments for premiums owed for your continuation of insurance coverage are to be made directly to the insurance provider.

When will the COBRA Coverage end?

If you choose not to pay any premiums by the due date, your coverage could cease. If you, or covered members of your family become entitled to Medicare or are covered under another employer-sponsored health plan, which does not limit coverage due to preexisting conditions, the continuation of coverage from Florida Blue could cease. Once the period of coverage continuation has expired, anyone receiving continuation coverage may be eligible to convert to an individual policy. Please check with Florida Blue directly in regards to when the coverage may end and if an individual policy is available.

Healthcare Reform & You
Do I have to have coverage?

The Patient Protection and Affordable Care Act & The Health Care and Education Affordability Reconciliation Act of 2010, together, create the most comprehensive health insurance reform ever under taken in recent history by our Country.

Many of the new law's required changes have already been incorporated into company health plans across the country since the effective date in September of 2010. However, there will be many more changes taking place in the months to come, as more guidance is issued by the government to employers, insurance carriers and individuals.

One of the key requirements of the new law beginning in 2014, is the mandate that all U.S. citizens & legal residents either carry health insurance or pay an income tax penalty. While the tax penalty is not too severe in the first year, it becomes progressively more costly each year thereafter.

Penalties for failing to buy coverage

Tax penalties for failing to buy coverage are phased in according to the following schedule:
In 2014, the greater of $95 or 1% of taxable income;
In 2015, the greater of $325 or 2% of taxable income;
In 2016, the greater of $695 or 2.5% of taxable income; and
After 2016, the penalty is indexed for inflation.

However, there are two ways to avoid the tax penalty:
You can buy coverage for you and your family through your place of employment, if your employer offers such coverage. That coverage must meet certain standards set by the law in order for you and the employer to escape respective tax penalties. The coverage must meet certain minimum coverage standards (Generally pays at least 60% of your covered medical expenses) and must be considered 'affordable' (Employer cannot charge you a premium for single or employee only coverage greater than 9.69% of your W-2 earnings for the year).

Or, you can provide coverage for you and your family through a Federal or State Insurance Exchange. Essentially, an Exchange is an interactive site where an individual can go to research, evaluate and buy health plans. (The State of Florida chose not to set up a state run exchange, so the Federal government took over that responsibility.)

If you obtain coverage through an Exchange:

The Exchange will sell insurance policies at certain levels of coverage:

- **Bronze level** – a medical plan designed to pay 60% of covered medical benefits;
- **Silver level** – a medical plan designed to pay 70% of covered medical benefits;
- **Gold level** – a medical plan designed to pay 80% of covered medical benefits;
- **Platinum level** – a medical plan designed to pay 90% of covered medical benefits;
- **Catastrophic** – available to young adults up to age 30 or those exempt from the individual mandate (additional requirements may apply)

You may only obtain coverage through an Exchange if you are not participating in your employer's plan.

If you satisfy certain low income thresholds and do not have medical coverage through an employer, or have employer-provided coverage that is considered "unaffordable" or pays benefits that are below the "Bronze" plan discussed above, there are tax credits available to help you pay the premiums for coverage purchased through the Exchange.

New Health Insurance Marketplace Coverage Options and Your Health Coverage

Form Approved
OMB No. 1210-0149
(expires 5-31-2020)

PART A: General Information

When key parts of the health care law take effect in 2014, there will be 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 and employment-based health coverage offered by your employer.

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. Open enrollment for health insurance coverage through the Marketplace begins in October 2013 for coverage starting as early as January 1, 2014.

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 Heath 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 9.69% of your household income for the year, 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. [1]

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 plan description or contact Crystal House.

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, including an online application for health insurance coverage and contact information for a Health Insurance Marketplace in your area.

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[1] 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.

PART B: Information About Health Coverage Offered by Your Employer

This section contains information about any health coverage offered by your employer. If you decide to complete an application for coverage in the Marketplace, you will be asked to provide this information. This information is numbered to correspond to the Marketplace application.

3. Employer Name Bay Laurel Center CDD	4. Employer Identification Number (EIN) 030453664	
5. Employer address 9850 SW 84th Court, Suite 400	6. Employer phone number 352-414-5454	
7. City Ocala	8. State FL	9. ZIP code 34481
10. Who can we contact about employee health coverage at this job? Crystal House		
11. Phone number (if different from above)	12. email address crystal_house@blccdd.com	

Here is some basic information about health coverage offered by this employer:

- As your employer, we offer a health plan to:

  ____ All employees. Eligible employees are:

  _x___Some employees. Eligible employees are:
  All employees working 25 hours or more per week

- With respect to dependents:

  __x__We do offer coverage. Eligible dependents are:
  Legal dependents of the employee, dependents up to age 30

  ____We do not offer coverage.

_x___ If checked, this coverage meets the minimum value standard, and the cost of this coverage to you is intended to be affordable, based on employee wages.

** Even if your employer intends your coverage to be affordable, you may still be eligible for a premium discount through the Marketplace. The Marketplace will use your household income, along with other factors, to determine whether you may be eligible for a premium discount. If, for example, your wages vary from week to week (perhaps you are an hourly employees or you work on a commission basis), if you are newly employed mid-year, or if you have other income losses, you may still qualify for a premium discount.

Required Annual Employee Disclosure Notices

Important Information About Your Benefits/Legal Notices

This document contains important information concerning the administration of your benefit plans. Although you will not need this information on a day-to-day basis, it is important for you to understand your rights, the procedures you need to follow should certain situations occur and where you can find our additional information. The information provided here is consistent with the Employee Retirement Income Security Act of 1974 (ERISA). Please refer to the individual plan documents, certificates of insurance, and /or summary plan descriptions (SPD) for FULL details as this is a synopsis only for some notices. If you have any questions regarding any of these notices or if you would like a copy of the Plan SPD (which contains more detailed information regarding Plan benefits, terms and conditions) please contact your Benefits Department.

Newborns' and Mothers' Health Protection Act of 1996

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

Women's Health and Cancer Rights Act of 1998

If you have had or are going to have a mastectomy, you may be entitled to certain benefits under the Women's Health and Cancer Rights Act of 1998 (WHCRA). For individuals receiving mastectomy-related benefits, coverage will be provided in a manner determined in consultation with the attending physician and the patient, for:

- All stages of reconstruction of the breast on which the mastectomy was performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance;
- Prostheses; and
- Treatment of physical complications of the mastectomy, including lymphedema.

These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under this plan.

If you would like more information on WHCRA benefits, contact your Benefits Department.

Genetic Information Nondiscrimination Act of 2008 (GINA)

The Genetic Information Nondiscrimination Act of 2008 ("GINA") protects employees against discrimination based on their genetic information. Unless otherwise permitted, your Employer may not request or require any *genetic information from you or your family members.*

"The Genetic Information Nondiscrimination Act of 2008 (GINA) prohibits employers and other entities covered by GINA Title II from requesting or requiring genetic information of an individual or family member of the individual, except as specifically allowed by this law. To comply with this law, we are asking that you not provide any genetic information when responding to this request for medical information. 'Genetic information," as defined by GINA, includes an individual's family medical history, the results of an individual's or family member's genetic tests, the fact that an individual or an individual's family member sought or received genetic services, and genetic information of a fetus carried by an individual or an individual's family member or an embryo lawfully held by an individual or family member receiving assistive reproductive services."

Michelle's Law

Note: Pursuant to Michelle's Law, you are being provided with the following notice because the your group plan may provide dependent coverage beyond age 26 and bases eligibility for such dependent coverage on student status. Please review the following information with respect to your dependent child's rights under the plan in the event student status is lost.

When a dependent child loses student status for purposes of your employer's group health plan coverage as a result of a medically necessary leave of absence from a post-secondary educational institution, the employer group health plan will continue to provide coverage during the leave of absence for up to one year, or until coverage would otherwise terminate under the group health plan, whichever is earlier.

In order to be eligible to continue coverage as a dependent during such leave of absence the group health plan must receive written certification by a treating physician of the dependent child which states that the child is suffering from a serious illness or injury and that the leave of absence (or other change of enrollment) is medically necessary. To obtain additional information, please contact your Benefits Department.

Premium Assistance Under Medicaid and the Children's Health Insurance Program (CHIP)

If you or your children are eligible for Medicaid or CHIP and you're eligible for health coverage from your employer, your state may have a premium assistance program that can help pay for coverage, using funds from their Medicaid or CHIP programs. If you or your children aren't eligible for Medicaid or CHIP, you won't be eligible for these premium assistance programs but you may be able to buy individual insurance coverage through the Health Insurance Marketplace. For more information, visit **www.healthcare.gov**.

If you or your dependents are already enrolled in Medicaid or CHIP, 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)**.

HIPAA Privacy Rule

This is a summary of Privacy Rule only. Because it is a summary, it does not address every detail of each provision. Please visit the following website for complete information or contact your Benefits Department at your employer:
https://www.hhs.gov/hipaa/for-professionals/privacy/laws-regulations/index.html

The *Standards for Privacy of Individually Identifiable Health Information* ("Privacy Rule") establishes, for the first time, a set of national standards for the protection of certain health information. The U.S. Department of Health and Human Services ("HHS") issued the Privacy Rule to implement the requirement of the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"). The Privacy Rule standards address the use and disclosure of individuals' health information—called "protected health information" by organizations subject to the Privacy Rule — called "covered entities," as well as standards for individuals' privacy rights to understand and control how their health information is used. Within HHS, the Office for Civil Rights ("OCR") has responsibility for implementing and enforcing the Privacy Rule with respect to voluntary compliance activities and civil money penalties.

A major goal of the Privacy Rule is to assure that individuals' health information is properly protected while allowing the flow of health information needed to provide and promote high quality health care and to protect the public's health and well being. The Rule strikes a balance that permits important uses of information, while protecting the privacy of people who seek care and healing. Given that the health care marketplace is diverse, the Rule is designed to be flexible and comprehensive to cover the variety of uses and disclosures that need to be addressed.

This is a summary of key elements of the Privacy Rule and not a complete or comprehensive guide to compliance. Entities regulated by the Rule are obligated to comply with all of its applicable requirements and should not rely on this summary as a source of legal information or advice. To make it easier for entities to review the complete requirements of the Rule, provisions of the Rule referenced in this summary are cited in the end notes. Visit our website listed above to view the entire Rule, and for other additional helpful information about how the Rule applies. In the event of a conflict between this summary and the Rule, the Rule governs.

Statutory and Regulatory Background

The Health Insurance Portability and Accountability Act of 1996 (HIPAA), Public Law 104-191, was enacted on August 21, 1996. Sections 261 through 264 of HIPAA require the Secretary of HHS to publicize standards for the electronic exchange, privacy and security of health information. Collectively these are known as the Administrative Simplification provisions.

HIPAA required the Secretary to issue privacy regulations governing individually identifiable health information, if Congress did not enact privacy legislation within three years of the passage of HIPAA. Because Congress did not enact privacy legislation, HHS developed a proposed rule and released it for public comment on November 3, 1999. The Department received over 52,000 public comments. The final regulation, the Privacy Rule, was published December 28, 2000.

In March 2002, the Department proposed and released for public comment modifications to the Privacy Rule. The Department received over 11,000 comments. The final modifications were published in final form on August 14, 2002. A text combining the final regulation and the modifications can be found at 45 CFR Part 160 and Part 164, Subparts A and E of our website listed at the beginning of this notice.

Who is Covered by the Privacy Rule

The Privacy Rule, as well as all the Administrative Simplification rules, apply to health plans, health care clearinghouses, and to any health care provider who transmits health information in electronic form in connection with transactions for which the Secretary of HHS has adopted standards under HIPAA (the "covered entities").

For the purpose of this notice we are going to focus on Business Associates.

REMINDER THIS IS A SYNOPSIS OF YOUR RIGHTS – PLEASE VISIT THE WEBSITE ABOVE FOR COMPLETE DETAILS.

Business Associate Defined. In general, a business associate is a person or organization, other than a member of a covered entity's workforce, that performs certain functions or activities on behalf of, or provides certain services to, a covered entity that involve the use or disclosure of individually identifiable health information. Business associate functions or activities on behalf of a covered entity include claims processing, data analysis, utilization review, and billing. Business associate services to a covered entity are limited to legal, actuarial, accounting, consulting, data aggregation, management, administrative, accreditation, or financial services. However, persons or organizations are not considered business associates if their functions or services do not involve the use or disclosure of protected health information, and where any access to protected health information by such persons would be incidental, if at all. A covered entity can be the business associate of another covered entity.

Business Associate Contract. When a covered entity uses a contractor or other non-workforce member to perform *"business associate"* services or activities, the Rule requires that the covered entity include certain protections for the information in a business associate agreement (in certain circumstances governmental entities may use alternative means to achieve the same protections). In the business associate contract, a covered entity must impose specified written safeguards on the individually identifiable health information used or disclosed by its business associates. Moreover, a covered entity may not contractually authorize its business associate to make any use or disclosure of protected health information that would violate the Rule. Covered entities that had an existing written contract or agreement with business associates prior to October 15, 2002, which was not renewed or modified prior to April 14, 2003, were permitted to continue to operate under that contract until they renewed the contract or April 14, 2004, whichever was first.

What Information is Protected

Protected Health Information. The Privacy Rule protects all *"individually identifiable health information"* held or transmitted by a covered entity or its business associate, in any form or media, whether electronic, paper, or oral. The Privacy Rule calls this information "protected health information (PHI)."

"Individually identifiable health information" is information, including demographic data, that relates to:

- the individual's past, present or future physical or mental health or condition,
- the provision of health care to the individual, or
- the past, present, or future payment for the provision of health care to the individual,

and that identifies the individual or for which there is a reasonable basis to believe it can be used to identify the individual. Individually identifiable health information includes many common identifiers (e.g., name, address, birth date, Social Security Number).

The Privacy Rule excludes from protected health information employment records that a covered entity maintains in its capacity as an employer and education and certain other records subject to, or defined in, the Family Educational Rights and Privacy Act, 20 U.S.C. §1232g.

De-Identified Health Information. There are no restrictions on the use or disclosure of de-identified health information. De-identified health information neither identifies nor provides a reasonable basis to identify an individual. There are two ways to de-identify information; either: (1) a formal determination by a qualified statistician; or (2) the removal of specified identifiers of the individual and of the individual's relatives, household members, and employers is required, and is adequate only if the covered entity has no actual knowledge that the remaining information could be used to identify the individual

General Principle for Uses and Disclosures

Basic Principle. A major purpose of the Privacy Rule is to define and limit the circumstances in which an individual's protected heath information may be used or disclosed by covered entities. A covered entity may not use or disclose protected health information, except either: (1) as the Privacy Rule permits or requires; or (2) as the individual who is the subject of the information (or the individual's personal representative) authorizes in writing.

Required Disclosures. A covered entity must disclose protected health information in only two situations: (a) to individuals (or their personal representatives) specifically when they request access to, or an accounting of disclosures of, their protected health information; and (b) to HHS when it is undertaking a compliance investigation or review or enforcement action. See additional guidance on Government Access here: https://www.hhs.gov/hipaa/for-professionals/privacy/guidance/restrictions-on-government-access-to-health-information/index.html?language=es

Permitted Uses and Disclosures. A covered entity is permitted, but not required, to use and disclose protected health information, without an individual's authorization, for the following purposes or situations: (1) To the Individual (unless required for access or accounting of disclosures); (2) Treatment, Payment, and Health Care Operations; (3) Opportunity to Agree or Object; (4) Incident to an otherwise permitted use and disclosure; (5) Public Interest and Benefit Activities; and (6) Limited Data Set for the purposes of research, public health or health care operations. Covered entities may rely on professional ethics and best judgments in deciding which of these permissive uses and disclosures to make. **FOR FULL DETAILS – SEE WEBSITE LISTED AT THE BEGINNING OF THIS NOTICE.**

Required Annual Employee Disclosure Notices – Cont'd

Important Notice about your Prescription Drug Coverage and Medicare

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with YOUR HEALTH PLAN and about your options under Medicare's prescription drug coverage. This information can help you decide whether or nor not you want to join a Medicare drug plan. If you are considering joining, you should compare your current coverage, including which drugs are covered at what cost, with the coverage and costs of the plans offering Medicare prescription drug coverage in your area. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice.

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

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

When can you join a Medicare Drug Plan?

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

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 plan coverage may be affected. See below for more information about what happens to your current coverage if you join a Medicare drug plan.

Since the existing prescription drug coverage under your group plan is creditable (e.g. as good as Medicare coverage), you can retain your existing prescription drug coverage and choose not to enroll in a Part D plan; or you can enroll in a Part D plan as a supplement to, or in lieu of, your existing prescription drug coverage.

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

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 with the group plan 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 at least 1% of the Medicare base beneficiary premium per month for every month that you did not have that coverage. For example, if you go nineteen months without creditable coverage, your premium may consistently be at least 19% higher than the Medicare base beneficiary premium. You may have to pay this higher premium (a penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following October to join.

For more information about this notice or your current prescription drug coverage…

Contact your Benefits Department.

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 your employer 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 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**).

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, therefor, whether or not you are required to pay a higher premium (penalty).

The information in this Benefits Summary is presented for illustrative purposes and is based on information provided by the employer. The text contained in this Summary was taken from various summary plan descriptions and benefit information. While every effort was taken to accurately report your benefits, discrepancies or errors are always possible. In case of discrepancy between the Benefits Summary and the actual plan documents, the actual plan documents will prevail. All information is confidential, pursuant to the Health Insurance Portability and Accountability Act of 1996. If you have any questions about this summary, contact Human Resources.

Presented by:

STRATEGIK PARTNERS