November 7, 2013

Dear City of Hollywood Health Plan Participant:

Our open enrollment period will be from November 14, 2013 to December 6, 2013. To make changes to your dependent coverage, please complete a new enrollment form and return it to Human Resources by December 6, 2013 for the effective date of January 1, 2014.

**Please note:** If you are not currently participating in the City's medical or dental plan, you may **not** elect to begin coverage at this time. **Important**: If you intend to add any dependents, please provide documentation – enrollment forms cannot be processed without documentation proving a legal relationship/dependency. Proper documentation includes birth certificates, marriage certificates, court orders, social security numbers, and dates of birth. All changes would be effective January 1, 2014.

**If you do not wish to make any changes – NO ACTION IS NECESSARY.**

Florida Blue (Blue Cross and Blue Shield) will remain the administrator of the City's Health Plan and Florida Combined Life for the City's Dental Plans. Attached is the "Summary of Benefits." The complete Benefit Booklet will be made available on-line under the Human Resources – Employee Benefits section of the City's website.

## ***HEALTH RATES FOR 2014 – ALL RATES ARE EFFECTIVE JANUARY 1, 2014***

**Medical Rates for Plan participants that pay for their dependent health coverage with the cost of Single Coverage paid by the City*:**

| Medical Coverage | Monthly Contribution |
|---|---|
| Single Coverage | $0 |
| Plus One Dependent | $566.27 |
| Plus Two or More Dependents | $1,245.79 |

*Note to Fire Retirees:

If you retired between:

10/1/2004 and 9/30/2005, please add an additional $54.17 to the above rates.

10/1/2005 and 9/30/2006, please add an additional $65.00 to the above rates.

10/1/2006 and 9/30/2007, please add an additional $75.83 to the above rates.

10/1/2007 and 9/30/2009, please add an additional $86.67 to the above rates.

10/1/2009 and 9/30/2010, please add an additional $97.50 to the above rates.

10/1/2010 and 9/30/2011, please add an additional $108.33 to the above rates.

10/1/2011 and 9/30/2014, please add an additional $119.17 to the above rates.

**Medical Coverage Rates for Plan participants that pay for single and dependent health coverage**

| Medical Coverage | Monthly Contribution |
|---|---|
| Single Coverage | $566.27 |
| Retiree + One Dependent | $1,132.54 |
| Retiree + Two or More Dependents | $1,812.06 |

## ***DENTAL RATES FOR 2014***

| **COMPREHENSIVE** ($1,000/yr coverage per person): | **Monthly Contribution** | **PREMIUM** ($2,000/yr coverage per person): | **Monthly Contribution** |
|---|---|---|---|
| Single Coverage | $29.28 | Single Coverage | $63.28 |
| Plus One Dependent | $49.49 | Plus One Dependent | $103.83 |
| Plus Two or More Dependents | $68.16 | Plus Two or More Dependents | $141.26 |

## ***LIFE RATES FOR 2014***

Life insurance will continue with Mutual of Omaha at the same rate as 2013. $5,000 of coverage continues to be $15.00 per month. As always, we encourage you to review your beneficiary, making any changes necessary. If you did **not** elect this coverage at the time of retirement, you may **not** do so now.

## ***VISION PLAN***

Davis Vision is offering a voluntary vision product. There are three (3) different options to choose from: Fashion Value, Designer, and Premier Platinum. See the attached benefit summary for specific coverage options.

| Davis Vision Options | I: Fashion Value | II: Designer | III: Premier Platinum |
|---|---|---|---|
| *Individual* | $4.83 | $5.83 | $8.15 |
| *Individual + Spouse* | $8.70 | $10.49 | $14.69 |
| *Individual + Children* | $9.18 | $11.10 | $15.50 |
| *Individual + Family* | $14.50 | $17.52 | $24.47 |

## MEDICARE BENEFICIARY WITH MEDICARE PART D:

If you and/or your dependents are a Medicare beneficiary, please read the attached notice concerning Medicare Part D.

The Office of Human Resources and Risk Management is available to answer your insurance questions. Please contact me or Tanya Bouloy, Human Resources Tech., at 954-921-3505 if you have any questions, and keep in mind that all enrollment forms must be returned to Human Resources by December 6, 2013.

Sincerely,

Lisa Powell
Assistant Director of Human Resources and Risk Management

Attachments:

- Schedule of Information and Enrollment Sessions
- Health and Dental Enrollment Form
- Davis Voluntary Vision Summary and Enrollment Form
- Designation of Life Beneficiary Form
- Notice to participants about Health Insurance Marketplace Coverage
- Medicare Part D Notice

# 2013 Open Enrollment
## Information and Enrollment Sessions

| DATE | LOCATION | TIME |
|---|---|---|
| Friday,<br>November 15, 2013 | Commission Chambers<br>2600 Hollywood Boulevard | 2:00pm – 4:00pm |
| Monday,<br>November 18, 2013 | Waste Water Treatment Plant (2nd floor)<br>1621 North 14th Avenue | 9:00am – 11:00am |
| Thursday,<br>November 21, 2013 | Police Department (1st floor Classroom)<br>3250 Hollywood Boulevard | 7:30am – 9:30am |
| Tuesday,<br>December 3, 2013 | Public Works (2nd floor Conference Room)<br>1600 South Park Road | 9:00am – 11:00 am |
| Thursday,<br>December 5, 2013 | Fire State 74 (1st floor Multi Purpose Room)<br>2741 Stirling Road | 9:00am – 11:00am |

Enrollment sessions will be held in the Conference Room of the Office of Human Resources and Risk Management (City Hall, Room 206) during the following dates and times:

| DATE | TIMES |
|---|---|
| Friday, November 22, 2013 | 2:00pm – 4:30pm |
| Wednesday, December 4, 2013 | 8:30am – 11:30am |
| Friday, December 6, 2013 | 9:00am – 12 noon |

City of Hollywood, Florida
2600 Hollywood Blvd., Rm. 206, Hollywood, FL 33020

**THIS ENROLLMENT FORM REPLACES ALL PREVIOUSLY COMPLETED ENROLLMENT FORMS**

**Group Medical and Dental Plan**

__New Enrollment, __Open Enrollment, __Change, __Reinstate

Office Use Only

Classification: **RETIREE**

Effective Date of Coverage:_____/_____/_____ Medical Code:_____ Dental Code:_____

**Subscriber Information**

| Retiree Last Name | First Name | M.I. | Social Security Number* | Date of Birth | Gender __M __F |
|---|---|---|---|---|---|
| | | | | | |

| Mailing Address | Apt | City | State | Zip |
|---|---|---|---|---|
| | | | | |

| Retirement Plan (circle): Police, Fire, Employee's Retirement Fund | Job Class (circle): Management, Executive, Confidential, Fire, General, Police, Professional, Supervisory or Other:_____ |
|---|---|

| Last Department/Division | Date of Retirement | Home Phone ( )_____-_____ | e-mail address |
|---|---|---|---|
| | | | |

**If this is a Change, Indicate Type:** __Add Dependent(s), __Cancel Dependent(s), __Cancel Retiree and Dependent(s), if any (attach document for proof)

__New address(as above), __New Name: From_____ to _____

**This Change is due to:** __Marriage __Birth __Medicare Eligibility __Other:_____ Date of Event: _____

**Additional Information**

Have you had continuous health care coverage for the past 12 months? __Yes __No

If yes, please attach a copy of your certificate of coverage as evidence of prior coverage (required for new enrollees only).

Other than this Health Plan, will you and/or your family have other Health Insurance Coverage as of this date? Yes __No Dental? __Yes __No

If yes, list Covered Person(s):_____ **Attach copy of ID Card(s)**

Insurance Company Name: _____ Do you or your spouse have Medicare? __Yes __No

| Covered Individuals | Medical | | Comprehensive Dental | | Premium Dental | |
|---|---|---|---|---|---|---|
| | Indicate Option | Office use Only | Indicate Option | Office use Only | Indicate Option | Office use Only |
| Retiree Only | ( ) | | ( ) | | ( ) | |
| Retiree and One Dependent* | ( ) | | ( ) | | ( ) | |
| Retiree and Two or More Dependents* | ( ) | | ( ) | | ( ) | |

*Eligible dependents are: spouse or domestic partner and/or natural, adopted or awarded child as defined in the plan document.

**List below all eligible dependents you wish to cover on your medical or dental plan. Only dependents listed below will have coverag**

| Last Name First M.I. | Date of Birth | Gender | Social Security Number* | Coverage Selections |
|---|---|---|---|---|
| (2) ___Spouse or ___Domestic Partner | MM-DD-YY | ___M ___F | | ___Add Medical ___Drop Medical ___Add Dental ___Drop Dental |
| (3) Dependent | MM-DD-YY | ___M ___F | | ___Add Medical ___Drop Medical ___Add Dental ___Drop Dental |
| (4) Dependent | MM-DD-YY | ___M ___F | | ___Add Medical ___Drop Medical ___Add Dental ___Drop Dental |
| (5) Dependent | MM-DD-YY | ___M ___F | | ___Add Medical ___Drop Medical ___Add Dental ___Drop Dental |
| (6) Dependent | MM-DD-YY | ___M ___F | | ___Add Medical ___Drop Medical ___Add Dental ___Drop Dental |

Proper documents required: marriage/domestic partner certificate, birth certificate, hospital birth record, adoption award, medical child support order.

**Authorization**

I hereby (1) **REQUEST** coverage for the Group Medical and/or Dental Plan for which I am, or may become eligible; (2) authorize the Pension Administrato to make the necessary deductions for the contributions, if any, required for the Health Plan. I hereby certify that the foregoing statements are true and correct to the best of my knowledge and I also authorize any hospital, physician or other persons who have attended me or examined me or my dependent(s) to disclose, when requested, any or all information with respect to any illness, injury, or medical history to the claims payor, utilization review company and/or case management company. A photostatic copy of this authorization shall be considered as effective and valid as the original. I understand that payments will be made directly to the hospital or physician for services rendered unless paid receipts are presented. *The social security number of all covered individuals is required pursuant to Section 111 of the Medicare, Medicaid, and SCHIP Extension Act of 2007.

**Retiree Signature** _____ **Date**_____

**Declination - complete this section only if canceling your single coverage**

I hereby **DECLINE** ___Medical and/or ___Dental coverage. I realize that once I cancel my single medical and/or dental coverage, I may not elect the canceled coverage in the future. Coverage must be continued from the time of retirement and, if canceled, cannot be reinstated.

**Retiree Signature** _____ **Date**_____

Distribution: Human Resources Pension Administrato

Rev. 6/2009

| Vision Benefits | | | |
|---|---|---|---|
| **Vision Insurance Benefits** | **Vision - Fashion Value** | **Vision - Designer** | **Vision - Premier Platinum** |
| **Frequency - Once Every** | | | |
| Eye Health Examination inclusive of Dilation (when professionally indicated) | 12 Months | 12 Months | 12 Months |
| Spectacle Lenses | 12 Months | 12 Months | 12 Months |
| Frame | 24 Months | 24 Months | 24 Months |
| Contact Lens Evaluation, Fitting & Follow-Up Care | 12 Months | 12 Months | 12 Months |
| Contact Lenses (in lieu of eyeglasses) | 12 Months | 12 Months | 12 Months |
| **In-Network Copayments** | | | |
| Eye Health Examination | $10 | $10 | $10 |
| Spectacle Lenses | $25 | $20 | $10 |
| Contact Lens Evaluation, Fitting & Follow-Up Care | Not Applicable (See Non-Collection Contact Lenses) | $20 | $10 |
| **In-Network Eyeglasses - Frame Benefits** | | | |
| Non-Collection Frame Allowance* (Retail) | Up to $100 - Plus a 20% discount on any overage | Up to $130 - Plus a 20% discount on any overage | Up to $150 - Plus a 20% discount on any overage |
| Davis Vision Frame Collection (in lieu of frame allowance) | | | |
| --Fashion Value Level | Included | Included | Included |
| --Designer Level | $15 copayment | Included | Included |
| --Premier Platinum Level | $40 copayment | $25 copayment | Included |
| **In-Network Eyeglasses - Spectacle Lens Benefits** | | | |
| All ranges of prescriptions and sizes | Included | Included | Included |
| Choice of glass or plastic lenses | Included | Included | Included |
| Oversize Lenses | Included | Included | Included |
| Tinting of plastic lenses | $15 | Included | Included |
| Scratch - Resistant Coating | Included | Included | Included |
| Polycarbonate Lenses | $30 ($0 if medically necessary) | $30 ($0 if medically necessary) | $30 ($0 if medically necessary) |
| Ultraviolet Coating | $15 | $12 | Included |
| Standard Anti-Reflective (AR) Coating | $40 | $35 | $35 |
| Premium AR Coating | $55 | $48 | $48 |
| Ultra AR Coating | $69 | $60 | $60 |
| Standard Progressive Lenses | $65 | $50 | Included |
| Premium Progressives (Varilux®, etc) | $105 | $90 | $40 |
| Intermediate - Vision Lenses | $30 | $30 | Included |
| Blended - Segment Lenses | $20 | $20 | Included |
| High Index Lenses | $60 | $55 | $55 |

| Vision Insurance Benefits (continued) | Vision - Fashion Value | Vision - Designer | Vision - Premier Platinum |
|---|---|---|---|
| Polarized Lenses | $75 | $75 | $75 |
| Photochromic Glass Lenses | $20 | $20 | Included |
| Plastic Photosensitive Lenses | $70 | $65 | $65 |
| Scratch Protection Plan - Single Vision Lenses \| Multifocal | $20\|$40 | $20\|$40 | $20\|$40 |
| **In-Network Contact Lens Benefits (in lieu of eyeglasses)** | | | |
| Non-Collection Contact Lenses - Materials Allowance* | Up to $100 - Plus a 15% discount on any overage | Up to $130 - Plus a 15% discount on any overage | Up to $150 - Plus a 15% discount on any overage |
| Evaluation, Fitting & Follow-Up Care - Standard Lens Types | 15% Discount | 15% Discount | Included |
| Evaluation, Fitting & Follow-Up Care - Specialty Lens Types | 15% Discount | 15% Discount | Up to $60 - Plus a 15% discount on any overage |
| Davis Vision Collection Contact Lenses (in lieu of allowance) - Materials, Evaluation, Fitting & Follow-Up Care | Not Applicable (See Non-Collection Contact Lenses) | Included (Up to 4 Boxes) | Included (Up to 8 Boxes) |
| Medically Necessary Contact Lenses (with prior approval) - Materials, Evaluation, Fitting & Follow-Up Care | Included | Included | Included |
| **Out-of-Network Reimbursement Schedule** | | | |
| Eye Examination | Up to $30 | Up to $30 | Up to $30 |
| Frame | Up to $30 | Up to $30 | Up to $30 |
| Single Vision Lenses | Up to $25 | Up to $25 | Up to $25 |
| Bifocal Lenses | Up to $35 | Up to $35 | Up to $35 |
| Trifocal Lenses | Up to $45 | Up to $45 | Up to $45 |
| Lenticular Lenses | Up to $60 | Up to $60 | Up to $60 |
| Elective Contact Lenses | Up to $75 | Up to $75 | Up to $75 |
| Medically Necessary Contact Lenses | Up to $225 | Up to $225 | Up to $225 |

| Monthly Premium | Employee Census | Vision - Fashion Value | Vision - Designer | Vision - Premier Platinum |
|---|---|---|---|---|
| Employee | | $ 4.83 | $ 5.83 | $ 8.15 |
| Employee plus Spouse | | $ 8.70 | $ 10.49 | $ 14.68 |
| Employee plus Child(ren) | | $ 9.18 | $ 11.10 | $ 15.50 |
| Employee plus Family | | $ 14.50 | $ 17.52 | $ 24.47 |
| **Total Monthly Premium** | | $ n/a | $ n/a | $ n/a |
| **Total Monthly Employer Contribution** | | $ n/a | $ n/a | $ n/a |

* Additional discount over allowances not applicable at Walmart or Sam's Club locations.

DAVISVISION
SEE LIFE

# Vision Benefits
# Retiree/Employee Enrollment Form

☐ New Enrollee ☐ Termination ☐ Change of Status ☐ Change of Address

## SECTION I: XB7 GROUP INFORMATION

| Group Name | Group Number | Effective Date |
|---|---|---|
| | | |

## SECTION II: EMPLOYEE INFORMATION

| Last Name: | First Name: | | Middle Initial |
|---|---|---|---|
| | | | |
| Social Security Number | Date of Birth mm/dd/yyyy | | Gender ☐ Male ☐ Female |
| | | | |
| Address | City | State | ZIP Code |
| | | | |

## SECTION III: DEPENDENT INFORMATION

| Spouse Name (Last, First, M.I.) *(if applying for spousal coverage)* | Date of Birth | Gender ☐ Male ☐ Female |
|---|---|---|
| | | |

**Other Eligible Dependent Information** ***(if additional space is needed, please attached a separate sheet of paper)***

| Name | Date of Birth | Gender | Relationship |
|---|---|---|---|
| | | ☐ M ☐ F | |
| | | ☐ M ☐ F | |
| | | ☐ M ☐ F | |

## SECTION IV: VISION COVERAGE SELECTIONS

Coverage Choice: *(check one coverage only)*

☐ Employee Only ☐ Employee + Spouse ☐ Employee + Child(ren) ☐ Employee + Family

Plan Choice: ☐ Fashion Value ☐ Designer ☐ Premier Platinum

I represent that the information provided above is true and correct to the best of my knowledge and belief. For those coverages I have declined, I understand that I can terminate or change previously elected coverage only during an employer-sponsored open enrollment period or on a qualifying event. If the plan provides that any contributions be made by me, I authorize my employer to deduct them from my pay.

**In Florida, any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.**

Employee Signature _____ Date _____

TERMINATION OF COVERAGE:

I wish to terminate my Vision coverage. I understand that I can terminate or change previously elected coverage only during an employer-sponsored open enrollment period or on a qualifying event.

Employee Signature _____ Date _____

Please return completed form via secure email to: FloridaVision@davisvision.com or Fax: 1-800-783-9046 or mail to:
Davis Vision Manual Enrollment, Attention: Florida Vision, P.O. Box 1501 Latham, NY 12110



Underwritten by HM Life Insurance Company

Brought to you by:

Mutual of Omaha

# Designation of Beneficiary Form

**Employer/Group Section** (To be completed by the employer/plan administrator. Required fields are marked with an asterisk (*).)

| *Employer/Group Name: | Group ID: |
|---|---|
| | |

**Employee/Member Section** (Please print clearly. Required fields are marked with an asterisk(*).)

| *Last Name: | *First Name: | MI: |
|---|---|---|
| | | |

| *Social Security Number: | *Birth Date (MM/DD/YYYY): | *Gender: | *Marital Status: |
|---|---|---|---|
| | | | |

| *Street Address: | E-mail Address: |
|---|---|
| | |

| *City: | *State: | *Zip Code: | Telephone: ( ) - |
|---|---|---|---|
| | | | |

**Beneficiary for Death Benefits** (Right to change beneficiary is reserved to the insured.)

Subject to the terms of the group contract(s), between Mutual of Omaha or a company affiliated with Mutual of Omaha and said employer, I request that the following beneficiary (beneficiaries) be substituted under said contract(s) as my designated beneficiary (beneficiaries), in lieu of any and all beneficiaries previously named by me.

If more than one beneficiary is named, the beneficiaries shall share benefits equally unless otherwise stated below. If indicating benefit percentages, the percentages must total 100% for Primary Beneficiaries and 100% for Secondary Beneficiaries. Unless otherwise expressly provided, if any beneficiary designated below predeceases me, the share which such beneficiary would have received if such beneficiary had survived me shall be payable equally to the remaining designated beneficiary or beneficiaries. If no designated beneficiary survives me, the beneficiary shall be determined as prescribed in the group contract(s).

**Primary Beneficiary Designation**

| Last Name | First Name | Relationship to Insured | Date of Birth (MM/DD/YYYY) | Address of Beneficiary (Address, City, State, Zip) | Benefit Percentage (%) |
|---|---|---|---|---|---|
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | Percentage Total: | 100% |

**Secondary Beneficiary Designation**

| Last Name | First Name | Relationship to Insured | Date of Birth (MM/DD/YYYY) | Address of Beneficiary (Address, City, State, Zip) | Benefit Percentage (%) |
|---|---|---|---|---|---|
| | | | | | |
| | | | | | |
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| | | | | | |
| | | | | | |
| | | | | | |
| | | | | Percentage Total: | 100% |

**Agreement and Signature**

I understand that this Designation of Beneficiary shall apply to all insurance contracts issued to me by Mutual of Omaha or a company affiliated with Mutual of Omaha, unless I make a separate designation for each coverage, either on or after the date of this designation. I also understand that this Designation of Beneficiary is subject to change as provided in the group contract(s).

By signing below, I acknowledge that (a) I understand and agree to the terms of this form as noted above; and (b) this Designation of Beneficiary is effective as of the date submitted.

**SIGNATURE OF EMPLOYEE/MEMBER** _____ **DATE** _____/_____/_____

# New Health Insurance Marketplace Coverage Options and Your Health Coverage

Form Approved
OMB No. 1210-0149
(expires 11-30-2013)

## 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 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 9.5% 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 Lisa Powell at 954 921-3218.

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.

[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<br>City of Hollywood | | | 4. Employer Identification Number (EIN)<br>59-6000338 |
| 5. Employer address<br>2600 Hollywood Blvd. | | | 6. Employer phone number<br>954 921-3218 |
| 7. City<br>Hollywood | | 8. State<br>Florida | 9. ZIP code<br>33020 |
| 10. Who can we contact about employee health coverage at this job?<br>Lisa Powell | | | |
| 11. Phone number (if different from above)<br>954 921-3218 | 12. Email address<br>lpowell@hollywoodfl.org | | |

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

- As your employer, we offer a health plan to:
  - ☐ All employees.
  - ☑ Some employees. Eligible employees are:

    Full time employees on the first of the month following 30 days and qualified eligible retirees

- With respect to dependents:
  - ☑ We do offer coverage. Eligible dependents are:

    Spouse, Domestic Partner as County registered, children: natural, newborn, adopted, foster, and step up to the age 26; newborn child of a dependent up to 18 months; handicap children beyond age 26 if they are incapable of self-sustaining employment by reasons of mental retardation or physical handicap and are chiefly dependent on the covered employee
  - ☐ We do not offer coverage.

☑ 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 employee 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.

If you decide to shop for coverage in the Marketplace, HealthCare.gov will guide you through the process. Here's the employer information you'll enter when you visit HealthCare.gov to find out if you can get a tax credit to lower your monthly premiums.

# Important Notice from
# Blue Cross and Blue Shield of Florida D/B/A Florida Blue and Health Options Inc. D/B/A Florida Blue HMO. About Your Prescription Drug Coverage and Medicare

***This notice applies ONLY to individuals who are over age 65 and on Medicare or approaching age 65 and eligible for Medicare or receiving Medicare Disability benefits. Please disregard this notice if you are not in one of these categories of individuals.***

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

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

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

2. Florida Blue has determined that the prescription drug coverage offered by your health 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. 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 Florida Blue coverage will be affected. You can keep this coverage if you elect to join a Medicare drug plan and your Florida Blue health plan will coordinate your benefits with Medicare for drug coverage. If you would like more information about the prescription drug plan provisions and options that Medicare eligible individuals may have when they become eligible for Medicare prescription drug coverage, see pages 7-9 of the CMS Disclosure of Creditable Coverage to Medicare Part D Eligible Individuals Guidance located at http://www.cms.hhs.gov/CreditableCoverage/.

If you do decide to join a Medicare drug plan and drop your current Florida Blue coverage, be aware that you and your dependents will 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 Florida Blue and don't join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later.

If you go 63 continuous days or longer without creditable prescription drug coverage, your monthly premium may go up by at least 1% of the Medicare base beneficiary premium per month for every month that you did not have that coverage. For example, if you go nineteen months without creditable coverage, your premium may consistently be at least 19% higher than the Medicare base beneficiary premium. You may have to pay this higher premium (a penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following October to join.

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

Contact us for further information at 1-800-FLA-BLUE (TTY: 711). **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 Florida Blue 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).

**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 (a penalty).**

Date: November 7, 2013
City of Hollywood: Florida Blue
Contact: Florida Blue Product Management
Address: P.O. Box 1798, Jacksonville, FL 32231
Phone Number: 1-800-314-0037, 8am – 9:30pm, Monday-Friday (TTY: 711)