LEE COUNTY
BOARD OF COUNTY COMMISSIONERS

2011

SMART BENEFITS

BENEFITS FOR TODAY AND TOMORROW

Website: *www.lee-county.com/gov/dept/Human Resources*

Help Desk: 239-533-2363

March 2011

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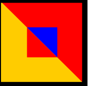

Table of Contents

This benefits guide contains only a summary of plan highlights. Complete details on each plan are set forth in the individual plan document and/or Summary Plan Description. If there is any conflict between the material in this packet and a plan document, the plan document will govern. Lee County reserves the right, at its discretion, to amend, revise, or terminate any benefit program at any time.

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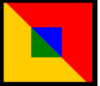
Please keep this guide for future reference. Plans may vary by entity.



Smart Tip

Shop Around

Costs can vary from one provider to another. Shop around and ask questions.

Ask the Right Questions

When you call a physician or specialist, do not ask: "Do you take Aetna insurance?" The right question is: *"Do you participate in my Aetna Plan's network?"* Many providers may accept your insurance for payment without being a member of the plan's network. If an out-of-network (or non-participating) physician accepts the Aetna Select member's card, the claim will be denied by Aetna. Choice POS II members will be responsible for the deductible, co-insurance, and charges in excess of the usual customary and reasonable charges.

Choosing only those providers within our network gives you the highest level of benefit from your medical plans.

Welcome to SmartBenefits

Lee County is pleased to offer a comprehensive benefits program that lets you elect the plans that make the most sense for you and your family.

This benefits guide contains important information you will need to understand your benefit options, and to enroll in the plans that are most suitable for you and your family. You will find information on each plan including plan overviews and features. For more specific plan details, please refer to the individual plan materials available on our web site at ***www.lee-county.com/HR***.

Please carefully review this guide to ensure that you fully understand the benefit options available to you. By being a wise health care consumer, you can save both time and money.

Being a Wise Health Care Consumer

Lee County is committed to making a significant investment in the health and welfare of our employees. It is important that both Lee County and our employees find ways to control these costs, and we encourage everyone to be wise health care consumers. Controlling health care costs must be a partnership between you and Lee County. Together, we can ensure a continued quality health care program that meets all our needs in a cost efficient way.

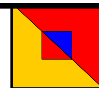
Part of being a wise health care consumer is asking questions of your providers if you don't understand something, getting second opinions when appropriate, and carefully reviewing your bills for accuracy. The more you do to control costs, the better off you and Lee County will be in the long run.

- Use network providers.
- Use generic and/or formulary drugs.
- Use walk-in clinics instead of emergency room care whenever possible.
- Inform the Human Resources Department when a dependent is no longer eligible for coverage.
- Practice preventive health care and make healthy lifestyle choices.

If you enroll in a medical plan:

- Inform our plan administrator (Aetna) when medical care is needed due to accidents covered by other types of insurance (i.e., Workers' Compensation or an automobile policy); and,
- Take advantage of Aetna Navigator ™, Aetna's round-the-clock member self-service Web site. You can access claims, coverage, and general health information as well as decision-support tools for your Aetna medical, dental, prescription drug or flexible spending account (FSA) plans at ***www.aetna.com***.

Please keep this guide for future reference. Plans may vary by entity.



Balance billing—When a plan allows the use of out-of-network providers, the plan pays a percentage of covered charges based on usual and customary (U&C) rates as determined by the plan. The provider may bill you for any balance due after the plan has paid.

Brand Name Drugs—A prescription drug with a proprietary name assigned to it by the manufacturer or distributor.

Coinsurance—The percentage of covered expenses the plan and the member pay for the POSII plan *after* deductibles are met for any out-of-network services rendered.

Co-payment (co-pay)—The fixed amount you pay for in-network provider services.

Coordination of Benefits—When you and/or your family member is covered by more than one health plan, one of the plans is considered to be the primary carrier and the other is considered to be the secondary carrier. The full benefit is coordinated between the plans.

Creditable Coverage — Term means that benefits provided by other drug plans are at least as good as those provided by the Medicare Part D program. This may be important to people eligible for Medicare Part D but who do not sign up at their first opportunity because if the other plan provided creditable coverage, plan members can later enroll in Medicare Part D without paying higher premiums than those in effect during their initial enrollment period.

Deductible—An amount that you must pay for covered services during the plan year before the plan will pay benefits. The Aetna Choice POS II plan has a deductible of $500 per individual, or $1,000 per family only when out-of-network services are used. The Aetna Select plan has NO deductible.

Disease Management— A system of coordinated health-care interventions and communications for patients with certain illnesses.

Emergency Medical Condition — A recent and severe medical condition which would lead a person to believe their condition, illness, or injury is of such a nature that failure to get immediate medical care could result in placing your health in serious jeopardy, serious impairment to bodily function, or serious dysfunction of a body part or organ.

Formulary—A formulary is a list of the drugs a health plan covers. The list usually includes both brand-name and generic drugs. Our formulary is available on Aetna Navigator. The formulary will change on an annual basis, but can change at any time throughout the year without notice.

Generic Drugs—A generic drug is a chemically equivalent version of a brand-name drug whose patent has expired. Even though generic drugs are available through our plan at the lowest co-pay ($10 from the local pharmacy and FREE through mail-order), remember that not all generic drugs are listed on our formulary. If the generic drug you take is not on our formulary, you will pay the highest co-pay for that drug, even though it is a generic. However, if the cost is less than the co-pay, you will only pay the lesser amount.

Guaranteed Issue — The maximum amount of insurance an employee can receive without evidence of insurability when first eligible under a plan, and enrollment is made within the enrollment period. This applies to optional life insurance and short term disability (STD).

In-network—Refers to the use of providers who participate in the health plan's provider network.

Smart Tip

Out-of-area Dependent Coverage

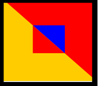
Note: Out-of-area dependents will remain on the same plan as the rest of the family.

If your out-of-area dependent lives in an open access Aetna network region, (either Aetna Select or Choice POS II) that dependent is eligible for the same benefits they would have if they lived with you.

If your out-of-area dependent does not live in an open access Aetna network region, they will pay 20% of usual and customary charges for the medical services received in that region.

To determine the availability of network physicians and facilities where your dependent lives, go to *www.Aetna.com*, select "DocFind", and search by ZIP code. Your dependent will be able to visit any of the participating providers listed in the search results.

If the search returns no providers for that area, they will have to pay 20% of usual and customary charges for services received there. This applies to both Aetna Select and the POS II Plans.



Mail Order Pharmacy— A place where prescription drugs are legally dispensed by mail.

Negotiated Charge— The maximum charge a network provider has agreed to make as to any service or supply for the purpose of the benefits under this plan.

Network Provider—A health care provider or pharmacy who has contracted to furnish services or supplies for a negotiated charge; but only if the provider is, with Aetna's consent, included in the directory as a network provider for the service or supply involved.

Out-of-network—The use of health care providers who have not contracted with the health plan to provide services. If you go out of the network (POS II only) for covered expenses, you will pay additional costs in the form of deductibles and coinsurance based on usual and customary charges.

Payment Limit—The maximum out-of-pocket amount you are responsible to pay for payment percentage for covered expenses during the calendar year. Once you satisfy the payment limit, the plan will pay 100% of the covered expenses for the rest of the calendar year.

POS II—A Point-of-Service (POS II) medical plan covers in- and out-of-network services. When you participate in a POS, the benefit levels are higher when you use participating providers. If you use out-of-network providers, you will pay a deductible plus 30% coinsurance based on the usual and customary charges. You will be balance billed for charges over and above the usual and customary charges.

Precertification or Precertify— A process where Aetna is contacted before certain services are provided, such as hospitalization or outpatient surgery, or complex imaging.

Preferred Drug Guide—A listing of prescription drugs established by Aetna which includes both brand name drugs and generic prescription drugs. This list is subject to periodic review and modification. Also known as "formulary".

Primary Care Physician— A preferred care provider who is selected by the member from the list of Primary Care Physicians. The PCP is responsible for a member's on-going health care.

Qualifying Event— A life change as defined under IRS Tax Code Section 125 and HIPAA. These events allow you to make a benefits mid-year change. See page 9 for additional information.

Specialist—A physician who practices in any generally accepted medical or surgical sub-specialty and provides non-routine medical care.

Specialty Pharmacy Network—A network of pharmacies designed to fill self-injectable drug prescriptions.

Usual and Customary (U&C) Charges—U&C charges are the provider fees determined by the benefit plan's insurance carrier for a specific geographic location, based on ZIP code. Each insurance carrier maintains a comprehensive database detailing what providers charge for every procedure and treatment.

Waiting Period— The time which must pass before a member can collect insurance benefits. Also known as "elimination period."

New Employee Eligibility for Benefits

You and your qualified dependents are eligible for benefits on the first day of the month following one full month of employment. For example, an employee who is hired on March 1st is eligible for benefits on April 1st. However, an employee starting between March 2nd and March 31st is eligible for benefits on May 1st. Your "hire date" is the first day you report for work and will be **different** from the date on which you were offered the job.

Choose carefully and *return your paperwork on time*. The elections you make when you are a new hire will remain in effect until the next open enrollment period, unless you experience a qualified status change as described under "Mid-Year Plan Election Changes." (See page 9)

The definitions listed below apply to the health plans only — medical, dental, and vision. *Note: Foster children and grandchildren are specifically excluded from the optional life insurance plan.*

Your dependents are defined as your:

- Legal spouse (your fiancé or partner is NOT an eligible dependent).
- Any children from birth through the end of the month in which they reach age 26.
- 26-30 year olds may remain covered on our plans if the employee is willing to pay the single employee coverage cost for them **in addition to** the monthly premium being paid for other covered family members. See our web site for current costs.
- A totally disabled child, regardless of age, will continue to be covered, if the child is incapable of self-sustaining employment by reason of mental or physical handicap; and, remains unmarried and dependent upon you for support. Proof of such dependency must be furnished, and a one-time affidavit must be submitted.

The term "children" includes:

- Any natural or legally adopted children.
- Any foster children, if placed in your home in compliance with Chapter 63 of the Florida Statutes, prior to the child's 18th birthday.
- Any other children of whom you have legal custody or court-appointed guardianship.
- The newborn child of your covered dependent child is eligible for benefits up to 18 months of age, as long as the mother or father of the newborn is eligible and covered under your plan at the time of the newborn's birth.
- If the parent of the newborn becomes ineligible at any time during that 18-month period, the newborn will also become ineligible.

Smart Tip

New Hire Enrollment

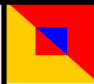
If you are a new hire, you must submit your benefit elections paperwork to Human Resources *within two weeks of your date of hire.*

REQUIRED DOCUMENTS IF YOU ARE ENROLLING A SPOUSE OR CHILD

SPOUSE:
- Birth Certificate or Driver's License
- Social Security Card
- Marriage License

DEPENDENTS:
- Birth Certificate
- Social Security Card
- Legal Documentation for adoption, fostering, or court appointed guardianship

Legible copies of these documents must be provided in order for your dependents to be added to your insurance plans.



Smart Tip

Social Security Cards

Note: Human Resources collects copies of protected, personal information, including copies of Social Security cards of employees and covered dependents. Having copies of such information is very important to prevent fraud as well as to verify and retrieve your personal information. This personal information is not subject to public records law. Only a limited number of employees and insurance companies will have access to the information when necessary for use in the normal course of business.

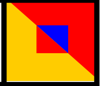
New Employee Eligibility for Benefits (continued)

DEPENDENTS AGE 26-30

An Employee may elect to continue their 26-30 year old dependent's coverage in the Medical Plan only, and pay an *additional* premium for each dependent. The premium is equivalent to the total cost of single employee coverage. An Affidavit of Dependent Eligibility is required to be submitted if coverage is to be continued beyond age 26.

The Lee County BoCC Health Plan offers to insure a dependent at least until the end of the calendar year in which the child reaches the age of 30, if the dependent:

- Is unmarried and does not have dependents of his or her own;
- Is a resident of the State of Florida or a full-time or part-time student; and,
- Is not eligible or provided coverage as a named subscriber, insured, enrollee, or covered person under any group, blanket, or franchise health insurance policy or individual health benefits plan, or is not entitled to benefits under Title XVIII of the Social Security Act.
- If your child was not previously a covered dependent under your benefits plans, they must have been continuously covered by other creditable coverage without a gap in insurance of more than 63 days after the end of the month in which the dependent reached age 26. *Proof of this continued creditable coverage must be submitted at the time of enrollment.*



Annual Open Enrollment

Lee County holds open enrollment for all benefits each year in the fall. If you do not wish to change your current elections for the next plan year, you do not have to do anything **except** for Flexible Spending Accounts (FSAs). You must enroll in a Medical Reimbursement Account and/or a Dependent Care Reimbursement Account *each year*, as these elections do not roll over to the next plan year. Forms are included in the Open Enrollment packet each year, and are also available online at *www.lee-county.com/HR*.

During open enrollment:

- Review the enrollment materials enclosed in your packet.
- Consider any changes you may need to make to your benefits.
- Carefully estimate how much you want to contribute to your FSA(s).
- Review your current beneficiary information to ensure that it is up to date.
- Make your benefit elections and turn your paperwork in to Human Resources before the end of the open enrollment period.
- If you elect plan(s) that were not previously elected for family members, legal documents are required if they are not already on file. Legal Documents are legible copies of your Marriage License, Social Security card, and Birth Certificate (spouse may use their drivers license in lieu of the birth certificate).

Mid-Year Plan Election Changes

Section 125 and HIPAA Qualifying Change in Status

Once you enroll in your benefit plans, your choices will remain in effect for the entire plan year. You can only change your benefit elections for the next plan year during that year's annual open enrollment period. However, exceptions exist under Internal Revenue Service (IRS) Section 125 (qualifying change in status) and the Health Insurance Portability and Accountability Act (HIPAA) that allow you to make changes to your elections during the plan year.

Under IRS Tax Code Section 125 and HIPAA, certain life changes are defined as "qualifying events." These events qualify you to make mid-plan year changes to those benefit plans affected by the event(s). No changes can be made without a qualifying event.

Please note that you will need to provide proper documentation as proof of the qualifying event. For example, you will need to provide proof of marriage with a marriage certificate, a copy of the divorce document if the event is a divorce, or a birth certificate with the birth of a child. Copies of Social Security cards are also required for all dependents added to your plans.

Visit the IRS's Web site at *www.irs.gov* for more information on Section 125 regulations and visit *www.hhs.gov* for more HIPAA information.

Smart Tip

Qualifying Events for Mid-Year Plan Changes:

- Marriage, divorce or annulment.
- Death of spouse or other dependent.
- Birth or adoption of a child (please see detailed instructions on the following page, "Adding Newborns to Coverage").
- A spouse's employment begins or ends.
- You or your spouse experience a change in work hours that affects benefit eligibility.
- Your dependent obtains other insurance coverage due to marriage, employment status change, military enlistment/ discharge.
- Relocation into or outside of your plan's service area (or, "Network").

Smart Tip

The benefit plan year is a calendar year—January 1st through December 31st.

Please note that premiums for Short Term Disability and Optional Life Insurance are *after-tax* benefits.

Understanding Your Plan

Understanding how your benefits work will help you be a better health care consumer.

Mid-Year Plan Election Changes (continued)

You are required to report any qualifying change in status events and make changes to the corresponding benefit(s) within 60 days of the event. This means the date of marriage/divorce or spouse's employment change, not the date that the insurance coverage would change. Otherwise, you will not be able to change your benefit elections until the next open enrollment.

Adding Newborns and Adopted Children to Coverage:

To enroll a newborn or adopted child who is an eligible dependent, you must complete an enrollment/change form and provide proof of birth (i.e., copy of birth record from the hospital, or a copy of the birth certificate) and/or court adoption documentation to the Human Resources Department.

You have 60 days from the date of birth or date of adoption to add the newborn to your health plan(s). The effective date of coverage for a newborn child is the date of birth.

In the event you do not complete the enrollment/change form and provide the proof of birth to add the newborn within 60 days of the date of birth, you will not be able to add the newborn until open enrollment. The effective date of coverage then would be January 1st of the following plan year.

If you should have any questions or concerns about this process, contact Human Resources at 239-533-2363. Our insurance carrier cannot take care of this for you – it *must* be done through Human Resources.

REMEMBER: You **must** have a "qualifying event" in order to change and/or drop plans, to drop any dependents from the plans, or to change premium levels at any time during the year other than during our annual open enrollment. Please see the detailed explanation at the top of this page in the highlighted box.

Pre-Tax Advantage

You pay for your portion of medical, dental, and/or vision insurance premiums with pretax dollars through convenient payroll deductions. Since your premium payments are deducted before taxes are withheld, you will not pay federal, Social Security, and in many cases, state and local income taxes on this money.

Paying for your benefits on a pretax basis will marginally reduce your Social Security benefits when you retire or if you become disabled. The exact amount of the reduction will depend on the length of time between now and when you draw your Social Security benefits. Studies have shown that the savings employees realize through reduced taxes during their career usually make up for any reduction in Social Security benefits. Contact a tax advisor for more information.

Lee County offers two medical plans—the Aetna Select and the Aetna Choice POS II plans. As a plan member, you have access to many consumer education tools and value-added programs designed to help you manage medical care for you and your dependents—24 hours a day, seven days a week. You can log on to *www.aetna.com* and take a virtual tour of Aetna's web site.

Program Features

The following chart compares the major features of both medical plans. For additional information, Benefits Summaries can be found on our website at *http://www.lee-county.com/gov/dept/HumanResources/Pages/Benefits_Health.aspx*

The Aetna Select and Aetna Choice POS II Features Comparison Chart

Feature	Aetna Select	Aetna Choice POS II
Primary Care Physician (PCP) Required	**No** **But Recommended**	**No** **But Recommended**
Out-of-Network Coverage	**No**	**Yes**
Co-pays	**Lower**	**Higher**
Annual Deductible Required	**No**	**In-Network—No** **Out-of-Network—Yes** $500 per individual or $1,000 per family
Referrals to Specialists Required	**No**	**No**
Co-Insurance	**No**	**In-Network - No** **Out of Network - 30% of Reasonable & Customary**

Aetna Select

Enrolling in Aetna Select entitles you to receive care from physicians, hospitals, or other providers who participate in the plan's network. You can confirm the participation of your physicians and other providers by using Aetna's DocFind tool. This plan appears as Aetna Select (SM) (Open Access). Participating providers must participate in both plans—Select and POSII.

CAUTION! Unlike the Aetna Choice POS II plan, if you choose the Aetna Select plan and go out of the network for services, you will pay the charges IN FULL yourself - **there is no coverage provided for out-of-network services in the Aetna Select plan except for a life- or limb-threatening emergency.**

Aetna Choice POS II Plan

The Choice Point-of-Service II (POS II) plan gives you all the advantages of the Aetna Select plan, plus coverage when you use out-of-network providers. Out-of-network services are available through the Aetna Choice POS II plan after you pay a $500 ($1,000 maximum for a family) deductible and 30% coinsurance based on usual and customary charges.

Smart Tip

Make No Mistake!

Drug mix-ups kill thousands of people every year.

Protect yourself:

- Talk to your doctor and pharmacist about your medications.
- Let your doctor and/or pharmacist know all the medicines, including supplements or herbal products, you take.
- Consider patronizing a single pharmacy. Doing so increases the chances that computer records will flag potentially dangerous drug combinations.
- If you get a refill and the packaging, or the product looks different than it did the last time, call your pharmacy and find out why.

Smart Tip

OPT-OUT Option

Opt out of Medical Plan Benefits and receive $50 per month cash benefit. (This is a taxed benefit.)

Choosing a PCP

Choosing a primary care physician (PCP) is no longer required by our medical plans. However, it is still a good idea to have all your medical care coordinated by a PCP. You can find a PCP by visiting Aetna's Web site at *www.aetna.com* and clicking on "DocFind".

NOTE: PCP selection can be accomplished ONLY by one of the methods described above, since PCP information cannot be transmitted electronically.

With the Choice POS II plan, you may choose a PCP from the network, but you are not required to do so. You never need a referral to go to a specialist. You can access covered services three ways: (1) Directly from your PCP; (2) Directly from other in-network providers without a PCP referral; (3) By going to any licensed out-of-network provider—deductible and coinsurance will apply.

Opt-Out of Medical Plan Benefit

Lee County offers an Opt-Out option to encourage those employees who have other insurance, either from a previous employer or through their spouse's coverage (not covered under Lee County's plan) to opt-out of our medical benefit plan. This benefit is $50 per month, and eligible employees must qualify at initial enrollment by proving they have other insurance. Once enrolled, this benefit will automatically "roll over" into each new plan year, unless the employee enrolls in an Aetna medical plan due to a mid-year qualifying event. Enrolling in a medical plan at any time will stop the $50 per month payment. The Opt-Out benefit only applies to the medical plan, it does not apply to dental or vision.

NOTE: The $50 opt-out payment is taxable income!

To enroll in or to drop this plan, check the appropriate box in the OPT OUT section of your preprinted Open Enrollment form. Employees who opt out may re-enroll in the medical plan *only* during the next annual open enrollment period for the following year; or at any time during the plan year with a documented qualifying event reported within 60 days of the date of that event.

Coordination of Benefits

For many families, it is not uncommon for both spouses to be in the workforce. As a result, both spouses and their dependents are likely to be covered by more than one medical plan. In situations where an insured is covered by two or more medical plans, the plan that pays first is the "primary" plan, while the plan that pays second is the "secondary" plan. After the primary plan processes a claim, the secondary plan will pay benefits on the claim not to exceed 100% of the total charges.

If you and/or your dependents are covered under two plans, please check with each plan's customer service to determine which plan is primary before submitting claims.

RETIREE NOTE: With regard to retirees age 65 and over (or disabled) where neither spouse works, Medicare is primary. You must apply for Medicare Part B either when you retire or when you turn 65. Retirees may choose to either enroll in Medicare Part D or remain covered by the Lee County Health Plan. Enrollment in Medicare Part D will result in your being automatically dropped from the Lee County Health Plan.

Aetna Navigator

Aetna Navigator is Aetna's easy-to-use Web site providing members access to a variety of self-service functions and health information from InteliHealth℠. Visit *www.aetnanavigator.com*.

Prescription Drug Benefits

The medical plans include prescription drug benefits designed to help you control costs. Aetna divides prescription drugs into three levels, called tiers, based on a formulary, and charges a different co-payment for each tier.

Retail Prescription Drugs

You can purchase up to a 30-day supply of a prescription drug at a participating pharmacy for a single co-pay, depending on the type of drug and the tier in which it falls. There is no coverage for drugs purchased from out-of-network pharmacies, although you can file a claim for reimbursement if you had to use an out-of-network pharmacy while traveling or away from home. The pharmacy network includes most commonly-recognized drug stores nationwide.

Mail Order Delivery (MOD)

You can save money by ordering maintenance prescriptions for ongoing conditions like high blood pressure through the Mail Order Delivery (MOD) program. You will pay two retail co-payments when you order up to a 90-day supply through Aetna's mail order pharmacy. **In other words, you get three refills for the price of two!** If you are taking any GENERIC maintenance drugs, they will be dispensed to you FREE of charge through the MOD service. Generic medications purchased at your local pharmacy will still cost you the Tier 1 (or lowest) co-pay. *Note:* The standard MOD co-pay will apply even if your prescription is written for less than a 90-day supply. Caution: No refunds are given by the MOD service for prescription order errors. The MOD dispenses prescriptions as written.

- The formulary is Aetna's preferred drug list. A copy of the formulary will be provided by Aetna at your request via return post card. You can also access the formulary online at *www.aetna.com*.

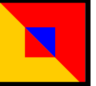
If you have questions about your prescription drug benefits, please refer to Aetna Navigator at *www.aetna.com or call Aetna Customer Service* at *888-266-5519*

- "Three tiers" means there are three different co-pay levels for covered prescription drugs. Your co-pay will be determined by whether the drug is a generic or brand-name medication and whether it is a formulary or non-formulary medication. Non-formulary drugs are not on the "preferred" drug list and have the highest co-payment.

Smart Tip

Retiree Note

Retirees who move out of the area and live in a more rural area where there is not an Aetna Network will be enrolled in the Traditional Choice Plan. This does not affect many retirees as Aetna's nationwide network has very good coverage all across the U.S.



Formulary Changes

Periodically throughout the year generic drugs may be introduced to replace existing brand-name formulary drugs, which will result in the removal of the brand-name drug from the formulary. The removed brand-name formulary drug is then moved to the brand-name nonformulary Tier 3 co-pay. Announcements about these changes are made on Aetna's Web site, through the news media, or via countywide e-mails.

If a generic formula is released for a brand-name formulary drug you are currently using, you have the option to either switch to the new generic drug for the Tier 1 co-pay (free if you use the MOD), or continue using the drug at the higher brand-name non-formulary Tier 3 co-pay. This decision is between you and your doctor.

Many allergy, acid reflux, and other medications are now being released as "over-the-counter" drugs, which will result in our plan either excluding payment for this type of medication altogether, or moving other drugs of the same type to the highest non-formulary Tier 3 co-pay. These changes are common occurrences and an industry-wide practice for insurance companies.

If you wish to avoid a "surprise" change in your drug co-pay, check the formulary listing on Aetna's Web site prior to re-ordering a prescription through mail order; and/or be sure to ask at your local pharmacy what the charge will be when you leave your prescription to be filled.

The entire Aetna formulary is subject to an annual review and will change yearly. Aetna will send a card to your home address when the updated formulary booklet is available.

Return the card if you wish to receive your own copy of the formulary booklet.

Smart Tip

Shop Around

Costs can vary from one provider to another. Shop around—and don't be afraid or embarrassed to ask questions!

QUEST Diagnostics

The lab charges a co-pay for all lab work requested by your doctor (this co-pay is the same amount you would pay to see any specialist). You may be asked to provide a cash payment or credit card at your appointment which you do not have to provide. You may request a bill be sent to you once the claim has been paid by Aetna. Quest Labs offer advance scheduling on their website for appointments at *www.questdiagnotics.com*.

There are some physicians who will draw a blood sample in house, but they will send it out to the lab for testing. If this occurs you will be responsible for a co-pay to the doctor and a co-pay to the lab.

Become a wise health care consumer! It is important to ask questions about all aspects of your treatment. If you have a condition which requires frequent monitoring through laboratory testing, you can save yourself one co-pay charge (as well as the time it takes) by asking your doctor to write the test order so that you can take it directly to the lab yourself. When completed, the lab always forwards the test results to your doctor's office. If frequent re-testing is required, the doctor can also write a "standing order" which you can deliver to the lab on your first visit.

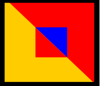
Employee Assistance Program (EAP)

The Employee Assistance Program (EAP) is available at no cost to ALL employees and their families, regardless of eligibility for any other benefits.

The EAP provides confidential counseling services that can help you and your dependents cope with such issues as family or relationship problems, parenting difficulties, financial stress, work-related problems, depression, substance abuse, stress due to natural disasters, and much more.

Three visits to an EAP counselor per incident per family member are covered under the EAP. If your situation requires longer-term counseling, the EAP counselors will direct you to another provider. Contact the EAP at 239-278-7435 or 800-226-7930.

Note: If you or a family member require more than the three covered visits, in-network coverage is available by calling the Behavioral Health number on your medical ID card.



Regular dental care is essential to good health. Daily brushing and flossing can go a long way toward protecting you from serious problems. However, regular preventive visits to the dentist are also important to maintain good oral health. Our plan was designed with an emphasis on preventive care. The dental Preferred Provider Organization (PPO) plan is administered through Aetna.

With the PPO dental plan, you can use an Aetna dentist, and your coinsurance is based on a negotiated fee schedule. Or, you may use _any_ dentist, but you may be balance billed if you go to an out-of-network dentist. The fee schedule determines the coinsurance that will be paid by the plan. If you go out of network, the provider can charge more than the fee schedule and bill you for what the plan doesn't pay ("*balance billing*").

You have open access to specialists—referrals are not required. There are four levels (types) of benefits determined by the type of service that you receive.

Benefit	**Dental PPO**
Deductible	$50/individual; $100 family
Benefit Maximum for Types 1,2,& 3 Services	$1,500 calendar year max, pp
Benefit Maximum for Type 4 Orthodontics	$1,000 lifetime max, pp
Type 1 Preventive Maintenance Services	Covered 100%
Type 2 Basic Services	Covered 80%
Type 3 Major Services	Covered 50%
Type 4 Orthodontic Services	$1,000 lifetime max, children under 20 years old only

Orthodontic work already in progress at time of hire will not be paid by the plan in any amount.

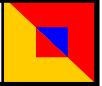
The deductible applies to Basic & Major Services only.

Medical/Dental Integration

There is an enhancement to our dental plan that provides additional covered services to eligible members. You are eligible if you are covered under both the medical and dental plans and have one of the following: Pregnancy, cerebrovascular disease, coronary artery disease, and diabetes. If these conditions are met, the following dental services will be considered covered dental expenses:

- One additional cleaning per year
- Deep cleanings, called scaling and root planing
- Full mouth debridement
- Periodontal maintenance (one additional treatment per year); and,
- Localized delivery of anti-microbial agents (not covered for pregnancy).

If you qualify for this enhanced benefit, speak to your dentist. Aetna will pay the provider, or you can pay the provider directly and file a claim for the reimbursement. Costs of these additional services will count toward the annual calendar year maximum of $1,500.



Protecting your eyesight is very important, which is why you should have your vision checked on a regular basis. If you are enrolled in an Aetna medical plan, you and your family are eligible for basic vision coverage through Aetna's Vision Discounts.

Aetna Vision Discounts (included in your Aetna medical plan)

With Aetna Vision Discounts, you are eligible for a vision exam every year. This program helps you save on eyeglasses, sunglasses, contact lenses and solutions, LASIK, and more.

The following are some of the Aetna Vision Savings you can receive. Please contact Aetna at 800-793-9717 or search online at *www.aetna.com* for more detailed information and a list of local Aetna Vision Discount providers.

Product/Service	**Member Pays***
Eyeglass Frames (retail price)	60% of charge
Single Vision Lenses	$40
Bifocal Lenses	$60
Trifocal Lenses	$80
Standard Progressive Lenses	$120
Standard Polycarbonate	$40 (in addition to standard lens price)
Standard Plastic Scratch-resistant Coating	$15 (in addition to standard lens price)
Ultraviolet (UV) Coating	$15 (in addition to standard lens price)
Solid or gradient tint	$15 (in addition to standard lens price)
Glass	80% of charge (in addition to standard lens price)
Photochromic	$40 single vision; $60 bifocal vision; $80 trifocal vision
Standard anti-reflective coating	$45 (in addition to lens price)
Contact Lenses—Conventional	85% of charge
Contact Lenses—Disposable	95% of charges
Contact Lense standard fit & follow-up	$40

*Prices are subject to change.

If you want more comprehensive coverage, you can enroll in the VSP (Vision Service Plan), our optional vision insurance plan. See the next page.

Smart Tip:

Eye Exams—Windows to Wellness

Regular eye exams are important because they can uncover major health problems such as diabetes and high blood pressure.

Our medical plan includes an annual eye exam for every covered member.

Take advantage of all preventive care options offered by our health plan!

Vision Service Plan (VSP)

VSP is a fully-insured vision care program designed to provide you and your eligible dependents with a variety of benefits including:

- Access to the nation's largest eye care provider network (available at *www.vsp.com*).
- Coverage for annual eye exam and necessary eyewear (lenses, frames, or contacts).
- Discounts on additional eyewear, including contact lenses and laser vision correction surgery.
- Coverage for out-of-network providers at higher out-of-pocket costs (you must file a claim @ *www.vsp.com*)

Two Plans to Choose From: The Basic plan, and the Vision2-High Option plan. Each of these plans has two tiers of coverage: Employee Only and Family.

This plan is separate from the vision benefits provided through the Aetna medical plans. If you elect this coverage, you pay the entire premium through pretax payroll deductions. Using your VSP benefit is easy when you select a network provider. There are no cards or claim forms to fill out.

- Simply tell the doctor you are a VSP member when you make your appointment.
- The doctor will verify your eligibility and your benefit with VSP.

If you choose to use an out-of-network provider, be aware that out-of-network benefits do not guarantee full payment. In addition:

- You are required to pay the provider in full at the time of service.
- You must file a claim. Log on to *www.vsp.com* and follow the instructions.

"Pre-Existing Medical Conditions" - If you have already been diagnosed with a medical condition in one or both eyes, you should ensure that the VSP provider you visit is also a participating provider in your medical plan. OR, visit your Aetna health plan provider (either an optometrist or an ophthalmologist) for the eye exam, and take your eyewear prescription to a VSP provider to purchase your glasses.

Network Availability

To determine if participating providers are available in your location, call VSP Member Services at 800-877-7195 or go to their web site at *www.vsp.com*.

Vision Service Plans (VSP) - continued

The following is a comparison between the Basic VSP Plan and the High Option VSP Plan.

The above material is for informational purposes only and it does not constitute a contract.

	BASIC PLAN	HIGH OPTION PLAN
EYE EXAM	$10.00 each CY	$10.00 each CY
PRESCRIPTION GLASSES	$15.00 each CY	$15.00 Each CY
LENSES	Allowed every year; Single vision, Lined Bifocal & Lined Trifocal Lenses; Polycarbonate; Photochromic, UV Protection	Same as Basic **PLUS** Progressive & Anti-Reflective Coating
FRAME	Allowed every other year; $120.00 Allowance; 20% off amount over your allowance	Allowed every other year; $150.00 Allowance; 20% off amount over your allowance
OR		
CONTACT LENS	$120.00 allowance for Contacts and Contact Lens Exam (fitting & evaluation).	$120.00 allowance for Contacts and Contact Lens Exam (fitting & evaluation).

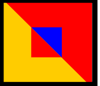
The above material is for informational purposes only and it does not constitute a contract.

Value Added Discounts

Laser Vision Care *sm*— VSP has contracted with many of the nation's finest laser surgery facilities and doctors, offering you discounted PRK and LASIK surgeries, available through contracted laser centers. Visit VSP's web site at *www.vsp.com* to learn more about this exciting program.

Contact Lenses—VSP also offers valuable savings on annual supplies of certain brands of contacts. You can receive these VSP member preferred prices even if you use your coverage for glasses.

Website Features—To access plan and vendor information, visit *www.vsp.com* and click on the "Prospective Members". If you have enrolled in VSP register on the VSP website to set up an account. Once you sign on, you will be able to browse all of Lee County's specific plan benefits. You can choose "Find a VSP network doctor" to locate your nearest provider, or call VSP Member Services at 800-877-7195.



Smart Tip

FSA ALERT!

You MUST re-enroll for the FSA EVERY plan year. Your contributions do not automatically roll over, but are "turned off" at December 31st of each plan year!

Will You Have any of these Health Care Expenses?

- Health insurance co-pays, deductibles, and/or coinsurance.
- Prescription eye-glasses or contact lenses
- Dental and/or orthodontia expenses.

Boost your income when you use a medical reimbursement account to reimburse yourself with tax-free dollars.

Flexible Spending Accounts (FSAs) are another Lee County Government-sponsored benefit that saves you money by allowing you to set up a regular pretax deduction from your paycheck to cover eligible health care and dependent care out-of-pocket expenses. Our FSA plans are administered by Aetna.

FSA's are established on a "use it or lose it" basis. This means that if your account balance exceeds your eligible expenses submitted for the year, including the extension, you will forfeit that remaining account balance. It is so important that you carefully estimate your expenses for the plan year (January 1 through December 31—"grace period" applies). The "Grace Period" for *spending* contributed funds is March 15th of the following plan year. The FINAL date for claiming expended funds is April 15th of the following plan year. *Example: Plan year ends December 31st, 2010; last date to spend is March 15th 2011; last date to file claims on expended funds is April 15th, 2011.*

Medical Reimbursement Account

The Medical Reimbursement Account (MRA) allows you to pay for your eligible health care expenses not covered under a health plan with pretax dollars. With this account, you can pay for out-of-pocket health care expenses during the year for yourself, your spouse, and all dependents you list on your federal income tax return, whether or not they are covered as dependents on the Lee County Benefits Plan.

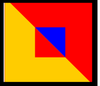
The maximum you may place in the account for the plan year is $5,000. A minimum contribution of $25 per paycheck is required. Health care expenses include, but are not limited to, co-pays, deductibles, and coinsurance for medical, dental, and vision care. For a complete list of eligible and ineligible expenses, please visit the IRS Web site at *www.irs.gov*.

Dependent Care Reimbursement Account

The Dependent Care Reimbursement Account (DCRA) allows you to pay for dependent care expenses with pretax dollars. You may authorize yearly deductions of up to $5,000 for married employees, filing jointly, or as head of household; or $2,500 if you are married and file your income tax returns separately from your spouse.

According to the DCRA, an eligible dependent will include:

- Your child or step-child under the age of 13.
- Any other dependent who is under the age of 13 and whose gross income for the plan year is less than $2,000.
- Any dependent who is physically or mentally incapable of caring for himself/herself, and who regularly spends at least eight (8) hours a day in your home.



Submitting Claims

You can get your claim forms from Human Resources, or download them from Aetna's Web site *www.aetna.com*. Complete the form, attach your paid receipts and/or explanation of benefits, and mail your claim to:

FSA – Medical Care (or FSA – Dependent Care)
Aetna
P.O. Box 4000
Richmond, KY 40476-4000

The print-out from Aetna Navigator showing all your paid claims can be used as your Explanation of Benefits (EOB) for FSA reimbursement processing purposes.

Special Features: Streamline—Aetna AutoDebit

If you have a health care spending account, you can elect or cancel the streamline claims option on the Aetna Navigator website. Streamlining automatically passes a medical, dental or pharmacy claim processed by Aetna to the FSA system so you don't have to submit a claim form.

This feature *automatically* includes auto debit for pharmacy purchases, either from a local pharmacy or by mail order. You will be able to debit your Medical Reimbursement Account (MRA) directly for pharmacy purchases without having to pay out-of-pocket first.

At the local pharmacy, you will not be charged if you have an existing MRA balance—the co-pay amount will be deducted from that balance, and you will pay nothing at the pharmacy.

By Mail Order: If you normally pay by credit card, you will not be charged if you have an existing MRA balance—the co-pay will be deducted from that balance.

Special Features Medical Reimbursement Account (MRA) Direct Deposit

If you choose, you may also elect direct deposit for those funds reimbursed to you from your MRA. This means that Aetna will send your reimbursement check to the bank account of your choice. Go online to Aetna Navigator under the "Requests & Changes Payment Options" tab. Online enrollment is the only way you may enroll in this special feature, which continues the following year. Remember that if your bank account changes sometime during the year, you will also have to change that account online.

Smart Tip

Extended Grace Period

As a result of an extended grace period granted by the Federal Government, you will have an additional 2½ months into the next plan year to spend any unused funds in your FSAs (either Medical or Dependent Care.)

The deadline for submitting all claims is April 15th. The "use it or lose it" rule remains unchanged—if you do not submit your receipts by April 15th, you will forfeit any balance(s) left in your account(s).

Smart Tip

Beneficiaries

A beneficiary is the person(s) you designate to receive your life insurance policy's stated benefits in the event of your death. You may change your beneficiary(ies) whenever, and as often as you wish.

It is important to keep your beneficiary designations up to date. Your beneficiary may need to be changed when you experience a qualifying status change event, such as marriage, death, divorce, etc. Please review your designations and remember to keep all of your beneficiary designations current.

Beneficiaries may need to be named or changed for the following plans in which you are enrolled:

- Basic life insurance
- Optional life insurance, if it has been purchased.
- Deferred Compensation Program.
- Florida Retirement System.

Life and Accidental Death and Dismemberment (AD&D) insurance can be an important benefit to those you leave behind in the event of your death or loss of limb/eyesight. Minnesota Life Insurance Company provides a Basic Life and AD&D insurance benefit to employees to protect their families' financial security.

Employees can purchase optional life insurance coverage for themselves and their dependents. You may name anyone you wish to receive your life insurance benefit in the event of your death – including a Trust, charitable organization, animal rights group, etc. Only PRIMARY beneficiaries are shown on your pre-printed Open Enrollment change form each year. Please be assured that whoever you name as your beneficiary will receive your life insurance proceeds.

Basic Life Insurance

Lee County provides a basic life insurance benefit of one times (1x) your annual salary, rounded up to the next highest thousand. Employees in pay grades 21 and above receive two times (2x) their annual salary, up to a maximum of $350,000.

AD&D

Accidental Death and Dismemberment (AD&D) insurance provides coverage beyond regular life insurance if you die or lose the use of limb(s), eyesight, etc., as a result of an accident, certain restriction apply. Lee County provides free AD&D coverage in addition to the Basic Life Insurance above.

Optional Life Insurance—Minnesota Life

You can buy optional life insurance coverage for yourself, your spouse, and your child(ren).

If you are a new employee, and you enroll during your new-hire election period, you can purchase guaranteed issue coverage in the amount of $200,000 for yourself; $50,00 for your spouse; and $25,000 for your children.

Current employees can apply for this coverage at any time throughout the plan year by submitting Evidence of Insurability (EOI) to the carrier. You must purchase a minimum of $50,000 of coverage for yourself in order to be eligible to cover your spouse (the minimum purchase is $25,000; and the spouse cannot have more than 50% of the value carried by the employee). If the employee's EOI is declined, they may not purchase coverage for spouse or dependents.

Children cease to be covered at the end of the month after they turn age 25. Be sure to remove them from optional life coverage when they are no longer eligible. *__Note__:* Foster children, grandchildren, and disabled dependent children over the age of 25 years are specifically excluded from the optional life insurance plan.

The employee is responsible for paying 100% of the premium for this coverage.

What would happen if you couldn't work for up to 12 weeks? Short-Term Disability provides partial replacement income to offset the financial losses that could result when you are unable to work for an extended period of time. The loss of time at work can result from physical injury, disease, pregnancy, or mental disorder.

Short Term Disability Benefit

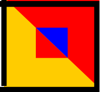
** The benefit will be reduced by any income received from other sources, such as other disability programs, Social Security, or retirement on a dollar-for-dollar basis.*

Feature	STD Insurance Benefits
Benefit Amount	Provides a benefit of 60% of your weekly pre-disability earnings, reduced by any other taxable income you receive*
Benefit Maximum	Provides up to 60% of annual salary of $52,000; or $600 per week for a maximum benefits period of 12 weeks
Elimination (Waiting) Period	Benefits begin on the eighth calendar day of disability
Other	During the elimination (waiting) period, you will be paid from your accumulated leave accruals (sick and vacation time)
Cost	The cost of STD coverage will vary based on your salary and your age. STD payroll deductions are made on an after-tax basis
Benefit Payments	STD benefits payments are **not** considered taxable income because you already paid the taxes on your premiums.

Smart Tip

Did you know?

64% of all disabilities are not work-related and fall outside the scope of Workers' Compensation?



If your disability extends beyond twelve weeks, LTD provides a monthly income amount in the event you suffer a total or partial disability that results in an extended absence from work for a non-work-related illness or injury.

Lee County pays 100% of your LTD premium.

Long Term Disability Benefit

** The benefit will be reduced by any income received from other sources, such as other disability programs, Social Security, or retirement on a dollar-for-dollar basis.*

Feature	LTD Insurance Benefits
Benefit Amount	60% of your monthly pre-disability earnings, reduced by any other taxable income you receive*
Benefit Maximum	Provides up to 60% of monthly salary of $100,000; or $5,000 per month until you are no longer disabled or until you have met your maxi-
Elimination (Waiting) Period	90 days of disability
Other	You must be diagnosed as totally disabled by a qualified physician, remain totally disabled during the 90-day waiting period, and meet all criteria for the plan
Cost	The cost of LTD coverage is totally paid for you by Lee County
Benefit Payments	LTD benefits payments are **taxable** income, since your employer has paid the premiums.

Useful STD and LTD Definitions

Disability—You have a disability when you cannot perform the material duties of your regular occupation because of injury or sickness.

Elimination Period—The number of days you are disabled before disability benefit payments start.

Pre-existing Condition (STD) - No benefit is payable for any disability that is caused by or contributed to by a “pre-existing condition” and starts before the end of the first 12 months following your effective date of coverage.

A disease or injury is a pre-existing condition if, during the 3 months before your effective date of coverage: it was diagnosed or treated; or services were received for the diagnosis or treatment of the disease or injury; or you took drugs or medicines prescribed or recommended by a physician for that condition.

Other Important Benefits

Lee County provides many other benefit programs. Below are the highlights of other benefits available to you. Please refer to your Policies & Procedures Manual or contact Human Resources for more information.

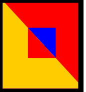
Educational Reimbursement

- Lee County recognizes that the skills and knowledge of our employees are critical to our success. That is why the County provides Educational Reimbursement as a way to assist you in continuing your college education.
- You can be reimbursed for courses taken at an accredited college or university that are ***directly related to your job.*** Courses are considered related to your job if the classes are designed to enhance knowledge, skills, and abilities relating to the official duties that you currently perform.
- Reimbursement is based on the tuition that State public universities and/or colleges charge students with Florida resident status for similar courses. Tuition includes books, lab fees, and registration fees.
- You must get prior approval from Human Resources before taking a course. Please call Human Resources with any questions about the Educational Reimbursement program.
- Bargaining Unit employees are subject to their Collective Bargaining Unit Agreements.

Vacation Leave

Vacation hours are accrued (earned) based on your length of service with Lee County. The table below reflects leave accruals for a regular full-time 40-hour per week employee.

Vacation Accrual Length of Service	Accrual Rate Per Pay Period	Annual Leave Accrued
0-4 Years	3.70 Hours	96.20 Hours
5-9 Years	4.62 Hours	120.12 Hours
10-14 Years	5.54 Hours	144.04 Hours
15-19 Years	6.01 Hours	156.25 Hours
20+ Years	6.47 Hours	168.22 Hours



Smart Tip

Take Advantage of Preventative Care

Preventative care leads to better health. By using your preventative care services, problems can be detected and treated earlier.

Two often overlooked services are:*

1. Your two FREE dental cleanings each year, provided by your dental plan; and,
2. Your annual physical, which is also FREE to you!

** This applies to employees enrolled in a Lee County BoCC-sponsored dental and/or medical plan.*

Sick Leave

- All 40-hour employees in full-time Board-approved positions accrue (earn) four hours of sick leave every bi-weekly pay period.
- 56-hour employees accrue 5.6 hours each pay period.
- 35-hour employees accrue 3.5 hours per pay period.
- There is no maximum accrual amount.

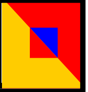
Sick Leave Pool *(for BoCC Employees only)*

The sick leave pool is a voluntary fund of donated sick leave, which has been established to provide limited additional sick leave benefits for participating members in the case of serious personal illness or injury. Sick leave pool hours may not be used intermittently or for the illness of a spouse or other family member. You must have the equivalent of two weeks of your own accumulated unused sick leave in order to join the pool. You can join at annual open enrollment, and will be required to donate one day of your own accumulated sick leave each year. Participation in the sick leave pool will be continuous unless you opt-out of the plan during open enrollment.

Sick Leave Buy-Back — **This program is currently suspended.**

Employees who have 200 hours or more of accumulated, unused sick leave may sell the County unused sick leave hours accrued during the *current* fiscal year. If you elect to sell your hours and you meet the requirements, payment will be made to you sometime in November of each year. *Note*: If Human Resources does not receive an Annual Buy Back election form from you by the due date, your unused hours will automatically be rolled over into your bank. **Banked hours are not paid out when your employment with the County ends.**

- Sick leave which counts toward the 200 hours you are required to have before these payouts can occur includes your current year's hours earned but not taken, plus your sick leave bank hours.
- You will be paid at 25% of your current hourly base rate of pay (as of a specified date in October), if you have less than six consecutive years of service; and paid at 50% of your current hourly base rate of pay if you have six or more current consecutive years of service.



Military Leave

Any employee who is a member of the National Guard or a reserve component of the Armed Forces of the United States will be granted leave with full pay for 30 days and without loss of benefits (including retirement) during the period in which the employee is ordered to active duty.

Currently, employees who have been called up for an extended length of time are paid the difference between their pay as an employee and the military pay they receive. If you are called up, your job is guaranteed under the provisions of the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA).

Jury Duty

When you are required to serve on jury duty, you will be paid the amount that you would have earned had you worked the time served for jury duty.

Bereavement Leave

Regular employees may be granted bereavement leave with pay due to a death in the family.

Family and Medical Leave Act (FMLA)

By law, the County must grant an eligible employee up to a total of 12 work weeks of unpaid leave during any 12-month period for one or more of the following reasons:

- For the birth and care of the newborn child of the employee.
- For placement with the employee of a son or daughter for adoption or foster care.
- To care for an immediate family member (spouse, child, or parent) with a serious health condition.
- To take medical leave when the employee is unable to work because of a serious health condition.
- Provide care to a family member who was injured or became ill while on active military duty.
- Provide leave to address health and family issues arising from the employee's spouse, son, daughter, or parent being on, or called to, active duty (or being notified of an impending call or order to active duty).

Credit Union

As a Lee County employee, you are entitled to membership in Suncoast Schools Federal Credit Union (SSFCU). You may become a "member" by opening a savings account in the amount of $5. Call the SSFCU Member's Call Center at 813-621-7511 directly; or, 800-999-5887 for more information.

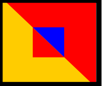
Payroll Direct Deposit

You may elect this convenient service directly through Payroll. Your pay will be automatically deposited into an account in the bank of your choice. Employees who do not sign up for direct deposit will be issued a Bank of America "pay card." This pay card will be credited each payday. Employees may then use the card to access their pay. Paper checks are no longer issued.

HOLIDAYS

- **New Year's Day**
  January 1st (and as designated)
- **Martin Luther King's Birthday**
  Third Monday in January
- **Memorial Day**
  Last Monday in May
- **Independence Day**
  July 4th
- **Labor Day**
  First Monday in September
- **Veteran's Day**
  November 11th
- **Thanksgiving Day**
  Fourth Thursday in November
- **Day After Thanksgiving**
  Fourth Friday in November
- **Christmas Day**
  December 25th
  (and as designated)

Please keep this guide for future reference. Plans may vary by entity.



Florida Retirement System (FRS)

Retirement Options

The Florida Retirement System (FRS) offers two retirement plans—the FRS Pension Plan and the FRS Investment Plan. You may choose to participate in either one of these plans.

The FRS Pension Plan is a traditional defined benefit, employer-sponsored retirement plan. Your benefit is "defined" based on a formula that uses factors such as service, age, and pay. The vesting period to qualify for a retirement benefit is six years (eight years for disability retirement). You may apply for service retirement from the pension plan upon meeting the normal retirement requirements based on age or years of service.

The FRS Investment Plan is a defined contribution plan. With this plan the contributions made to the plan are "defined", rather than your benefit. Your benefit is based on contributions to your account, as well as your account's investment earnings. Your investment earnings will depend, to a large extent, on how much risk you are willing to take and the fees charged to you by the investment funds. The vesting period to qualify for a retirement benefit is one year. This plan is "portable", meaning you can take your retirement plan with you to a new job and you control the way your account is invested. However, once a distribution has been made from this plan, you are considered to be retired from the FRS.

Please be aware that retired individuals, or those that took a distribution from the FRS investment plan, are not eligible for re-enrollment in either of the FRS retirement plans if rehired with an FRS employer on or after July 1, 2010.

On your date of hire, you are automatically placed in the Pension Plan. You have up to five months from your date of hire to choose whether you want to stay in that plan or switch to the Investment Plan.

For more information on both of these plans, refer to your FRS Retirement Guide for your membership class, visit the FRS Web site at *www.MyFRS.com*, or call 866-44MyFRS (866-446-9377).

Deferred Compensation Program (457b)

You are eligible to participate in the Deferred Compensation Program (DCP), Lee County 's supplemental retirement program. Lee County offers two plans in which you may participate: Nationwide Retirement Solutions; or ICMA-RC. Enrollment packets are available by calling the Benefits Help Desk at 239-533-2363.

You may contribute 100% of your eligible compensation, up to a $16,500 maximum based on your 2011 income for the 2011 plan year. If you are age 50 or older, you may participate in the "50+ Catch-Up" provision. Please contact your deferred compensation representative or the Payroll Department for this year's maximum "50+ Catch-up" contribution. The amount you elect to contribute will depend on your individual situation. You may increase, decrease, or stop contributions at any time throughout the year. Before enrolling:

- Read the Program Highlights.
- Decide how much you will need to save for retirement.
- Decide how you would like to invest your money by completing the asset allocation questionnaire
- Decide which funds you would like to invest in after reviewing your investment options.

Retiree Participation in Lee County Benefit Plans

Retirees are eligible for:

- Medical coverage through the Aetna Select, Aetna Choice POS II, or Traditional (rural areas with no established network) plans.
- Dental coverage
- Vision Coverage
- Retiree Life Insurance coverage

Upon retirement, employees hired prior to January 1, 2008 will pay 50% of the Board's total cost of medical premiums. If hired on or after January 1, 2008, retired individuals will pay 100% of the Board's total cost of medical insurance premium. Other benefits elected, (i.e. dental, vision and life) are paid by the retiree at 100%.

Retiree's who wish to participate in any plan must do so immediately upon retirement. If an eligible plan is not elected at the time of retirement, it cannot be elected at a later date. Retiree's may make changes to their already elected plans at annual open enrollment; however, they may not enroll in plans that were not elected at the time of retirement. Once a plan is dropped, there will be no future opportunity to re-enroll in that plan.

If you are considering retirement, you should make an appointment with Human Resources to learn more about your benefits and options.

Smart Tip

Take Information Home

Don't be shy to ask your doctor for written instructions. Inquire about brochures, audiotapes, and videotapes that could help you.

Follow Up With Your Providers

Call your doctor when you have questions. If your symptoms get worse, or if you have problems with your medication.

COBRA—Very Important Notice for Lee County Benefits Plan

- **Consolidated Omnibus Budget Reconciliation Act-** If you, your spouse, or eligible dependent lose coverage under the Lee County Benefits Plan because of a COBRA-qualifying event, then you may have the right to continue coverage under the Consolidated Omnibus Budget Reconciliation Act (COBRA).

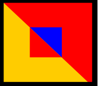
- If you, your spouse, and/or dependent have a COBRA-qualifying event, you must notify the Human Resources Department immediately.

- If your coverage ends due to a COBRA-qualifying event, Lee County, through its plan administrator, will send you a notice of your continuation rights. At that time, you will have up to 60 days—from the date of your event or the date you received your notice—to decide whether you want to continue your health coverage.

- If you *drop your spouse's coverage* in anticipation of a divorce (i.e., during open enrollment), your spouse still has COBRA continuation rights that begin with the first day of the month following the date the actual event occurs. It is strongly advised that you consult your attorney before taking such action.

- If you request to *drop your spouse's coverage* at any time, you will be asked to give the reason, in order to protect both yourself and the Lee County Health Plan.

- A divorced ex-spouse is not eligible to remain on any of the plans as your dependent, but he/she does have COBRA rights. A divorce should be reported to the Human Resources office immediately to avoid the possible reversal of claims incurred after coverage should have ended.



COBRA—Very Important Notice for Lee County Benefits Plan (continued)

Your Initial Notice for Your Group Health Continuation Under COBRA

Attention: Active Employee, Spouse, and Dependent Children:

If you, your spouse, or your dependent child (ren) lose coverage under our group health and dental plan because of a qualifying event, then you may have the right to elect continuation coverage under the Public Health Services Act. This continuation coverage is sometimes called COBRA coverage.

Who May Elect Continuation Coverage?

An employee, spouse or dependent child who has coverage under our group health and dental plan on the day before a qualifying event may elect continuation coverage. An employee may also elect continuation coverage for children born or adopted by the employee during the continuation period.

For families that lose coverage, each family member can separately elect continuation coverage. However, unless otherwise specified, an employee's election to continue coverage will be deemed to include an election of continuation for the employee's spouse and dependent children. Similarly, a spouse's election to continue coverage will be deemed to include an election of continuation for any dependent child covered by the plan.

Although an employee and spouse can continue coverage on behalf of other family members, they cannot decline coverage on behalf of other family members. For example, if an employee declines continuation coverage, the spouse and/or dependent child can elect to continue their coverage.

What Is Continuation Coverage?

If you, your spouse, or your child experiences a qualifying event, you may continue the health coverage you had immediately before the event occurred. If you continue coverage, you will not have to provide proof of insurability in order to continue coverage, and during open enrollment periods, you will have the same rights as active employees to change your coverage.

What Is a Qualifying Event?

A qualifying event occurs when you, your spouse, or a dependent child lose coverage under Lee County's health and dental plan because:

- A covered employee terminates employment for any reason other than gross misconduct or has a reduction in hours to fewer than the number required for plan participation.
- A covered employee dies.
- A covered employee becomes divorced from the spouse.
- A covered retiree becomes eligible for Medicare.
- A covered child loses dependent status under a plan.

Do I Have to Notify Lee County of Any Qualifying Events?

Yes, employees or their families must notify Human Resources in the event of a divorce, or when a child no longer qualifies as a covered dependent under the plan within 60 days after these events occur. For other qualifying events, Lee County will notify you. Individuals failing to notify Human Resources of these events within the 60-day period will not be permitted to change their coverage as requested, but will have to wait for the next open enrollment.

Smart Tip

24 Hour Informed Health® Nurse Line

For TDD, hearing and speech impaired only call 1-800-556-1555 or 1-800-270-2386

Call Aetna's informed Health® Line to speak with a registered nurse who can help you:

- Learn about medical procedures and treatment options.
- Improve the way you communicate with your health care providers.
- Describe your health symptoms more accurately.
- Ask the right questions.
- Provide a history of your eating, exercise and lifestyle habits.

Smart Tip

Watch For Billing Mistakes

Costs from medical billing errors can add up. Review your bills to confirm that the charges listed are for the services you received. If you think you have found an error, call the plan's member services number at:
1-866-266-5519

COBRA (continued)

Can I Have More Than One Qualifying Event?

Sometimes, a spouse or dependent child can have more than one qualifying event. A second qualifying event occurs if the following three conditions are met:

- The first event is the employee's employment termination or reduction in hours.
- The second event is a sort that gives rise to 36 months of continuation coverage (e.g., a covered employee's death or divorce).
- The second event takes place while continuation coverage is in effect.
- If a second qualifying event occurs, we will extend the maximum coverage period from 18 months to 36 months, measured from the date of the first qualifying event. A qualified beneficiary is not entitled to more than 36 months of continuation coverage.

How Do I Elect Continuation Coverage?

If you, your spouse, and/or dependent child (ren) have a qualifying event, we will send you a notice of your continuation rights. At that time, you will have up to 60 days to decide whether you want to continue your health coverage through the Lee County plan.

This election period will end 60 days from the later of the following two dates:

- The date coverage would otherwise terminate.
- The date Lee County notifies you of your continuation rights.

How Long Can I Continue Coverage?

If the qualifying event is employment termination or reduction in hours, the maximum period of time you can continue coverage is 18 months from the date of the qualifying event. For other qualifying events, the maximum period is 36 months. However, if the employee is covered by Medicare prior to the time of the termination or reduction, the period of coverage for the spouse and dependents will end after 18 months or, if greater, 36 months from the date the employee became covered by Medicare.

Can Lee County Terminate My Continuation Coverage Before the Maximum Coverage Period Ends?

Lee County can terminate your continuation coverage before the maximum coverage period ends for any of the following reasons:

- Payment for continuation coverage is not received on a timely basis.
- After electing continuation coverage, you become covered by another group health plan maintained by another employer that does not limit or exclude your coverage for any pre-existing medical condition.
- After electing continuation coverage, you become covered by Medicare.
- Lee County ceases to provide group health plan coverage for all active employees.
- For cause, such as submission of a fraudulent claim.

COBRA (continued)

Do I Have to Pay for My Continuation Coverage?

You must pay the full cost of continuation coverage, plus two percent for Lee County's administrative expenses.

We will include information on the cost of continuation coverage and the payment terms in notices to individuals who have a qualifying event.

Do Special Provisions Apply to the Disabled?

If the Social Security Administration determines that you were disabled at any time during the first 60 days of continuation coverage, you can request an extension of the maximum coverage period from 18 to 29 months. This extension applies not only to the disabled individual, but also to covered family members.

To obtain this extended coverage, you must notify the plan administrator at the address under "Who Can I Contact If I Have Questions About Continuation Coverage" within 60 days of Social Security's disability determination and 18 months of the qualifying event.

If you receive this extended coverage, you must pay 102 percent of the full cost of the continuation coverage for the first 18 months. After 18 months, the required payments will increase from 102 percent to 150 percent of the full cost of coverage if the disabled individual elects the extended coverage. Otherwise, the required payments will remain at 102 percent.

If you receive the extended coverage, you are required by law to notify the plan administrator that you are no longer disabled within 30 days of any such determination made by Social Security. Once notified, your extended coverage will be terminated effective the first day of the month beginning more than 30 days after Social Security's determination.

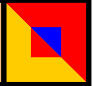
Who Do I Notify About an Address Change?

You must keep your plan informed of address changes. In order to protect your family's rights and receive information in a timely manner, you should keep the Benefits Office informed of any changes to your address or the addresses of covered family members who do not reside with you. If you leave Lee County employment and have not reported your current address, your COBRA notice will be delayed in reaching you or may not reach you at all. You should keep a copy of any notices you send to the Benefits Office for your own records.

Who Can I Contact If I Have Questions About Continuation Coverage?

If you have any questions about continuation coverage in the Lee County Benefits Plan, contact the Lee County Human Resources Benefits Manager at P.O. Box 398, Fort Myers, Florida 33902-0398, telephone 239-533-2363.

This General Notice does not fully describe COBRA or the Lee County Benefits Plan. More complete information is available in the Summary Plan Documents located on our Web site at www.lee-county.com. Click on "County Departments," scroll down to Human Resources, and choose "Employee Benefits." Click on "Summary Plan Documents" at the bottom of the page and choose the plan you want to view.



HIPAA

(Health Insurance Portability and Accountability Act)

This legislation was passed to allow employees certain rights with respect to health plan waiting periods, special enrollments, and pre-existing conditions. The Lee County Benefit Plan has no pre-existing condition imposed in the Aetna Select, Aetna Choice POS II and Traditional plans.

HIPAA requires employers providing group health coverage to employees to provide a Certificate of Creditable Coverage to any participant, who for any reason, is no longer participating in the plan. If your last day of coverage is less than 63 days from the date you become eligible to enroll in the Lee County health plan, all pre-existing conditions will be waived. HIPAA states pregnancy will not be considered a pre-existing condition.

If you have any questions regarding your rights under the HIPAA legislation, please contact the HIPAA Privacy Officer at 239-533-2230.

HIPAA—Privacy Act Legislation

- The health plan and your health insurance carrier(s) and providers are obligated to protect confidential health information that identifies you or could be used to identify you and relates to a physical or mental health condition or the payment of your health care expenses.
- Effective April 14, 2003, the health plan and your health insurance carrier(s) and providers were required to notify you and your beneficiaries about their policies and practices to protect the confidentiality of your health information.
- If you have questions about your medical privacy call 239-533-2230.

Women's Health and Cancer Rights Act

- The Women's Health and Cancer Rights Act of 1998 requires your health care plan to provide benefits for mastectomy-related services.
- These services include reconstruction and surgery to achieve symmetry between the breasts, prostheses, and complications resulting from a mastectomy (including lymph edemas).
- Coverage for these benefits or services will be provided in consultation with the participant's or beneficiary's attending physician.
- If you are receiving, or in the future receive, benefits under a group medical contract in connection with a mastectomy, you are entitled to coverage for the benefits and services described above if you elect breast reconstruction.
- Your qualified dependents are also entitled to coverage for those benefits or services described above, on the same terms.
- Coverage for the mastectomy-related services or benefits required under the Women's Health law are subject to the same deductibles and coinsurance or co-payment provisions that apply to other medical or surgical benefits your group medical contract provides.

About your Prescription Drug Coverage and Medicare

Important Notice from Lee County BoCC

Medicare Certificate of Creditable Service

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with Lee County BoCC Self-Funded Health Plan 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 Medi care. 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. Lee County Board of County Commissioners has determined that the prescription drug coverage offered by the Lee County BoCC Self-Funded 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.

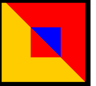
When Can You Join A Medicare Drug Plan?

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

Smart Tip

Remember: Keep this Notice. If you enroll in one of the plans approved by Medicare which offer prescription drug coverage you may be required to provide a copy of this notice when you join to show that you are not required to pay a higher premium amount.



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

If you do decide to enroll in a Medicare prescription drug plan and drop your Lee County BoCC Self-Funded Health Plan prescription drug coverage, be aware that you will not be able to get this coverage back.

You should compare your current coverage, including which drugs are covered, with the coverage and cost of the plan offered under Medicare D. See pages 7- 9 of the CMS Disclosure of Creditable Coverage To Medicare Part D Eligible Individuals Guidance (available at *http://www.cms.hhs.gov/CreditableCoverage/*), which outlines the prescription drug plan provisions/options that Medicare eligible individuals may have available to them when they become eligible for Medicare Part D.

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 Lee County BoCC Self-Funded Health 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.

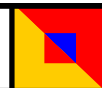
If you go 63 continuous days or longer without creditable prescription drug coverage, your monthly premium may go up by at least 1% of the Medicare base beneficiary premium per month for every month that you did not have that coverage. For example, if you go nineteen months without creditable coverage, 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 November to join.

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 Lee County BoCC Self-Funded Health Plan 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 Medicare 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:	January 1, 2011
Name of Entity/Sender:	Lee County Board of County Commissioners
Contact--Position/Office:	Director, Department of Human Resources
Address:	2115 Second Street, Fort Myers, FL 33901
Phone Number:	(239) 533-2245

Smart Tip

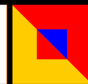
Visit

www. Medicare.gov

1-800-MEDICARE

800-633-4227

TTY 877-486-2048



Lee County BoCC Health Plan

Notice of Privacy Practices

Original Effective Dates: 4/14/03 • Revised Date: 10/1/03

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.

THE LEE COUNTY HEALTH PLAN ("the Health Plan") is required by law to maintain the privacy of your confidential medical information. Medical information is called Protected Health Information, or "PHI." It is information that identifies you and relates to your past, present or future physical or mental health conditions and related health care services. The Health Plan is administered by employees in the Lee County Human Resources Benefits Unit. Only persons in that unit have access to your PHI because they have the "need to know" in order to provide services to you or for plan administration purposes. This notice, or revisions that you will receive, outlines some of the ways your PHI may be used or disclosed, and your rights concerning your own information.

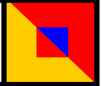
Uses and Disclosures of PHI: PHI may be used for the purposes of treatment, payment, and health care operations. Some uses will require your written permission.

Examples of our use of your PHI:

For treatment. Lee County Human Resources/Benefits may ask you for information about your medical condition and treatment you have received to gain authorizations for further treatment. They may ask the same questions of your doctors and their staff. They may give your PHI to providers involved in your treatment.

For payment. This includes any activities the plan must undertake in order to pay claims or collect premiums, including providing information needed to determine medical necessity or helping you resolve your claims or coverage problems.

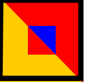
For health care operations: This might include quality review activities, case management, claims audits and training programs to ensure that staff follows our privacy policies and procedures.



Use and Disclosure of PHI Without Your Authorization: Lee County Human Resources/Benefits employees who administer the Health Plan are permitted to use PHI without your written authorization, or opportunity to object, in certain situations that include:

- For health care and legal compliance activities;
- To a family member or other individual involved in your care if we obtain your verbal agreement. You have the right to object to the sharing of this information in most cases. We may also release PHI in urgent or emergency situations when we are unable to obtain your agreement and believe the disclosure is in your best interest;
- For law enforcement activities in limited situations, such as when responding to a warrant;
- For military, national defense and security and other special government functions;
- To avert a serious threat to the health and safety of a person or the public;
- For workers' compensation purposes, and in compliance with workers' compensation laws;
- To coroners, medical examiners, and funeral directors for identifying a deceased person, determining cause of death, or carrying on their duties as authorized by law;
- To a public health authority in cases of abuse, neglect or domestic violence;
- For certain health oversight activities undertaken by government agencies to oversee the health care system;
- For judicial and administrative proceedings when we receive a court or administrative order, or in some cases in response to a subpoena or other legal process;
- If you are an organ donor, Lee County Human Resources/Benefits employees may release health information to appropriate organizations to facilitate organ donation and transplantation;
- For research projects, subject to strict oversight and approval;
- Disclosures of health information about you that does not personally identify you.

Any use or disclosure of PHI other than those listed above will only be made with your written authorization. You may revoke your authorization at any time, in writing, except to the extent that they have already used or disclosed medical information in reliance on that authorization. They will always follow the most stringent law that protects your privacy, whether the law is a state law or federal law.



Lee County BOCC Health Plan Privacy Officer Contact Information

Privacy Officer
P.O. Box 398
Ft. Myers, FL 33902-0398
Phone: 239-533-2230

Email:
privacyofficer@leegov.com

Your Rights: As an employee or member of the Health Plan, you have a number of rights with respect to your PHI:

The right to see and copy your PHI: In most cases, you may ask to see and get copies of your records. Requests must be made in writing so everybody has a record. The law allows 30 days to respond though they will try to get it more quickly. There will be a small fee for the cost of copying your records. In very rare circumstances we may deny access to some of your medical information. You may be able to appeal that denial. They will provide a written response if they deny access and will also let you know your appeal rights. If you wish to inspect and copy your medical information, you should contact the Privacy Officer.

The right to ask for confidential communications: You may ask Lee County to limit the manner in which we communicate with you. Please contact our Privacy Officer to discuss your request.

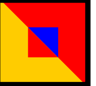
The right to ask us to correct your PHI: You may ask Lee County to change or add information to your records if you think there is a mistake. If they agree to your request, the information will generally be amended within 60 days or less of your request and they will notify you when this has been done. Your request may be denied in certain circumstances permitted by the law; for instance, if they believe the information you have asked them to change is correct. If you wish to request that they change medical information that they have about you, please contact our Privacy Officer.

The right to ask for a list of disclosures: You may ask Lee County for a list of certain disclosures of your medical information that they have made after April 14, 2003. They are not required to list information they have used or disclosed for purposes of treatment, payment or health care operations, or when they share your health information with our business associates, like our claims payor or our fiscal office. They also won't list those times they disclosed PHI when you had already given them written authorization. If you wish to request an accounting, contact our Privacy Officer.

The right to ask us to restrict the uses and disclosures of your PHI: You may ask that they restrict how they use and disclose your PHI. The Health Plan is not required to agree to any restrictions you request, but any restrictions the Health Plan agrees to in writing are binding on the Health Plan and our Business Associates.

Revisions to the Notice and the right to obtain a copy: You can get a copy of the latest version of this Notice by contacting the Privacy Officer (see contact information below). The Health Plan reserves the right to change the terms of this Notice at any time, and the changes will be effective immediately and will apply to all PHI that they maintain. Any material changes to the Notice will be promptly posted to Lee County's Web site and distributed as required by law.

Your Legal Rights and Complaints: You have the right to complain to the Health Plan, or to the Secretary of the United States Department of Health and Human Services if you believe your privacy rights have been violated by the Health Plan. Your benefits will not be affected, and you will not be retaliated against in any way for filing a complaint with Lee County or to the government. Should you have any questions, comments or complaints you may direct all inquiries to the Privacy Officer.



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

Offer Free Or Low-Cost Health Coverage To Children And Families

If you are eligible for health coverage from your employer, but are unable to afford the premiums, some States have premium assistance programs that can help pay for coverage. These States use funds from their Medicaid or CHIP programs to help people who are eligible for employer-sponsored health coverage, but need assistance in paying their health premiums.

If you or your dependents are already enrolled in Medicaid or CHIP and you live in a State listed below, you can contact your State Medicaid or CHIP office to find out if premium assistance is available.

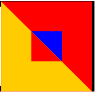
If you or your dependents are NOT currently enrolled in Medicaid or CHIP, and you think you or any of your dependents might be eligible for either of these programs, you can contact your State Medicaid or CHIP office or dial **1-877-KIDS NOW** or ***www.insurekidsnow.gov*** to find out how to apply. If you qualify, you can ask the State if it has a program that might help you pay the premiums for an employer-sponsored plan.

Once it is determined that you or your dependents are eligible for premium assistance under Medicaid or CHIP, your employer's health plan is required to permit you and your dependents to enroll in the plan – as long as you and your dependents are eligible, but not already enrolled in the employer's plan. This is called a "special enrollment" opportunity, and **you must request coverage within 60 days of being determined eligible for premium assistance**.

You may be eligible for assistance paying your employer health plan premiums. Contact the State Florida for further information on eligibility –

Website: *http://www.fdhc.state.fl.us/Medicaid/index.shtml*

Phone: 1-866-762-2237



The Affordable Care Act

Patient Protection Disclosures

Extension of Dependent Coverage to Age 26 - Notice of Opportunity to Enroll

The Patient Protection and Affordable Care Act (PPACA), also known as Health Care Reform, requires coverage for dependent children up to age 26 without any eligibility requirements (e.g. marriage, student status, financial dependency, etc.).

Here's what this means to you . . .

If you have dependent children whose coverage ended, or were not eligible for coverage because the availability of dependent coverage of children ended before attainment of age 26, they are now eligible to enroll in the Lee County BoCC group health plan. Individuals may request enrollment for such children for 30 days from the date of notice. Enrollment will be effective January 1, 2011. For more information contact the Benefits Help Desk at 533-2363.

Notice of Lifetime Limit No Longer Applies and Enrollment Opportunity

The Lee County BoCC group health plan does not impose annual or lifetime dollar limits on benefits; therefore, does not offer a special enrollment opportunity based on the elimination of lifetime dollar limits.

Primary Care Provider Designation

The Lee County BoCC health plan allows the designation of a primary care provider. You have the right to designate any primary care provider who participates in our network and who is available to accept you or your family members. For information on how to select a primary care provider, or for a list of the participating primary care providers, please visit Aetna's website at *www.aetna.com* or contact the Aetna Member Services number on your Aetna medical identification card.

For children, you may designate a pediatrician as the primary care provider.

You do not need prior authorization from Aetna or from any other person (including a primary care provider) in order to obtain access to obstetrical or gynecological care from a health care professional in our network who specializes in obstetrics or gynecology. 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. For a list of participating health care professionals who specialize in obstetrics or gynecology, please visit Aetna's website at *www.aetna.com* or contact the Aetna Member Services number on your Aetna medical identification card.

NOTES

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