2024 OPEN ENROLLMENT

GUIDE FOR RETIREES

Lee County
Southwest Florida

CONTACTS

Lee County Benefits

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(ask for benefits)

(239) 485-2052

benefits@leegov.com

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Jim Cotter Dedicated Aetna Representative cotterj@aetna.com	(239) 533-0829

BENEFIT	CARRIER	WEBSITE	TELEPHONE
Medical	Aetna	www.aetna.com	888-266-5519
Pharmacy	Aetna	www.aetna.com	866-612-3862
Telemedicine	TelaDoc	www.Teladoc.com/Aetna	1-855-TELADOC (835-2362)
MAP Medical Plan	Aetna	www.aetnaretireeplans.com	888-267-2637
Dental	Aetna	www.aetna.com	877-238-6200
Vision	VSP	www.vsp.com	800-877-7195
Life	The Standard	www.standard.com	800-628-8600

IN THIS GUIDE

We've carefully selected highlighted info on benefits available to you that we feel you'll want to know. In case we missed anything, we have included the Summary Benefits of Coverage for each benefit and contact information for each carrier. This will allow you to compare the different benefit plans and make the best selection for you and your family.

Lee County Government offers group insurance benefits to all eligible retirees. The Employee Benefit Highlights Booklet provides a general summary of the benefit options as a convenient reference. Please refer to the Summary Plan Descriptions for detailed descriptions of all available employee benefit programs and stipulations therein. If retiree requires further explanation or needs assistance regarding claims processing, please refer to the customer service phone numbers under each benefit description heading or contact Human Resources.

OPEN ENROLLMENT DETAILS

Open Enrollment is held in the fall of each year for changes effective January 1 of the following year. Open Enrollment is your only opportunity to make changes to your coverage unless you experience a qualified change in status (Qualifying Event). You may need to submit additional documentation with your Open Enrollment Change form to ensure you and your family members are covered.

All benefit changes made during the Open Enrollment period will be effective on **January 1 of the following year**.

What you can change during Open Enrollment:

- You may **drop** or **add** qualified dependents to any plans in which you are currently enrolled. Note: Any participant enrolling in the Medicare Advantage plan must be Medicare eligible.
- You may **change the type of coverage** you are enrolled in (example: change from Aetna Select to Aetna POS II or to the Medicare Advantage Plan)

  Note: Benefits that are not elected immediately upon retirement, or were dropped during a past Open Enrollment will not be eligible for re-enrollment.

OPTIONS TO SUBMIT YOUR ELECTIONS:

- **In Person:** Lee County Human Resources,
  1825 Hendry Street, #200
  Fort Meyers, FL 33901
- **By Mail:** Lee County Human Resources,
  P.O. Box 398, Fort Myers, FL 33902
- **Fax:** (239) 485-2052
- **Email:** Benefits@leegov.com

All documents must be completed and returned by the deadline provided each fall

Please Note:

It is the responsibility of each individual retiree to read through the information contained in this packet. Failure to read or understand the information contained within this packet will not constitute an event that would allow changing or dropping elected coverage.

Please review the details in this guide to determine what benefit plans are best for you and your family. Summary of Benefits of Coverage for each benefit are included and will allow you to compare benefit plans and make the best selection for you and your family.

WE'LL MAKE THIS QUICK

Here's a quick checklist for you to use as you go through your enrollment. Additional details can be found at **https://www.leegov.com/hr/retirees**.

As you go through the enrollment process, you'll also have a number of opportunities that will help you navigate your benefits. And as always, your benefits team is here to help. Please reach out at (239) 533-2245.

- ❑ **Review Your Current Benefit Elections**
- ❑ **Review Your Benefit Guide**
- ❑ **Make Your Benefits Selection**
  - ❑ **If you do not want to make any changes for the next year**, you do not need to complete a form – your current benefits elections will remain the same and premiums will automatically be updated.
  - ❑ **Submit your Benefits Election Form if you want to make changes**
    This is the form you must turn in with your elections if you:
    - Change benefit plans
    - Add or delete dependents (if covering more than seven dependents, please provide information requested for all additional dependents on a separate sheet and submit with your Election Form)
    - Experience a qualified life event. Failure to report the qualifying life event timely may result in a reversal of claims, which will become your financial responsibility. Please report to HR within 60 days.
  - ❑ **Complete the Acknowledgement Section** and provide a contact phone number in case we have questions about your election
- ❑ **Submit Your Elections to HR**

QUALIFYING EVENTS

Open Enrollment is your only opportunity to make changes to your coverage, unless you experience a qualified change in status.

"Qualifying Event" includes but is not limited to:

- Marriage, divorce, or annulment;
- The birth or adoption of a child;
- The death of your spouse or child;
- A change in the number of your dependents;
- A change in employment status for you, your spouse, or your dependent that results in a change of insurance eligibility.

A qualifying event **must be received within 60 days of your qualifying event or during Open Enrollment**. Due to Health Care Reform policy changes, the above-mentioned status changes for dependent children may be subject to revision based on future amendments to regulations that govern "changes in status" for cafeteria benefits plans. Failure to report the qualifying event timely may result in a reversal of claims, which will become your financial responsibility.

NEED TO REQUEST A CHANGE?

Legal documents are required for any dependent(s) that have not previously been enrolled in the plan(s) you elect. Failure to provide the necessary documentation for dependents will result in the dependents not being added to the plan.

NEED TO ADD A SPOUSE OR DEPENDENT TO YOUR BENEFITS?

The Human Resource Benefits Team will need the following to add a dependent to your benefit plan (please staple together with all your forms you are submitting for Open Enrollment):

To Add Spouse:

- Marriage License
- Social security card
- Drivers License or Passport

To Add Dependent:

- Birth Certificate
- Social security card
- Legal documentation for adoption, fostering, or court appointed guardianship
- Stepchildren: marriage license, birth certificate and social security card.

RETIREE MEDICAL BENEFITS OPTIONS

Federal Government Sponsored

A Medicare Part A
Covers hospital stays

B Medicare Part B
Covers doctors and outpatient visits

Can be supplemented with:

Group Plan

Group Plan
LCBOCC-sponsored with Aetna
Covers some or all the costs not covered by Medicare Part A and Part B
(this is the group plan that is available to all employees; the Aetna Select and Aetna POS II)

Or

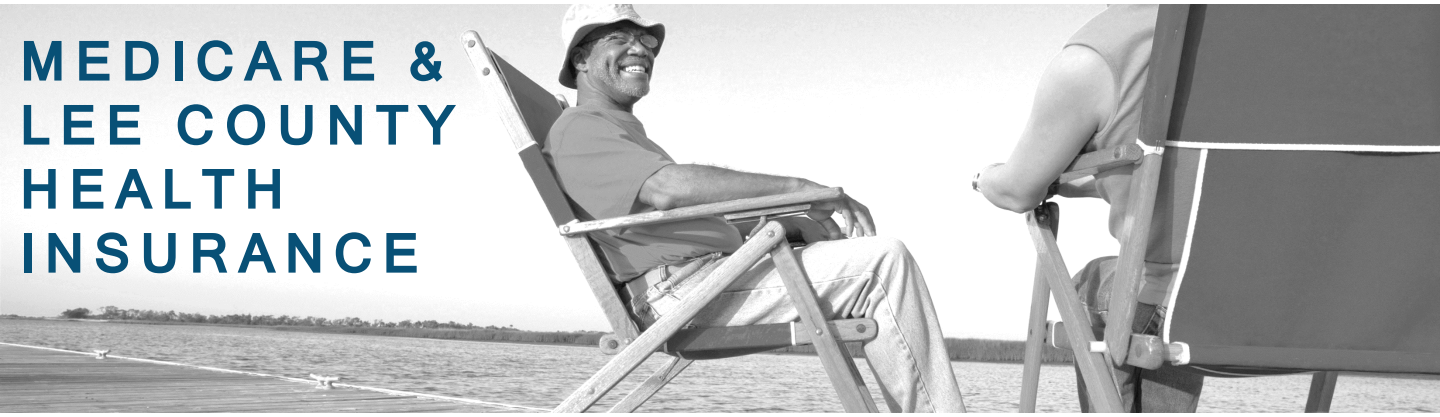
Group Medicare Advantage (MAP)
LCBOCC-sponsored with Aetna
Combines Part A and B and includes Medicare Part D (prescription drug coverage)

Or

Open Market Options
Such as Medicare Advantage Plans, Medicare Supplement plans (Medigap), Medicare Prescription Drug Plans (Part D)

Retirees not enrolled in Medicare can enroll in the Aetna Select or Aetna POS II plan. Rates for these plans can be found in your enrollment packet. Lee County requires all retirees/spouses to enroll in Medicare when they're eligible.

MEDICARE & LEE COUNTY HEALTH INSURANCE



Turning 65 and Medicare

Lee County requires Retirees/spouses insured under the medical plan to enroll in Medicare Part A and Part B when they become eligible. Medicare will become your primary insurance, and Lee County's Aetna Select or POS II plan will become the secondary insurance and will include prescription drug coverage.

Please note the following information:

- Your first point of contact with the Medicare program is Social Security. You don't have to draw Social Security benefits to be covered by Medicare; however, whether or not you already draw Social Security benefits at age 65 does determine when and how you enroll.
- If you are already drawing Social Security before the age of 65, you will be automatically enrolled in both Part A and Part B. Your Medicare card will be sent to you approximately 3 months before you turn 65.
- If you will not be receiving Social Security benefits at 65, you have to contact Social Security to enroll in Medicare – they will not contact you. Call Social Security at 1-800-772-1213 to begin your enrollment process three (3) months prior to your Medicare effective date.
- Human Resources will mail you a reminder letter 3 months prior to your 65th birthday. If Medicare information is not received your medical coverage will end the end of the month in which you turn 65.

Upon enrollment in both Medicare Parts A & B, your Lee County medical insurance becomes the *secondary payer* after Medicare. Human Resources will contact Aetna to enroll you in Medicare Direct to ensure that your medical claims are coordinated with Aetna and Medicare. Aetna will notify Medicare and all claims should be automatically routed to Aetna for secondary review and payment.

Medicare Part D: The Prescription Drug Plan (and other Medicare Supplements)

- Careful consideration should be given to your own personal situation before a decision is made to enroll in a Medicare Part D or any other Medicare supplement that includes a prescription drug plan.
- You should compare your current coverage, including which drugs are covered, with the coverage and cost of the plan offered under Medicare D.
- Enrollment in a Medicare Part D (Prescription Drugs) will remove you from your participation in our medical plans.

Disability, Medicare, & the Lee County Medical Plan:

If you are disabled at the time of your retirement and are not yet 65, you may become eligible for Medicare after two years of continuous disability, regardless of your age.

The same "primary payer" rule applies to Social Security disability status as for turning age 65: once you become eligible for Medicare, you must enroll in both Parts A & B, and Medicare will become the primary payer of your medical claims, regardless of your age at the time you become eligible for Medicare. This rule also applies to a disabled spouse who is currently on Medicare, if you have enrolled your disabled spouse in the Lee County Medical plan.

KEY NOTES FOR RETIREES ENROLLING IN THE MEDICARE ADVANTAGE PLAN:

In order to enroll in the Medicare Advantage Plan, the person(s) must be Medicare Eligible and enrolled in Medicare Part A and Part B in order to participate in this plan.

Retirees are required to pay Part B premium through Medicare in addition to the Medicare Advantage premium.

All covered family members are enrolled individually in this plan and must be Medicare eligible.

Medicare Eligible retirees who wish to continue covering a spouse or dependent children who are NOT ELIGIBLE for Medicare may only do so by remaining in the Aetna POS II or Aetna Select self-funded plan.

Enrollment in the Medicare Advantage Plan does not affect continued participation in the Life (limited amount), Dental and/or Vision plans. Each plan is elected separately and enrollment may continue until cancelled by the retiree. Once plans are cancelled retirees are unable to re-enroll.

If you have received your Medicare card and have not sent a copy to Human Resources, please do so in one of the following ways:

- **In Person:** Lee County Human Resources,
  1825 Hendry Street, #200
  Fort Myers, FL 33901
- **By Mail:** Lee County Human Resources,
  P.O. Box 398, Fort Myers, FL 33902
- **Fax:** (239) 485-2052
- **Email:** Benefits@leegov.com

MEDICARE ADVANTAGE PLAN

aetna

Lee County Government offers two medical plans and a Medicare Advantage Plan (MAP) through Aetna. The Medicare Advantage benefits are highlighted on the following pages.

	AETNA MAP
PCP Requirement	You have the option to choose a PCP. When Aetna knows who your doctor is, they can better support your care, however it is not required.
Referrals Required	Your plan doesn't require a referral from a PCP to see a specialist. Keep in mind, some providers may require a recommendation or treatment plan from your doctor in order to see you.
Prior Authorizations	Your doctor will work with Aetna to get approval before you receive certain services or drugs. Benefits that may require a prior authorization are listed in the Summary of Benefits included in this booklet.

ANNUAL DEDUCTIBLE	$0
MAXIMUM OUT OF POCKET	$1,500

Annual maximum out-of-pocket limit amount includes any deductible, copayment or coinsurance that you pay. It will apply to all medical expenses except Hearing Aid Reimbursement and Medicare prescription drug coverage that may be available on your plan.

	MEMBER COST
PHYSICIAN SERVICES	
PCP	$10
Specialist	$35
Preventive Care (Medicare-covered)	$0
EMERGENCY/URGENT CARE	
Emergency Care	$65
Urgently Needed Care	$50

Additional benefits included on the next page.

The contents included here are intended to provide a high-level overview. Please refer to the detailed summaries included in this packet.

HOSPITAL CARE	MEMBER COST
Inpatient Care	$500 per stay
Outpatient Services & Surgery	$200
Ambulatory Surgery Center	$200
DIAGNOSTIC	
Diagnostic Radiology (MRI/Pet Scan/CAT Scan/Stress Test)	$50
Lab Services	$35
Outpatient X Rays	$35
HEARING AIDS	
Routine Hearing Screening	$0
Hearing Aid Reimbursement	$500 every 36 months
PREVENTATIVE SERVICES	
Annual Wellness Visit/Bone Mass Measurement/Breast Exams/Breast Cancer Screening/Mammogram/Cervical and Vaginal Cancer Screenings/Colorectal Cancer Screenings/Depression Screenings/Diabetes Screenings/Prostate Cancer Screenings	
OTHER BENEFITS	
Skilled Nursing Facility	$0 per day, days 1-100
Transportation (non-emergency)	24 trips with 60 miles allowed per trip
Meals	Covered up to 14 meals following an inpatient stay
Telehealth Services	Cost depends on service type

PHARMACY BENEFITS	MEMBER COST
Generics	$10
Preferred	$20
Non-Preferred Brand	$35
Specialty	$35

TELADOC BENEFITS	
Telehealth PCP	$10
Telehealth Specialist	$35
Telehealth Other Health Care Providers	$35
Telehealth Individual Mental Health	$35
Telehealth Group Mental Health	$35
Telehealth Urgent Care	$50

OUT OF NETWORK BENEFITS?

Yes! Same cost share as in-network benefits.

SILVER SNEAKERS FITNESS BENEFIT

Silver Sneakers is a fitness resource designed specifically for seniors that is included with your enrollment in a MAP plan through Lee County. Take advantage of free online and in person fitness classes. Class options include yoga, cardio dance, stability, meditation, strength and balance and more! You can even access hundreds of workouts and nutritional webinars on demand.

AETNA SELECT & POS II

Lee County Government offers two medical plans and a Medicare Advantage Plan through Aetna. Aetna Select and Aetna Choice POS II benefits are highlighted on the following pages. Both are comprehensive plans with services that include, but are not limited to routine, preventive, mental health, hospitalization, and prescription drug benefits.

	AETNA SELECT OPEN ACCESS	AETNA CHOICE POSII OPEN ACCESS
PCP Requirement	None	None
Referrals Required	No	No
Out of Network Benefits	No	Yes
Teladoc Benefits	Yes	Yes
CO-PAYS		
PCP	$10	$10
Behavioral Health	$10	$10
Specialist	$25	$35
Urgent Care	$50	$50
Lab	$25	$35
Emergency Room	$150	$150
Hospital Admission	$500	$500
Outpatient Services	$200	$200
TelaDoc	$10	$10

PCP: Primary Care Physician

All co-pays listed above are for in network benefits. To view additional plan details including the out of network benefits on the Aetna Select Open Access plan, please review the Summary of Benefits and Coverage & Summary Plan Descriptions at **https://www.leegov.com/hr/retirees/benefits**.

FIND A NETWORK PROVIDER

You are encouraged to create a login for your Aetna.com account to identify in-network providers based on your enrolled plan.

www.aetna.com/individuals-families/find-a-doctor.html

PREVENTIVE SERVICES

The following in-network preventive services will be offered at no cost to the member:

- Routine Adult Physical Exams
- Routine GYN
- Routine Cancer Screenings (Mammography/Colon Screening/DRE/PSA)
- Routine Vision Exam

COMPLEX IMAGING SERVICES

Have a $50 co-pay for either plan. These services include but are not limited to:

- MRI
- PET Scan
- CAT Scan
- Nuclear Stress Test

Pre-authorization for these services is required and must be obtained by your physician's office. Please visit Aetna's website at www.aetna.com for additional services.

AETNA VISION DISCOUNTS

Provides discounts on one routine eye exam every 12 months and provides discounts on eyeglasses, sunglasses, contact lenses and solutions, LASIK surgery, and more. This coverage is included with your Aetna health benefits plan at no additional cost for the program.

TELADOC

Talk to a doctor anytime, anywhere by phone or video. It's included in your medical plan.

- 24/7 access to care by web, phone or mobile app
- High quality care with over 7,000 U.S. board-certified doctors
- Get help with TelaDoc's comprehensive suite of services
- Simple and easy registration

1-855-TELADOC (835-2362) | Teladoc.com/Aetna

Create an Account

Use your phone, the app, or the website to create an account and complete your medical history.

Talk to a Doctor

Request a time and a Teladoc doctor will contact you.

Feel Better

The doctor will diagnose symptoms and send a prescription if necessary.

PHARMACY

RETAIL STORES

Generic	$10
Formulary Brand	$20
Non-Formulary Brand	$35

DOWNLOAD THE APPS

Available for Apple or Android

Teladoc
24/7 access to a doctor

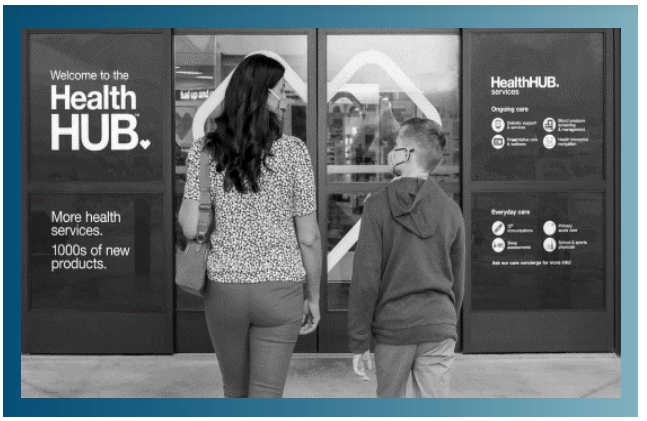
Aetna Health
View benefits details, member ID cards and more!

MAIL ORDER OPTIONAL PROGRAM

Want one less thing to worry about? Sign up to have a 90-day supply of your maintenance medications shipped right to your door with Aetna's Mail Order Program!

For more information, call 888-792-3862 or login to your www.aetna.com account, navigate to the Pharmacy tab and select "Start a New Mail-Order Prescription". You can also ask your doctor to send your prescription to CVS Caremark.

CVS HealthHUB



Convenient care at $0 cost to you!

CVS HealthHUB provides access to health services for certain acute and chronic conditions — delivered by a local care team that's focused on providing personalized, one-on-one support. Services include:

- Preventative care and wellness
- Care for minor illnesses and injuries
- Blood pressure, Diabetic screenings, and sleep apnea screenings
- Medication consultations and reconciliation
- Over-the-counter health support

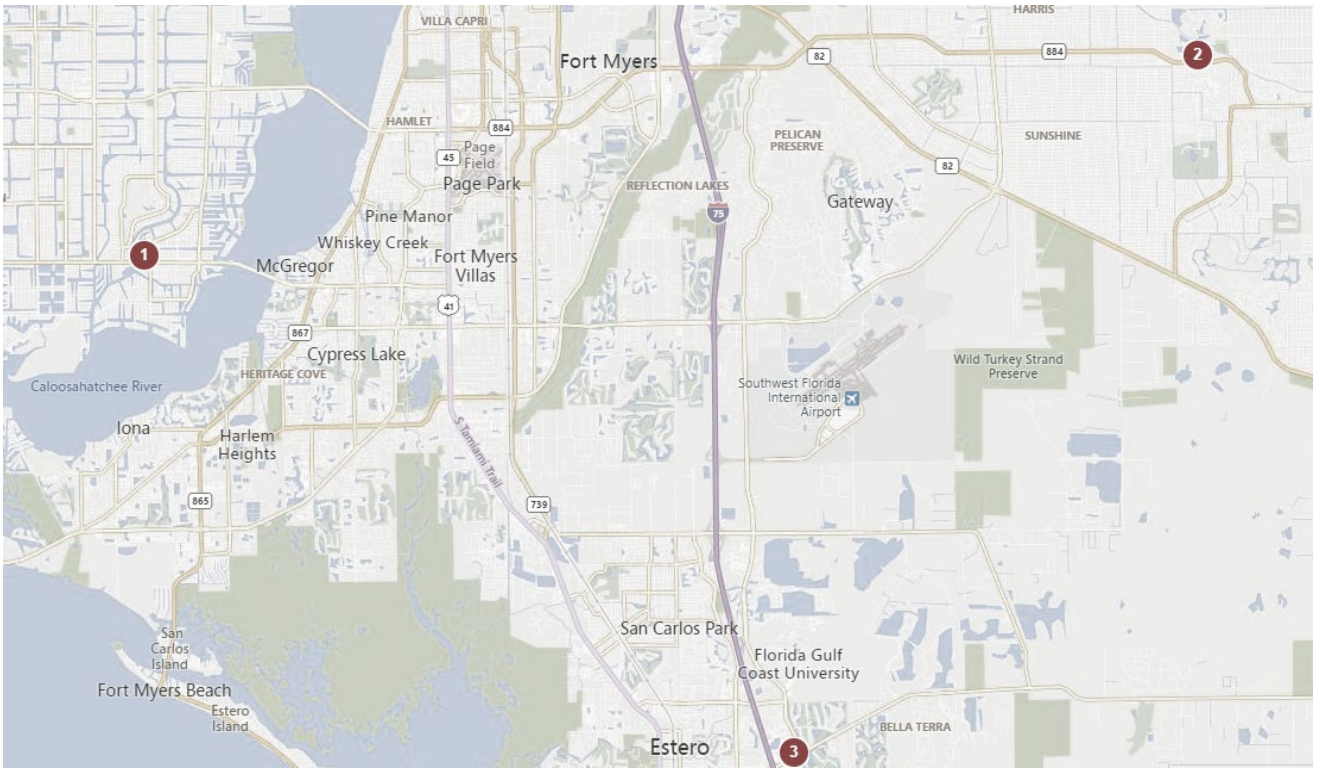
CVS HealthHUB providers can also administer vaccines and write prescriptions, when medically appropriate.

Find a HealthHUB near you:

https://www.cvs.com/content/health-hub

Book an appointment online and walk right in

With flexible hours, including nights and weekends, you can get care that meets your busy schedule.



OVERAGE DEPENDENT ELIGIBILTY & AFFIDAVITS

Over-Age Dependent Affidavits (Age 26-30) **must be completed annually**. Contact Human Resources (239) 533-2245 for details.

Eligibility for Coverage from Age 26-30 and Affidavit of Dependent Eligibility:

At the end of the month in which a covered dependent attains the age of 26, he/she will be dropped from all insurance plans.

The retiree may elect to continue their dependent(s) coverage in the POS II and Select medical plans only and pay an additional premium for each dependent covered in the 26-30 age group. Currently, that rate is $1,180 per month in addition to any other applicable tier of medical premiums.

The dependent(s) must meet the eligibility requirements, and an Affidavit of Dependent Eligibility (26-30 years old) must be completed for each dependent in order to continue coverage for that dependent. For retirees who currently access this benefit, you must complete and verify dependent's eligibility each year during open enrollment.

MEDICAL OPTIONS SIDE-BY-SIDE

This comparison was prepared to highlight general differences between plan benefits, it is not to be construed as a complete description of benefits.

	Aetna Group Retiree Medicare Advantage ESAPPO Plan	**Aetna Choice POS II** Secondary to Medicare (current benefits)	**Aetna OA Select** Secondary to Medicare (current benefits)
	In-Network & Out-of-Network	In-Network & Out-of-Network	In-Network & Out-of-Network
Annual Medical Deductible	None	$500/$1000 Out of Network	None
Annual Medical Out-of-Pocket Maximum	$1,500	$1,500	$1,500
Office Visits - PCP	$10 copay	$10 copay	$10 copay
Office Visits - Specialist	$35 copay	$35 copay	$25 copay
Inpatient Hospital Coverage	$500 copay per admit	$500 copay per admit	$500 copay per admit
Diagnostic Laboratory and X-ray except for Complex Imaging	$35 copay	$35 copay	$25 copay
Diagnostic X-ray for Complex Imaging	$50 copay	$50 copay	$50 copay
Urgent Care Provider	$50 copay	$50 copay	$50 copay
Emergency Room	$65 copay	$150 copay	$150 copay
Ambulance	$0 copay	$0 copay	$0 copay
Durable Medical Equipment	$0 copay	$0 copay	$0 copay
Routine Podiatry	$35 copay	$35 copay	$25 copay
Outpatient Surgery	$200 copay	$200 copay	$200 copay
Outpatient Mental Health	$35 copay	$35 copay	$25 copay
Outpatient Alcohol / Drug Abuse	$35 copay	$35 copay	$25 copay
PREVENTIVE CARE			
Routine Adult Physical Exams	$0 copay	$0 copay	$0 copay
Immunizations	$0 copay	$0 copay	$0 copay
Routine Gynecological Care Exams	$0 copay	$0 copay	$0 copay
Routine Mammograms	$0 copay	$0 copay	$0 copay
Colorectal Cancer Screening	$0 copay	$0 copay	$0 copay
Routine Eye Exams	$0 copay	$0 copay	$0 copay
Routine Hearing Exams	$0 copay	$0 copay	$0 copay
Hearing Aid Reimbursement	$500 every 36 months	Yes, up to $2,500	Yes, up to $2,500
Meals after Inpatient Care	Included	Not Included	Not Included
PRESCRIPTION DRUGS - RETAIL (Up to a 30-day supply at a Network Pharmacy)			
Generics	$10 copay	$10 copay	$10 copay
Preferred Brand-name	$20 copay	$20 copay	$20 copay
Non-Preferred Brand-name	$35 copay	$35 copay	$35 copay
Specialty drugs	$35 copay	$35 copay	$35 copay
PRESCRIPTION DRUGS - GENERAL INFORMATION			
Formulary	Covers all Medicare approved drugs	Covers all Medicare approved drugs	Covers all Medicare approved drugs
Step Therapy	Not Included	Not Included	Not Included
Coverage Gap (Donut Hole)	Same copays as above	Same copays as above	Same copays as above
WELLNESS BENEFITS			
Fitness / SilverSneakers	Silver Sneakers	Global Fitness	Global Fitness
Caregiver	Included	Included	Included
NurseLine	Included	Included	Included
Disease Management Chronic Heart Failure (CHF) Coronary Artery Disease (CAD)/Diabetes End Stage Renal Disease (ESRD)	Included	Included	Included
Group Retiree Case Management	Included	Included	Included
Advanced Illness Care Management	Included	Included	Included

Lee County Human Resources

MEDICARE PPO - AETNA MEDICARE ADVANTAGE PLAN (MAP)
Premiums for Plan Year 2024

- ***Subsidy Eligibility: BOCC Employees who have six or more years of consecutive BOCC employment prior to retirement are eligible to receive the Medical Subsidy.**
- **** If the subsidy criteria are not met, the retiree is responsible for the total cost.**

Lee County is very pleased to continue offering a **M**edicare **A**dvantage **P**lan option for retirees for plan year 2024.

In order to enroll in the Medicare Advantage Plan, the person(s) must be Medicare Eligible and enrolled in **Medicare Part A and Part B** in order to participate in this plan.

The Part B premium is in addition to the premium amounts shown below for each family member enrolled. Medicare requires payment for the Medicare Part B premium.

All covered members are enrolled individually in this plan.

Medicare Eligible retirees who wish to continue covering a spouse or dependent children who are NOT ELIGIBLE for Medicare may only do so by remaining in the Aetna POS2 or Aetna Select self-funded plan.

With the Medicare Advantage Plan option, retirees will pay only 40% of the total cost for their premiums on the medical plan – the (former) employer pays the other 60%.

Retirees' Medicare Option Premiums (Includes Prescription Drugs)	***COUNTY Share**	***RETIREE'S Share**	****TOTAL Cost**
Retiree Only	$194.74	$129.82	$324.56
Retiree + Spouse	$389.48	$259.64	$649.12
Retiree + One Dependent	$389.48	$259.64	$649.12

Enrollment in the Medicare Advantage Plan does not affect continued participation in the Life (limited amount), Dental and/or Vision plans. Each plan is elected separately, and enrollment may continue until ***cancelled*** by the retiree.

AETNA MEDICARE ADVANTAGE PLAN (MAP) – No Subsidy

Premiums for Plan Year 2024

Lee County is very pleased to continue offering a **M**edicare **A**dvantage **P**lan option for retirees for plan year 2024.

In order to enroll in the Medicare Advantage Plan, the person(s) must be Medicare Eligible and enrolled in **Medicare Part A and Part B** in order to participate in this plan.

The Part B premium is in addition to the premium amounts shown below for each family member enrolled. Medicare requires payment for the Medicare Part B premium.

All covered members are enrolled individually in this plan.

Medicare Eligible retirees who wish to continue covering a spouse or dependent children who are NOT ELIGIBLE for Medicare may only do so by remaining in the Aetna POS2 or Aetna Select self-funded plan.

Retirees' Medicare Option Premiums (Includes Prescription Drugs)	****TOTAL Cost**
Retiree Only	$324.56
Retiree + Spouse	$649.12
Retiree + One Dependent	$649.12

Enrollment in the Medicare Advantage Plan does not affect continued participation in the Life (limited amount), Dental and/or Vision plans. Each plan is elected separately, and enrollment may continue until ***cancelled*** by the retiree.

LEE COUNTY BOARD OF COUNTY COMMISSIONERS

Retiree Monthly Premiums – with Subsidy

PLAN YEAR 2024

***Medical Subsidy Eligibility:* Effective 01/01/2019, BOCC Employees who have six (6) or more years of consecutive BOCC employment prior to retirement are eligible to receive the Medical Subsidy. If the criteria for the subsidy is not met, the retiree pays the Total Monthly Premium Cost.**

The medical rates below are a la carte. Please add the appropriate "Retiree's Share" premiums to calculate the total monthly amount for your elected coverage tier premium. For example, for a Retiree who has Medicare with a Spouse who does not have Medicare, please add $493.60+397.50 to get the total monthly amount owed = $891.10.

Aetna Select & Aetna POS2 Retiree Medical Premiums	**County Share	**Retiree's Share	Total Cost
Retiree Only - No Medicare	$590.00	$590.00	$1,180.00
Retiree Only w/Medicare	$493.60	$493.60	$ 987.20
Spouse Only - No Medicare	$397.50	$397.50	$ 795.00
Spouse Only w/Medicare	$301.10	$301.10	$ 602.20
Dependent Only - No Medicare	$382.50	$382.50	$ 765.00
Dependent Only w/Medicare	$286.10	$286.10	$ 572.20
Family Only – No Medicare	$405.00	$405.00	$ 810.00
Family Only w/Medicare	$308.60	$308.60	$ 617.20

AETNA - DENTAL PREMIUMS	
Retiree Only	$ 42.00
Retiree + Spouse and/or Dependent(s)	$ 77.00

VSP – VISION PREMIUMS	
Retiree Only – Low Option	$ 8.45
Retiree + Spouse and/or Dependents – Low Option	$ 16.45
Retiree Only – High Option	$ 14.70
Retiree + Spouse and/or Dependents – High Option	$ 28.07

***RETIREE LIFE INSURANCE* - $5,000.00 (limited)**	$ 13.35

Medical Medicare Premium Rates are calculated on the premium rate of $96.40, as last approved by the Board of County Commissioners. The Board subsidizes this rate upon proof of enrollment in Medicare Part B, in addition to 50% of the total cost of our medical plan for retirees.

Lee County Human Resources

RETIREE MONTHLY PREMIUM RATES – NO SUBSIDY
PLAN YEAR - 2024

Employees retiring with less than 6 years of consecutive BOCC service prior to retirement are not eligible for the monthly medical subsidy.

Aetna Select and Aetna POS2 **Retirees' Medical Insurance Premiums**	**Total**
Individual Premiums	
Retiree Only	$1,180.00
Retiree + Spouse	$1,975.00
Retiree + Dependents	$1,945.00
Family (Includes Dependents & Spouse)	$1,990.00

AETNA DENTAL PREMIUMS	
Retiree Only	$ 42.00
Retiree + Spouse and/or Dependents	$ 77.00

VSP - VISION PREMIUMS	
Retiree Only – Low Option	$ 8.45
Retiree + Spouse and/or Dependents – Low Option	$ 16.45
Retiree Only – High Option	$ 14.70
Retiree + Spouse and/or Dependents – High Option	$ 28.07

Retirees' Life Insurance **- $5,000.00**	$ 13.35

DENTAL PLAN

aetna

The County offers one great dental plan that offers both in and out of network benefits. For additional benefits details, https://www.leegov.com/hr/retirees/benefits

ANNUAL DEDUCTIBLE*	IN NETWORK	OUT OF NETWORK
Individual	$50	$50
Family	$100	$100
COINSURANCES	**PLAN PAYS**	
Preventive	100%	100%
Basic	80%	80%
Major	50%	50%
BENEFIT MAXIMUM		
Annual Maximum****	$1,500	$1,500
ORTHODONTIC		
Deductible	$0	$0
Coinsurance	50%	50%
Eligibility	Dependent Child Only**	Dependent Child Only**
PROVIDER BILLING		
	Contracted Rates	May Charge More than Contracted Rates***

* Deductible applies to basic and major services only
**Orthodontia appliance must be placed prior to age 20
***Balance of bill for out of network providers becomes patient's responsibility
**** Lifetime Maximum for Orthodontia is $1000

VISION PLAN

The County offers two fantastic vision plan options for you to choose from. For additional benefits details, please review additional details at www.leegov.com by selecting “departments” then “Human Resources” and then select “Retirees” from the list on the left side of the page.

	VSP LOW PLAN	VSP HIGH PLAN
Routine Eye Exam Frequency	1x per year	1x per year
Lenses	1x per year	1x per year
Frames	1x every other year	1x every other year
Eye Exam Copay	$10	$10
Frames & Lenses Copay	$15	$15
FRAME ALLOWANCE (plus 20% off any remaining balance)		
Standard	$120	$150
Featured Brands	$170	$200
Costco	$65	$80
LENS ENHANCEMENTS		
Progressive Lenses	$0 Standard $95-$105 Premium $150-$175 Custom	$0
Anti-reflective	$41-$85	$0
Scratch Coating	$0	$0
Polycarbonate	$10	$0
Photochromic	$75	$0
UV (ultraviolet)	$10	$0
CONTACTS (instead of glasses)		
Contact Lens Exam	Up to $60	Up to $60
Allowance	$120	$150

RETIREE LIFE INSURANCE

The Retiree (term) Life Insurance value is a flat $5,000 at a monthly premium of $13.35. The amount does not reduce as age increases. Upon death, the full amount will be paid to the named beneficiary or beneficiaries. If there are no named or eligible beneficiaries, the death benefit will be paid as indicated in the Term Life Certificate.

Updating Beneficiaries

It is very important to review and update your beneficiaries at least annually. To change or update beneficiaries any time during the year, please obtain a form by visiting our website: https://www.leegov.com/hr/retirees/benefits

Please email form to benefits@leegov.com or fax to (239) 485-2052.

GLOSSARY

Balance Billing: When an out-of-network provider bills you for the difference between the provider's charge and your insurance's allowed amount. For example, if the provider's charge is $100 and the allowed amount is $70; the provider may bill you for the remaining $30. An in-network provider cannot balance bill you for the covered services.

Beneficiary: A person who is designated as the recipient of an insurance policy payout.

Co-insurance: Your share of the costs of a covered medical service calculated as a percent of the allowed amount for the service. For example, if your plan has a 30% co-insurance rate, the Carrier will pay 70% of the allowed amount while you pay the balance.

Coordination of Benefits: When you and/or your family member is covered by more than one insurance 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.

Co-payment: A fixed amount that you pay at the time of service. Co-pays are most common for PCP or specialist office visit, emergency room, urgent care and prescription drugs.

Deductible: The amount you must pay for eligible expenses before your plan begins to pay for benefits. A deductible may be per service/test, per visit, per supply or per coverage year. For example, our dental plan has an annual deductible for an individual of $50 which must be paid before the plan will pay.

Dependent: Typically a relative of an employee who may be eligible for benefits coverage if they meet certain criteria. Our benefit plans offer coverage to spouses and children up to age 26 who are totally or substantially reliant on their parents for support, thereby defined as "dependent children".

Diagnostic Test: Medical tests designed to establish the presence (or absence) of disease as a basis for treatment decisions in symptomatic or screen positive individuals. Note that diagnostic tests are different than screening tests. Screenings are primarily designed to detect early disease or risk factors for disease in apparently healthy individuals (i.e. annual mammograms).

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

Durable Medical Equipment (DME): Equipment and supplies ordered by a healthcare provider for everyday or extended use. Coverage for DME may include oxygen equipment, CPAP machines, wheelchairs or crutches.

Eligible Expense: Amount on which payment is based for covered medical services. This may be called “allowed amount maximum,” “payment allowance” or “negotiated rate”. If an out-of-network provider charges more than the allowed amount, you may have to pay the difference. (See Balance Billing.)

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.

Evidence of Insurability (EOI): is an application process in which you provide information on the condition of your health or your dependent's health to get certain types of insurance coverage such as optional life or short-term disability (STD).

Explanation of Benefits (EOB): Every time you use your health insurance, your health plan sends you a record called an “explanation of benefits” (EOB) or “member health statement” that explains how much you owe. The EOB also shows the total cost of care, how much your plan paid and the amount an in-network doctor or other healthcare professional is allowed to charge a plan member (called the “allowed amount”).

Formulary: 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: Medications that are comparable to brand name drugs in dosage form, strength, quality, performance characteristics and intended use, per the FDA. Generic drugs are almost always priced more attractively than their brand name counterparts.

In-Network Provider: A provider who has a contract with your health insurer or plan to provide services to you at a discount. In-Network Providers have contracted with the insurance carrier to accept reduced fees for services provided to plan members. Using in-network providers will cost you less money. When contacting an In-Network Provider, remember to ask “are you a contracted provider with my plan?” Never ask if a provider “takes” your insurance, as they will all take it. The key phrase is contracted.

Mail Order: Members can obtain a 90-day supply at one time vs. 30 days at a traditional pharmacy. Most suitable for maintenance medications or any drug taken daily, such as contraceptives or blood pressure medications.

Medically Necessary: Medical services or supplies needed to prevent, diagnose or treat an illness, injury, condition, disease or its symptoms and that meet accepted standards of medicine.

Medicare Advantage Plan (MAP): A County-sponsored plan option that combines Medicare Part A and B and includes Medicare Part D (prescription drug coverage).

Member Health Statement: Every time you use your health insurance, your health plan sends you a record called a "member health statement" or an "explanation of benefits" (EOB) that explains how much you owe. The member health statement also shows the total cost of care, how much your plan paid and the amount an in-¬network doctor or other healthcare professional is allowed to charge a plan member (called the "allowed amount").

Network: The facilities, providers and suppliers a health insurance carrier has contracted with to provide medical services at pre-negotiated discount. Your out-of-pocket expenses will be lower and you will not be responsible for filing claims if you visit a participating in-network provider.

Non-Preferred Brand Name Drugs: Generally these are higher-cost medications that have recently come on the market. In most cases, an alternative preferred medication is available, be it a preferred brand name drug or a generic.

Non-Preferred Provider: A provider who doesn't have a contract with your health insurer or plan to provide services to you. You'll pay more to see a non-preferred provider.

Open Enrollment: The annual period during which you may freely enroll in or change benefit programs.

Out-of-Network Provider: A provider who doesn't have a contract with your health insurer or plan to provide services to you at a pre-negotiated discount. You'll pay more to see an out-of-network provider, sometimes referred to as a non-preferred provider.

Out-of-Network Co-insurance: The percent you pay of the allowed amount for covered medical services to providers who do not contract with your health insurance carrier. Out-of-network co-insurance costs you more than in-network co-insurance. An out-of-network provider can balance bill you for charges over the allowed amount. (See Balance Billing.)

Out-of-Pocket Limit/Maximum: The most you will pay during a policy period (a year) before your plan begins to pay 100% of the allowed amount. This limit does not include your premium or balance-billed charges.

Over-the-Counter Drug: A drug that you can buy without a prescription from a drugstore or most general or grocery stores. For example, Benadryl, Tylenol, and Ibuprofen are sold over-the-counter. The opposite of a prescription drug.

Payment Allowance: Amount on which payment is based for covered medical services. This may be called "allowed amount maximum," "negotiated rate" or "eligible expense". If an out-of-network provider charges more than the allowed amount, you may have to pay the difference. (See Balance Billing.)

Preauthorization: A medically necessary determination by a health insurance carrier for a medical service, treatment plan, prescription drug, medical or prosthetic device or certain types of durable medical equipment. Sometimes called prior authorization, prior approval or precertification, many plans require preauthorization for certain services before you can receive them, except in cases of emergency. Preauthorization isn't a promise your medical plan will cover the cost.

Preferred Brand Name Drug: These are medications for which generic equivalents are not available. They have been in the market for some time and are widely accepted. They cost more than generic drugs, but less than non-preferred brand-name drugs.

Preferred Provider: A provider who has a contract with your health insurer or plan to provide services to you at a pre-negotiated discount.

Premium: The amount that must be paid up front, typically via semi-monthly or bi-weekly payroll deductions for insurance coverage.

Prescription Drugs: Medications you can only obtain with a prescription from your Doctor. Prescriptions must be taken to a pharmacy (or sent to a mail-order facility) where a licensed pharmacist will fill it for you. For example, Lipitor and Albuterol can only be obtains with a prescription. The opposite of an over-the-counter drug.

Preventative Care: Medical treatments performed with the intention of preventing a health issue. For example, vaccinations and age-appropriate screenings are almost always considered to be preventative.

Primary Care Physician (PCP): A physician who directly provides or coordinates a wide range of medical services for a patient. Primary Care Physicians include Medical Doctors, Doctors of Osteopathic Medicine, Internists, Family Practitioners, General Practitioners and Pediatricians. The opposite of a specialist.

Provider: A physician, healthcare professional or healthcare facility, certified or accredited as required by state law.

Qualifying Event: A life change as defined under IRS Tax Code Section 125 and HIPAA. These events allow you to make a mid-year change in benefit coverage.

Specialist: A physician who focuses on a specific area of medicine or a group of patients to diagnose, manage, prevent or treat for certain types of symptoms and conditions. The opposite of a Primary Care Physician (PCP). For example, a Dermatologist is considered a specialist.

Specialty Drugs: Prescription medications that require special handling, administration or monitoring. These drugs are used to treat complex, chronic and often costly conditions, such as multiple sclerosis, rheumatoid arthritis, hepatitis C, and hemophilia.

Urgent Care: An illness or injury serious enough that a reasonable person would seek care right away, but not severe as to require emergency room care.

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.

DISCLOSURES & LEGAL NOTICES

Patient Protection and Affordable Care Act Disclosure Notices

The following disclosures are required under the Health Care Reform Act. Lee County's group health plan is already compliant with the following reforms.

The Affordable Care Act Patient Protection Disclosure

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.

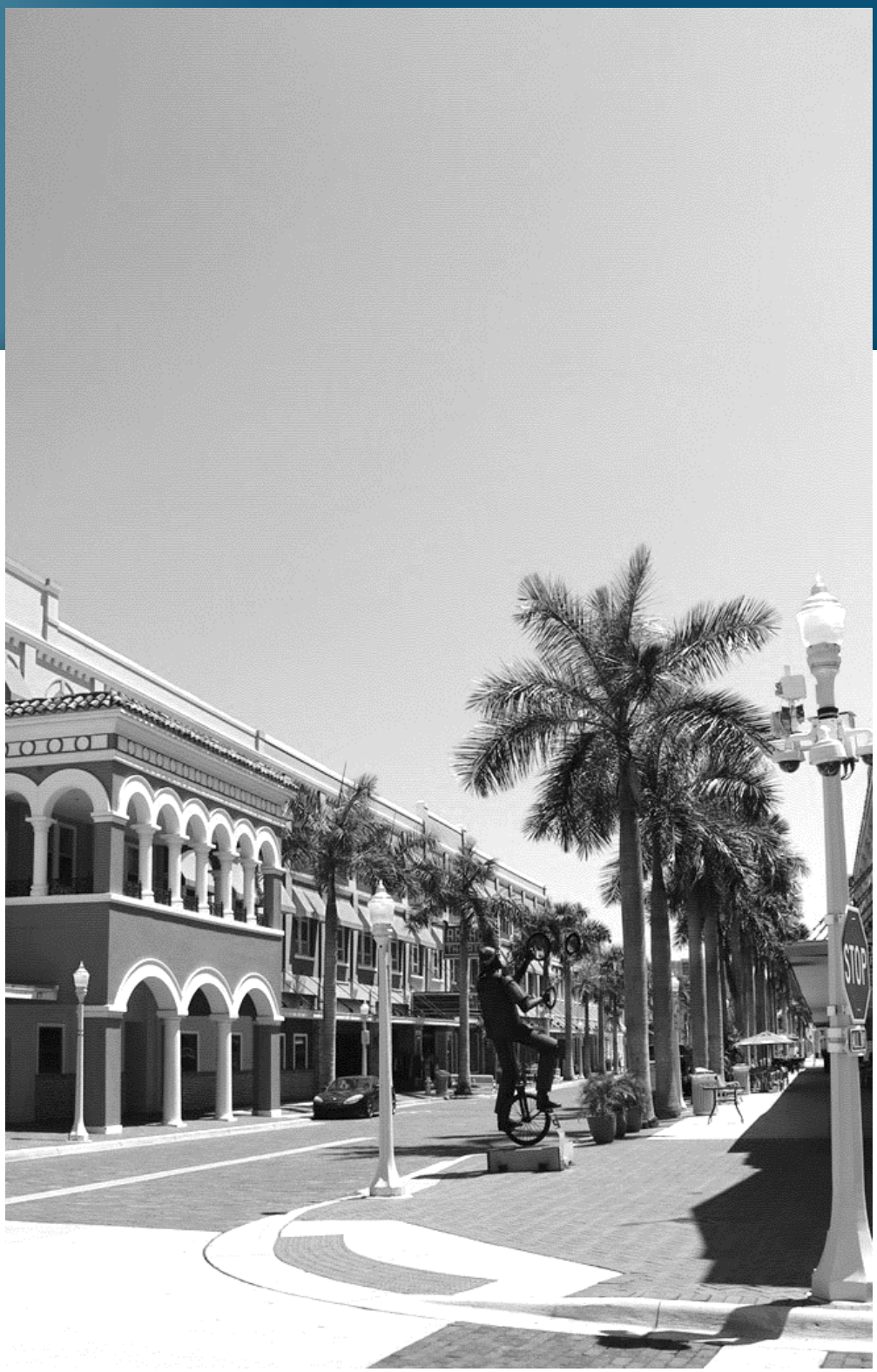
For children, you may designate a pediatrician as the primary care provider. You do not need prior authorization from Aetna or from any other person (including a primary care provider) in order to obtain access to obstetrical or gynecological care from a health care professional in our network who specializes in obstetrics or gynecology.

The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for 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 http://www.aetna.com or contact the Aetna Member Services number on your Aetna medical identification card.

The following legal notices are available online at
https://www.leegov.com/hr/retirees/hipaa

- Medicare Part B Creditable Coverage
- Children's Health Insurance Plan (CHIP)
- Health Insurance Marketplace Notice
- Privacy Notice (HIPAA)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