AETNA MEDICARE GROUP AGREEMENT

This Group Agreement is by and between the Aetna entity or entities identified in Section 1.2 below ("Aetna") and Lee County Board of County Commissioners (the "Contract Holder"). This Group Agreement takes effect on January 1, 2018 (the "Effective Date").

This Group Agreement consists of the combination of the following documents:

- The **Evidence of Coverage** issued to Members in connection with this Group Agreement, including the attached Schedule of Copayments/Coinsurance (the "EOC"). The EOC is issued by Aetna to Members on an annual basis. Upon request, Aetna will provide Contract Holder with a copy of the EOC.
- The most recent **rate exhibits, plan designs and financial conditions** issued by Aetna to the Contract Holder in connection with the original issuance and renewal of this Group Agreement, and, if Aetna is billing both the Contract Holder and Members a portion of the monthly premium, the **Service Agreement** between Aetna and Contract Holder that describes this split billing arrangement. These documents are collectively referred to herein as the "Financial Documents".
- This **Group Agreement**, including the attached CMS/Regulatory Requirements Addendum and the Addendum labeled "Aetna Medicare Advantage HMO Affiliate Addendum".
- Contract Holder's **Group Application** (the "Group Application").
- Any riders, amendments, inserts or attachments issued pursuant to any of the foregoing documents.

The Group Application, EOC and Financial Documents are collectively referred to as the "Incorporated Documents."
Aetna and Contract Holder agree as follows:

Section 1. COVERAGE

1.1. **Covered Benefits.** The Financial Documents identify the fully-insured Aetna Medicare Plan(s) (the "Plan(s)") offered to the Contract Holder under this Group Agreement for the corresponding time periods and the service area(s) (the "Service Area(s)") where the Plans are offered. Aetna shall provide coverage to Members for all of the health care services and supplies that are covered by the Plan(s) (the "Covered Benefits").

1.2. **Aetna Insurer/HMO.** Aetna's Medicare Advantage PPO Plans are offered by Aetna Life Insurance Company, Coventry Health and Life Insurance Company, HealthAssurance Pennsylvania, Inc., and Coventry Health Care of Illinois, Inc. With regard to such Plans, "Aetna" means Aetna Life Insurance Company, Coventry Health and Life Insurance Company, HealthAssurance Pennsylvania, Inc., and Coventry Health Care of Illinois, Inc.

Aetna Medicare Rx Plans are offered by Aetna Life Insurance Company. With regard to such Plans, "Aetna" means Aetna Life Insurance Company,

With regard to Medicare Advantage HMO Plans, "Aetna" means the licensed HMO(s) identified in the Addendum to this Group Agreement labeled "Aetna Medicare Advantage HMO Affiliate Addendum".

Section 2. TERM

2.1. **Term.** The term of this Group Agreement (the "Term") will be 12 months beginning at 12:01 a.m. on January 1, 2018 (the "Effective Date").

Section 3. PREMIUMS

3.1 **Premiums.** Aetna uses three different methods for billing premiums. A monthly premium can either be billed to the Member ("Direct Billing"), to the Contract Holder ("Contract Holder Billing") or to both the Member and the Contract Holder ("Split Billing"). In some cases, Aetna uses multiple billing methods for the same Contract Holder. The Group Application will indicate the billing method(s) that apply to the Plan(s) under this Agreement. If Contract Holder and Aetna agree to change the billing method(s) applicable to the Plan(s) after the Term, the Financial Documents will indicate the billing method(s) that apply to the Plan(s) under this Agreement. In all cases, the "Premium Due Date" shall be the Effective Date and the 1st day of each succeeding calendar month.

- For Members who are subject to Direct Billing, Aetna will charge the Member a monthly premium (the "Member Premium") determined by Aetna based on the Member Premium in effect on the Premium Due Date, as stated in the Financial Documents.
- Where Contract Holder Billing is applicable, Aetna will charge the Contract Holder a monthly premium (the "Contract Holder Premium") determined by Aetna based on the Contract Holder Premium in effect on the Premium Due Date, as stated in the Financial Documents.
- Where Split Billing is applicable, Aetna will charge the Contract Holder and each Member a monthly premium (comprised of both Member Premiums and Contract Holder Premiums aggregating to a "Split Billing Premium") determined by Aetna based on the Split Billing Premium in effect on the Premium Due Date, as stated in the Financial Documents.

"Member Premium", "Contract Holder Premium" and "Split Billing Premium" are collectively referred to herein as "Premium".

Members shall pay all Member Premium and the Contract Holder shall pay all Contract Holder Premium to Aetna on or before each Premium Due Date. Membership as of each Premium Due Date will be determined by Aetna in accordance with Aetna's Member records.

Aetna may change the rates for the Member Premium, the Contract Holder Premium and the Split Billing Premium and the Covered Benefits at the beginning of any Subsequent Term. The applicable Financial Document may identify certain circumstances when Aetna may change the rates for the Contract Holder Premium or the Split Billing Premium (other than the Member Premium portion) during the Term.

A Premium payment check does not constitute payment until it is honored by a bank. Aetna may return a check issued against insufficient funds without making a second deposit attempt.

Aetna may accept a partial payment of Premium without waiving the right to collect the entire amount due. If the Group Agreement terminates for any reason, the Members will continue to be held liable for all Member Premiums due and unpaid before the termination and the Contract Holder will continue to be held liable for all Contract Holder Premiums due and unpaid before the termination.

3.2 **Membership Adjustments.** Aetna may make retroactive additions of Members at its discretion based upon Aetna's eligibility and enrollment guidelines consistent with all Mandates. Such additions are subject to the payment of all applicable Premiums.

Aetna may also make retroactive adjustments to the Contract Holder's billings for the termination of Members, but only for a maximum of 1 billing periods.

Section 4. ENROLLMENT/DISENROLLMENT

4.1 **Enrollment.** The Contract Holder shall offer enrollment in the Plan(s) in compliance with all applicable Mandates as follows:

- At least once during the Term, the Contract Holder shall hold an open enrollment period ("Open Enrollment Period") when all eligible individuals may enroll in the Plan(s). The Open Enrollment Period shall be held at the same time as the open enrollment period for all other group health benefit plans being offered by the Contract Holder to retirees.
- The Contract Holder shall also enable all eligible individuals to enroll in the Plan(s) within 31 days of becoming eligible to receive coverage under the Plan(s).

All eligible individuals and dependents not enrolled in the Plan(s) within the Open Enrollment Period or within 60 days of becoming eligible may be enrolled during any subsequent Open Enrollment Period. Coverage under the Plan(s) will not become effective until confirmed by Aetna. The Contract Holder shall permit Aetna

representatives to meet with eligible individuals and dependents during each Open Enrollment Period.

4.2 **Eligibility.** The Contract Holder shall not change the Open Enrollment Period or any other eligibility requirements of the Plan(s) unless Aetna agrees to the change in writing. Actively working employees and their dependents are not permitted to enroll in the Plan(s).

4.3 **Enrollment/Disenrollment Processing.** The Parties shall agree in advance who shall bear responsibility for enrollment and disenrollment transactions. The Party bearing responsibility for enrollment/disenrollment transactions shall perform the function in accordance with all applicable Mandates, including Mandates relating to timeframes for processing and submission of such transactions. All of the enrollment and disenrollment requirements described in this Group Agreement also apply to any third party administrator retained by the Contract Holder to accept enrollment/disenrollment requests on its behalf.

Aetna will not be liable to Members for the fulfillment of any obligation before Aetna receives enrollment and eligibility information for the Member in a form satisfactory to Aetna. The Contract Holder must notify Aetna of the date in which a Member's eligibility ceases for the purpose of termination of coverage under this Group Agreement.

SECTION 5. TERMINATION

5.1 **Termination by Contract Holder.** The Contract Holder may terminate this Group Agreement in its entirety or in any particular Service Area, for any reason, by giving Aetna at least 60 days prior written notice of when such termination will become effective. The notice shall specify the effective date of the termination, which shall be the first day of the month, and the Plan(s) and Service Areas to be terminated if not the entire Group Agreement. *(Note: Aetna requires 60 days' notice in order to provide sufficient time to meet the CMS requirement to provide Members with at least 21 calendar days' notice of termination.)*

5.2 **Termination by Aetna.** An individual Member's coverage under this Group Agreement may be terminated by Aetna in compliance with Mandates if all Member Premiums are not received by Aetna from that Member within 3 months following the Premium Due Date (the "Member Grace Period").

If the Contract Holder has not paid all Contract Holder Premiums within 30 days following the Premium Due Date (the "Contract Holder Grace Period"), Aetna may terminate the Group Agreement immediately upon notice to Contract Holder.

This Group Agreement may also be terminated as follows:

- Upon 30 days written notice to the Contract Holder if the Member Premiums owed by ten percent or more of Members remain unpaid at the end of the applicable Member Grace Period;
- Upon 30 days notice to the Contract Holder if the Contract Holder has committed fraud or any intentional misrepresentation of a material fact relevant to the coverage provided under this Group Agreement;
- Effective upon any anniversary of the Effective Date if Aetna will no longer offer any of the products most recently offered to Contract Holder in any Service Areas covered under this Group Agreement, because: (1) CMS terminates or otherwise non-renews the Aetna's CMS Contract, or (2) Aetna terminates its CMS Contract or reduce the Service Areas referenced in Aetna's CMS Contract;
- Immediately upon notice to the Contract Holder if the Contract Holder no longer has any Member under the Plan(s) who resides in the Service Area;
- Upon 30 days' written notice to the Contract Holder if the Contract Holder (i) breaches a provision of this Group Agreement and such breach remains uncured at the end of the notice period; (ii) fails to meet Aetna's contribution or participation requirements applicable to this Group Agreement as set forth in the applicable Financial Document; (iii) provides 30 days' written notice to Members stating that coverage under this Group Agreement will no longer be provided to Members; (iv) changes its eligibility or participation requirements without Aetna's consent; or (v) ceases to meet any Mandates applicable to offering the Plan(s), including the Service Area Extension Mandates described in the CMS/Regulatory Compliance Addendum, if applicable;
- Upon 90 days' written notice to the Contract Holder (or such shorter notice as may be permitted by Mandates, but in no event less than 30 days) if Aetna ceases to offer a product or coverage in any market in which Members covered under this Group Agreement reside;
- Upon 60 days' written notice to the Contract Holder for any other reason which is acceptable to CMS and consistent with HIPAA or other Mandates; or
- Upon 60 days' written notice to the Contract Holder if the Contract Holder is a member of an employer-based association group, and the Contract Holder's membership in the association ceases.

This Group Agreement may also be terminated in part as to a particular Plan within one or more Service Areas by Aetna upon any anniversary of the Effective Date if Aetna will no longer offer that Plan in any Service Areas covered under this Group Agreement because (1) CMS terminates or otherwise non-renews the applicable Aetna CMS Contract, (2) Aetna terminates the applicable CMS Contract or reduce the Service Areas referenced in the applicable CMS Contract, or (3) Aetna or Contract Holder cease to meet any Mandates applicable to offering the Plan(s), including the Service Area

Extension Mandates described in the CMS/Regulatory Compliance Addendum, if applicable.

5.3 **Effect of Termination.** No termination of this Group Agreement will relieve Aetna or the Contract Holder from any obligation incurred under this Group Agreement before the date of termination. When terminated, this Group Agreement and all coverage provided hereunder will end at 12:00 midnight on the effective date of termination. In the event of termination for any reason, Members must continue to pay all Member Premiums due and unpaid before the effective date of the termination and the Contract Holder must continue to pay all Contract Holder Premiums due and unpaid before the termination, including Member Premiums and Contract Holder Premiums due during the applicable Member or Contract Holder Grace Period. Members also remain responsible for Member cost sharing and other required contributions during the Member Grace Period.

5.4 **Auto-Enrollment Upon Termination of Plan**. This Section 5.4 only applies if Contract Holder terminates this Group Agreement or any Plan is terminated in any Service Area, and Contract Holder elects to offer health insurance policies to Members through a public or private exchange in which Contract Holder participates.

If this Group Agreement is terminated or any Plan is terminated in any Service Area, certain Mandates permit Aetna to disenroll Members from the Plan and automatically enroll such Members in a comparable individual Medicare plan offered by Aetna ("Aetna Individual Medicare Plan"), unless the Member opts out or makes another health plan choice.

The Contract Holder agrees that if it establishes a Health Reimbursement Account ("HRA") and provides a subsidy for use by Members to pay health insurance premiums for individual health insurance policies, the Contract Holder will allow Members who are automatically enrolled in an Aetna Individual Medicare Plan as described in this Section 5.4 to continue to receive the same level of subsidy and use such HRA to pay the health insurance premium for the Aetna Individual Medicare Plan. The Contract Holder will not limit such Members' use of the HRA solely to health insurance policies issued through a public or private exchange in which the Contract Holder participates.

Section 6. PRIVACY AND SECURITY OF INFORMATION

6.1. **Compliance with Privacy and Security Laws.** Aetna and the Contract Holder shall each abide by all Mandates regarding the confidentiality and the safeguarding of individually identifiable health and other personal information, including the privacy and security requirements of HIPAA.

6.2. **Disclosure of Protected Health Information.** Aetna will not provide protected health information ("PHI"), as defined in HIPAA, to the Contract Holder, and the Contract Holder will not request PHI from Aetna, unless the Contract Holder has provided the certification required by 45 C.F.R. § 164.504(f) and amended the Contract Holder's Plan documents to incorporate the necessary changes required by such rule.

Section 7. INDEPENDENT CONTRACTOR RELATIONSHIPS

7.1. **Relationship Between the Parties.** The relationship between the Parties is a contractual relationship between independent contractors. Neither Party is an agent or employee of the other in performing its obligations pursuant to this Group Agreement.

7.2. **Relationship Between Aetna and Network Providers.** The relationship between Aetna and providers contracted with Aetna to participate in the Plan(s)' provider network ("Network Providers") is a contractual relationship among independent contractors. Network Providers are not agents or employees of Aetna nor is Aetna an agent or employee of any Network Provider.

Network Providers are solely responsible for any health services rendered to their patients. Aetna makes no express or implied warranties or representations concerning the qualifications, continued participation, or quality of services of any Network Provider. A Network Provider's participation in the provider network for the Plan(s) may be terminated at any time without advance notice to the Contract Holder or Members, subject to Mandates. Network Providers provide health care diagnosis, treatment and services for Members. Aetna administers and determines Plan benefits.

Section 8. DEFINITIONS

8.1. "CMS" means the Centers for Medicare and Medicaid Services.

8.2. "CMS Contract" means the contract between Aetna and CMS under which Aetna offers the Plan(s) in the applicable time period.

8.3. "EOC" means the Evidence of Coverage, which is a document issued pursuant to this Group Agreement that outlines coverage for Members under the Plan(s). The EOC includes the Schedule of Copayments/Coinsurance and any riders or amendments.

8.4. "ERISA" means the Employee Retirement Income Security Act of 1974, as amended.

8.5. "HIPAA" means the Health Insurance Portability and Accountability Act of 1996, as amended, and the regulations promulgated thereunder.

8.6. "Mandates" means applicable laws, regulations and government requirements in effect during the Term of this Group Agreement including, without limitation, applicable Medicare laws, regulations and CMS requirements (including CMS manuals, memo guidance and other directives).

8.7. "Member" is a Medicare beneficiary who: (1) has enrolled in the Plan(s) and whose enrollment in the Plan(s) has been confirmed by CMS, and (2) is eligible to receive coverage under the Plan(s), subject to the terms and conditions of this Group Agreement and the EOC.

8.8. "Party, Parties" means Aetna and the Contract Holder.

Section 9. MISCELLANEOUS

9.1. **Delegation and Subcontracting.** Aetna may delegate functions and services under this Group Agreement to third party vendors (i.e., pharmacy, behavioral health vendors). Aetna's arrangements with third party vendors are subject to change in accordance with Mandates. Aetna shall be responsible for its third party vendors, including their compliance with Mandates and other legal requirements.

9.2. **Disease Management and Care Management Programs.** From time to time, Aetna may offer programs that are designed to improve quality of care, ensure access to Covered Benefits or coordinate care delivered to Members under the Plan(s) ("Disease and Care Management Programs"). Aetna will administer Disease and Care Management Programs consistent with any applicable Mandates. The Contract Holder acknowledges that Aetna may alter or discontinue the Disease and Care Management Program offered to Members at any time, consistent with all Mandates.

9.3. **Prior Agreements; Severability.** As of the Effective Date, this Group Agreement replaces and supersedes all other prior agreements between the Parties as well as any other prior written or oral understandings, negotiations, discussions or arrangements between the Parties related to matters covered by this Group Agreement or the documents incorporated herein. If any provision of this Group Agreement is deemed to be invalid or illegal, that provision shall be fully severable and the remaining provisions of this Group Agreement shall continue in full force and effect.

9.4. **Claim Determinations and Administration of Covered Benefits.** Aetna is a fiduciary for the purpose of Section 503 of Title 1 of ERISA. Aetna has complete authority to determine whether and to what extent eligible individuals and beneficiaries are entitled to coverage and to construe any disputed or doubtful terms under this Group Agreement. Aetna shall be deemed to have properly exercised such authority unless it abuses its discretion by acting arbitrarily and capriciously. Aetna's review of claims may include the use of commercial software and other tools to take into account factors such as an individual's claims history, a provider's billing patterns, complexity of the service or treatment, amount of time and degree of skill needed and the manner of billing.

9.5. **Incontestability.** Except as to a fraudulent misstatement, or issues concerning Premiums due:

- No statement made by the Contract Holder or any Member shall be the basis for voiding coverage or denying coverage or be used in defense of a claim unless it is in writing.
- No statement made by Contract Holder shall be the basis for voiding this Group Agreement after it has been in force for two years from the Effective Date.

9.6. **Assignability.** No rights or benefits under this Group Agreement are assignable by Contract Holder to any other Party unless approved in advance by Aetna. Aetna may without Contract Holder's consent (but upon 30 days' written notice to Contract Holder) assign this Group Agreement to an affiliate, consistent with CMS requirements without the prior approval of the Contract Holder.

9.7. **Waiver.** Aetna's failure to implement, or insist upon compliance with, any provision of this Group Agreement or the terms of the EOC incorporated hereunder, at any given time or times, shall not constitute a waiver of Aetna's right to implement or insist upon compliance with that provision at any other time or times.

9.8. **Conflict.** In the event of a conflict between the terms of this Group Agreement and any of the Incorporated Documents or among any of the Incorporated Documents, the order of priority shall be as the listing of incorporated documents set forth in the second

paragraph of this Group Agreement. Any riders, amendments, inserts and attachments shall have the same priority as the document to which they are attached.

9.9. **Third Parties.** This Group Agreement does not give any rights or impose any obligations on third parties except as specifically provided herein.

9.10. **Non-Discrimination.** The Contract Holder shall not encourage or discourage enrollment in the Plan(s) based on health status or health risk and shall follow all applicable Mandates on non-discrimination.

9.11. **Compliance with Mandates; Amendment to Comply with Mandates.** Aetna and the Contract Holder shall comply with all Mandates applicable to the performance of their respective obligations under this Group Agreement. The Contract Holder shall comply with the applicable provisions of the CMS/Regulatory Addendum, which is designed to ensure Contract Holder's and Aetna's compliance with specific Mandates.

9.12. **Applicable Law.** This Group Agreement shall be governed and construed in accordance with applicable federal law and the applicable law, if any, of the State of Florida .

9.13. **Force Majeure.** If due to circumstances not within Aetna's reasonable control, including but not limited to major disaster, epidemic, complete or partial destruction of facilities, riot, civil insurrection, disability of a significant part of Aetna's Network Providers or entities with whom Aetna has contracted for services under this Group Agreement, or similar causes, the provision of medical or hospital benefits or other services provided under this Group Agreement is delayed or rendered impractical, Aetna shall not have any liability or obligation on account of such delay or failure to provide services, except to refund the amount of the unearned prepaid Premiums held by Aetna on the date such event occurs. Aetna is required only to make a good-faith effort to provide or arrange for the provision of services, taking into account the impact of the event.

9.14. **Use of the Aetna Name and all Symbols, Trademarks, and Service Marks.** Aetna controls the use of its name and all symbols, trademarks, and service marks presently existing or subsequently established. The Contract Holder shall not use any of them in advertising or promotional materials or in any other way without Aetna's prior written

consent. The Contract Holder shall stop any and all use immediately upon Aetna's request or upon termination of this Group Agreement.

9.15. **Coordination of Benefits.** This Section 9.15 applies solely if the Contract Holder is a Member's former employer and the Member sustains a work related injury before he or she leaves employment, regardless of when symptoms become evident. In such event, the Contract Holder shall protect Aetna's interests in any workers' compensation claims or settlements with any Member by reimbursing Aetna for all paid medical expenses which have occurred as a result of the work related injury that is compensable or settled in any manner.

Upon Aetna's request, the Contract Holder shall also submit a monthly report to Aetna listing all workers' compensation cases for Members who have outstanding workers compensation claims involving the Contract Holder. The list shall contain the name of the Member, the date of loss and the diagnosis.

9.16. **Notices.** Any notice required or permitted under this Group Agreement shall be in writing and shall be deemed to have been given on the date when delivered in person; or, if delivered by first-class United States mail, on the date mailed, proper postage prepaid, and properly addressed to the address set forth in the Group Application, or to any more recent address of which the sending Party has received written notice or, if delivered by facsimile or other electronic means, on the date sent by facsimile or other electronic means.

9.17. **Amendments.** This Group Agreement may be amended as follows:

- This Group Agreement shall be deemed to be automatically amended to conform with all Mandates promulgated at any time by any state or federal regulatory agency or authority having supervisory authority over Aetna;
- By mutual written agreement between both Parties; or
- By Aetna upon 30 days' written notice to the Contract Holder.

The Parties agree that an amendment does not require the consent of any Member or other person. Except for automatic amendments to comply with Mandates, all amendments to this Group Agreement must be approved and executed by Aetna.

9.18. **Clerical Errors.** Clerical errors or delays by Aetna in keeping or reporting data relative to coverage will not reduce or invalidate a Member's coverage. Upon discovery of an error or delay, an adjustment of Premiums shall be made. Aetna may also modify or replace a Group Agreement, EOC or other document issued in error.

9.19. **Misstatements.** If any fact as to the Contract Holder or a Member is found to have been misstated, an equitable adjustment of Premiums may be made. If the misstatement affects the existence or amount of coverage, the true facts will be used in determining whether coverage is or remains in force and its amount.

9.20. **Public Records.** This Group Agreement is subject to the provisions of Chapter 768.28, Florida Statutes, except to the extent that Chapter 768.28, Florida Statutes conflicts with laws, rules and regulations applicable to the Medicare Advantage and Medicare prescription drug benefit programs, and nothing herein shall be considered a waiver of any of Contract Holder's statutory or constitutional sovereign immunity protections.

This Group Agreement is subject to Chapter 119, Florida Statutes, except to the extent that Chapter 119, Florida Statutes conflicts with federal laws, rules and regulations applicable to the Medicare Advantage and Medicare prescription drug benefit programs, including those CMS requirements set forth in Section 2.0 of the CMS/Regulatory Requirements Addendum to this Agreement. Aetna specifically acknowledges its obligations to comply with section 119.0701, Florida Statutes, with regard to public records, and shall:

1) keep and maintain public records that ordinarily and necessarily would be required by the Contract Holder in order to perform the services required under this Group Agreement;

2) upon request from the Contract Holder, provide the Contract Holder with a copy of the requested records or allow the records to be inspected or copied within a reasonable time at a cost that does not exceed the cost provided in Chapter 119, Florida Statutes, or as otherwise provided by law;

3) ensure that public records that are exempt for confidential and exempt from public records disclosure requirements are not disclosed, except as authorized by law; and

4) meet all requirements for retaining public records and transfer, at no cost to the Contract Holder, all public records in possession of Aetna upon termination of this agreement and destroy any duplicate public records that are exempt for confidential and exempt from public records disclosure requirements, as permitted under Mandates.

All records stored electronically must be provided to the Contract Holder in a format that is compatible with the information technology system of the Contract Holder.

If Aetna has questions regarding the application of Chapter 119, Florida statutes, to Aetna's duty to provide public records relating to the contract, contact the Custodian of Public Records at 239-533-2221. Address: 2115 Second Street, Fort Myers, Florida 33901, publicrecords@leegov.com;http://www.leegov.com/publicrecords.

Signed as of the Effective Date.

Aetna:

By: _____

Nancy Cocozza

Senior Vice President

Lee County Board of County Commissioners :

By: _____

Name: Chair Commissioner Cecil L Pendergrass

Title: Lee County Board of County Commissioners
District 2

Attest: LINDA DOGGETT
CLERK OF CIRCUIT COURT

Missy Flint
DEPUTY CLERK

Approved as to Form for the
Reliance of Lee County Only

By: Chuck Lim
Office of the County Attorney

BOARD OF COUNTY COMMISSIONERS
SEAL
LEE COUNTY, FLORIDA

CMS/REGULATORY REQUIREMENTS ADDENDUM

The following provisions describe critical regulatory requirements that apply to all plan sponsors offering Aetna group Medicare plans, and they are included in this Group Agreement to ensure Aetna and Contract Holder's compliance with Mandates.

Section 1.0 CMS Uniform Premium Requirements.

1.1 **Medicare Advantage – Premium Requirements**. This Section 1.1 applies only if Aetna is offering a Medicare Advantage HMO or PPO Plan to Members, and Contract Holder and Members are paying any portion of the Premium for the Medicare Advantage benefit ("MA Premium").

Contract Holder will comply with the following conditions with respect to any subsidization of MA Premium and any required MA Premium contribution by the Member:

- Contract Holder may subsidize different amounts of MA Premium for different classes of Members and their dependents, provided such classes are reasonable and based on objective business criteria, such as years of service, date of retirement, business location, job category, and nature of compensation (e.g., salaried vs. hourly).
- MA Premium contribution levels cannot vary for Members within a given class.
- Direct subsidy payments from CMS to Aetna must be passed through to reduce the amount of any required MA Premium payment by the Member.

1.2 **Part D – Premium and Low Income Subsidy Requirements**. This Section 1.2 applies only if Aetna is offering an Aetna Medicare Rx Plan or a Medicare Advantage HMO and/or PPO plan with Medicare prescription drug plan benefits to Members.

Contract Holder will comply with the following conditions with respect to any subsidization of that portion of Premiums paid by Contract Holder for the Medicare Prescription Drug benefit ("PD Premium") and any required PD Premium contribution by the Member:

- Contract Holder may subsidize different amounts of PD Premium for different classes of Members and their dependents, provided such classes are reasonable and based on objective business criteria, such as years of service, date of retirement, business location, job category, and nature of compensation (e.g., salaried vs. hourly). Classes of Members and their dependents cannot be based on eligibility for the Low Income Subsidy ("LIS").
- PD Premium contribution levels cannot vary for Members within a given class.
- Direct subsidy payments from CMS to Aetna must be passed through to reduce the amount of any required PD Premium payment by the Member ("Member Contribution") so the Member in no event shall be required to pay more than

the sum of: a) the standard Medicare Part D premium, net of the direct subsidy payment from CMS, and b) one hundred percent (100%) for any supplemental coverage selected by the Member.

Contract Holder shall comply with the following conditions with respect to any LIS payment received from CMS for any LIS-eligible Member:

- Any monthly LIS payment received from CMS for an LIS-eligible Member shall be used to reduce any Member Contribution. Any remainder may then be used to reduce the amount of the Contract Holder's PD Premium contribution. However, if the sum of the Member Contribution and Contract Holder's PD Premium is less than the LIS payment, any portion of the LIS payment will be returned to CMS by Aetna.
- If the LIS payment for any LIS-eligible Member is less than the Member Contribution required by such individual (including the Member Contribution for supplemental benefits, if any), Contract Holder shall communicate with the LIS-eligible Member about the cost of remaining enrolled in Contract Holder's Plan versus obtaining coverage as an individual under another Medicare Part D Prescription Drug plan.
- In the event that the LIS-eligible Member is due a refund of the LIS payment (i.e., there was no upfront reduction of the PD Premium by the LIS amount), such refund shall be completed by Aetna or Contract Holder, as applicable, within 45 days of the date Aetna receives the LIS payment for that Member from CMS.

Section 2.0 Records.

2.1 **Maintenance of Information & Records**. Contract Holder agrees to maintain Information and Records (as those terms are defined in Section 2.2 below) in a current, detailed, organized and comprehensive manner and in accordance with Mandates, and to maintain such Information and Records for the longer of: (i) a period of ten (10) years from the end of the final contract period for the Plan(s), (ii) the date the U.S. Department of Health and Human Services, the Comptroller General or their designees complete an audit, or (iii) the period required by Mandates.

2.2 **Access to Information and Records**. Contract Holder will provide Aetna and federal, state and local governmental authorities having jurisdiction, directly or through their designated agents (collectively "Government Officials"), upon request, access to all books, records and other papers, documents, materials and other information (including, but not limited to, contracts and financial records), whether in paper or electronic format, relating to the arrangement described in this Group Agreement ('Information and Records"). Contract Holder agrees to provide Aetna and Government Officials with access to Information and Records for as long as it is maintained as provided in Section 2.1 above. Access to Information and Records will be provided

within 14 calendar days of receipt of an applicable request, where practicable, and in no event later than the date required by an applicable law or regulatory authority.

2.3 **Survival**. The preceding provisions of this Section 2.0 shall survive termination of this Group Agreement regardless of the cause of termination.

Section 3.0 Medicare Secondary Payer Requirements. Records.

3.1 **Generally**. Aetna and Contract Holder agree to comply with all Medicare Secondary Payer ("MSP") Mandates that apply to Contract Holder, the Plan and Aetna ("MSP Requirements").

3.2 **MSP Requirements Applicable to Medicare Beneficiaries Diagnosed with End Stage Renal Disease ("ESRD")**. Aetna and Contract Holder agree to comply with all MSP Requirements applicable to Contract Holder's active employees and retirees and their dependents who are Medicare beneficiaries diagnosed with ESRD ("ESRD Beneficiaries" or "ESRD Beneficiary"), including, without limitation, those MSP Requirements set forth in 42 U.S.C. § 1395y (b)(1)(C), 42 C.F.R. §§ 411.102(a), 411.161, and 411.162 and 42 C.F.R. §§ 422.106 and 422.108 ("ESRD MSP Requirements").

3.3 Contract Holder acknowledges and agrees that if an ESRD Beneficiary is eligible for or entitled to Medicare based on ESRD, the MSP Requirements require the commercial group health plan offered by Contract Holder ("GHP") to be the primary payer for the first 30 months of the ESRD Beneficiary's Medicare eligibility or entitlement ("30-month coordination period"), regardless of the number of employees employed by Contract Holder and regardless of whether the ESRD Beneficiary is a current employee or retiree.

3.4 To ensure Aetna's and Contract Holder's compliance with ESRD MSP Requirements, Contract Holder agrees to confirm to Aetna whether ESRD Beneficiaries are in their 30-month coordination period, and not seek to enroll ESRD Beneficiaries in the Plan(s) during their 30-month coordination period unless coverage under the GHP is maintained for such ESRD Beneficiaries for that period. If Contract Holder seeks to enroll an ESRD Beneficiary in a Plan, Contract Holder agrees to provide Aetna, upon request, with information or documentation to verify compliance with ESRD MSP Requirements, including any MSP reporting or other requirements established by CMS.

Section 4.0 Office of Foreign Asset Control. If coverage provided by the Group Agreement violates or will violate any economic or trade sanctions, the coverage is immediately considered invalid. For example, Aetna cannot make payments for health care or other claims or services if it violates a financial sanction regulation. This includes sanctions related to a blocked person or a country under sanction by the United States, unless permitted under a written Office of Foreign Asset Control (OFAC) license.

Section 5.0 CMS Enrollment & Disenrollment Requirements.

5.1 To the extent that Contract Holder directly accepts enrollment and/or disenrollment requests from potential Members or Members that Contract Holder forwards to Aetna

for processing and submission to CMS, Contract Holder will comply with all Mandates that relate to the handling and processing of enrollment and disenrollment requests that apply to the Plan(s). A Member's signature on an enrollment/disenrollment form must be dated prior to the requested enrollment/disenrollment effective date.

If requesting retroactive enrollment or disenrollment, Contract Holder will forward enrollment and disenrollment forms completed by potential Members or Members to Aetna no later than 90 days after the Member's enrollment or termination effective date. If there is a delay between the time a Member submits an enrollment/disenrollment request to Contract Holder and when the enrollment/disenrollment request is received by Aetna, the enrollment/disenrollment transaction may not be processed by CMS, unless Aetna requests and CMS approves a retroactive enrollment/disenrollment transaction for the Member. Aetna will determine whether to submit retroactive enrollment and disenrollment transaction requests to CMS, and will make such determinations in accordance with Mandates.

All Members must be notified that they will be enrolled in a Plan. CMS requires that this notice be provided by Aetna or Contract Holder not less than 21 calendar days prior to the effective date of the Member's enrollment in the Plan to allow Members the opportunity to evaluate other available health plan options.

5.2 The effective date of enrollments and disenrollments in the Plan(s) cannot be earlier than the date the enrollment or disenrollment request was completed by a Member. If approved by CMS, the effective date of an enrollment or disenrollment may be retroactive up to, but may not exceed, 90 days from the date that Aetna received the enrollment or disenrollment request from the Contract Holder, and the enrollment or disenrollment form must be completed and signed by the Member prior to the requested enrollment or disenrollment effective date.

5.3 CMS does not permit retroactive termination of a Member's coverage under the Plan(s) if the Member no longer meets Contract Holder's eligibility criteria to remain enrolled in the Plan(s). To meet this CMS requirement, Contract Holder will provide Aetna with advanced written notice if Contract Holder chooses to terminate a Member's coverage under the Plan based on loss of eligibility, and Contract Holder acknowledges that the Member's prospective coverage termination effective date will be determined in accordance with Mandates.

5.4 If Contract Holder elects to change Plan coverage offered to Members or to terminate a Member's coverage under the Plan(s), Contract Holder must provide written notice to such Member(s) at least 21 calendar days prior to the effective date of the change in the Member's coverage or disenrollment from the Plan(s), as applicable. This written notice must include a description of how the Member can contact Medicare to obtain information regarding other Medicare Advantage or Medicare Part D plan options that may be available to the Member. Aetna will assist Contract Holder with developing appropriate notices.

5.5 Aetna reserves the right to notify Members of the involuntary termination of their coverage under this Group Agreement for any reason.

5.6 If eligible individuals are to be enrolled and/or disenrolled in the Plan(s) electronically, the electronic forms used for this process must be approved by CMS for use by the Plan(s) and conform to all Mandates applicable to format, data fields and other required information. Aetna will work with Contract Holder to develop appropriate electronic forms.

5.7 Electronic enrollments and disenrollments will be deemed effective on the first day of the month requested, subject to compliance with any applicable Mandates.

5.8 Contract Holder will produce, at Aetna's request, the original copy of any enrollment or disenrollment form or record received by Contract Holder.

Section 6.0 Notices to Members.

6.1 **Notice re Changes.** Contract Holder will provide Members with written notice describing any changes made to premiums, benefits or other terms of the Plan(s) as required under Mandates. If Contract Holder does not distribute notices as required under this Section 6.0 Aetna may, at its discretion, distribute such notices to Members.

6.2 **Notice re Termination of Coverage**. Contract Holder will notify Members of the termination of the Plan(s) in compliance with Mandates. However, Aetna reserves the right to notify Members of termination or suspension of the Plan(s) for any reason. Contract Holder will provide written notice to Members of their rights upon termination of coverage as required under Mandates.

6.3 **Member Plan Materials.** The Contract Holder shall cause any Member Plan materials that have not been approved by CMS to comply with ERISA or, in the case of a non-ERISA Plan, any applicable alternative regulatory disclosure requirements.

6.4 **Plan Reporting and Disclosure Requirements.** The Contract Holder agrees that it is responsible for any and all Plan reporting and disclosure requirements imposed by ERISA and other applicable law, including updating the Summary of Benefits and Coverage (SBC) or Summary Plan Description (SPD) and other Plan documents and issuing any necessary summaries of material modifications to reflect any changes in benefits.

Section 7.0 Service Area Extension & Network Adequacy for Plan. This Section 7.0 only applies if Aetna is offering a Medicare Advantage PPO Plan to Members who reside in an Extended Service Area (as defined below).

To enable employers/unions to offer group Medicare Advantage ("MA") plans to all of their Medicare-eligible retirees/dependents wherever they reside, CMS has established a waiver of service area requirements ("Waiver") for organizations that are approved by CMS to offer MA plans ("MAOs"). Under this Waiver, MAOs offering a group MA plan in a given Service Area, can

extend coverage to an employer/union sponsor's Medicare-eligible retirees/dependents residing outside of that Service Area, even if the MAO does not offer a provider network for the group MA plan ("Provider Network") that meets CMS network adequacy requirements in that Service Area ("Extended Service Area").

Aetna and Contract Holder agree that Aetna will use this Waiver to offer the Medicare Advantage PPO Plan to Members who reside in an Extended Service Area ("MA PPO Plan"). The Parties acknowledge that Aetna must meet certain CMS requirements to offer the MA PPO Plan in an Extended Service Area, and these requirements include, but are not limited to, the following:

(1) at least 51% of retirees/dependents who are currently enrolled in Aetna MA HMO or PPO plans offered by Contract Holder must be enrolled in an Aetna MA HMO or PPO plan that offers a Provider Network that meets CMS network adequacy requirements, and

(2) all Members who reside in an Extended Service Area must receive the same Covered Benefits at the preferred in-network cost-sharing for all Covered Benefits.

The Parties agree to comply with all Mandates that apply to use of this Waiver. Further, Contract Holder acknowledges and agrees that: (1) Members who reside in an Extended Service Area do not have access to a Provider Network that meets CMS network adequacy requirements, and (2) health care providers and suppliers that are not contracted with Aetna to participate in the Provider Network are not required to accept the Plan and furnish Covered Benefits to Members who reside inside or outside of an Extended Service Area, except as required under Mandates. Failure to meet CMS requirements of this Waiver may result in termination of the MA PPO Plan in Extended Service Areas.

AETNA MEDICARE ADVANTAGE HMO AFFILIATE ADDENDUM

Aetna's Medicare Advantage HMO Plans are offered by the following licensed HMOs or their successors in the following states:

State of Member's Permanent Residence	Aetna Affiliate offering the Plan[1]
Arizona, Colorado, Delaware, Illinois, Kansas, Kentucky, Maryland, Massachusetts, Missouri, Nevada, North Carolina, Ohio, Oklahoma, Pennsylvania, Tennessee, Virginia & District of Columbia	Aetna Health Inc., a Pennsylvania corporation
California	Aetna Health of California Inc.
Arkansas, Kansas, Missouri, Illinois & Oklahoma	Coventry Healthcare of Missouri, Inc.
Connecticut	Aetna Health Inc., a Connecticut corporation
Florida & Iowa	Aetna Health Inc., a Florida corporation
Georgia	Aetna Health Inc., a Georgia corporation
Louisiana	Aetna Health Inc., a Louisiana corporation
Maine	Aetna Health Inc., a Maine corporation
New Jersey	Aetna Health Inc., a New Jersey corporation
New York	Aetna Health Inc., a New York corporation
Texas	Aetna Health Inc., a Texas corporation
Utah & Wyoming	Aetna Health of Utah Inc.
West Virginia	Coventry Health Care of West Virginia, Inc.

With regard to Medicare Advantage HMO Plans, "Aetna" means the licensed HMO(s) identified in the above table corresponding to each Member's state of permanent residence ("Affiliate"). To the extent that there are no Members permanently residing in a state or states listed in this Addendum, the corresponding Affiliate is not a party to this Group Agreement. Aetna may without Contract Holder's consent (but upon 30 days' prior written notice to Contract Holder) update this Addendum to change the list of Affiliates from time to time, consistent with CMS requirements. Aetna will provide an updated list of Affiliates to Contract Holder on reasonable request.

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[1] The Affiliates that offer Medicare Advantage HMO plans to Members in the states of Illinois and Missouri vary. Aetna will provide a list of Affiliates offering Medicare Advantage HMO plans to Members in these two states to Contract Holder on reasonable request.

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January 24, 2018

Lee County Board of County Commissioners
1500 Monroe Street 4th Floor
Fort Meyers, FL 33901

Plan Sponsor Unique No. 11187771

Re: Medicare Group Application & Aetna Medicare Group Agreement

Dear Lee County Board of County Commissioners:

Enclosed is a copy of your signed Group Application(s) and Aetna Medicare Group Agreement ("Group Agreement") applicable to the fully-insured Aetna/Coventry Group Medicare Advantage and/or Medicare prescription drug plans you have selected to offer (collectively "Group Medicare Plans").

We encourage you to review the enclosed Group Agreement in its entirety. Please note the following about your Group Agreement:

- The Group Agreement covers all fully-insured Group Medicare Plans that you have selected to offer, and covers all Aetna/Coventry companies that underwrite those Plans. This means that you will receive only one Group Agreement for all Group Medicare Plans you have elected to offer. If you later choose to change your Group Medicare Plan offerings, please notify your account manager and you will be provided with a new Group Application to complete to reflect those changes.
- CMS requires that Aetna provide all Group Medicare Plan members with an Evidence of Coverage (EOC). The EOC is provided to members on an annual basis and provides a detailed description of the benefits available under the member's Group Medicare Plan. The EOC also includes information regarding coverage terms, cost-sharing and member rights and responsibilities. EOCs will be mailed to your retirees enrolling in Group Medicare Plans in the fall of each year. Please contact your Aetna account representative if you would like a copy of any EOCs delivered to your retirees.

Please review and electronically sign the group agreement.

We appreciate your business. If you have any questions or concerns, please contact your account manager for assistance.

Sincerely,

Aetna

Enclosures

AETNA MEDICARE
GROUP AGREEMENT COVER SHEET

Contract Holder:	Lee County Board of County Commissioners
Plan Sponsor Unique (PSU) Number:	11187771
Effective Date:	12:01 a.m. on January 1, 2018
Term of Group Agreement:	The Term shall be: From January 1, 2018 through December 31, 2018.
Premium Due Dates:	The Group Agreement Effective Date and the 1st day of each succeeding calendar month.

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MEDICARE ADVANTAGE RATE PROPOSAL

Plan Sponsor Name:	**Lee County Board of County Commissioners**
Policy Period Start Date:	**01/01/2018**
Policy Period End Date:	**12/31/2018**
Medical Plan:	**Medicare (V01) ESA PPO Plan**
Pharmacy Plan:	**Rx $10/$20/$35/$35**
Hearing Aid Reimb Adjustment:	**$500 / 36 months**
Fitness Rider:	**Healthways Silver Sneakers**

- Please refer to the Financial Conditions and Plan Design Exhibits for an outline of the level of benefits quoted, as well as the terms and conditions of this proposal.
- Filed benefits (including copayment amounts), value added services and premiums are subject to CMS approval, and are effective January 1, 2018 through December 31, 2018.
- All rates are on a Per Member Per Month (PMPM) basis.
- These rates exclude commissions.
- The Patient Protection and Affordable Care Act imposes a new Health Insurer Fee (hereinafter "Fee"). The Fee is effective as of January 1, 2014. This rate quote includes, where permitted, the estimated proportionate allocation of this Fee. Should the HIF remain suspended for 2018, the rates below will be adjusted

Medical Health Insurer Fee:	$32.27
Rx Health Insurer Fee:	$7.45
Total Health Insurer Fee:	$39.72

	Medical Rate Excluding HIF	Pharmacy Rate Excluding HIF	Total Rate Excluding HIF	Medical Rate Including HIF	Pharmacy Rate Including HIF	Total Rate Including HIF
Proposed	$111.09	$209.00	$320.09	$143.36	$216.45	$359.81

Total Medicare Eligible Members	327

State	Medicare Eligible Members	Medical Rate Excluding HIF	Pharmacy Rate Excluding HIF	Total Rate Excluding HIF	Medical Rate Including HIF	Pharmacy Rate Including HIF	Total Rate Including HIF
Arizona	1	$111.09	$209.00	$320.09	$143.36	$216.45	$359.81
Arkansas	3	$111.09	$209.00	$320.09	$143.36	$216.45	$359.81
California	3	$111.09	$209.00	$320.09	$143.36	$216.45	$359.81
Florida	283	$111.09	$209.00	$320.09	$143.36	$216.45	$359.81
Georgia	5	$111.09	$209.00	$320.09	$143.36	$216.45	$359.81
Kentucky	1	$111.09	$209.00	$320.09	$143.36	$216.45	$359.81
Michigan	3	$111.09	$209.00	$320.09	$143.36	$216.45	$359.81
North Carolina	7	$111.09	$209.00	$320.09	$143.36	$216.45	$359.81
Ohio	5	$111.09	$209.00	$320.09	$143.36	$216.45	$359.81
Pennsylvania	6	$111.09	$209.00	$320.09	$143.36	$216.45	$359.81
South Carolina	3	$111.09	$209.00	$320.09	$143.36	$216.45	$359.81
Tennessee	4	$111.09	$209.00	$320.09	$143.36	$216.45	$359.81
Texas	1	$111.09	$209.00	$320.09	$143.36	$216.45	$359.81
Virginia	2	$111.09	$209.00	$320.09	$143.36	$216.45	$359.81

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Group Employer Medicare Advantage Plan and Medicare Prescription Drug Plan Application

APPLICANT

Plan Sponsor Unique ID Number (PSU#)
(for Aetna use only)

PSU#
Group also purchased Coventry Medicare Products ☐ Yes ☒ No

Company Name: Lee County Board of County Commissioners
Doing Business As (DBA):
Corporate Headquartered Address: 2115 2nd St.
City: Fort Myers State: FL Zip Code: 33901
Federal Tax ID Number: 596000702
Parent Company name (if applicable):
Employer Sponsor Type: Employer (click on "choose an item")
Employer Organization Type: Local Government (click on "choose an item")
The purpose of the application is to request: a. ☒ Issuance of new coverage
b. ☐ Change in existing coverage
c. ☐ Extension of existing coverage to additional eligible individuals

Once the Medicare Group agreement is drafted, it will be emailed to Customer Email Address:
Application will not be processed if Customer Email Address is not provided.

Medicare Coverage
Medical/RX Coverage Selection: Provided or administered by Aetna Life Insurance Company, Aetna Health of California Inc., and/or Aetna Health Inc.

Types of Coverage – Select All that Apply

☐ Medicare Advantage HMO Plan
☐ Medicare Advantage HMO Plan with Medicare prescription drug benefits

☐ Medicare Advantage PPO Plan and/or Medicare Advantage PPO Plan with Extended Service Area
☒ Medicare Advantage PPO Plan with Medicare prescription drug benefits and/or Medicare Advantage PPO Plan with Extended Service Area with Medicare prescription drug benefits

☐ Fully-Insured Standalone Medicare prescription drug plan
☐ Self-Insured Standalone Medicare prescription drug plan

Premium Billing – Select All that Apply
Aetna offers three different methods for billing premiums. A monthly premium can either be billed to individuals enrolled in the Aetna Medicare Plan ("Direct Billing"), to you ("Contract Holder Billing") or to both you and individuals enrolled in the Aetna Medicare Plan ("Split Billing"). Please select all of the billing methods that apply to the Medicare coverage you selected in this application:

☐ Direct Billing
☒ Contract Holder Billing
☐ Split Billing

General Enrollment and Eligibility Section

Requested effective date: 01/01/18 (Actual effective date will be assigned by Aetna if this application is accepted and an agreement between Aetna and Applicant for the coverage specified herein is issued)

Renewal date: 12/31/18 For all Medicare Advantage HMO and PPO plans with Medicare prescription drug coverage and Standalone Medicare prescription drug plans, the renewal date must be January 1st.

Late Enrollment Penalty Attestation (Please review and complete if applying to obtain coverage under a Medicare Advantage plan with Medicare prescription drug coverage ("MA-PD plans") or Standalone Medicare prescription drug plan ("PDP"))

Pursuant to Section 1860D-13(b) of the Social Security Act and 42 C.F.R. §§ 423.46 and 423.56(g), Medicare beneficiaries may incur a late enrollment penalty ("LEP") if there is a continuous period of 63 days or more at any time after the end of the beneficiary's Medicare Part D initial enrollment period during which the beneficiary was eligible to enroll, but was not enrolled in a Medicare Part D plan and was not covered under any creditable prescription drug coverage. "Creditable prescription drug coverage" is prescription drug coverage that is expected to pay at least as much as Medicare's standard prescription drug coverage. To ease the administrative burden associated with implementation of these LEP-related procedures, the Centers for Medicare and Medicaid Services permits Aetna to accept attestations from plan sponsors wherein the plan sponsor attests to the creditable coverage history of eligible individuals submitted for enrollment in the plan sponsor's group MA-PD plan or PDP for purposes of reporting covered months. If an individual was assessed a LEP prior to the effective date of the new coverage, the individual's LEP will carry over even if the employer attests to creditable coverage.

☒ **Yes, Applicant will attest to the creditable prescription drug coverage history of all individuals submitted by Applicant for enrollment in Aetna's MA-PD plans or PDP for purposes of reporting covered months.** By checking this box and signing this application, Applicant attests that all individuals submitted for enrollment in Aetna's MA-PD plans or PDPs were either previously enrolled in another Medicare prescription drug plan or had other creditable prescription drug coverage prior to applying to enroll in an Aetna MA-PD plan or PDP. Applicant understands that by signing this application, Applicant is attesting that it has read and understands the contents of this attestation and that this attestation is truthful, accurate and complete.

☐ **No, Applicant will not attest to the creditable prescription drug coverage history of all individuals submitted for enrollment in Aetna's MA-PD plans or PDPs for purposes of reporting covered months.** Applicant understands that without an attestation from Applicant, all individuals submitted by Applicant for enrollment in Aetna's MA-PD plans or PDPs will be submitted by Aetna through CMS systems to determine if gaps of 63 days or more exist in creditable prescription drug coverage since the close of the individual's initial Medicare Part D enrollment period. Individuals who are identified to have such gaps of creditable prescription drug coverage will receive letters requesting that they attest to any creditable prescription drug coverage during those gaps, and these individuals may contact Applicant for assistance in determining creditable coverage history.

"Age-In" Program

Aetna executes a monthly communications program known as the "Age-in" Program. This Program provides Applicant's retirees who are approaching age 65 with timely information regarding your Aetna Medicare Plan. The "Age-in" Program currently consists of a mailing sent 2 months before the 65th birthday month and the mailing list is determined solely based on age. This means that these mailings may be sent to both Applicant's retirees and active employees who are nearing their 65th birthday. The mailing clearly indicates that only retirees and their eligible dependents (if Applicant permits dependent enrollment) are eligible to enroll in the Aetna Medicare Plan. The scope of this Program is subject to change.

Important Note: Please notify your Account Executive if your organization does not want to participate in the "Age-in" Program. If your organization does not provide this notice to your Account Executive within 30 days of the date you sign this Application, Aetna will proceed with including your organization in the "Age-in" Program.

Electronic Enrollment & Optional Mechanism Enrollment

Please check the appropriate box to document if you will use one of the following methods to enroll eligible individuals in the Aetna Medicare Plan(s) selected by you in this application:

Applicant will use electronic enrollment (choose one)? ☒ Yes ☐ No
Applicant will use optional mechanism enrollment (choose one)? ☒ Yes ☐ No

If you selected "yes" with either option, please review the following section titled "Enrollment Requirements". By signing this application, you are agreeing to the requirements in this Section.

Enrollment Requirements

The Centers for Medicare and Medicaid Services ("CMS") allows Applicant to enroll eligible individuals in an Aetna Medicare Plan using an electronic group enrollment process ("Electronic Enrollment Process") or a process referred to by CMS as the "Group Enrollment Process – Optional Mechanism" ("Optional Mechanism Enrollment Process"). With both enrollment processes, eligible individuals must be informed prior to enrollment that they can make the initial election of a new Aetna Medicare Plan by taking no action. This eliminates the need for eligible individuals to complete and submit a paper enrollment application.

If Applicant elects to use either the Electronic Enrollment Process or the Optional Mechanism Enrollment Process, Applicant must comply with all applicable laws, regulations and CMS instructions, including the following:

1. For each eligible individual that Applicant submits for enrollment to Aetna through the Electronic Enrollment Process or Optional Mechanism Enrollment Process, Applicant agrees to:

- Provide a Summary of Benefits and all information necessary for the eligible individual to make an informed choice regarding Aetna Medicare Plan benefits, including, but not limited to, Aetna Medicare Plan rules and requirements and enrollment processes.
- Provide written notice not less than 21 calendar days prior to the requested effective date of the eligible individual's enrollment in an Aetna Medicare Plan. This notice must advise eligible individuals that they can elect to enroll in a new Aetna Medicare Plan by taking no action,

and that they will be enrolled in the Aetna Medicare Plan unless they notify Applicant of their intent to opt out of enrollment. This written notice must describe in detail the opt-out process the eligible individual must follow to decline enrollment in the new Aetna Medicare Plan.

2. Applicant acknowledges that it received from Aetna the data element and format requirements for submission of enrollment transactions to Aetna ("Enrollment Submission Requirements"), and Applicant agrees that all enrollment transactions it submits to Aetna for processing will comply with these Enrollment Submission Requirements. Applicant acknowledges and agrees that Aetna will not process an enrollment transaction submitted by Applicant that does not comply with Enrollment Submission Requirements. Applicant agrees to exclude all eligible individuals who have elected to opt out of enrollment in an Aetna Medicare Plan from any enrollment transactions submitted to Aetna for processing.

Applicant Acknowledgements and Agreements

It is agreed that no coverage shall become effective as to any person who is not then eligible for coverage under applicable laws, rules, regulations and CMS instructions ("Mandates"). All statements herein shall be deemed representations and not warranties. The Applicant acknowledges that it has selected the coverage specified herein based upon written information provided by Aetna and that no broker, agent or consultant is authorized to modify the terms of the offer or to agree to changes. Applicant has selected, in accordance with Mandates, the coverage to be offered to Applicant's retirees and Applicant has solely determined any/all coverage options for the Applicant's retirees and the contribution amounts.

The plan documents (which consist of the Evidence of Coverage and the agreement(s) between Aetna and Applicant relating to the coverage(s) specified herein ("Medicare Agreement") will determine the contractual provisions, including procedures, exclusions and limitations relating to the coverage and will govern in the event they conflict with any benefits comparison, summary or other description of the coverage. Aetna will use the e-mail address provided by Applicant in this application to send Applicant the Medicare Agreement. Applicant will notify Aetna in writing if it prefers that the Medicare Agreement be sent to a different address. Aetna and Applicant agree that the Medicare Agreement will be considered received by Applicant on the date that Aetna sends the Medicare Agreement to the e-mail address provided by Applicant (as described in this application). All data that may have a bearing on coverage or premiums will be open for Aetna to inspect while the Medicare Agreement is in force, and as required under Mandates and the Medicare Agreement. The availability of a plan or program may vary by geographic service area. "Aetna" is the brand name used for products and services provided by one or more of the Aetna group of subsidiary companies.

With the exception of Aetna Rx Home Delivery, all participating providers and vendors are independent contractors and are neither agents nor employees of Aetna. Aetna Rx Home Delivery, LLC, is a subsidiary of Aetna Inc. The availability of any particular provider cannot be guaranteed. With respect to those Aetna group Medicare plans that are network-based, provider network composition is subject to change. Notice of a change in provider network composition shall be provided to individuals enrolled in these Aetna group Medicare plans in accordance with applicable federal law. Aetna does not provide health or dental care services and, therefore, cannot guarantee any results or outcome. Some benefits are subject to limitations or maximums.

Important Information

Any person who knowingly and with intent to injure, defraud or deceive any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

Alaska, Connecticut, Idaho, Nevada, New Hampshire, North Carolina & South Carolina: Any person who knowingly and with intent to injure, defraud or deceive any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

Arkansas, District of Columbia, Louisiana, Rhode Island and West Virginia Residents: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

California: For your protection California law requires notice of the following to appear on this form: Any person who knowingly presents a false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

Colorado: It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado division of insurance within the department of regulatory agencies.

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

Indiana/Illinois: Any person who knowingly and with intent to injure, defraud or deceive any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

Kansas/Missouri: Any person who knowingly and with intent to injure, defraud or deceive any insurance company or other person submits an enrollment form for insurance or statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto may have violated state law.

Kentucky: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime.

Louisiana: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.
Maine and Tennessee: It is a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines, or denial of insurance benefits.
Maryland: Any person who knowingly and willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly and willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.
Minnesota: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.
New Jersey: Any person who includes any false or misleading information on an application for an insurance policy or knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties.
New York: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each violation.
Ohio: Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.
Oklahoma: WARNING: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.
Oregon: Any person who with intent to injure, defraud, or deceive any insurance company or other person submits an enrollment form for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto may have violated state law.
Pennsylvania: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.
Puerto Rico: Any person who knowingly and with the intention to defraud includes false information in an application for insurance or file, assist or abet in the filing of a fraudulent claim to obtain payment of a loss or other benefit, or files more than one claim for the same loss or damage, commits a felony and if found guilty shall be punished for each violation with a fine of no less than five thousand dollars ($5,000), not to exceed ten thousand dollars ($10,000); or imprisoned for a fixed term of three (3) years, or both. If aggravating circumstances exist, the fixed jail term may be increased to a maximum of five (5) years; and if mitigating circumstances are present, the jail term may be reduced to a minimum of two (2) years.
Texas: Any person who knowingly and with intent to injure, defraud or deceive any insurance company or other person files an application for insurance or statement of claim containing any intentional misrepresentation of material fact or conceals, for the purpose of misleading, information concerning any fact material thereto may commit a fraudulent insurance act, which may be a crime and may subject such person to criminal and civil penalties.
Utah: Any person who knowingly and with intent to injure, defraud or deceive any insurance company or other person files an application for insurance or statement of claim containing any intentional misrepresentation of material fact or conceals, for the purpose of misleading information concerning any fact material thereto may commits a fraudulent insurance act, which is may be a crime and may subjects such person to criminal and civil penalties.
Vermont: Any person who knowingly and with intent to injure, defraud or deceive any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which may be a crime and may subject such person to criminal and civil penalties.
Virginia: Any person who knowingly and with intent to injure, defraud or deceive any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent act, which is a crime and subjects such person to criminal and civil penalties.
Washington: It is a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines, and denial of insurance benefits.

ORDER OF PRIORITY

Once this application is signed and Aetna accepts it, this application will form part of a Medicare Agreement issued by Aetna. If there is a conflict between anything in this application and any other part of the Medicare Agreement, the other parts of the Medicare Agreement will take priority.

Signature Section

I hereby apply for the coverage(s) indicated above. I certify that all information provided in this application is accurate and complete. I understand that this application will form a part of the Medicare Agreement issued by Aetna relating to such coverage and by my signature below I agree to be bound by the terms and conditions of that Medicare Agreement. I understand that Aetna may choose not to accept this application at its sole discretion, subject to any federal and/or state requirements.

Signed at (location): Fort Myers, Florida (City, State) — Lee County Board of County Commissioners (Applicant (Company Name))

By: John Manning
Authorized Applicant Signature

Chair
Official Title

Kim Rasner
Witness

11/7/2017
Date

Your premium purchases insurance coverage from Aetna, as well as the services of any Aetna-appointed licensed independent agent or broker identified in the member's Application For Group Coverage. Aetna has various programs for compensating producers (agents, brokers and consultants). If you would like information regarding compensation programs for which your producer is eligible, payments (if any) which Aetna has made to your producer, or other material relationships your producer may have with Aetna, you may contact your producer or your Aetna account representative. Information regarding Aetna's programs for compensating producers is also available at www.aetna.com. **We appreciate your business and the opportunity to serve you.**

Please keep a copy of this application for your records. If this application is accepted by Aetna, this application will become part of the issued Medicare Agreement.

Distribution: Sales submits as part of new business submission

Approved as to Form for the
Reliance of Lee County Only
Office of the County Attorney

LINDA DOGGETT
CLERK OF CIRCUIT COURT
DEPUTY CLERK

SEAL

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LEE COUNTY BOARD OF COUNTY COMMISSIONERS

Aetna Medicare[SM] Plan (PPO)

Medicare (V01) ESA PPO Plan

Rx $10/$20/$35/$35

Benefits and Premiums are effective January 01, 2018 through December 31, 2018

PLAN DESIGN AND BENEFITS

PROVIDED BY AETNA LIFE INSURANCE COMPANY

PLAN FEATURES	Network & Out-of-Network Providers
Annual Deductible	$0
This is the amount you have to pay out of pocket before the plan will pay its share for your covered Medicare Part A and B services.	
Annual Maximum Out-of-Pocket Amount	$1,500
The maximum out-of-pocket limit applies to all covered Medicare Part A and B benefits including deductible.	
Primary Care Physician Selection	Optional
There is no requirement for member pre-certification. Your provider will do this on your behalf.	
Referral Requirement	None
PREVENTIVE CARE	**This is what you pay for Network & Out-of-Network Providers**
Annual Wellness Exams One exam every 12 months.	$0
Routine Physical Exams One exam every 12 months.	$0
Medicare Covered Immunizations Pneumococcal, Flu, Hepatitis B	$0
Routine GYN Care **(Cervical and Vaginal Cancer Screenings)**	$0
One routine GYN visit and pap smear every 24 months.	
Routine Mammograms **(Breast Cancer Screening)**	$0
One baseline mammogram for members age 35-39; and one annual mammogram for members age 40 & over.	
Routine Prostate Cancer Screening Exam	$0

For covered males age 50 & over, every 12 months.	
Routine Colorectal Cancer Screening For all members age 50 & over.	$0
Routine Bone Mass Measurement	$0
Additional Medicare Preventive Services*	$0
Routine Eye Exams One annual exam every 12 months.	$0
Routine Hearing Screening One exam every 12 months.	$0
PHYSICIAN SERVICES	**This is what you pay for Network & Out-of-Network Providers**
Primary Care Physician Visits	$10
Includes services of an internist, general physician, family practitioner for routine care as well as diagnosis and treatment of an illness or injury and in-office surgery.	
Physician Specialist Visits	$35
DIAGNOSTIC PROCEDURES	**This is what you pay for Network & Out-of-Network Providers**
Outpatient Diagnostic Laboratory	$35
Outpatient Diagnostic X-ray	$35
Outpatient Diagnostic Testing	$35
Outpatient Complex Imaging	$50
EMERGENCY MEDICAL CARE	**This is what you pay for Network & Out-of-Network Providers**
Urgently Needed Care; Worldwide	$50
Emergency Care; Worldwide (waived if admitted)	$65
Ambulance Services	$0
HOSPITAL CARE	**This is what you pay for Network & Out-of-Network Providers**
Inpatient Hospital Care	$500 per stay

The member cost sharing applies to covered benefits incurred during a member's inpatient stay.

Outpatient Surgery	$200
Blood	All components of blood are covered beginning with the first pint.
MENTAL HEALTH SERVICES	**This is what you pay for Network & Out-of-Network Providers**
Inpatient Mental Health Care	$500 per stay

The member cost sharing applies to covered benefits incurred during a member's inpatient stay.

Outpatient Mental Health Care	$35
ALCOHOL/DRUG ABUSE SERVICES	**This is what you pay for Network & Out-of-Network Providers**
Inpatient Substance Abuse (Detox and Rehab)	$500 per stay

The member cost sharing applies to covered benefits incurred during a member's inpatient stay.

Outpatient Substance Abuse (Detox and Rehab)	$35
OTHER SERVICES	**This is what you pay for Network & Out-of-Network Providers**
Skilled Nursing Facility (SNF) Care	$0 copay per day, day(s) 1-100

Limited to 100 days per Medicare Benefit Period**.

The member cost sharing applies to covered benefits incurred during a member's inpatient stay.

Home Health Agency Care	$0
Hospice Care	Covered by Medicare at a Medicare certified hospice.
Outpatient Rehabilitation Services (Speech, Physical, and Occupational therapy)	$35
Cardiac Rehabilitation Services	$35
Pulmonary Rehabilitation Services	$30

Radiation Therapy	$60
Chiropractic Services Limited to Medicare - covered services for manipulation of the spine	$10
Durable Medical Equipment/ Prosthetic Devices	$0
Podiatry Services Limited to Medicare covered benefits only.	$35
Diabetic Supplies Includes supplies to monitor your blood glucose from LifeScan	$0
Diabetic Eye Exams	$0
Outpatient Dialysis Treatments	$30
Medicare Part B Prescription Drugs	20%
Medicare Covered Dental Non-routine care covered by Medicare	$35

ADDITIONAL NON-MEDICARE COVERED SERVICES	
Meals	Covered up to 14 meals following an inpatient stay.
Hearing Aid Reimbursement	$500 once every 36 months
Fitness Benefit	Silver Sneakers
Resources for Living For help locating resources for every day needs	Covered
Routine Podiatry	$35

PHARMACY - PRESCRIPTION DRUG BENEFITS	
Prescription drug calendar year deductible Prescription drug calendar year deductible must be satisfied before any Medicare Prescription Drug benefits are paid. Covered Medicare Prescription Drug expenses will accumulate toward the pharmacy deductible.	$0
Pharmacy Network	S2

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LEE COUNTY BOARD OF COUNTY COMMISSIONERS

Aetna Medicare[SM] Plan (PPO)

Medicare (V01) ESA PPO Plan

Rx $10/$20/$35/$35

Your Medicare Part D plan is associated with pharmacies in the above network. To find a network pharmacy, you can visit our website (http://www.aetnaretireeplans.com).

Formulary	Open 2 Plus
Initial Coverage Limit (ICL)	$3,750

The Initial Coverage Limit includes the applicable plan deductible. Until covered Medicare Prescription Drug expenses reach the Initial Coverage Limit (and after the deductible is satisfied), cost-sharing is as follows:

4 Tier Plan	**Retail cost-sharing (in-network) up to a 30-day supply**	**Retail cost-sharing up to a 90-day supply**	**Preferred mail order cost-sharing up to a 90-day supply**
Tier 1 - Generic Generic Drugs	$10	$0	$0
Tier 2 - Preferred Brand Preferred Brand Drugs	$20	$40	$40
Tier 3 - Non-Preferred Brand Non-Preferred Brand Drugs	$35	$70	$70

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4 Tier Plan	Retail cost-sharing (in-network) up to a 30-day supply	Retail cost-sharing up to a 90-day supply	Preferred mail order cost-sharing up to a 90-day supply
Tier 4 - Specialty Includes high-cost/unique generic and brand drugs	$35	Limited to one-month supply	Limited to one-month supply

Coverage Gap†

Once covered Medicare Prescription Drug expenses have reached the Initial Coverage Limit, the Coverage Gap begins. Member cost sharing between the Initial Coverage Limit and until $5,000 in true out-of-pocket costs for Covered Part D drugs are incurred is as follows:

Your plan sponsor/former employer provides additional coverage during the Coverage Gap stage. This means that you will generally continue to pay the same amount for covered drugs throughout the Coverage Gap stage of the plan as you paid in the Initial Coverage stage. Once you reach $5,000 in out of pocket drug expenses, you qualify for the Catastrophic Coverage phase.

Catastrophic Coverage	$3.35 copayment for a generic drug or a drug that is treated like a generic, or a $8.35 copayment for all other drugs. Our plan pays the rest of the cost.

Catastrophic Coverage benefits start once $5,000 in true out-of-pocket costs is incurred.

Requirements:	
Precertification	Applies
Step-Therapy	Does Not Apply

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Non-Part D Drug Rider

- Not Covered

* Additional Medicare preventive services include:
  - Ultrasound screening for abdominal aortic aneurysm (AAA)
  - Cardiovascular disease screening
  - Diabetes screening tests and diabetes self-management training (DSMT)
  - Medical nutrition therapy
  - Glaucoma screening
  - Screening and behavioral counseling to quit smoking and tobacco use
  - Screening and behavioral counseling for alcohol misuse
  - Adult depression screening
  - Behavioral counseling for and screening to prevent sexually transmitted infections
  - Behavioral therapy for obesity
  - Behavioral therapy for cardiovascular disease
  - Behavioral therapy for HIV screening
  - Hepatitis C screening
  - Lung cancer screening

**A benefit period begins the day you go into a hospital or skilled nursing facility. The benefit period ends when you haven't received any inpatient hospital care (or skilled care in a SNF) for 60 days in a row. If you go into a hospital or a skilled nursing facility after one benefit period has ended, a new benefit period begins. There is no limit to the number of benefit periods.

Not all PPO Plans are available in all areas

Aetna Medicare is a PDP, HMO, PPO plan with a Medicare contract. Our SNPs also have contracts with State Medicaid programs. Enrollment in our plans depends on contract renewal.

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This information is not a complete description of benefits. Contact the plan for more information. Limitations, copayments, and restrictions may apply. Benefits, formulary, pharmacy network, premium and/or co-payments/co-insurance may change on January 1 of each year.

Plans are offered by Aetna Health Inc., Aetna Health of California Inc., and/or Aetna Life Insurance Company (Aetna). Not all health services are covered. See Evidence of Coverage for a complete description of benefits, exclusions, limitations and conditions of coverage. Plan features and availability may vary by location.

The formulary and pharmacy network may change at any time. You will receive notice when necessary.

Members who get "extra help" are not required to fill prescriptions at preferred network pharmacies in order to get Low Income Subsidy (LIS) copays.

You must be entitled to Medicare Part A and continue to pay your Part B premium and Part A, if applicable.

See Evidence of Coverage for a complete description of benefits, exclusions, limitations and conditions of coverage. Plan features and availability may vary by location.

Aetna receives rebates from drug manufacturers that may be taken into account in determining Aetna's preferred drug list. Rebates do not reduce the amount a member pays the pharmacy for covered prescriptions. Pharmacy participation is subject to change.

Participating physicians, hospitals and other health care providers are independent contractors and are neither agents nor employees of Aetna. The availability of any particular provider cannot be guaranteed, and provider network composition is subject to change.

In case of emergency, you should call 911 or the local emergency hotline. Or you should go directly to an emergency care facility.

The following is a partial list of what isn't covered or limits to coverage under this plan:

- Services that are not medically necessary unless the service is covered by Original Medicare or otherwise noted in your Evidence of Coverage
- Plastic or cosmetic surgery unless it is covered by Original Medicare
- Custodial care
- Experimental procedures or treatments that Original Medicare doesn't cover
- Outpatient prescription drugs unless covered under Original Medicare Part B

†Your plan sponsor or former employer provides additional coverage during the coverage gap phase for covered brand name drugs. This means that you will generally continue to pay the same amount for covered brand name drugs throughout the coverage gap phase of the plan as you paid in the initial coverage phase.

Coinsurance is applied against the overall cost of the drug, before any discounts or benefits are applied.

Aetna's retiree pharmacy coverage is an enhanced Part D Employer Group Waiver Plan that is offered as a single integrated product. The enhanced Part D plan consists of two components: basic Medicare Part D benefits and supplemental benefits. Basic Medicare Part D benefits are offered by Aetna based on our contract with CMS. We receive monthly payments from CMS to pay for basic Part D benefits. Supplemental benefits are non-Medicare benefits that provide enhanced coverage beyond basic Part D. Supplemental benefits are paid for by plan sponsors or members and may include benefits for non-Part D drugs. Aetna reports claim information to CMS according to the source of applicable payment (Medicare Part D, plan sponsor or member).

There are three general rules about drugs that Medicare drug plans will not cover under Part D. This plan cannot:

- Cover a drug that would be covered under Medicare Part A or Part B.
- Cover a drug purchased outside the United States and its territories.
- Generally cover drugs prescribed for "off label" use, (any use of the drug other than indicated on a drug's label as approved by the Food and Drug Administration) unless supported by criteria included in certain reference books like the American Hospital Formulary Service Drug Information, the DRUGDEX Information System and the USPDI or its successor.

Additionally, by law, the following categories of drugs are not normally covered by a Medicare prescription drug plan unless we offer enhanced drug coverage for which additional premium may be charged. These drugs are not considered Part D drugs and may be referred to as "exclusions" or "non-Part D drugs". These drugs include:

- Drugs used for the treatment of weight loss, weight gain or anorexia
- Drugs used for cosmetic purposes or to promote hair growth
- Prescription vitamins and mineral products, except prenatal vitamins and fluoride preparations
- Outpatient drugs that the manufacturer seeks to require that associated tests or monitoring services be purchased exclusively from the manufacturer as a condition of sale
- Drugs used to promote fertility
- Drugs used to relieve the symptoms of cough and colds
- Non-prescription drugs, also called over-the-counter (OTC) drugs
- Drugs when used for the treatment of sexual or erectile dysfunction

Aetna receives rebates from drug manufacturers that may be considered when determining our preferred drug list. Rebates do not reduce the amount you pay the pharmacy for covered prescriptions. Pharmacy participation is subject to change.

You must use network pharmacies to receive plan benefits except in limited, non-routine circumstances when a network pharmacy is not available. If you become ill while traveling in the United States, but are outside of your plan's service area, you may need to use an out-of-network pharmacy. An additional cost may be charged for drugs received at an out-of-network pharmacy. Quantity limits and restrictions may apply.

If you reside in a long-term care facility, your cost share is the same as at a retail pharmacy and you may receive up to a 31-day supply.

You may get drugs from an out-of-network pharmacy in certain situations, but are limited to a 30-day supply.

You may be able to get Extra Help to pay for your prescription drug premiums and costs. To see if you qualify for Extra Help, call:

- **1-800-MEDICARE (1-800-633-4227)**. TTY users should call **1-877-486-2048**, 24/7
- The Social Security Office at **1-800-772-1213** between 7 a.m. and 7 p.m., Monday through Friday. TTY users should call **1-800-325-0778**
- Your state Medicaid office

If you qualify, Medicare could pay for up to 75 percent or more of your drug costs including monthly prescription drug premiums, annual deductibles and coinsurance. Additionally, those who qualify will not be subject to the coverage gap or a late enrollment penalty. Many people are eligible for these savings and don't even know it.

If there is a difference between this document and the Evidence of Coverage (EOC), the EOC is considered correct.

Information is believed to be accurate as of the production date; however, it is subject to change. For more information about Aetna plans, go to www.aetna.com.

*****This is the end of this plan benefit summary*****

GRP_0009_659

Lee County Board of County Commissioners
January 1, 2018 through December 31, 2018

Effective date
The rates and benefit plan designs provided in this proposal are effective January 1, 2018 through December 31, 2018.

The following conditions allow us to assess the potential financial impact and adjust premium rates, subject to applicable state and federal mandates:

- **Pricing and underwriting basis** - We've assumed the proposed plan of benefits will extend to the Medicare eligible membership included on the census file submitted with the request for proposal. The proposed rates assume member enrollment by plan type as outlined below:

Product	Enrolled members
Medicare Advantage ESA PPO w. Rx	327

  We reserve the right to rerate or restructure our rating if: a) the total enrollment varies by more than 10 percent from the enrollment assumption used in the enclosed rating or, b) if any site's enrolled membership expressed as a percent of total enrolled membership varies by more than +/- 10 percent from that assumed when rating the case. Aetna group retiree coverage does not extend to additional employer groups unless we are able to review supplemental census information and other underwriting information for appropriate financial review.

- **Slice offering** - This proposal, including the assumptions relating to member enrollment for each plan set forth above, assumes Aetna group retiree benefits are offered as an option for retirees alongside other Medicare based plans.

- **Legislative action** – Aetna reserves the right to rerate or restructure our rating when legislative action causes a material change to:

  - Benefits offered
  - Claim payment requirements or procedures
  - State premium taxes or assessments
  - ACA taxes or fees
  - Any other changes affecting the manner or cost of providing coverage that is required because of legislative or regulatory action

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- **Employer contribution requirements** - This offering assumes a minimum employer contribution level of 50 percent of the group premium for medical/pharmacy plan. If the actual employer contribution differs from this assumed percentage, the medical and pharmacy rates are subject to revision.

- **Rate and benefit approval** -This proposal is subject to Centers for Medicare and Medicaid Services ("CMS") renewal and approval of the plans' current or pending Medicare Advantage and Medicare prescription drug contracts, applications and service areas for calendar year 2018. Filed benefits, including cost sharing amounts and premiums, are subject to regulatory approval(s), where applicable, and are effective January 1, 2018 through December 31, 2018.

- **Medicare Part D-** Aetna reserves the right to re-rate the Medicare Part D component of the MAPD rate if any legislative changes are made to the structure of the Medicare Part D program that may include, but are not limited to, the manufacturer coverage gap discount program or subsidies such as catastrophic reinsurance.

  The premium developed in this proposal excludes any additional income-related Medicare Part D premium payments required of Medicare-eligible members in order for the member to be eligible for the Part D product.

  Aetna reserves the right to communicate with enrolled members regarding opportunities to reduce out of pocket prescription drug costs.

- **Health Care Reform** - The Patient Protection and Affordable Care Act and the Health Care and Education Reconciliation Act of 2010 were signed into law by President Obama in 2010 (PPACA). PPACA includes the following provisions related to the Part D coverage gap: (1) Medicare beneficiaries with Part D coverage will receive a 50 percent discount off the price of brand-name drugs during the coverage gap (the "doughnut hole") starting in 2011, and (2) the coverage gap will gradually reduce the cost-sharing during the coverage gap for both brand-name and generic drugs until it equals 25 percent of the negotiated price of the drug in 2020 (similar to cost-sharing under the initial coverage limit). These PPACA provisions may impact Part D benefits included in this phase of the plan every year until 2020.

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- **Affordable Care Act - fees and assessments** - The Affordable Care Act (ACA) imposed several fees/assessments, including the Health Insurance Provider Fee, the Transitional Reinsurance Contribution and the Patient-Centered Outcomes Research Institute Fee. The Transitional Reinsurance Contribution and Patient-Centered Outcomes Research Institute Fee are not applicable to Medicare.

  - Health Insurance Providers Fee (HIF) is a recurring, annual, industry fee assessed based on each insurer's share of the fully insured market, as determined by the IRS. A total of $11.3 billion will be collected across the industry for 2016. The total assessment will increase each year, to an estimated $14.3 billion in 2018 and will then increase at the rate of industry premium growth thereafter. The Omnibus Bill, signed into law on 12/18/15, includes a one year suspension of the HIF for calendar year 2017. HIF will be reinstated for calendar year 2018.

  Aetna reserves the right to modify these rates, or otherwise recoup such fees, based on future regulatory guidance, subsequent state regulatory approval, or if estimates are materially insufficient.

- **Medical deductible credits** - This quote excludes medical deductible credits from our proposed medical plan.

- **Use of pharmacy data for medical management** - The enclosed medical rates assume: a) we are the pharmacy benefit administrator or PDP carrier or, b) we receive weekly pharmacy data feeds in an appropriate format from either you or your designated third party. The medical rates are subject to revision if either of these conditions does not occur.

- **Pharmacy plans** - This offering assumes that where our Medicare Advantage plans with prescription drug coverage (MA-PD plans) or standalone Medicare Prescription Drug plan (PDP) is a retiree option alongside any competitor plan, our benefit design is not positioned as the richest pharmacy plan available.

- **Mail Order refill data transfer**- You must provide a Mail Order pharmacy open refill data file for electronic transfer of prescriptions to Aetna. The file must be received by October 01, 2017. Aetna does not charge a fee for incoming open refill files.

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- **Aetna Mail Order and Specialty** - Aetna's mail order benefits are filled by Aetna Rx Home Delivery(ARxHD). This mail order service supplies medications for drugs taken on a regular basis (we call these maintenance drugs). Examples of maintenance drugs include medications used to treat chronic conditions such as arthritis, high cholesterol, asthma, or high blood pressure. ARxHD does not supply medications used for short-term illnesses, such as cold medications or antibiotics. Additionally, certain drugs that require special handling may not be available through mail order. These drugs are sometimes called specialty drugs and may require storage at controlled temperatures or other unique handling requirements which cannot be accommodated through a traditional mail order arrangement. Therefore, most specialty drugs are not available at the mail order benefit (cost share) and instead will pay at the retail benefit (cost share).

- **End stage renal disease** - We assume that you don't enroll retirees and their dependents who are Medicare beneficiaries diagnosed with End Stage Renal Disease (ESRD Beneficiaries) in the Aetna Medicare Advantage plan during their 30-month coordination period, unless the ESRD beneficiaries maintain coverage under your commercial group health plan as the primary payer during their 30-month coordination period and the Medicare Advantage plan is the secondary payer.

  We will only offer group Medicare Advantage plans to retirees and their dependents who are Medicare beneficiaries diagnosed with ESRD (ESRD Beneficiary) in a manner that is consistent and complies with applicable laws, rules and regulations, including, but not limited to, 42 C.F.R. Section 422.50(a)(2) and other Medicare Advantage and Medicare Secondary Payer (MSP) laws, rules and regulations and Centers for Medicare and Medicaid Services ("CMS") instructions. If an ESRD Beneficiary is eligible for or entitled to Medicare based on End Stage Renal Disease, federal law requires your commercial group health plan ("GHP") to be the primary payer for the first thirty months of the ESRD Beneficiary's Medicare eligibility or entitlement ("30-month coordination period"), regardless of the number of employees and regardless of whether the ESRD Beneficiary is a current employee or retiree. Therefore, you must confirm whether ESRD Beneficiaries are in their 30-month coordination period, and not enroll ESRD Beneficiaries in our Medicare Advantage plans during their 30-month coordination period unless coverage under the GHP is maintained for such ESRD Beneficiaries for that period.

Additional financial information
The following are brief descriptions of some of the important features of the group retiree plans quoted in this proposal:

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- **Plan eligibility-** This proposal assumes all members are retired and enrolled in Medicare Part A and Part B.

- **Timely premium payments-** If a premium payment is not paid in full on or before the premium due date, a late payment charge of one and one half percent of the total amount due per month may be added to the amount due, beginning with the premium due date. We also have the right to assess late premium payment and costs of collection of any unpaid premiums or fees, including reasonable attorney's fees and cost of suit.

- **Medicare Advantage – Premium Requirements** - The following requirements apply only if Aetna is offering a Medicare Advantage HMO or PPO Plan to your members, and you and your members are paying any portion of the premium for the Medicare Advantage benefit ("MA Premium"). CMS requires that we notify you of these requirements. You must comply with the following conditions with respect to any subsidization of MA Premium and any required MA Premium contribution by the member:

    1. You may subsidize different amounts of MA Premium for different classes of members and their dependents, provided such classes are reasonable and based on objective business criteria, such as years of service, date of retirement, business location, job category, and nature of compensation (e.g., salaried vs. hourly).

    2. MA Premium contribution levels cannot vary for members within a given class.

    3. Direct subsidy payments from CMS to Aetna must be passed through to reduce the amount of any required MA Premium payment by the member.

- **Prospective rating basis-** The enclosed insured rates are offered on a prospectively rated basis. No policy year accounting balance will be calculated for these coverages.

- **Run-in claim processing-** Expenses associated with run-in claims from any prior plan (claims incurred before the effective date of our plan) are excluded from the proposed rates.

- **Additional products and services-** We will bill you for the cost of special services that aren't included or assumed in the pricing. For example, you'll be subject to additional charges for customized communication materials. Costs will depend on the actual services performed and are determined at the time the service is requested.

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Inaccurate or incomplete information - We're relying on information from you and your representatives in establishing the rates and terms of this proposal. If any of this information is inaccurate or incomplete and has a material impact on the cost of the programs, we reserve the right to adjust our rates and terms.

Conclusion
We present this proposal on the condition that it will be accepted in its entirety. Furthermore, we've assumed that you'll continue to offer all other coverages, products, and services that you purchased previously. If there is a material change in this regard, we reserve the right to review and reprice this proposal. If you're interested in a subset of our proposal, then we will gladly review and reprice, if necessary. Before accepting the rates in this proposal, you must disclose any material deviation, current or expected, from these assumptions.

The most recent version of this document issued by Aetna to you, including any attachments to this document, ("Financial Documents") are part of your group agreement with Aetna to offer fully-insured group Medicare Advantage plans and/or standalone Medicare prescription drug plans ("Group Agreement"). In the event of a conflict between the terms of the Financial Documents and your Group Agreement and the documents incorporated into the Group Agreement, the order of priority shall be as described in your Group Agreement. Any riders, amendments, inserts and attachments shall have the same priority as the document to which they are attached.

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Medicare Advantage - medical plans
CMS group enrollment waiver
CMS has established a waiver of network service area requirements ("Waiver") for some employer/union groups. Under this waiver, the employer/union may enroll their retirees in an MA HMO or PPO plan even if they reside in a service area that does not have access to network providers. We refer to these non-network service areas as "Extended Service Areas" (ESA).

In order to be eligible for the Waiver, at least 51% of your retirees and dependents must live in a service area that provides adequate access to network providers. Aetna will apply the CMS network requirements when determining if a county or service area meets adequate access requirements.

It is important to know that:

- Members in an ESA plan may not have access to the Aetna network of providers.
- Providers that are not contracted with Aetna are not required to accept the Aetna ESA PPO plan except for emergency and urgently needed care.

We will monitor the network adequacy throughout the year to confirm that standards are met. Our network teams will work to strengthen our provider networks to meet CMS network adequacy requirements to help avoid potential disruption to our members.

As of July 2017, 95 percent of your members reside in service areas that meet CMS network adequacy requirements. If the total percentage of members falls below 51% by the effective date of your Aetna MA PPO plan, we cannot offer you our MA PPO ESA plan. However, we will work with you to evaluate other group health plan options that can be offered in these extended service areas to help reduce potential Member disruption.

Prescription drug coverage
Our retiree pharmacy coverage consists of two components: basic Medicare Part D benefits and supplemental benefits.

- We offer Medicare Part D plan coverage pursuant to our contract with the CMS. We receive monthly payments from CMS for the Part D portion of your coverage.

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- We offer supplemental coverage that wraps around the basic Medicare Part D benefits, allowing you to offer enhanced pharmacy benefits. We receive monthly premium payments from you and/or your retirees for the supplemental coverage. Depending on your plan design, supplemental coverage may also include benefits for non-Part D covered drugs.

We will report drug claims information to CMS, based on the source of the applicable coverage payment - Medicare Part D, plan sponsor or member.

Administration of the open formulary
For the Open 2 formulary, newly approved drugs won't be covered until they've undergone internal clinical review as well as external review by our Pharmacy and Therapeutics (P&T) Committee. Following the review, we will determine in which tier the drug will reside, include any applicable utilization management edits as approved by the P&T committee, and release the drug for coverage under open formulary plans.

Medicare Part D creditable coverage
If an applicant cannot demonstrate that he/she had prior creditable coverage, the applicant may incur late enrollment penalties, consistent with laws, rules and regulations applicable to the Part D program.

Helping your retirees obtain Medicaid coverage
We're pleased to provide group plan sponsors with an outreach program through Altegra Health™. The program provides continuous monitoring of social program eligibility and enrollment status to ensure appropriate access to benefits for which members are entitled.

The program includes:

- Initial Outreach
- Enrollment Assistance
- Annual Recertification
- Screen & Electronically Submit for Medicare's Part D Extra Help Program

We believe our Medicaid outreach program provides a valuable service to potentially eligible members by educating them about and screening for Medicaid programs. Medicaid eligibility may help reduce member out-of-pocket cost sharing and premiums. It can also help us reduce annual plan premium increases due to the additional payment we receive from CMS for these beneficiaries.

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If your organization doesn't wish to participate and have your retirees contacted by Altegra Health, your organization may "opt-out" of our Medicaid outreach program. To do so, please contact your Aetna representative no later than October 01, 2017.

Please Note: If we don't receive your "opt-out" notification by October 01, 2017, your organization will be included in our Medicaid outreach program.

Federal

The Federal Mental Health Parity Provisions of the "Emergency Economic Stabilization Act of 2008" were signed into law in October 2008 and became effective on October 3, 2009 (the "Act"). Interim final regulations ("IFR") governing implementation of this law were published on February 2, 2010 and generally apply to group health plans for plan years beginning on or after July 1, 2010 (with exceptions for collectively bargained plans). Aetna has assessed the anticipated impact of this law and continues to examine the impact of the IFR on our fully insured medical benefit plans. Aetna's analysis included an in-depth comparison of the federal law to each state's regulations pertaining to mental health and substance use disorder benefits. Plan designs have been modified based on our understanding of the intent of the Act. However, Aetna reserves the right to make additional plan design and premium changes for purposes of complying with the Act and its accompanying regulations.

Based on our understanding of the Act and the IFR, Aetna has identified certain plan design guidelines, which we include as a standard part of our fully insured medical benefit plan offering. These guidelines include:

- The member cost share for outpatient behavioral health and/or substance use disorder benefits is equal to (or less than) that applied to the plan's appropriate outpatient medical/surgical benefit as determined by the quantitative treatment limitation test of the IFR (i.e., the "Substantially All" and "Predominant" test).

- The member cost share for inpatient behavioral health and/or substance use disorder benefits is equal to (or less than) that applied to Inpatient Hospital Admissions with no day limits or maximum benefit amounts unless also applied to Inpatient Hospital Admissions

- Any plan level deductibles or out of pocket maximums will be combined across all benefits, including behavioral health and/or substance use disorder benefits.

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Employer Reporting Requirements:
Under Internal Revenue Code (IRC) Section 6055 health insurance issuers, certain employers, government agencies and other entities that provide Minimum Essential Coverage (MEC) to individuals must report to the IRS information about the type and period of coverage and furnish related statements to covered individuals. This information is used by the IRS to administer the individual shared responsibility provision and by individuals to show compliance with the individual shared responsibility provision.

For insured group health plans, the reporting obligation under Section 6055 is on the insurer. We will report the required information to the IRS about the type and period of coverage provided to each individual member enrolled in our insured plans, and will furnish the required statements to subscribers. We will send these statements either by first class mail or, when we receive appropriate consent, electronically. We must report the entire Social Security numbers (SSN) to the IRS for each subscriber and dependent in order to complete our required reporting. However, the final rules allow the use of truncated social security numbers on statements furnished to individuals (for example, give only the last four digits of the SSN). If we don't receive the SSN through the employer, the law requires we reach out to each subscriber up to three separate times to request the information.

IRC Section 6056 requires large employers (those having employed an average of 50 or more full-time employees during the preceding calendar year) to report to the IRS information about the health care coverage they have offered and also furnish applicable statements to employees. The purpose is to allow the IRS to enforce the employer responsibility provisions.

To satisfy the 6056 employer reporting requirements, you must file the required returns with the IRS by no later than February 28 of the year following coverage (if filing on paper) or March 31 (if filing electronically), and furnish a statement to all full-time employees by January 31st of the year following the calendar year to which the return relates (i.e., January 31, 2019 for the 2018 calendar year).

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Broker commissions - The enclosed rates exclude broker commissions.

We honor 'Agent of Record' or 'Broker of Record' letters when an agent, broker, or consultant sells new business or takes over an Aetna case from another agent, broker, or consultant. Please have an appropriate representative from your organization sign the letter using your organization's letterhead. The change will become effective on the first day of the month after our payment unit receives the 'Agent of Record' or 'Broker of Record' letter, unless another future date is designated in the letter.

Producers (brokers, agents, consultants) - Licensed and appointed producers may earn compensation in the form of a commission on the sale of this product. The amount of compensation varies. It depends on a number of factors, including customer segment and the products selected. Additional bonus programs may also apply. Please ask your broker for more information about their compensation for this sale, including commission and any applicable bonus programs. The producer is prohibited by law from altering the amount of compensation they get from us based in whole or in part on the sale.

Salaried Aetna employees - Salaried employees may be compensated for selling Aetna products. The amount of compensation varies. It depends on a number of factors, including customer segment and products selected. Combining all factors, and excluding limited-benefit plans, compensation for each product quoted averages less than 0.30 percent of the total first year annual premium. Our additional bonus programs may also apply. Neither Aetna nor the employee has material ownership interests in the other. The employee may not alter the amount of their compensation. Contact us at **https://www.aetna.com/about-aetna-insurance/contact-us/forms/employer/transparency.html** for more information about the compensation eligible employees may receive, which is based in whole or in part on the sale of an Aetna product or alternative options presented.