2024 BENEFIT HIGHLIGHTS

GUIDE FOR EMPLOYEES

Lee County
Southwest Florida

CONTACTS

Lee County Benefits	(239) 533-2245 *(ask for benefits)* (239) 485-2052 benefits@leegov.com
Robin Lears Manager of Benefits & Wellness rlears@leegov.com	(239) 533-0846
Angie Vierling Benefits Specialist avierling@leegov.com	(239) 533-0826
Ashley Mengel Benefits Specialist amengel@leegov.com	(239) 533-0820
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Jim Cotter Dedicated Aetna Representative cotterj@aetna.com	(239) 533-0829

Lee County
Southwest Florida

2024 BENEFITS

CARRIER CONTACTS

Florida Retirement System (FRS)	(866) 446-9377 www.myfrs.com

BENEFIT	CARRIER	WEBSITE	TELEPHONE
Medical	Aetna	www.aetna.com	888-266-5519
Pharmacy	Aetna	www.aetna.com	866-612-3862
Telemedicine	TelaDoc	www.Teladoc.com/Aetna	1-855-TELADOC (835-2362)
Dental	Aetna	www.aetna.com	877-238-6200
Vision	VSP	www.vsp.com	800-877-7195
Life	The Standard	www.standard.com	800-628-8600
Short-Term Disability	The Standard	www.standard.com	800-378-2395
Long-Term Disability	The Standard	www.standard.com	800-378-2395
Flexible Spending Account (FSA)	PayFlex	www.payflex.com	888-678-8242
EAP (Employee Assistance Program)	Aetna	www.resourcesforliving.com	888-238-6232

IN THIS GUIDE

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

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

WE'LL MAKE THIS QUICK

Here's a quick checklist for you to use as you go through your enrollment. Additional details can be found in the appendix of this document and on the intranet. As you go through the enrollment process, you'll also have a number of opportunities that will help you navigate your benefits. And as always, your benefits team is here to help. Please reach out at (239) 533-2245.

- ❑ **Review your benefit options**
- ❑ **Enroll in your benefits**
- ❑ **Send any necessary dependent paperwork to HR**
  - ❑ Covering dependents: marriage certificate, social security card, birth certificate
- ❑ **If you are enrolling in Short Term Disability or Voluntary Life Insurance after your initial eligibility period, please visit https://myeoi.standard.com/164657 to complete Evidence of Insurability forms. Please note that late enrollees are subject to Underwriting approval/denial.**
- ❑ **Double check your beneficiaries**
- ❑ **Review your benefits statement to ensure it is correct**

QUALIFYING EVENTS

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

"Qualifying Event" includes but is not limited to:

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

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

NEED TO REQUEST A CHANGE?

Please contact your Human Resources department immediately to obtain forms and initiate enrollment following a qualifying event. Enrollment changes will take effect on the first of the month following receipt of completed paperwork.

NEED TO ADD A SPOUSE OR DEPENDENT TO YOUR BENEFITS?

The Human Resource Benefits Team will need the following to add a dependent to your benefit plan:

To Add Spouse:

- Marriage License
- Social security card
- Drivers License or Passport
- Spouse COBRA acknowledgement form

To Add Dependent:

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

MEDICAL PLAN

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Two medical plans are available – Aetna Select and Aetna Choice POS II. Both are comprehensive plans with services that include, but are not limited to routine, preventive, mental health, hospitalization, and prescription drug benefits. Please note that the Select Open Access plan does not cover any out-of-network claims. The Aetna Point of Service plan allows you to visit in network and out-of-network doctors and hospitals of your choice. Out-of-network doctors and hospitals do not contract with our insurance carrier, Aetna. They normally charge more for their services and you might have to pay the difference between what the plan pays for services and the amount they charge.

	AETNA SELECT OPEN ACCESS	AETNA CHOICE POSII OPEN ACCESS
PCP Requirement	None	None
Referrals Required	No	No
Out of Network Benefits	No	Yes
Teladoc Benefits	Yes	Yes

CO-PAYS

Primary Care Physician (PCP)	$10	$10
Behavioral Health	$10	$10
Specialist	$25	$35
Urgent Care	$50	$50
Lab (Quest or LabCorp)	$25	$35
Emergency Room	$150	$150
Hospital Admission	$500	$500
Outpatient Services	$200	$200
TelaDoc	$10	$10

All co-pays listed above are for in network benefits. To view additional plan details please review the plan documents and Summary Plan Descriptions.

FIND A NETWORK PROVIDER

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

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

PREVENTIVE SERVICES

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

- Routine Adult Physical Exams
- Routine Well Child Physical Exams (includes audiometric exam)
- Routine GYN
- Routine Cancer Screenings (Mammography/Colon Screening/DRE/PSA)
- Routine Vision Exam

COMPLEX IMAGING SERVICES

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

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

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

AETNA VISION DISCOUNTS

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

OPTING OUT OF MEDICAL BENEFITS?

The Opt-Out option is available to employees who have coverage other than the Lee County Health Plan and wish to "opt-out" of our medical plan.

- Eligible employees must qualify at initial enrollment by providing proof of other coverage.
- Once enrolled, this benefit will "roll over" into each new plan year.
- An employee may "opt back in" to the medical plan at the next annual open enrollment period; or, with a qualifying event reported within 60 days of the date of the event.
- To enroll in or to drop this plan, complete the Opt Out form and provide proof of other coverage.

If you are covered as a spouse or dependent in the Lee County Health Plan, or another entity covered by our insurance plans, you are not eligible to elect this option.

If you have coverage outside of the Lee County plan, consider opting out of Lee County's medical coverage. Being double covered doesn't necessarily mean you'll have fewer out-of-pocket costs. You'll be paying 2 premiums for coverages and may incur additional expenses related to Coordination of Benefits. Talk to a member of the Benefits team if you have questions.

TELADOC

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

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

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

Create an Account

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

Talk to a Doctor

Request a time and a Teladoc doctor will contact you.

Feel Better

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

PHARMACY

RETAIL STORES

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

DOWNLOAD THE APPS

Available for Apple or Android

Teladoc
24/7 access to a doctor

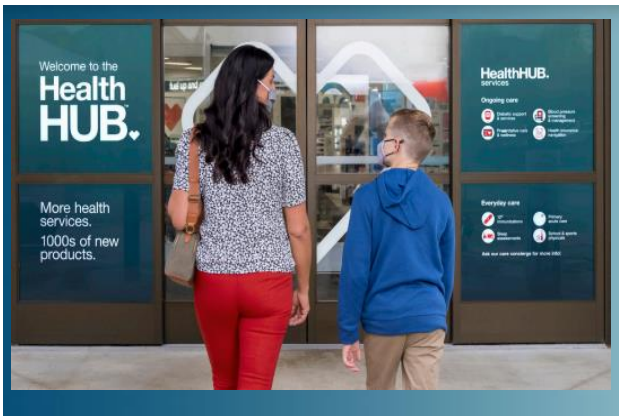
Aetna Health
View benefits details, member ID cards and more!

MAIL ORDER OPTIONAL PROGRAM

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

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

CVS HealthHUB



Convenient care at $0 cost to you!

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

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

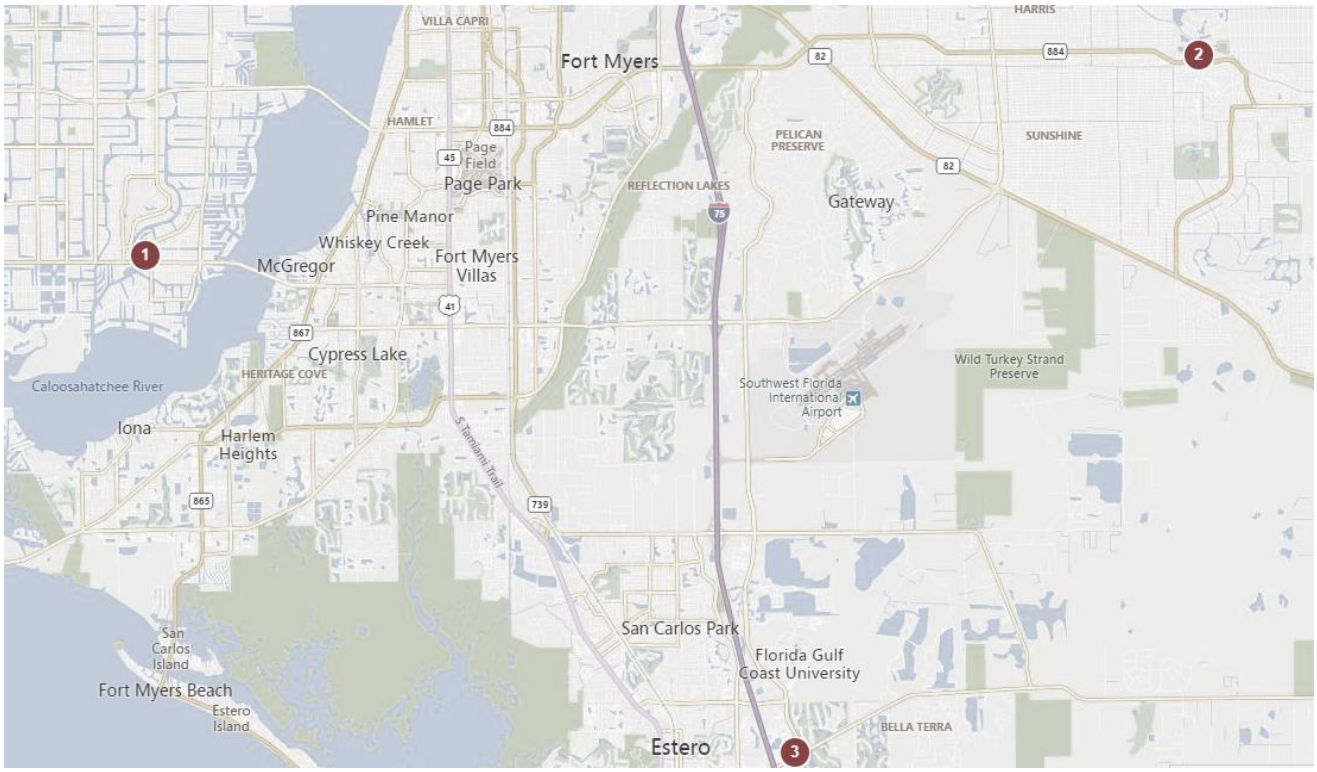
CVS HealthHUB providers can also administer vaccines and write prescriptions, when medically appropriate.

Book an appointment online and walk right in

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

Find a HealthHUB near you:

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



OVERAGE DEPENDENT ELIGIBILTY & AFFIDAVITS

Over-Age Dependent Affidavits (Age 26-30), if you are currently receiving this benefit, the required form must be updated annually. Contact Human Resources if you have questions.

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

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

The employee may elect to continue their dependent(s) coverage in the medical plan only and pay an additional premium for each dependent covered in the 26-30 age group. For the plan year 2023, that rate is $1,180 per month in addition to any other applicable tier of medical premiums.

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

DENTAL PLAN

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The County offers one great dental plan that offers both in and out of network benefits. For additional benefits details, please review the plan summary documents for more detail

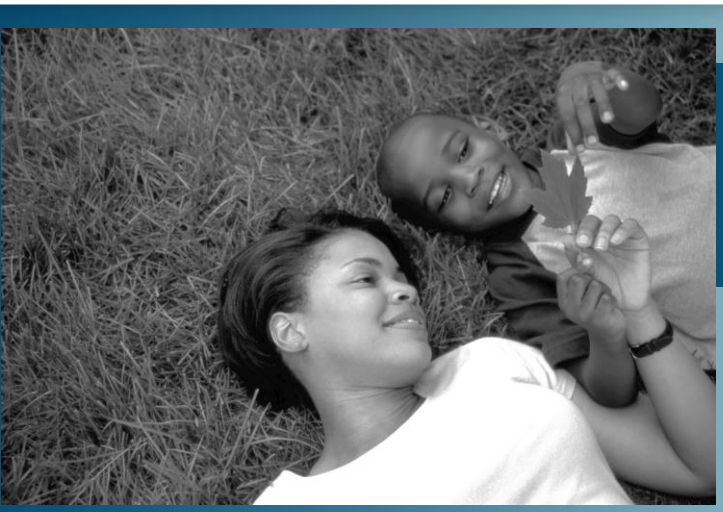
ANNUAL DEDUCTIBLE*	IN NETWORK	OUT OF NETWORK
Individual	$50	$50
Family	$100	$100
COINSURANCES	**PLAN PAYS**	
Preventive	100%	100%
Basic	80%	80%
Major	50%	50%
BENEFIT MAXIMUM		
Annual Maximum****	$1,500	$1,500
ORTHODONTIC		
Deductible	$0	$0
Coinsurance	50%	50%
Eligibility	Dependent Child Only**	Dependent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

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

VISION PLAN

The County offers two fantastic vision plan options for you to choose from. For additional benefits details, please review the plan summary documents.

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



FLEXIBLE SPENDING

A Flexible Spending Account (FSA) is an account you set up to pre-fund your anticipated eligible medical expenses or dependent care expenses on **a pre-tax basis**. Select either a Medical Spending FSA, a Dependent Care FSA or both!

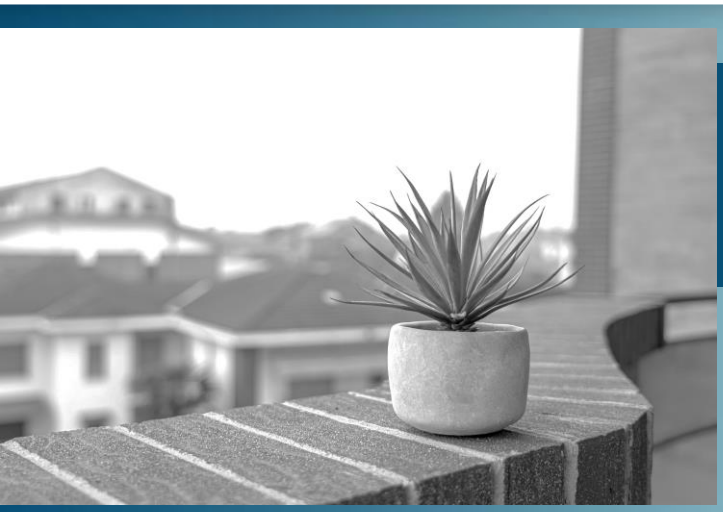
The Medical Spending FSA comes with the availability of a Debit MasterCard for your medical reimbursement convenience. PayFlex offers a mobile app for your convenience and it can be downloaded in the Apple App store or Android Google Play.

Your participation in these accounts does not automatically continue from year to year – you must set FSAs up each year by completing the form or enrolling using the Vista HRMS Wizard. Your FSA funds are evenly deducted from your paycheck before taxes are calculated, which lowers your taxable income and saves you tax dollars on money you plan to spend anyway.

CONTRIBUTION	MEDICAL SPENDING FSA	DEPENDENT CARE FSA
Minimum	$600	$600
Maximum	$3,200	$5,000

OTHER DETAILS		
Funds Expire?	Yes	Yes
For Expenses Incurred	1/1/2024 - 3/15/2025	1/1/2024 – 3/15/2025
Submit for Reimbursement by	3/31/2025	3/31/2025
Can be Used For:	Medical, dental, vision expenses	Daycare expenses for dependents*

*children under age 13 or elder/tax-dependents for whom you are responsible.
**Maximums at the time this guide was published, subject to change as IRS guidelines are updated.



LIFE INSURANCE

The County provides term Life and Accidental Death & Dismemberment insurance for their employees at no cost, through The Standard. Benefit amount is based upon pay grade, but at least 1X annual salary.

Eligible employees may wish to purchase additional term life insurance through the County's Group Optional Life Insurance program. This is a voluntary, payroll-deducted benefit designed for employees for themselves, spouse, and/or children.

Group Optional Life allows you to select the amount of additional life insurance which best fits your needs. Guarantee Issue amounts listed below are applicable at time of initial eligibility. Enrollments outside of the initial enrollment period are subject to providing Evidence of Insurability (EOI). Once EOI is completed, the Standard will approve or deny your increased life insurance request.

	MINIMUM	INCREMENTAL UNIT	GUARANTEE ISSUE AMOUNT	MAXIMUM
Employee	$25,000	$1,000	$300,000	$500,000
Spouse	$25,000	$1,000	$50,000	$250,000
Child	$5,000	$5,000	not applicable	$25,000

Updating Beneficiaries

To change or update beneficiaries any time during the year, please obtain a form from Human Resources.

Please send your original signed forms to Lee County Benefits via email at benefits@leegov.com or fax to (239) 485-2052.

Married participants of Lee County Benefits cannot cover each other for Optional Life and they cannot cover their dependents who are employees.

DISABILITY INSURANCE

SHORT-TERM DISABILITY

The carrier for Short Term Disability (employee purchased), is The Standard. Premiums for Short Term Disability are based on your annual salary. The premium will change when a change in your salary occurs.

Short-term disability is a voluntary, payroll deducted benefit that enables employees to receive disability income to offset financial losses that result from a non-work-related injury, illness, disease, or pregnancy. Approved disability claims provide 60% of your pre-disability income up to a weekly maximum of $600, reduced by any other taxable income you receive. Your short-term disability income is not taxable.

Employees who declined coverage and wish to enroll at a later date must submit an EOI (Evidence of Insurability) form to the Standard for certain levels of coverage. The Standard will accept or deny part or all of your requested coverage amount according to the information received.

LONG -TERM DISABILITY

The carrier for Long Term Disability (fully paid for you by your employer) is The Standard. This benefit pays a monthly income amount for a total or partial disability resulting in an extended absence from non-work-related illness or injury.

There is a 90-day waiting period before benefits begin. The benefit pays 60% pre-disability base salary, reduced by any other taxable income you receive up to a maximum monthly benefit of $5,000 until you are no longer disabled or until you have met your maximum benefit period. LTD benefits are considered taxable income and premiums are paid 100% by Lee County.

EOI FORMS

EOI forms can be obtained by visiting our website: https://myeoi.standard.com/164657

DISABILITY CLAIMS

To file a claim for either short-term disability (STD) or long-term disability (LTD), please contact ehs@leegov.com or call Human Resources at 239-533-2245.

WELLNESS PROGRAM

ACTIVITY CHALLENGES

We host activity challenges several times a calendar year using our employer-sponsored activity platform. Our programming offers individual or team-based health challenges.

WELL - BEING SPACES + FITNESS CLASSES

Our wellness team can help your department and/or divisions create a tranquil office space. Employees can enjoy the use of meditation products, yoga mats, resistance bands, and/or Bluetooth speaker. We also offer virtual and onsite lunchtime classes to help keep employees moving and grounded.

WELL-BEING WEBINARS

Our Aetna On-site Wellness Coordinator hosts a variety of well-being webinars throughout the year. Topics include healthy eating, sleep health, stress management, work/life balance, financial wellbeing, and more.

VACCINATION CLINICS

During the fall, we host no-cost, on-site vaccination clinics for employees on the Lee County health plan.

AETNA WORKPLACE WELL-BEING AWARD WINNER

For the third year in a row, Lee County BoCC has been awarded an Aetna Workplace Well-being Award. In 2022 and 2023, we were awarded the Gold Making a Difference Award. This is based on the evaluation of our employer well- being program. This award is the culmination of our employees' desire to live healthier, more active lives and make well-being a priority.

BIOMETRICS

We partner with Quest Diagnostics® to offer free on-site wellness screenings. This convenient test measures cholesterol, blood sugar, blood pressure, and body mass index. Off-site options at local Quest Patient Service Centers and Physician Forms are also available. Employees enrolled in the Lee County health plan can earn a $50 gift card*.

* Reward considered taxable earnings.

EAP

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Aetna Resources for Living is an employer sponsored program, available at no cost to you and all members of your household. Children living away from home are covered up to age 26.

Services are confidential and available 24 hours a day, 7 days a week.

Call
1 (888) 238-6232

Web
www.resourcesforliving.com
username: LCBOCC
Password: EAP

EMOTIONAL WELLBEING SUPPORT

You can access up to 5 counseling sessions per issue each year. You can also call us 24 hours a day for in-the-moment emotional well-being support.

Counseling sessions are available face to face, via televideo or chat therapy. Services are free and confidential. We're always here to help with a wide range of issues including:

- Anxiety
- Relationship Support
- Depression
- Stress Management
- Work/life Balance
- Family Issues
- Greif and Loss
- Self-esteem and Personal Development
- Substance Misuse and more!

DAILY LIFE ASSISTANCE

Competing day-to-day needs can make it tough to know where to start. Call us for personalized guidance. We'll help you find resources for:

- Childcare, Parenting & Adoption
- Care for Older Adults
- Caregiver Support
- School and Financial Aid Research
- Special Needs
- Community Resources/Basic Needs
- Home Repair and Improvement
- Summer Programs for Kids
- Pet Care
- Household Services and more!

FINANCIAL SERVICES

Simply call for a free 30-minute consultation for each new financial topic related to:

- Budgeting
- Credit and Debt Issues
- Retirement and Other Financial Planning
- College Funding
- Mortgages and Refinances
- Tax and IRS Questions

You can get a 25 percent discount on tax preparation services. You also have access to financial articles, calculators and a financial assessment on your member website.
*Services must be for financial matters related to the employee and eligible household members.

ONLINE RESOURCES

Your member website offers a full range of tools and resources to help with emotional wellbeing, work/life balance and more. You'll find:

- Articles and Self-Assessments
- Video Resources
- Adult care and Child care Provider Search
- Live and Recorded Webinars
- Stress Resources Center
- Mobile App

Discount Center
Find deals on brand name products and services including electronics, entertainment, gifts and flowers, travel, fitness, nutrition and more.

Mind Check
Online tools that make it easy to improve your emotional wellbeing. Measure your mindset and get feedback and resources to maintain a positive outlook.

LEGAL SERVICES

You can get a free 30-minute consultation with a participating attorney for each new legal topic related to:

- General
- Family
- Divorce
- Wills and Other Document Prep
- Civil/Criminal Law
- Real Estate Transactions
- Elder Law and Estate Planning
- Medication Service

If you opt for services beyond the initial consultation you can get a 25 percent discount. You also have free access to legal documents and forms on your member website.
*Services must be related to the employee and eligible household members. Work-related issues are not covered. Discount does not include flat legal fees, contingency fees and plan mediator services.

ADDITIONAL SERVICES

Chat therapy — Send secure text messages to your counselor, who will respond within one working day up to five days a week. A week of texting counts as one session. You can also schedule to meet online for 30-minute televideo sessions. Each televideo session counts as one visit. Work on the same kinds of issues you'd see a counselor face-to-face to talk about.

Identity theft services — One hour fraud resolution phone consultation or coaching about ID theft prevention and credit restoration. Services include a free emergency kit for victims.

GLOSSARY

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

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

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

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

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

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

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

Dependent Care Account: A flexible spending account (FSA) designed to provide tax-exempt funds to employees for eligible childcare and dependent care expenses. (See FSA.)

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

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

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

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

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

Employee Contribution: The amount an employee contributes through payroll deductions for their medical and other insurance and savings program benefits.

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

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

Flexible Spending Account (FSA): Funded through pre-tax payroll deductions, an FSA is a cost-savings tool that allows you to pay for qualified healthcare-related expenses with pre-tax dollars. Funds deposited in an FSA must be spent in the same year in which they are set aside or they are forfeited. This rule is often referred to as "use it or lose it".

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Pre-tax Deduction: Payments deducted from your gross pay before Medicare, Federal, and State taxes are calculated, thus reducing your taxable wages and tax liability.

Post-tax Deduction: Payments deducted from your net pay after Medicare, Federal, and State taxes are calculated, thereby having no impact on your taxable wages and tax liability.

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

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

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

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

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

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

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

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

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

DISCLOSURES & LEGAL NOTICES

Patient Protection and Affordable Care Act Disclosure Notices

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

The Affordable Care Act Patient Protection Disclosure

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

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

The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for services, following a pre-approved treatment plan, or procedures for making referrals.

For a list of participating health care professionals who specialize in obstetrics or gynecology, please visit Aetna's website at http://www.aetna.com or contact the Aetna Member Services number on your Aetna medical identification card.

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

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

Continuation Coverage Rights Under COBRA

You are receiving this notice because you have recently become covered under a group health plan (the Plan). This notice contains important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan.

This notice generally explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect the right to receive it.

The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage can become available to you when you would otherwise lose your group health coverage.

It can also become available to other members of your family who are covered under the Plan when they would otherwise lose their group health coverage. For additional information about your rights and obligations under the Plan and under federal law, you should review the Plan Summary Plan Description or contact the Plan Administrator.

You may have other options available to you when you lose group health coverage. For example, you may be eligible to buy an individual plan through the Health Insurance Marketplace (www.healthcare.gov). By enrolling in coverage through the Marketplace, you may qualify for lower costs on your monthly premiums and lower out-of-pocket costs. Additionally, you may qualify for a 30-day special enrollment period for another group health plan for which you are eligible (such as a spouse's plan), even if that plan generally doesn't accept late enrollees.

Additional details on the following page.

What is COBRA Continuation Coverage?

COBRA continuation coverage is a continuation of Plan coverage when coverage would otherwise end because of a life event known as a "qualifying event". Specific qualifying events are listed later in this notice. After a qualifying event, COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." You, your spouse, and your dependent children could become qualified beneficiaries if coverage under the Plan is lost because of the qualifying event. Under the Plan, qualified beneficiaries who elect CORBA continuation coverage must pay for COBRA continuation coverage.

If you are an **employee**, you will become a qualified beneficiary if you lose your coverage under the Plan because either one of the following qualifying events happens:	If you are the **spouse of an employee**, you will become a qualified beneficiary if you lose your coverage under the Plan because of any of the following qualifying events happens:	Your **dependent children** will become qualified beneficiaries if they lose coverage under the Plan because any of the following qualifying events happen:
• Your hours of employment are reduced, or • Your employment ends for any reason other than gross misconduct.	• Your spouse dies; • Your spouse's hours of employment are reduced; • Your spouse's employment ends for any reason other than his or her gross misconduct; • Your spouse becomes entitled to Medicare benefits (under Part A, Part B or both); or • You become divorced or legally separated from your spouse	• The parent-employee dies; • The parent-employee's hours of employment are reduced; • The parent-employee's employment ends for any reason other than his or her gross misconduct; • The parent-employee becomes entitled to Medicare benefits (under Part A, Part B or both); • The parents become divorced or legally separated; or • The child stops being eligible for coverage under the plan as a "dependent child.'

When is COBRA Coverage Available?

The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Plan Administrator has been notified that a qualifying event has occurred. When the qualifying event is the end of employment or reduction of hours of employment, death of the employee, or the employee's becoming entitled to Medicare benefits (under Part A, Part B, or both), the employer must notify the Plan Administrator of the qualifying event.

You Must Give Notice of Some Qualifying Events

For the other qualifying events (divorce or legal separation of the employee and spouse or a dependent child's losing eligibility for coverage as a dependent child), you must notify the Plan Administrator **within 60 days after the qualifying event** occurs. You must provide this notice to: Lee County Board of County Commissioners Benefits Department.

How is COBRA Coverage Provided?

Once the Plan Administrator receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. Covered employees my elect COBRA continuation coverage on behalf of spouses, and parents may elect CORBA continuation coverage on behalf of their children. Any qualified beneficiary who does not elect COBRA within the **60-day election period** specified in the election notice **will lose his or her right to elect COBRA**.

COBRA continuation coverage is a temporary continuation of coverage that generally lasts for 18 months due to employment termination or reduction of hours of work. When the qualifying event is the death of the employee, the employee becoming entitled to Medicare benefits (under Part A, Part B, or both), your divorce or legal separation, or a dependent child's losing eligibility as a dependent child, COBRA continuation coverage lasts for up to a total of 36 months. When the qualifying event is at the end of employment or reduction of work hours and the employee becomes eligible to Medicare benefits less than 18 months before the qualifying event, COBRA continuation coverage for qualified beneficiaries other than the employee lasts until 36 months after the date of Medicare entitlement. For example, if a covered employee becomes entitled to Medicare 8 months before the date on which his employment terminates, COBRA continuation coverage for his spouse and children can last up to 36 months after the date of Medicare entitlement, which is equal to 28 months after the date of his qualifying event (36 months minus 8 months). Otherwise, when the qualifying event is the end of employment or reduction of the employee's hours of employment, COBRA continuation coverage generally lasts for only up to a total of 18 months. There are two ways in which this 18-month period of COBRA can be extended.

Disability extension of 18-month period of continuation coverage

If you or anyone in your family covered under the Plan is determined by the Social Security Administration to be disabled and you notify the Plan Administrator in a timely fashion, you and your entire family may be entitled to receive up to an additional 11 months of COBRA continuation coverage, for a total maximum of 29 months. The disability would have to have started at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period of continuation coverage.

The disability extension is available only if you notify the Plan Administrator in writing of the Social Security Administration's determination of disability within 60 days after the latest of the date of the Social Security Administration's disability determination; the date of the overed employee's termination of employment or reduction of hours; and the date on which the qualified beneficiary loses (or would lose) coverage under the terms of the Plan as a result of a covered employee's termination or reduction of hours. You must also provide this notice within 18-months after the covered employee's termination or reduction in hours in order to be entitled to this extension.

Second qualifying event extension of 18-month period of continuation coverage

If your family experiences another qualifying event while receiving 10 months of COBRA continuation coverage, the spouse and dependent children in your family can get up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months, if notice of the second qualifying event is properly give to the Plan. This extension may be available to the spouse and any dependent children receiving continuation coverage if the employee or former employee dies, becomes entitled to Medicare benefits (under Part A, Part B, or both), or gets divorced or legally separated, or if the dependent child stops being eligible under the Plan as a dependent child, but only if the event would have caused the spouse or dependent child to lose coverage under the Plan had the first qualifying event not occurred.

Other Coverage Options

Instead of enrolling in COBRA continuation coverage, there may be other coverage options for you and your family through the Health Insurance Marketplace, Medicaid, or other group health plan coverage options (such as a spouse's plan) through what is called a "special enrollment period." Some of these options may cost less than COBRA continuation coverage. You can learn more about many of these options at www.healthcare.gov.

If you have Questions

Questions concerning your Plan or your COBRA continuation coverage rights should be addressed to the contact or contacts identified below. For more information about your rights and laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit the EBSA website at www.dol.gov/ebsa. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.)

Keep Your Plan Informed of Address Changes

In order to protect your family's rights, you should keep the Plan Administrator informed of any changes in the addresses of family members. You should also keep a copy, for your records, of any notices sent to you by the Plan Administrator.

Plan Contact information

For further information regarding the plan and COBRA Continuation, please contact:

LCBOCC Benefits Department

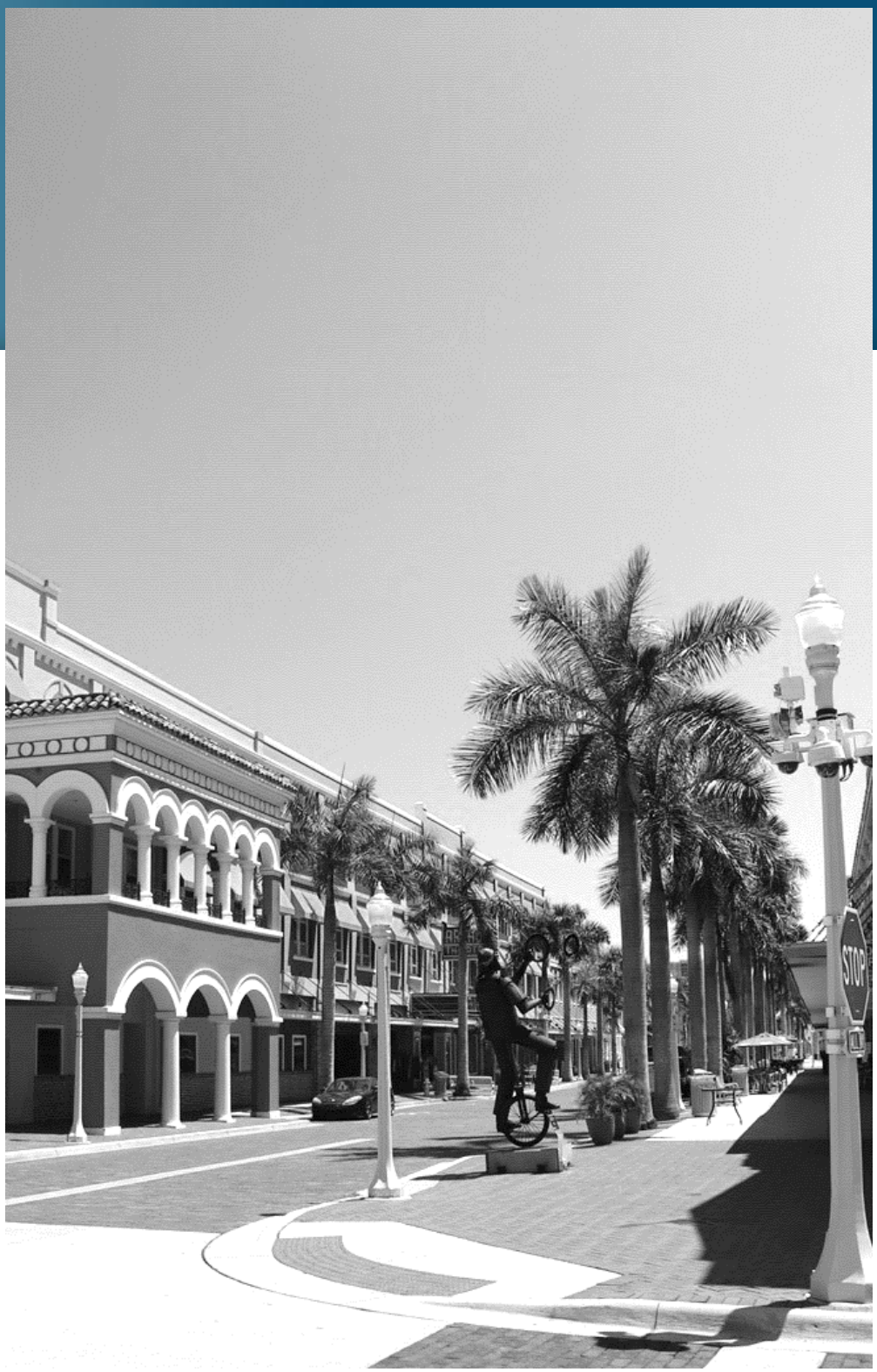
Phone: (239) 533-2245 *ask for benefits*

Email: benefits@leegov.com

PayFlex Systems, USA

Phone: (866) FSAFLEX

Web: www.payflex.com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