



LAKE COUNTY BOARD OF COMMISSIONERS INSURANCE DEPARTMENT

LAKE COUNTY GOVERNMENT CENTER
2293 NORTH MAIN STREET
CROWN POINT, IN 46307
PH. 219/755-3211 • FAX 219/755-3897
219/755-3212



DATE:-----

DEAR:-----

WE HAVE JUST RECEIVED NOTICE THAT YOU ARE ELIGIBLE TO APPLY FOR RETIREE BENEFITS AS OFFERED THROUGH THE LAKE COUNTY INSURANCE PLAN. MEDICAL, DENTAL AND VISION COVERAGE WILL REMAIN THE SAME AS THE CURRENT PLAN. IN ORDER TO CONTINUE YOUR GROUP COVERAGE AS A RETIREE, YOU MUST PAY THE PREMIUM WITHIN 45 DAYS OF YOUR LAST DAY OF COVERAGE AS AN ACTIVE EMPLOYEE. THE EFFECTIVE DATE FOR YOUR COVERAGE IF YOU ELECT TO PARTICIPATE IN THE RETIREE BENEFIT PLAN WILL BE:

- AT \$90.00 FOR SINGLE COVERAGE OVER AGE 65
- AT \$165.00 FOR FAMILY COVERAGE OVER 65
- AT \$125.00 FOR SINGLE COVERAGE UNDER AGE 65
- AT \$200.00 FOR FAMILY COVERAGE UNDER AGE 65

RETIREES AND DEPENDENTS MUST CARRY MEDICARE A&B WHEN ELIGIBLE. YOUR LIFE INSURANCE BENEFITS AS A RETIREE WILL BE \$5,000.00 DEATH BENEFIT FOR BASIC LIFE ONLY UNTIL YOU REACH THE AGE OF 70. NO AD&D (ACCIDENTAL DEATH AND DISMEMBERMENT) NOR DEPENDENT LIFE BENEFITS ARE AVAILABLE FOR RETIREES. IF YOU REQUIRE MORE INFORMATION CONCERNING YOUR CURRENT LIFE INSURANCE AMOUNT, PLEASE CALL OUR OFFICE AT 755-3211 DURING THE HOURS OF 8:30 A.M. TO 4:30 P.M.

NOTE: IF YOU DECIDE TO CONTINUE THIS COVERAGE, THE PREMIUM PAYMENT WILL BE DUE IN THIS OFFICE NO LATER THAT THE 15TH DAY OF THE MONTH PRIOR TO THE MONTH DUE. YOU WILL NOT BE SENT A NOTICE WHEN THE PREMIUM IS DUE.

MAKE CHECKS PAYABLE TO: LAKE COUNTY BOARD OF COMMISSIONERS. CHECK SHOULD INDICATE THE RETIREE'S NAME AND THE MONTH, WHICH YOU ARE PAYING THE PREMIUM FOR.

RETIREE INSURANCE CONTINUATION FORM

NAME

DATE OF BIRTH

LAST FOUR SSN

SPOUSE NAME

DATE OF BIRTH

LAST FOUR SSN

I WILL CONTINUE ON INSURANCE AFTER MY RETIREMENT

I WILL NOT CONTINUE ON INSURANCE AFTER MY RETIREMENT

ADDRESS

TELEPHONE NUMBER

CELL PHONE NUMBER

TO BE COMPLETED BY INSURANCE:

HIRE DATE

TERMINATION DATE

LAST PAY DATE

AMOUNT OF PREMIUM

FREE AFTER 65? YES NO CIRCLE ONE

COVERAGE EFFECTIVE DATE

NOTE: IT IS THE RETIREE'S RESPONSIBILITY TO NOTIFY INSURANCE WHEN HE/SHE
TURNS 65.

AUTHORIZATION FOR DIRECT PAYMENT VIA ACH

I authorize the LAKE COUNTY TREASURER to electronically debit my below listed account (and, if necessary, electronically credit my account to correct erroneous errors) as follows:

Checking Account / Savings Account (select one) at the depository institution named below. I agree that the ACH transaction I authorize complies with all applicable law.

DEPOSITORY NAME _____

ROUTING NUMBER _____

ACCOUNT NUMBER _____

AMOUNT OF DEBIT _____

START DATE _____ FREQUENCY: MONTHLY

I understand this authorization will remain in full force and effect until I notify the LAKE COUNTY TREASURER or LAKE COUNTY INSURANCE DEPARTMENT in writing that I wish to revoke this authorization. I understand that LAKE COUNTY requires at least thirty (30) days prior notice to cancel this authorization.

NAME PRINTED: _____

SIGNATURE: _____

DATE: _____

RETURN FULLY COMPLETED FORM IN PERSON OR BY MAIL TO:

LAKE COUNTY BOARD OF COMMISSIONERS

INSURANCE DEPARTMENT

2293 N. MAIN ST.

CROWN POINT, IN 46307



LAKE COUNTY HUMAN RESOURCES DEPARTMENT

Danielle D. Royster, MBA, Human Resources Director
LAKE COUNTY GOVERNMENT CENTER
2293 NORTH MAIN STREET
CROWN POINT, IN 46307

To: Lake County Government Retirees

From: Lake County Board of Commissioners

RE: Life Insurance Past the Age of 70

Dear Retirees:

The Lake County Board of Commissioners is offering our Lake County retirees an opportunity to continue their life insurance. **For a premium of \$60.00 pre year, a retiree may continue to have \$5,000 for life insurance after the age of 70 for the rest of retiree's life, if the retiree meets the following criteria.**

- You must have 25 years of continuous service
- You must be over the age of 65

If you are interested please contact Rickeyta Dancy in the Lake County Human Resource Department. A payment of \$60.00 payable to "Lake County Board of Commissioners" will be required.

Please feel free to call 219-755-3212 if you should have any questions.

Sincerely,

A handwritten signature in cursive script that reads "Rickeyta Dancy".

Rickeyta Dancy
Benefits Coordinator

Enrollment instructions

Answer all questions completely. Incomplete or incorrect information may delay the start of your coverage. Below are the instructions for each section of the enrollment form. You can use this form to enroll or submit a plan change if you're already enrolled.

- Effective date:** Your coverage will begin on the first day of the month after you sign this enrollment form, or the date your enrollment is completed. **The effective date can't be earlier than the day you sign this form.**
- Former employer information:** Write the name of the former employer/union/trust offering this health plan (the company you retired from). List the group number and class code if you know it. The group number and class code number are not required. (This information may be pre-filled.)
- Personal information:** This is your name, address, phone number, etc. **Print clearly.**
- Medicare information:** This is your Medicare insurance information, found on your red, white and blue Medicare Card. Complete all the fields to avoid a delay in your coverage.
- Health plan selection:** Check the box next to the plan you want to enroll in. (There may be only one plan available). For more plan details, look at the benefit summary included in your enrollment packet.
- Select a provider:** For Aetna Medicare Plan (HMO): You're required to have a primary care physician (PCP) on file with us. This means you need to tell us who your doctor is. Write in the name of your PCP and their Primary Care ID number. You'll find this information in our Provider Directory.
For Aetna Medicare Plan (PPO): You have the option to choose an Aetna network PCP. But when we know your doctor we can better coordinate your care. Write in the name of your Aetna Network PCP and their Primary Care ID number. You'll find this information in our Provider Directory.
- Select a dentist:** **For Aetna Medicare Plan (HMO) only:** If DMO dental benefits are included in your plan, a primary dentist is required. Write the name of your Aetna dentist and their office ID number.
- Medicare-related questions:** Read and answer these Medicare questions.
- Read this important section carefully:** DISCLOSURES
- Signature required:** Sign and date the application in the space provided.
Authorized representatives: Sign the form and write in your information
- Make a copy for yourself and mail original:** Make a copy of the entire application for your records. Then mail your completed original form to the address below. A separate enrollment form must be completed for each Medicare-eligible dependent. Two forms may have been included for your convenience.

Call your former employer/union/trust or Aetna Medicare with any questions.

Phone number: 1-800-307-4830 (TTY: 711)
Hours: Monday - Friday, 7 a.m. - 8 p.m. CT
Mail to: Lake County HR
2293 North Main Street, Crown Point, IN
Website: <http://www.aetnaretireplans.com>

Make a copy for yourself and return the original

Effective date

/ 01 /

Lake County Government

Group number

Class code

Personal Information

Last name		First name		Middle initial		<input type="checkbox"/> Mr. <input type="checkbox"/> Mrs. <input type="checkbox"/> Ms.	
Birth date (M M / D D / Y Y Y Y) (M M / D D / Y Y Y Y)		Sex <input type="checkbox"/> M <input type="checkbox"/> F		Home phone number ()			
Permanent residence street address (PO Box is not allowed)							
City		State		ZIP code		County	
Mailing address (only if different from your permanent residence address)				Email address (optional)			
Emergency contact name (optional)				Relationship to you			
Phone number				Cell phone number			

Medicare Information

Please take out your red, white and blue Medicare card to complete this section. <ul style="list-style-type: none"> Fill out this information as it appears on your Medicare card. -OR- Attach a copy of your Medicare card or your letter from Social Security or the Railroad Retirement Board. 	Name (as it appears on your Medicare card):	
	Medicare Number: _____ Is Entitled To: _____ Effective Date: _____ HOSPITAL (Part A) _____ MEDICAL (Part B) _____ You must have Medicare Part A and Part B to join a Medicare Advantage plan.	

Health plan selection: Check the box next to the type of plan you want to enroll in. Then write the name of the specific plan on the line provided. (This information may be pre-filled). For more plan details, look at the benefit summary included in your enrollment kit. **Make sure to read the important health plan disclosures on Page 4.**

- Aetna Medicare PPO ESA Rx Former Option B
- Aetna Medicare PPO ESA Rx Former Option F

Fill out the following:

I'm currently enrolled in a Medicare Advantage plan issued by (insurance company name) _____. I'd like to change to an Aetna plan. I understand this plan may have different health benefits and monthly payments than my current plan.

Select providers: A primary care physician (PCP) is required for HMO plans and is recommended for PPO plans. If you choose an HMO plan with DMO dental benefits, you must also choose a dentist. To select a PCP or dentist, look at the Aetna Medicare provider directory or call the phone number on the instruction page.

PCP first and last name	PCP office ID
Dentist first and last name (for HMO plans with DMO dental benefits)	Dentist office ID (for HMO plans with DMO dental benefits)

Applicant name: _____ Effective date: / 01 /

Medicare-Related Questions

Yes No **Are you an Aetna member?** If Yes, provide your member ID number _____

Yes No **Are you the retiree?** If Yes, provide retirement date (MM/DD/YYYY): ____ / ____ / ____
If No, name of retiree: _____

Yes No **Are you covering a spouse or dependents under this employer, trust or union plan?**
If Yes, name of spouse: _____ Name of dependents: _____

Yes No **Do you or your spouse work?**

Yes No **Do you have end-stage renal disease (ESRD)?** If you've had a successful kidney transplant and/or you don't need regular dialysis any more, **please attach a letter or records from your doctor** showing you've had a successful kidney transplant or you don't need dialysis. Otherwise, we may need to contact you to obtain additional information.
If Yes, what is the date of your first dialysis treatment? Date: (month) ____ (year) _____

Yes No **Did you become eligible for Medicare because of ESRD and has it been less than 30 months since you became eligible?** If so, Medicare Advantage Coverage will be your secondary coverage for the first 30 months of the coordination period.
If Yes, provide your prior commercial coverage carrier's name: _____
Member number: _____ Effective date ____ / ____ / ____

Yes No **Was your previous policy terminated?** If Yes, provide termination date: ____ / ____ / ____

Yes No **Are you a resident in a long-term care facility, such as a nursing home?**
If Yes, provide the following information:
Name of institution: _____ Phone number: (____) _____
Address: _____ State: _____ ZIP: _____

Yes No **Are you enrolled in your state Medicaid program?** If Yes, provide your Medicaid number: _____

Please check one of the boxes below if you would prefer that we send you information in a language other than English or in an accessible format: Spanish Other _____
Please contact us at **1-888-267-2637** if you need information in an accessible format or language other than what is listed above. Our office hours are 8 a.m. to 6 p.m., local time, Monday through Friday. TTY users should call 711.

Other Rx coverage: Complete only if you have other prescription drug coverage.

Yes No Some individuals may have other drug coverage, including other private insurance, TRICARE, Federal employee health benefits coverage, VA benefits or state pharmaceutical assistance programs.
Will you have other prescription drug coverage in addition to the Aetna Medicare Advantage Rx plan? If Yes, please list your other coverage and identification number(s) for this coverage:
Name of other coverage: _____
ID #: _____ Group #: _____

Yes No **Have you had creditable coverage since you became eligible for Medicare prescription drug coverage?**
If so, from date (MM/DD/YY) _____ to date (MM/DD/YY) _____
Creditable coverage is prescription drug coverage that is at least as good as Medicare prescription drug coverage.
NOTE: If you've not had creditable coverage, you may have to pay a late enrollment penalty. Aetna may ask you to provide evidence of creditable coverage. If you have questions about the late enrollment penalty, call Aetna at the number provided on this form.

Applicant name:	Effective date: / 01 /
Disclosures – Read this section carefully.	
<p>By completing this enrollment application, I agree to the following: Aetna Medicare is a HMO, PPO plan with a Medicare contract. Enrollment in our plans depends on contract renewal. I will need to keep my Medicare Parts A and B coverage. I can only be in one Medicare Advantage plan at a time and I understand that my enrollment in this plan will automatically end my enrollment in another Medicare health plan. It is my responsibility to inform you of any prescription drug coverage that I have or may get in the future. If I'm enrolling in a Medicare Advantage plan without prescription drug coverage (medical benefits only), I understand that if I don't have Medicare prescription drug coverage, or creditable prescription drug coverage (as good as Medicare's), I may have to pay a late enrollment penalty if I enroll in Medicare prescription drug coverage in the future. Enrollment in this plan is generally for the entire year. Once I enroll, I may leave this plan or make changes only at certain times of the year if an enrollment period is available or under certain special circumstances. The Aetna Medicare Advantage plan serves a specific service area. If I move out of the area that Aetna Medicare Advantage plan serves, I need to notify the plan and my former employer/union/trust so I can disenroll and find a new plan in my new area. Once I'm a member of the Aetna Medicare Advantage plan, I have the right to appeal plan decisions about payment or services if I disagree. I will read the Evidence of Coverage document from Aetna when I get it to know which rules I must follow to get coverage with this Medicare Advantage plan. I understand that people with Medicare aren't usually covered under Medicare while out of the country except for limited coverage near the U.S. border. I may also be disenrolled if I do not pay any applicable plan premiums within the grace period. The effective date of disenrollment is in accordance with federal requirements. HMO plans - I understand that beginning on the date Aetna Medicare Advantage plan coverage begins, I must get all my health care from the Aetna Medicare Advantage plan, except for emergency or urgently needed services or out of area dialysis services. Services authorized by the Aetna Medicare Advantage plan and other services contained in my Aetna Medicare Advantage plan Evidence of Coverage document (also known as the member contract or subscriber agreement) will be covered. Without authorization, NEITHER MEDICARE NOR THE AETNA MEDICARE ADVANTAGE PLAN WILL PAY FOR THE SERVICES. PPO plans: I understand that beginning on the date Aetna Medicare Advantage plan coverage begins, using services in network can cost less than using services out of network, except for emergency or urgently needed services or out-of-area dialysis services. I understand I can go to doctors, specialists or hospitals in or out of network. I understand that providers must be licensed and eligible to receive payment under the federal Medicare program and agree to accept the PPO plan. I also understand I may have to pay more for services I receive out of network. Services authorized by the Aetna Medicare Advantage plan and other services contained in my Aetna Medicare Advantage plan Evidence of Coverage document (also known as the member contract or subscriber agreement) will be covered. Without authorization when required by the plan, NEITHER MEDICARE NOR THE AETNA MEDICARE ADVANTAGE PLAN WILL PAY FOR THE SERVICES. I've been advised not to cancel or drop any supplemental insurance I currently have until I receive written notification of my confirmed effective date from Aetna. I understand the providers in the Aetna network are independent contractors in private practice and are neither employees nor agents of Aetna or its affiliates. I understand if I'm getting assistance from a sales agent, broker, or other individual employed by or contracted with Aetna's Medicare Advantage plans, he/she may be paid based on my enrollment in the Aetna Medicare Advantage plan. Release of information: By joining this Medicare health plan, I acknowledge that the Medicare health plan will release my information to Medicare and other plans as is necessary for treatment, payment and health care operations. I also acknowledge that Aetna Medicare will release my information, including my prescription drug event data to Medicare, who may release it for research and other purposes which follow all applicable Federal statutes and regulations. The information on this enrollment form is correct to the best of my knowledge. I understand if I intentionally provide false information on this form, I will be disenrolled from the plan. I understand my signature (or the signature of the person authorized to act on my behalf under the laws of the state where I live) on this application means I have read and understand the contents of this application. If signed by an authorized individual (as described above), this signature certifies that: 1) this person is authorized under State law to complete this enrollment and 2) documentation of this authority is available upon request from Medicare.</p>	
Signature:	Today's date:
If you're the authorized representative, you must sign above and provide the following information:	
Representative's name:	Address:
Phone number:	Relationship to enrollee:

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

Benefit Feature/Option	Original Medicare Pays	Lake County Retiree Medical Plans	
		Option B Retiree Medical Plan	Option F Retiree Medical Plan
Plan Deductible	N/A	N/A	N/A
Plan In Network Out-of-Pocket Maximum	No out-of-pocket maximum	\$1,500 per person; \$4,000 per family	\$1,500 per person; \$4,000 per family
Plan Out of Network Out-of-Pocket Maximum	No out-of-pocket maximum	\$2,500 per person; \$6,500 per family	\$2,500 per person; \$6,500 per family
Part A – Hospital Care <u>Days 1-60:</u>	All except the current Medicare Part A deductible	Member pays nothing	Member pays nothing
<u>Days 61-90:</u>	All except current per day cost each benefit period	Member pays nothing	Member pays nothing
<u>Days 91 and after (within which is included a 60 day lifetime reserve)</u>	All except current per "lifetime reserve day" after day 90, each benefit period	Member pays nothing	Member pays nothing
<u>Additional 365 days</u>	Member pays 100%	Member pays nothing for additional 365 days of coverage	Member pays nothing for additional 365 days of coverage
<u>Beyond the Lifetime Maximum of 365 days</u>	Member pays 100%	Member pays all costs	Member pays all costs
Inpatient Care in Medicare certified psychiatric facility	Inpatient Psychiatric – limited to 190 days per lifetime in a psychiatric hospital	Same as Inpatient Hospitalization. Limited to 190 days lifetime	Same as Inpatient Hospitalization. Limited to 190 days lifetime
Skilled Nursing Facility <u>Days 1-20</u>	100% each benefit period	Member pays nothing	Member pays nothing
<u>Days 21-100:</u>	All except current per day cost each benefit period	Member pays current per day cost each benefit period	Member pays nothing
<u>Days 100 and beyond:</u>	Member Pays 100%	Member pays 100%	Member pays 100%
Part B – Physician, Outpatient Hospital or Other Professional Provider Services	Member pays current deductible yearly for Part B covered services or items	Member pays Part B Deductible	Member pays nothing
Remainder of approved amounts for other than preventive Part B services	20% of the Medicare-approved amount for most doctor services, outpatient therapy, and preventive services	Member pays nothing	Member pays nothing
Durable Medical Equipment	Member pays 20% of Medicare-approved amount for DME after Part B annual deductible	Member pays nothing	Member pays nothing
Medicare Part B Excess Charges	Member pays 100%	Member pays 100%	Member pays nothing (up to the Medicare balance billing limit)
Foreign Travel Emergency	Member pays 100%	Member pays 100%	Member pays \$250 annual deductible
Outpatient Psychiatric	Member pays 20% for most outpatient mental health care	Member pays nothing	Member pays nothing
Non-Medicare covered Preventive Services	Member pays 100%	Member pays 100%	Member pays 100%

Your Cost	Your Current contribution	Your Current Contribution plus \$34.14 per month per person
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For illustrative purposes only. Consult with Medicare for coverage confirmation.