BENEFIT GUIDE

Retired Fairfax County Employees **2019 Plan Year**

What's Inside

What You Need To Know

- **NEW EXTENDED DATES:** For Plan Year 2019, Fairfax County Government will be extending the Retiree Open Enrollment. The Open Enrollment period will begin on October 9, 2018 and will be extended through November 30, 2018, for retirees only. This extended period is being offered to allow retired employees and their families more time to review their benefit enrollment options
- All changes must be submitted to the Benefits Division before close of business on November 30, 2018. If you do not wish to make changes, DO NOT submit a form.
- **NEW MEDICAL PLAN:** Cigna MyChoice Plan is now open for non-Medicare eligible retirees and their families.
- **CO-INSURANCE PLANS:** Beginning January 1, 2019, Emergency Room and Urgent Care visits for participants in the Cigna managed Co-Insurance Plans will be charged a co-insurance after the plan deductible has been met. There will also be new deductibles. See chart below.

CIGNA OAP 90% Co-Insurance Plan		
Individual/Two-Party or Family*	In-Network	Out-of-Network
	$300/$600	$600/$1,200
CIGNA OAP 80% Co-Insurance Plan		
Individual/Two-Party or Family	In-Network	Out-of-Network
	$450/$900	$900/$1,800

- **CO-PAY PLAN:** Beginning January 1, 2019, there will be new in-network co-pays for some services. See chart below.

	In-Network
Primary Care Physician (PCP)	$35 PCP co-pay; then Plan pays 100%
Specialty Care	$70 Specialist co-pay; then Plan pays 100%
Outpatient Hospital Facility	$75 per facility visit co-pay, then Plan pays 100%
Chiropractic Care	$35 per visit; then Plan pays 100%
TMJ, Surgical and Non-Surgical (Physician's Office)	$35 PCP or $70 Specialist co-pay; then Plan pays 100%

- **BENEFIT ASSISTANCE**: Retirees interested in a 30 minute benefit counseling session with either Keisha Lewis, Cigna's On-Site Rep, or Agnetta Palacios, Fairfax County's Retiree Benefits Specialist are invited to make an appointment. Only Fairfax County sponsored plans can be reviewed. For availability, call (703) 324-3311.

Medical

Prior Authorization/Pre-Certification

Cigna helps you access the right care, at the right time, and in the right setting. With pre-certification, you know in advance whether a procedure, treatment or service will be covered under your health plan. Call Cigna to see if an upcoming procedure like advanced imaging and short-term rehabilitative therapies requires a pre-authorization. Remember that for in-network services, your doctor can help you with pre-certification. It could save you time and money.

Moving Out of the Area

All of the plans managed by Cigna are nationwide. Kasier's HMO is limited to the local area. If you are covered by Kaiser Permanente and you move outside of their plan's service area, you must contact the Department of Human Resources and elect a new plan for which you are eligible. **You must also notify Kaiser in writing of your move.** These actions must be taken within 30 calendar days of your move out of Kaiser Permanente's service area.

NEW Cigna Pharmacy Updates. See Page 12.

Cigna Managed OAP 90% Co-Insurance Plan

A co-insurance is the percentage of the bill that an employee is responsible for after meeting an annual deductible. Participants in this plan are responsible for 10% of the negotiated rate for services they receive in-network. After the $300 deductible, a service for $100 would cost 10% or $10. That's less than a co-pay! Participants have access to both in- and out-of-network services and pay co-insurances until they reach the out-of-pocket maximum. This plan gives you access to the Open Access Plus (OAP) Network and requires no referrals or PCP selection. A Pharmacy Plan with separate deductible is included.

Cigna Managed OAP 80% Co-Insurance Plan

Similar to the 90% Plan above, this lower premium plan offers a co-insurance. After meeting an annual deductible, participants are responsible for a 20% co-insurance for a service of $100 your cost would be 20% or $20. Participants have access to in- and out-of-network services and pay co-insurances until they reach the out-of-pocket maximum. This plan gives you access to the Open Access Plus (OAP) Network and requires no referrals or PCP selection. A Pharmacy Plan with separate deductible is included.

Cigna Managed OAP Co-Pay Plan (closed to new enrollees)

This plan offers a Co-pay structure or a flat fee for services that are in the in-network. There is no deductible for in-network services but those seeking services with non-Cigna providers will have to meet an annual deductible and pay a co-insurance. This plan gives you access to the Open Access Plus (OAP) Network and requires no referrals or PCP selection. A Pharmacy Plan with separate deductible is included. This plan has the highest premium and is closed to new entrants. **NOTE: This plan will be discontinued December 31, 2020.**

Cigna Managed OAP MyChoice CDHP

This plan is similar to the 90% Co-Insurance Plan discussed above. The main differences are the lower premium, higher deductibles. Participants have access to in- and out-of-network services and pay co-insurances until they reach the out-of-pocket maximum. Both drug and medical costs count against the annual deductible. This plan allows you to contribute to a Health Savings Account (HSA), a tax-advantaged, medical savings account. Not available for Medicare eligible retirees and there is no county contribution.

Kaiser Permanente HMO

Local medical center based design HMO. Participants pay a co-pay for in-network services at Kaiser Facilities. There are no out-of-network services allowed and a pharmacy plan is included.

Medicare Must Knows

Retirees Eligible for Medicare

Retirees who become eligible for Medicare, due to age or disability, are required to apply for and maintain Medicare Part A and Part B at their earliest eligibility. To continue coverage under the County's health plan, Medicare eligible retirees and dependents must submit a copy of their Medicare card to the Benefits Division.

It is recommended that participants apply for Medicare at the earliest opportunity, 90 days before their eligible birth month or qualified disability date, to ensure your coverage is in effect on time. Retirees are not required to elect Medicare Part D. Coverage for retirees who do not maintain Medicare Part A and Part B coverage will be terminated.

Coordination with Medicare

If you have coverage through one of the County's plans and Medicare, each type of coverage is called a "payer". Medicare becomes the primary payer of claims and the Fairfax County Government health plan becomes the secondary "payer". When there is more than one potential payer, there are coordination of benefits rules to decide who pays first. The first or "primary payer" pays what it owes on your bills first and then sends the rest to the second or "secondary payer". In some cases, there may also be a third payer.

Whether Medicare pays first depends on a number of things including the situations listed in the following chart. However, please keep in mind that this chart does not cover every situation.

Important Notes

- The primary payer, Medicare, pays up to the limits of its coverage.
- The secondary payer, County insurance only pays if there are costs the primary payer didn't cover up to the benefit level of the County coverage. The secondary payer may not pay all of the uncovered costs.
- You will still be responsible for any co-pay or co-insurance amounts for the services in accordance with your county sponsored plan.

Secondary, Supplemental, Gap and Advantage

Once you are enrolled in Medicare, your county medical benefits become secondary. **Secondary Insurance** covers some items Medicare does not and can help offset the costs of some services but does not eliminate all out-of-pocket costs. **You will always be responsible for your co-pays, co-insurances and deductibles.**

Medicare Advantage Plans are private insurance plans that contract with Medicare to provide benefits. Many offer extra coverage like vision, hearing or dental. This style plan is not offered by Fairfax County Government at this time.

Medigap or Medicare Supplemental Plans are extra health insurance plans that help cover the out-of-pocket costs not covered by Medicare. The county's retiree medical plan is not a Medigap or Medicare Supplemental plan.

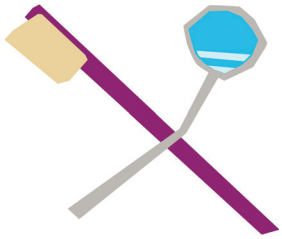
Retirees and their covered dependents who become eligible for Medicare due to age or disability are required to elect and maintain Medicare Part A and Part B at their earliest eligibility. To ensure you do not lose your county medical coverage, you should apply for Medicare three (3) months before your 65th birthday or qualified disability date.

Vision

Vision insurance, provided by Davis Vision, covers eye exams, glasses and contacts. Typically you only need one eye exam per year and by using an in-network provider, your exam is only a $15 co-payment. Have glasses already? In lieu of eyeglasses, you may select contact lenses. Vision is bundled with your medical plan so no election is required if you are enrolled in a County medical plan.

Benefits at a Glance	In-Network	Out-of-Network
Routine Eye Examination (once every 12 months)	$15 co-pay (includes eye examination with dilation, as professionally indicated)	Covered up to $40
Frames (once every 12 months in lieu of contact lenses)	**Davis Vision Designer and Premier Collection: Covered in full. (Value up to $225). Non-Davis Vision Collection (available at all independent and retail network providers): $150 allowance/$200 allowance at Vision Works**	**Covered up to $50**
Spectacle Lenses (once every 12 months in lieu of contact lenses)		
Single Vision	Covered in Full	Covered up to $50
Bifocal Vision	Covered in Full	Covered up to $75
Trifocal Vision	Covered in Full	Covered up to $100
Lenticular Lenses	Covered in Full	Covered up to $150
Scratch Resistant Coating	Covered in Full	Included in base lens reimbursement above
Other Lens Options	Available at discounted fixed fees	Not covered
Contact Lenses (once every 12 months in lieu of eyeglasses)		
Contact Lens Materials	One pair of standard, soft daily wear; two boxes of planned replacement lenses or four boxes of disposables covered in full if from Davis Vision Formulary. Note: Number of lenses in box varies by brand.	Covered up to $100
	Elective contact lenses outside of Davis Vision Formulary, $150 allowance	
Contact Lens Fitting Fee with Two Follow-up Visits	Covered in full after $20 co-pay for Formulary contact lenses	Covered up to $40
Medically Necessary Contact Lenses (with prior approval)	Covered in full	Covered up to $225
Additional Features		
One-Year Eyeglass Breakage Warranty	Included on all spectacle lenses, Davis Vision Collection frames and retailer supplied frames	Not included
Lens 1-2-3! ® Membership	Included	N/A
Laser Vision Correction Discount	Up to 25 percent off the provider's usual and customary fees, or a 5 percent discount on any advertised special	Not covered
Low-Vision Coverage	Included	Not included

Dental



Your teeth can be expensive to maintain, especially if you don't take care of them, but with regular dental care, you can prevent cavities, stop tooth loss, boost your overall health and save money. With Fairfax County's Dental Benefit offered through Delta Dental's national PPO and Premier Networks, you will have access to providers who perform a range of covered services including orthodontia, for children under age 19.

Plan Benefit Design	General Plan Information	
Annual Deductible	$50 /$150	$50 per person, $150 per family, per calendar year.
Annual Benefit Maximum	$2,000	Per enrollee, per calendar year. Preventive care expenses do not count toward the annual benefit maximum.
Orthodontic Lifetime Maximum	$2,000	Per eligible covered dependent child.

Coverage	In-Network		Out-of-Network	Benefit Limitations
	PPO	Premier		
Diagnostic and Preventive Care	100%	100%	80%	Exempt from the deductible. No benefit waiting period.
Oral exams and cleanings				Twice each calendar year.
Fluoride applications				Twice each calendar year under the age of 19.
Bitewing/vertical bitewing X-rays				Once each calendar year, limited to posterior teeth.
Full mouth/panelipse X-rays				Limit of one in a 5-year period.
Space maintainers				One per quadrant, per arch under the age of 14.
Sealants				Under the age of 19, with limitations.
Healthy Smile, Healthy You ® Program				Pregnant, diabetic and members with certain high-risk cardiac conditions are entitled to an additional cleaning and exam.
Basic Dental Care	90%	80%	80%	Deductible applies. No benefit waiting period.
Amalgam (silver) and composite (white) fillings				One per surface in a 24-month period
Stainless steel crowns				Primary (baby) teeth for enrollees under the age of 14.
Denture repair and re-cementation of crowns, bridges and dentures				Once in a 12-month period.
Simple extractions				
Other Basic Dental Care	60%	50%	50%	Deductible applies. No benefit waiting period.
Endontic services/root canal therapy				Retreatment only after 24 months from initial root canal therapy treatment.
Periodontics services				Once per quadrant in a 24-36 month period based on services rendered.
Complex Oral Surgery				Surgical extractions and other surgical procedures.
Major Dental Care	60%	50%	50%	Deductible applies. No benefit waiting period.
Crowns				Once per tooth every 7 years for enrollees age 12 and older.
Prosthodontics				Once every 7 years for enrollees age 16 and older.
Implants				Once per site for enrollees age 16 and older.
TMJ				Occlusal orthotic device.
Orthodontic services	50%	50%	35%	For dependent children through the end of the month they reach age 19.

MotivateMe

Total Well-Being Incentive Rewards 2019

Earn up to $200 per year for making healthy choices!

Cigna subscribers: Cigna subscribers must track and manage their rewards through mycigna.com. Cigna participants are required to complete a physical with a primary care provider **and** Cigna's online health assessment annually to receive any rewards. All activities must be completed and tracked on mycigna.com by December 31, 2019.

Kaiser Permanente subscribers: Kaiser Permanente subscribers must track their rewards using a paper "passport". The passport can be downloaded from the LiveWell website on FairfaxNet or by emailing LiveWell@fairfaxcounty.gov. Kaiser participants are required to complete Kaiser's total health assessment at kp.org every year. Annual physical and biometric screening results must **also** be up to date in Kaiser's medical portal to meet the physical requirement. The completed "passport" must be scanned and emailed to LiveWell@fairfaxcounty.gov by December 31, 2019.

Goal Type	Description	Award Type	Amount
Annual physical	A preventive exam with a primary care provider, including lab work, that's used to reinforce good health and address potential or chronic health issues.	**Required annually for Cigna members** **Must be up to date, per Kaiser Permanente guidelines.**	Combined $100 for completing both goals
Health Assessment: Employee	A confidential online questionnaire that asks about your health behaviors and wellbeing. Available through mycigna.com or kp.org.	**Required annually for Cigna members** **Required annually for Kaiser members**	
Health Assessment: Spouse covered under a Fairfax County health plan	A confidential questionnaire that asks about your health behaviors and wellbeing. Spouses must be covered under a Fairfax County health plan.	One per year	$25
Screenings	Choice of one screening per year: • Colon cancer screening • Cervical cancer screening • Prostate cancer screening • Skin cancer screening • Mammogram	One per year	$30
Online Health Coaching	Online health coaching programs, available through mycigna.com or kp.org.	One per year	$10
Telephonic Health Coaching	Reach your health goals with personalized coaching. Call your health plan's member services number to access a coach.	One per year	$10
Dental Exam*	Visit your dentist for a dental/oral examination.	Two per year	$5 each
Vision Exam*	Visit an optometrist, ophthalmologist or other eye health professional for a vision exam.	One per year	$10
LiveWell-Sponsored Workshop*	Participate in a live, on-site LiveWell workshop.	Two per year	$10 each
LiveWell-Sponsored Webinar*	Participate in a live, online LiveWell webinar through Cigna, Kaiser Permanente, the EAP, Weight Watchers, and other partners.	Three per year	$5 each

Tip: Plan ahead. Complete your goals as early as possible to ensure that the activities are fully completed and tracked by the end of the year.

Motivate*Me* FAQ's

What is the purpose of Motivate*Me*?
Motivate*Me* is an incentive program for employees and retirees who subscribe to a Fairfax County health plan. The purpose of the program is to encourage participants to *actively* engage in their health and wellbeing through a relationship with their primary care provider, educational activities, and screenings.

How do I register?
Participants don't need to register for Motivate*Me*, specifically. Subscribers to a Fairfax County health plan are automatically enrolled in the Motivate*Me* program.

Who can participate in Motivate*Me*?
Fairfax County Government employees and retirees who are over the age of 18 and subscribe to a County health plan (Cigna or Kaiser Permanente) are eligible to participate and earn rewards.

How do I manage my Motivate*Me* points?
Cigna members can manage their points online at mycigna.com. Kaiser members can track their points via a paper "passport", available by emailing LiveWell@fairfaxcounty.gov.

What activities are required to earn rewards?
New for 2019--there are two requirements to earn rewards. Participants must have an annual physical with a primary care provider **AND** complete their health plan's online health assessment during the calendar year. Additional points and activities can be completed or tracked before the requirements are completed, but points will not be awarded until the physical and health assessment are complete.

I'm a retiree who has Medicare as my primary insurance? How do I submit my well exam?
Send a copy of the Medicare explanation of benefits (EOB) from your well visit to LiveWell@fairfaxcounty.gov as soon as possible, following your exam, before December 31. Please do not send any medical information.

I'm a retiree who has a physical through Occupational Health. Does this count as my annual physical for Motivate*Me*?
No. Starting in 2019, all physical exams must be completed through a primary care provider. The goal of Motivate*Me* is to encourage employees and retirees to build a relationship with a primary care provider and remain **actively engaged** in their health and wellbeing throughout the year.

I had an annual physical this year, but haven't received credit for it. What should I do?
It can take up to 5 weeks for an annual physical to appear in the Cigna wellness portal. If it has been 5 weeks and you do not see the credit in your wellness portal, please contact LiveWell@fairfaxcounty.gov. *Tip: Let your health care provider know that the visit is a well visit when you schedule the exam and confirm the coding before you leave the office visit.*

Does an annual "well woman" exam through an OB/GYN count as a wellness visit?
No. The preventive exam must be completed through a primary care provider and is different from a well woman exam.

When, and how, do I receive my Motivate*Me* rewards?
Rewards will be available in February of the following year, as a one-time additional subsidy, in your pension check.

Stay In Touch!

Join the LiveWell retiree listserv to receive the monthly newsletter and other program updates. Email LiveWell@fairfaxcounty.gov to join the listserv or with any questions. You can also call HR Central at 703-324-3311 and ask for a LiveWell staff member.

	NEW: CIGNA OAP MyChoice CDHP with HSA		CIGNA OAP 90% C
	In-Network	**Out-of-Network**	**In-Network**
Primary Care Physician (PCP)	Plan pays 90% co-insurance after plan deductible is met	Plan pays 70% co-insurance after plan deductible is met	Plan pays 90% co-insurance after plan deductible is met
Specialty Care	Plan pays 90% co-insurance after plan deductible is met	Plan pays 70% co-insurance after plan deductible is met	Plan pays 90% co-insurance after plan deductible is met
HSA Fund	Not Eligible for Fund	Not Eligible for Fund	Not Eligible for Fund
Annual Deductible	$1,350 Individual $2,700 Family	$2,700 Individual $5,400 Family	**$300 Individual $600 Family**
Annual Out-of-Pocket Limit	$4,000 Individual $8,000 Family	$8,000 Individual $16,000 Family	$2,000 Individual $4,000 Family
Preventive Care - All Ages Routine Preventive Care, Immunizations, Mammogram, PAP, PSA Tests	Plan Pays 100%	**Through age 17:** Plan pays 70% co-insurance, no plan deductible A**ges 18 and above:** Plan pays70% co-insurance after deductible is met	Plan Pays 100%
Inpatient Hospital Facility	Plan pays 90% co-insurance after plan deductible is met	Plan pays 70% co-insurance after plan deductible is met	Plan pays 90% co-insurance after plan deductible is met
Outpatient Hospital Facility	Plan pays 90% co-insurance after plan deductible is met	Plan pays 70% co-insurance after plan deductible is met	Plan pays 90% co-insurance after plan deductible is met
Outpatient Professional Service	Plan pays 90% co-insurance after plan deductible is met	Plan pays 70% co-insurance after plan deductible is met	Plan pays 90% co-insurance after plan deductible is met
Chiropractic Care	Plan pays 90% co-insurance after plan deductible is met	Plan pays 70% co-insurance after plan deductible is met. Max 12 visits per year.	Plan pays 90% co-insurance after plan deductible is met
Hearing Aids	Plan pays 90% co-insurance after plan deductible is met Max benefit is $2,800 every 36 months	Plan pays 90% co-insurance after plan deductible is met Max benefit is $2,800 every 36 months	Plan pays 90% co-insurance after plan deductible is met Max benefit is $2,800 every 36 months
Emergency Room	Plan pays 90% co-insurance after plan deductible is met	Plan pays 90% co-insurance after plan deductible is met	**Plan pays 90% co-insurance after plan deductible is met**
Urgent Care Facility	Plan pays 90% co-insurance after plan deductible is met	Plan pays 90% co-insurance after plan deductible is met	**Plan pays 90% co-insurance after plan deductible is met**
Mental Health & Substance Abuse Treatment (In-Patient)	Plan pays 90% co-insurance after plan deductible is met	Plan pays 70% co-insurance after plan deductible is met	Plan pays 90% co-insurance after plan deductible is met
Annual Prescription Drug Deductible	Medical and Prescription Drug deductible combined		$50 Individua
Annual RX Out-of-Pocket Limit	Medical and Prescription Drug limit combined		$1,500 Individua
NOTE: Diabetic Medications and Supplies are free for participants in all Cigna managed plans when the prescription is filled via home delivery pharmacy or at a retail pharmacy	**Retail – 30 day supply** $4 co-pay Generic Preventive Drugs (deductible waived) $4 co-pay Generic 20% Preferred Brand (max. $50) 35% Non-preferred (max. $100) **Retail – 90 day supply** Only at ***Cigna 90 Now*** Pharmacies **Home Delivery – 90 day supply** $0 co-pay Generic Preventive Drugs (deductible waived) $8 co-pay Generic 20% Preferred Brand (max. $100) 35% Non-preferred (max. $200)	Retail – You pay 30% after deductible Home Delivery – Not Covered	**Retail – 30 day supply** $7 co-pay Generic 20% Preferred Brand (max. $50) 30% Non-preferred (max. $100) **Retail – 90 day supply** Only at ***Cigna 90 Now*** Pharmacies **Home Delivery – 90 day supply** $0 co-pay Generic Maintenance Medications; $14 co-pay Generics non-maintenance 20% Preferred Brand (max. $100) 30% Non-preferred (max. $200)

Co-Insurance Plan	CIGNA OAP 80% Co-Insurance Plan		Kaiser Permanente HMO
Out-of-Network	**In-Network**	**Out-of-Network**	**In-Network - Local**
Plan pays 70% co-insurance after plan deductible is met	Plan pays 80% co-insurance after plan deductible is met	Plan pays 60% co-insurance after plan deductible is met	$10 PCP co-pay No Charge for Children under 5
Plan pays 70% co-insurance after plan deductible is met	Plan pays 80% co-insurance after plan deductible is met	Plan pays 60% co-insurance after plan deductible is met	$10 PCP co-pay
Not Eligible for Fund	Not Eligible for Fund	Not Eligible for Fund	Not Eligible for Fund
$600 Individual $1,200 Family	**$450 Individual $900 Family**	**$900 Individual $1,800 Family**	$0
$4,000 Individual $8,000 Family	$2,500 Individual $5,000 Family	$5,000 Individual $10,000 Family	$3,500 Individual $9,400 Family
Through age 17: Plan pays 70% co-insurance, no plan deductible A**ges 18 and above:** Plan pays70% co-insurance after deductible is met	Plan Pays 100%	**Through age 17:** Plan pays 60% co-insurance, no plan deductible A**ges 18 and above:** Plan pays60% co-insurance after deductible is met	No Charge
Plan pays 70% co-insurance after plan deductible is met	Plan pays 80% co-insurance after plan deductible is met	Plan pays 60% co-insurance after plan deductible is met	No Charge
Plan pays 70% co-insurance after plan deductible is met	Plan pays 80% co-insurance after plan deductible is met	Plan pays 60% co-insurance after plan deductible is met	$10 visit
Plan pays 70% co-insurance after plan deductible is met	Plan pays 80% co-insurance after plan deductible is met	Plan pays 60% co-insurance after plan deductible is met	$10 visit
Plan pays 70% co-insurance after plan deductible is met. Max 12 visits per year.	Plan pays 80% co-insurance after plan deductible is met	Plan pays 60% co-insurance after plan deductible is met. Max 12 visits per year.	$15 co-pay; Annual limit 20 visits
Plan pays 90% co-insurance after plan deductible is met	Plan pays 80% co-insurance after plan deductible is met	Plan pays 80% co-insurance after plan deductible is met	Covered in full to maximum. One hearing aid/ear every 36 months-max $1,000
Max benefit is $2,800 every 36 months	Max benefit is $2,800 every 36 months	Max benefit is $2,800 every 36 months	
Plan pays 90% co-insurance after plan deductible is met	**Plan pays 80% co-insurance after plan deductible is met**	**Plan pays 80% co-insurance after plan deductible is met**	$150 per visit (co-pay waived if admitted other than observation)
Plan pays 90% co-insurance after plan deductible is met	**Plan pays 80% co-insurance after plan deductible is met**	**Plan pays 80% co-insurance after plan deductible is met**	$10 visit
Plan pays 70% co-insurance after plan deductible is met	Plan pays 80% co-insurance after plan deductible is met	Plan pays 60% co-insurance after plan deductible is met	**Inpatient -** covered in full when medically necessary **Outpatient** - $10 individual $5 group
l/$100 Family	$50 Individual/$100 Family		Kaiser-Pharmacy – 30 day supply $10 Generic $20 Preferred Brand $35 Non-preferred Brand Community Pharmacy – 30 day supply $20 Generic $40 Preferred Brand $55 Non-Preferred Brand Mail Order – 90 day supply $20 Generic $40 Preferred Brand $70 Non Preferred Brand
al/$3,000 Family	$1,500 Individual/$3,000 Family		
Retail – You pay 30% after Pharmacy deductible Home Delivery – Not Covered	**Retail – 30 day supply** $7 co-pay Generic 20% Preferred Brand (max. $50) 30% Non-preferred (max. $100) **Retail – 90 day supply** Only at ***Cigna 90 Now*** Pharmacies **Home Delivery – 90 day supply** $0 co-pay Generic Maintenance Medications; $14 co-pay Generics non-maintenance 20% Preferred Brand (max. $100) 30% Non-preferred (max. $200)	Retail – You pay 30% after Pharmacy deductible Home Delivery – Not Covered	

CIGNA OAP Co-Pay Plan		
	In-Network	**Out-of-Network**
Primary Care Physician (PCP)	**$35 PCP co-pay; then Plan pays 100%**	Plan pays 70% co-insurance after plan deductible is met
Specialty Care	**$70 Specialist co-pay; then Plan pays 100%**	Plan pays 70% co-insurance after plan deductible is met
Annual Deductible	$0	$250 Individual/$500 Family
Annual Out-of-Pocket Limit	$2,500 Individual/$5,000 Family	$5,250 Individual/$10,500 Family
Preventive Care - All Ages Routine Preventive Care, Immunizations, Mammogram, PAP, PSA Tests	Plan Pays 100%	**Through age 17:** Plan pays 70% co-insurance, no plan deductible **Ages 18 and above:** Plan pays70% co-insurance after deductible is met
Inpatient Hospital Facility	$200 per admission co-pay then Plan pays 100% co-insurance	Plan pays 70% co-insurance after plan deductible is met
Outpatient Hospital Facility	**$75 per facility visit co-pay, then Plan pays 100% co-insurance**	Plan pays 70% co-insurance after plan deductible is met
Outpatient Professional Service	Plan pays 100% co-insurance	Plan pays 70% co-insurance after plan deductible is met
Chiropractic Care	**$35 per visit; then Plan pays 100%**	Plan pays 70% co-insurance after plan deductible is met. Max 12 visits per year.
Hearing Aids	Plan pays 100% Maximum benefit is $2,800 every 36 months	Plan pays 100% Maximum benefit is $2,800 every 36 months
Emergency Room	$150 per visit (co-pay waived if admitted); then Plan pays 100%	$150 per visit (co-pay waived if admitted); then Plan pays 100%
Urgent Care Facility	$50 per visit (co-pay waived if admitted);	$50 per visit (co-pay waived if admitted); then Plan pays 100%
TMJ, Surgical and NonSurgical (Physician's Office)	**$35 PCP or $70 Specialist co-pay; then Plan pays 100%**	Plan pays 70% co-insurance after plan deductible is met
Mental Health & Substance Abuse Treatment (In-Patient)	$200 per admission co-pay, then Plan pays 100% co-insurance	Plan pays 70% co-insurance after plan deductible is met
Annual Prescription Drug Deductible	$50 Individual/$100 Family	
Annual RX Out-of-Pocket Limit	$1,500 Individual/$3,000 Family	
NOTE: Diabetic Medications and Supplies are free for participants in all Cigna managed plans when the prescription is filled via home delivery pharmacy or at a retail pharmacy	**Retail – 30 day supply** $7 co-pay Generic 20% Preferred Brand (max. $50) 30% Non-preferred (max. $100) **Retail – 90 day supply** Only at ***Cigna 90 Now*** Pharmacies **Home Delivery – 90 day supply** $0 co-pay Generic Maintenance Medications; $14 co-pay Generics non-maintenance 20% Preferred Brand (max. $100) 30% Non-preferred (max. $200)	Retail – You pay 30% after Pharmacy deductible Home Delivery – Not Covered

Telehealth: The internet has transformed our lives and as a result, seeing a doctor is more convenient than ever. Whether it's a late night illness or you're not feeling well on vacation, Cigna participants have access to telehealth providers, American Well® and MDLIVE®. Through these services, you can speak with a doctor for help with minor acute conditions like flu, sinus infections, pink eye, strep throat, knee pain, migraines and more. So next time you're feeling under the weather and just can't make it to the doctor, take a few minutes and choose a doctor you from a list that shows their experience and ratings before you start your visit. And because you're never sure when illness can strike, download the app and enroll today.

Financial Benefits

Group Term Life Insurance

Fairfax County Government offers reduced group term life insurance to retirees who have maintained their coverage into retirement. This coverage is provided by The Standard Insurance Company, a leading provider of both life and disability insurance across the nation. The plan provides group term life insurance (no cash value from which to borrow) and includes United Healthcare Global, a program designed to respond to most medical care situations and emergencies when traveling more than 100 miles from home.

Benefit Reductions: Coverage reduces to 65 percent of the original face value when you turn 65 or you retire, whichever comes first. It then reduces to 30 percent of the original face amount at age 70. Reductions in coverage take effect the first of the month following the reduction event. Retirees may also reduce their coverage to $12,500 at any time; at age 80, the county pays 100% of the $12,500 coverage.

Spouse and Dependent Life Insurance: Employees who elected and maintained spouse and dependent coverage can continue that same coverage into retirement. Two dependent life insurance options are available.

Spouse life insurance cannot exceed the amount in effect for the retiree. If a scheduled reduction decreases the retiree coverage below $15,000, the spouse life insurance will be reduced to $10,000.

	Spouse	Child	Rate/Month
Option 1 (Low)	$10,000	$5,000	$2.64
Option 2 (High)	$15,000	$7,500	$5.30

Deferred Compensation

Retirees cannot continue to contribute to this program; however, the plan provides a number of features that help retirees manage their accounts to provide additional income. A wide-range of investment options are available — each with a differing level of risk, returns and fees. Plan design features also include financial planning services and self-directed brokerage arrangements. For more information, contact the on-site T. Rowe Price representative at Fairfax457@troweprice.com.

Additional Coverage Information

Continuous Coverage Requirement

The County requires retirees to have continuous coverage in Fairfax County Government (FCG) Life, Health and/or dental plans. After retirement, if you lose coverage, for any reason, there is no opportunity to re-elect coverage at a later date.

The County allows coverage to be transferred from the active County Government employee group to the retiree group and vice versa, however, transfers to and from the Fairfax County Public Schools (FCPS) are not allowed for purposes of retaining continuous coverage, as FCPS is a separate employer.

Changing Coverage

If you experience a qualified change in family status during the plan year, you have the opportunity to change your benefit elections. Change forms must be received by DHR Benefits within 30 calendar days of the event. For a list of qualifying events, see the Benefits page on FairfaxNet. You can drop dependents or cancel coverage at any time.

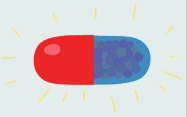
Coverage for Surviving Spouses

Surviving spouses of deceased retirees may continue health and/or dental insurance coverage until they remarry. If a retiree or dependent with coverage dies or remarries, please contact the Retirement Systems Office as soon as possible so that premiums can be adjusted.

Health Insurance Orders

The County is required to enroll any qualified dependent(s) listed on a valid health insurance order into the named employee or retiree's county-sponsored health plan.

Cigna Pharmacy Updates for Non-Medicare Eligible Retirees



Cigna 90 Now - This maintenance medication program allows a 90-day retail benefit at select network pharmacies. It limits the retail locations where participants can obtain a 90-day supply of medications.

Essential Protection Package - Fairfax County has the opportunity to improve the health and safety of members and help avoid costs by moving to the Essential Protection Package. Similar to formulary management, which is already in place, this pharmaceutical program promotes safe and appropriate use of cost-effective medications through additional utilization management including prior authorization, quantity limits and Global Step Therapy. Opioids can have serious side effects and can be extremely dangerous if taken too often or in the wrong way. The Essential Protection packages oversees proper utilization of these powerful medications and others like them.

Retiree Subsidies

Retirees pay the full cost of health and/or dental insurance. Retirees age 55 or older, or those retired on a service-connected disability, receive a monthly subsidy from the County toward the cost of a county health plan. Surviving spouses are entitled to a subsidy only if they receive a Joint and Last Survivor Benefit.

Monthly Subsidy for Retirees Ages 55+	
Years of Service at Reitrement	Subsidy Amount
5 - 9	$40
10 - 14	$75
15 - 19	$165
20 - 24	$200
25 or more*	$230
*Also includes retirees of any age who are approved for a service-connected disability retirement and covered under a county health plan and police officers who retired	

Quick Contacts

Benefits/HR Central	Fairfax County	(703) 324-3311	HRCentral@fairfaxcounty.gov
Marie Canterbury Kelli Parris	T. Rowe Help Desk	(703) 324-4995	Fairfax457@TRowePrice.com
Dental	Delta Dental of Virginia	(800) 237-6060	www.deltadentalva.com
Group Life/LTD	The Standard	(800) 628-8600	www.standard.com
Lonna Owens	Standard, On-Site Rep	(703) 324-3351	lonna.owens@standard.com
Medical: Cigna OAP	Cigna	(800) 244-6224	www.myCigna.com
Keisha Lewis	Cigna, On-Site Rep	(703) 324-2446	keisha.lewis@cigna.com
Medical: Kaiser HMO	Kaiser Permanente	(301) 468-6000	www.kp.org
Retirement Systems	Fairfax County	(703) 279-8200	www.fairfaxcounty.gov/retirement
Vision	Davis Vision	(800) 208-2112	www.davisvision.com

Other Resources for Medicare Eligible Retirees

- Centers for Medicare and Medicaid Services (CMS) - Medicare is a federal government program that provides health care coverage if you are 65 or older. Visit their site at Medicare.gov
- State Health Insurance Assistance Programs (SHIP) - State-specific programs with information about local, personalized counseling and assistance to people with Medicare and their families. For Virginia visit www.vda.virginia.gov/
- Healthy Aging for Older Adults - A website sponsored by the National Center for Chronic Disease Prevention and Health Promotion. It provides information on a wide range of topics.
- Social Security Administration - Find information on retirement and disability benefits, Medicare and more. This helpful site, www.ssa.gov/, offers retirement estimators, F.A.Q.s and information in almost 20 languages.

IMPORTANT FEDERALLY MANDATED NOTICES

Newborns' and Mothers' Health Protection Act of 1996 (NMHPA)

This federal law includes important protection for mothers and their newborn children with regard to the length of hospital stays following the birth of a child. The law stipulates that "group health plans and health insurance issuers generally may not under federal law restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section." However, federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). Plans and issuers may not under Federal law require that a provider obtain authorization from the plan or the issuer for prescribing a length of stay less than 48 hours (or 96 hours).

Genetic Information Nondiscrimination Act (GINA)

GINA sets a national level of protection by prohibiting employers from requiring or purchasing genetic information about you or your family members. The law also prohibits group and individual health insurers from using your genetic information in determining eligibility or premiums.

Women's Health and Cancer Rights Act of 1998 (WHCRA)

This federal law requires group health plans that provide coverage for medically necessary mastectomies to also provide the following coverage for those that elect breast reconstruction:

- All stages of reconstruction of the breast on which the mastectomy has been performed;
- Surgery and reconstruction of the other breast to provide a symmetrical appearance; and
- Prostheses and physical complications of all stages of the mastectomy, including lymphedema.

The county's medical plans cover mastectomies and the benefits required by this act.

Health Insurance Portability and Accountability Act (HIPAA)

To obtain a copy of the Notice of Privacy Practices for the Fairfax County Health Plans you may contact the Benefits Office at 703-324-3311, E-Mail: HRCentral @ fairfaxcounty.gov or you may download a copy from FairfaxNET.

If you wish to obtain more information on the HIPAA law, you may contact Medicare and Medicaid Services (CMS) at http://cms.hhs.gov/hipaa/hipaa1/default.asp; Phone: 410-786-1565 (not toll free).

FEDERALLY MANDATED NOTICES CONTINUED

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

If you or your children are eligible for Medicaid or CHIP and you are eligible for health coverage from your employer, your State may have a premium assistance program that can help pay for coverage, using funds from their Medicaid or CHIP programs. If you or your children aren't eligible for Medicaid or CHIP, you won't be eligible for these premium assistance programs but you may be able to buy individual insurance coverage through the Health Insurance Marketplace. For more information, visit www.healthcare.gov.

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

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

If you or your dependents are eligible for premium assistance under Medicaid or CHIP, as well as eligible under your employer plan, your employer must permit you to enroll in your employer plan if you are not already enrolled. This is called a "special enrollment" opportunity, and you must request coverage within 60 days of being determined eligible for premium assistance. If you have questions about enrolling in your employer plan, you can contact the Department of Labor electronically at www.askebsa.dol.gov or by calling toll-free 1-866-444-EBSA (3272).

Prescription Drug Coverage and Medicare

NOTICE OF CREDITABLE COVERAGE

Important Notice from Fairfax County Government About Your Prescription Drug Coverage and Medicare

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with Fairfax County Government and about your options under Medicare's prescription drug coverage. This information can help you decide whether or not you want to join a Medicare drug plan. If you are considering joining, you should compare your current coverage, including which drugs are covered at what cost, with the coverage and costs of the plans offering Medicare prescription drug coverage in your area. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice.

There are two important things you need to know about your current coverage and Medicare's prescription drug coverage:

1. Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.

2. Fairfax County Government has determined that the prescription drug coverage offered by all of the Cigna plans offered by the County and the Kaiser HMO are, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

When Can You Join A Medicare Drug Plan?

You can join a Medicare drug plan when you first become eligible for Medicare and each year from October 15th through December 7th. However, if you lose your current creditable prescription drug coverage, through no fault of your own, you will also be eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare drug plan.

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

If you decide to join a different Medicare drug plan, your current Fairfax County Government Health Plan coverage may be affected.

You have the following options regarding your health and prescription drug coverage:

- Keep your current Fairfax County Government Health Plan coverage (which includes prescription drug coverage) and don't enroll in a different Medicare Part D plan; or

- Opt out of your current Fairfax County Government Health Plan coverage (which includes prescription drug coverage) and enroll in a different Medicare Part D plan. You will not be able to get your Fairfax County Government Health plan coverage back if you opt out of it, unless (as a dependent) you become eligible to re-enroll due to a Qualifying Change in Status Event.

Remember: Your current county health coverage pays for other health expenses, in addition to prescription drugs, and you will not be eligible to receive all of your current health and prescription drug benefits if you choose to enroll in a different Medicare prescription drug plan and drop your health coverage with the county.

When Will You Pay A Higher Premium (Penalty) To Join A Medicare Drug Plan?

You should also know that if you drop or lose your current coverage with the Fairfax County Government and do not join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later.

If you go 63 continuous days or longer without creditable prescription drug coverage, your monthly premium may go up by at least 1% of the Medicare base beneficiary premium per month for every month that you did not have that coverage. For example, if you go nineteen months without creditable coverage, your premium may consistently be at least 19% higher than the Medicare base beneficiary premium. You may have to pay this higher premium (a penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following October to join.

More Information About This Notice or Your Current Prescription Drug Coverage

Contact HR Central at 703-324-3311 for further information or call CIGNA at 800-244-6224, or Kaiser Permanente at 800-777-7902.

Note: You will get this notice each year. You will also get it before the next period you can join a Medicare drug plan and if this coverage through Fairfax County Government changes. You also may request a copy of this notice at any time.

More Information About Your Options Under Medicare Prescription Drug Coverage

More detailed information about Medicare plans that offer prescription drug coverage is in the "Medicare & You" handbook. You'll get a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare drug plans.

For more information about Medicare prescription drug coverage:

- Visit www.medicare.gov
- Call your state Health Insurance Assistance Program (see the inside back cover of your copy of the "Medicare & You" handbook for their telephone number) for personalized help.
- Call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

If you have limited income and resources, extra help paying for Medicare prescription drug coverage is available. For information about this extra help, visit Social Security on the web at www.socialsecurity.gov or call them at 1-800-772-1213 (TTY 1-800-325-0778).

2019 Health and Dental Premiums

Open Enrollment: October 9 - November 30, 2018

Benefit Plan	Total Monthly Premium (without Subsidy)
Cigna OAP Co-Pay Plan (Plan Closed to New Entrants)	
Individual	$871.35
Individual with Medicare	$601.01
2 Individuals	$1,699.14
2 Individuals - 1 with Medicare, 1 without	$1,464.59
2 Individuals with Medicare	$1,188.29
Family	$2,535.42
Family - 1 with Medicare	$2,388.37
Family - 2 with Medicare	$2,226.01
Family - 3 with Medicare	$2,063.66
Cigna OAP 90% Co-Insurance Plan	
Individual	$729.25
Individual with Medicare	$509.66
2 Individuals	$1,433.24
2 Individuals - 1 with Medicare, 1 without	$1,239.75
2 Individuals with Medicare	$1,019.33
Family	$2,107.75
Family - 1 with Medicare	$1,966.86
Family - 2 with Medicare	$1,823.85
Family - 3 with Medicare	$1,680.84
Cigna OAP 80% Co-Insurance Plan	
Individual	$514.69
Individual with Medicare	$356.17
2 Individuals	$1.003.68
2 Individuals - 1 with Medicare, 1 without	$867.94
2 Individuals with Medicare	$704.57
Family	$1,497.77
Family - 1 with Medicare	$1,400.34
Family - 2 with Medicare	$1,289.42
Family - 3 with Medicare	$1,178.48
Cigna MyChoice Plan - New Plan for Non-Medicare Eligible Retirees	
Individual	$472.76
2 Individuals	$921.84
Family	$1,375.69
Kaiser Permanente HMO	
Individual	$629.01
Individual with Medicare	$308.12
2 Individuals	$1,225.86
2 Individuals - 1 with Medicare, 1 without	$946.10
2 Individuals with Medicare	$615.32
Family	$1,823.65
Family - 1 with Medicare	$1,553.28
Family - 2 with Medicare	$1,254.22
Family - 3 with Medicare	$923.44
Delta Dental PPO	
Individual	$41.46
2 Individuals	$78.32
Family	$129.08

To request this information in an alternate format or for reasonable ADA accommodations, please call HR Central at 703-324-3311 (TTY 711)

A Fairfax County, Va. Publication
September 2018