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FAIRFAX COUNTY

2013 Benefit Programs

Enrollment Guide

Retirees of Fairfax County Government

What This Guide Covers

This guide provides a summary of the benefit programs available to Fairfax County Government employees and retirees. The information provided in the guide, as well as other available materials, should be carefully reviewed before making new benefits choices for the 2013 plan year.

Many important factors are taken into consideration when designing benefit plans for county employees and retirees. The Department of Human Resources strategy focuses on:

- Providing comprehensive coverage that helps keep employees, retirees and their families physically and financially healthy,
- Maintaining plans that are affordable and sustainable for all participants and the county,
- Offering variety in the plan designs to best meet the diverse needs of our population, and
- Continuing to operate compliant, responsible benefit programs in an increasingly complex regulatory and fiscal environment.

It should be noted that based on these and other factors, the county's benefit plans are subject to modification or discontinuance.

The Department of Human Resources is committed to communicating frequently with employees in an honest, open and timely manner about benefits and all other matters.

Note: This resource guide is not intended to be fully comprehensive and should be used in conjunction with other benefit materials including but not limited to plan summaries and certificates of coverage (available on fairfaxNET or by contacting the Fairfax County Government's Benefits Division). FairfaxNET is accessible to retirees through the county's Retirement Administration Agency website. Vendor contact information and internal county benefits resources are listed in the back of this guide.

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Welcome to the 2013 Benefit Plan Year

Fairfax County Government takes pride in its work to protect and enrich the quality of life for the people, neighborhoods and diverse communities of Fairfax County. We also take pride in our retirees, an exceptional group of people who chose to dedicate themselves to the county's mission.

For the 2013 plan year, we encourage all participants to use these tools to:

- ***Assess*** your health status and benefit needs,
- ***Build*** a plan to achieve your goals, and
- ***Commit*** to a healthier you.

In addition to providing premium rates for 2013 benefits, this guide contains important details on several new benefit offerings and changes that will be effective January 1, 2013, including:

- ***Revised prescription drug plan***. Prescription drugs currently account for 22-24 percent of the county's overall claims for its self-insured medical plans. In order to better control costs while providing comprehensive prescription coverage, the current flat copay for prescription drugs in the Open Access Plus-High Plan (managed by Cigna) and the Point of Service Plan (managed by CareFirst) will be replaced by coinsurance (i.e., a percentage of the cost of medications) on non-generic medications. This type of prescription drug program is currently in place on our Open Access Plus-Low Plan (managed by Cigna).

- ***Health Assessments.*** As part of our Assess, Build and Commit campaign, all employees are encouraged to become better informed about their current health status and risks by taking a confidential, online health assessment offered by their medical plan.

- ***Healthcare Reform Measures.*** Several features of the healthcare reform legislation will soon go into effect. This Open Enrollment will feature:
    - The introduction of the new Summary of Benefit Coverage statements in formats prescribed by Health and Human Services (HHS)
    - Annual W-2s for 2012 (issued in early 2013) will include disclosure of health insurance benefit values
    - The expansion of the provision of certain women's healthcare services and prescription drugs including those used for contraception on a zero-cost basis (i.e., no copay or coinsurance).

Eligibility and Enrollment Opportunities

Eligibility

Open Enrollment for eligible Fairfax County retirees occurs in the fall of each year. The effective date for all open enrollment elections is of January 1st of the following year. Open Enrollment is the time to review your current coverage to ensure that elections meet the needs of you and your family. Important dates and other Open Enrollment details are posted on fairfaxNet as well as mailed to retirees' homes. Retirees may access fairfaxNET through www.fairfaxcounty.gov/retirement/.

Enrollment

New retirees have the following options within 30 days of retirement:

- Continue in the same health plan that was held as an active employee until the next open enrollment period. Eligibility and residency requirements must still be met, if applicable to the health plan selected.
- If no longer eligible for coverage in the current plan (either because of Medicare or because of living outside of the plan's service area), the retiree must:
    - Elect other coverage for which they are eligible.
    - Reduce coverage level (drop dependents).
    - Drop coverage altogether. However, once dropped, coverage may never be reinstated.

Note: Current retirees who move out of the HMO (managed by Kaiser Permanente) service area must change to a qualifying plan within 30 days of the move or coverage will be cancelled. Current retirees who move out of the POS (managed by CareFirst) service area will have the option to move to a different plan within 30 days of the move. If no such election is made, coverage will not be canceled, but participants will be responsible for paying for services at out-of-network levels.

Who Can Be Covered?

Retirees may choose individual, two-party coverage (retiree + dependent) or family coverage for the health and dental plans. You must be legally married (as recognized by the Commonwealth of Virginia) to cover your spouse under the county's health and dental plans. Retirees who enroll a spouse must provide a copy of their marriage certificate **or** the top of the most recent tax return showing both social security numbers and filing status.

An eligible dependent child is defined as any biological child, stepchild, adopted child, (or child placed for adoption,) or child for whom the retiree has been appointed legal guardian or who has been granted permanent legal custody. Dependent children must be under the age of 26 and not eligible for their own employer-sponsored coverage. Disabled dependents, regardless of age, are eligible to remain on the county's health plans if the disability occurred before age 26. A birth certificate or legal custody document must be provided when enrolling dependent children.

Continuous Coverage

To be eligible for a retiree health or dental plan, a potential retiree must have been covered by the applicable county health and/or dental plan as an active employee at the time of retirement. In addition, retirees must generally maintain "continuous coverage" after retirement to remain eligible for county plans. The county, however, allows the coverage to be transferred from the active county government employee group to the retiree group and vice versa – this generally occurs when a retiree is re-employed by the county. In addition, re-employed annuitants who (1) enroll in coverage offered as a result of their new employment status and (2) terminate employment after 1/1/2012 will be eligible to have the health and/or dental coverage in place at the end of the second employment period even if there was a previous break in that coverage. Re-employed annuitants may also continue in life insurance based on the coverage in place during the initial retirement.

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. Two examples follow:

Example 1: You are retiring and your spouse is also employed by FCG in a merit position. Your spouse may enroll in coverage for both of you and any covered dependents when you retire. If your spouse is already enrolled in a FCG health plan, he or she may add you to the policy by completing an enrollment/ change form with the Department of Human Resources within 30 days of your retirement date.

If your spouse terminates employment with FCG, you may enroll in coverage for both of you and any covered dependents by requesting the coverage within 30 days of your spouse's termination date. Coverage begins the first of the month after receipt of the enrollment form.

Example 2: You retire from FCG, then return to work for FCG in a merit position. The county will transfer your coverage back to the active employee group if you submit a new enrollment form to the Department of Human Resources within 30 days of your re-employment date. The effective date will be the first of the calendar month following receipt of the enrollment form by the Employee Benefits Division. At termination, your coverage will be transferred back to the retiree group if you complete a new enrollment form requesting coverage through the retiree group.

Coordination with Medicare

Retirees who become eligible for Medicare due to age or disability **must apply for Medicare Part A and Part B as soon as they are eligible** for that federal benefit. Upon receipt of Medicare coverage, Medicare becomes the primary source for payment of claims, and the FCG health plan becomes secondary. Retirees are not required to elect Medicare Part D Prescription Drug Coverage.

Retirees or dependents must submit a copy of their Medicare card to the Department of Human Resources showing the effective dates of Part A and Part B coverage as soon as it is available – up to

three months prior to the effective dates. The monthly premium for Medicare Part B will be deducted from their Social Security checks. Submitting a copy of the card in a timely manner will limit the need for any retroactive adjustments and will ensure that claims are paid correctly. If a copy of the card is not submitted by the eligibility date, coverage will be cancelled. It cannot be reinstated after three months.

For most Fairfax County health insurance plans, retirees with Medicare are responsible for paying the same deductible, copay, coinsurance and other out-of-pocket expenses that they would have been responsible for paying prior to receiving Medicare. However, retirees with Medicare who participate in the county's POS plan (managed by CareFirst) are not required to get referrals from their primary care physicians before visiting specialists.

Retirees and dependents with Medicare Part A and Part B coverage may be eligible for reduced health insurance premiums. Retirees who do not apply for and maintain Medicare Part A and Part B coverage will be subject to termination of coverage from FCG health plans. For more information on applying for Medicare, as well as how the FCG health plans will coordinate with Medicare, visit the Benefits Division webpage on fairfaxNet or the Medicare website at:

http://www.ssa.gov/pgm/medicare.htm

http://www.medicare.gov/Publications /Pubs/pdf/11219.pdf.

Medicare Part D

For information on Medicare Part D, refer to the Important Notices section of this guide.

Coverage for surviving spouses

Surviving spouses of deceased retirees may continue health and/or dental insurance coverage. Surviving children may continue their coverage until they become ineligible because of age. If the survivors are not covered under a county plan at the time of the retirees' death, they are not eligible to continue coverage.

If a retiree or dependent with coverage becomes deceased, please contact the Retirement Administration Agency as soon as possible so that premiums can be adjusted.

Surviving spouses who are age 55 or older and who receive a survivor's benefit from the county are also eligible to receive a monthly subsidy. Surviving spouses who do not receive a survivor's benefit are not eligible for any subsidy. If an active employee deceases prior to retirement, his/her spouse may continue health and/or dental insurance through the Retirement Administration Agency if he/she is eligible to immediately receive a retirement annuity. Surviving children may continue their coverage until they are no longer eligible. Surviving spouses who are age 55 or older of retirement-eligible active employees are also eligible to receive a monthly subsidy from the county if they elect to receive an annuity.

Survivors of retirees who become ineligible for coverage may also be eligible for COBRA coverage.

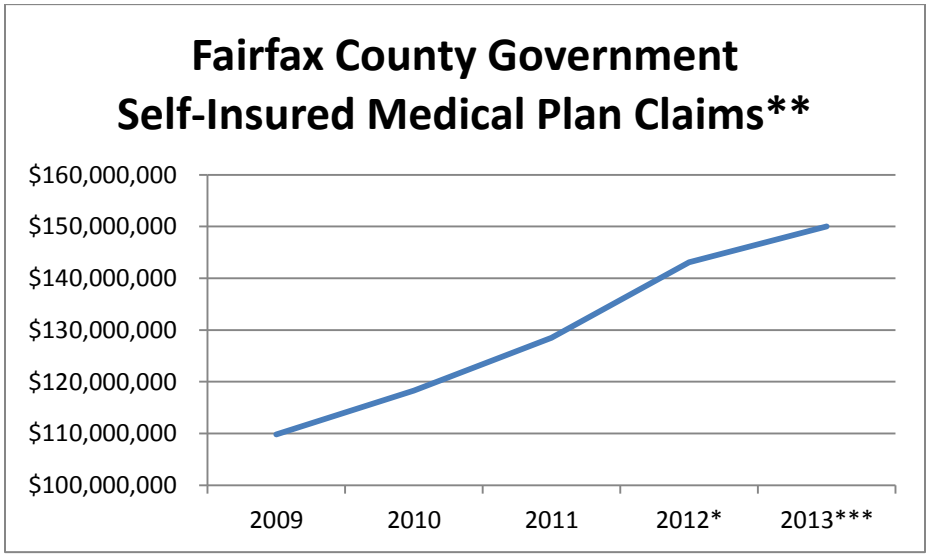
Health Programs

Fairfax County recognizes that everyone's healthcare needs are different and offers a comprehensive health benefit package to retirees, including ***four*** medical and prescription plan options, vision care and dental insurance. Healthcare benefits make routine medical treatment affordable and protect employees and their families from financial hardship because of accident or illness. This guide includes a summary of these plans. Additional in-depth information on the plans can be obtained from fairfaxNET or by contacting the health plan vendors.

The Rising Cost of Healthcare

As previously noted, the county strives to provide comprehensive coverage that is affordable and sustainable for participants and for the county. These goals are particularly challenging given the dramatic rise in the cost of healthcare in the United States over the last several years.

The county's health plans have not been immune to this national trend as shown in the chart below.



* Data as of June 30, 2012 has been annualized.
** Not including Incurred but Not Received (IBNR) reserves.
*** Projected claims for the 2013 plan year.

The increasing cost of healthcare directly impacts everyone's bottom line. It is important to understand that the county and participants share in plan expense in a number of different ways.

Cost sharing through premiums. "Premiums" for a particular benefit plan represent the cost of coverage. The county's Open Access Plus-High, Point of Service and Open Access Plus-Low plan options are self-insured programs. This means that the county pays actual claim amounts as opposed to payments from an insurer. "Premiums" for the coming year are calculated using estimates of what claims will be (based upon national medical trends and the county's own claims experience), as well as

administrative expenses for vendors and required reserves for claims liability. The "fully insured" programs, Kaiser Permanente and Delta Dental, determine their own premiums.

Premiums are set to cover the true cost of offering these benefits. The county cushions premium increases for employees by 1.) bearing the "lion's share" of premium increases as it has historically covered 85 percent of the premium for individual coverage and 75 percent of two-party and family coverage and 2.) by consistently reviewing plan designs to ensure a balance between offering comprehensive services and keeping the program as cost-effective as possible for participants.

Premiums may also be impacted by higher than expected claims in a given year (due to large individual claims or events that affect a segment of the population, such as a flu epidemic), federal and state mandates and regulatory changes, or new reimbursement agreements for providers, facilities or prescription drugs providers.

See page 22 of this guide for more information on premiums for the 2013 plan year.

Cost Sharing through Deductibles, Copays and Coinsurance. While premiums are the periodic payments made to participate in a given coverage option, participants who use services or purchase products such as prescription drugs often share in the cost of those specific items. The county's health plans use a variety of cost-sharing mechanisms, including deductibles (for some plans), copays and coinsurance. A **deductible** is the amount that an individual or family must pay "out of pocket" before the plan begins to pay claims. A copay is a flat dollar amount that a participant is charged at the time of a service such as an office visit to a physician or a prescription. Regardless of the total price of the underlying treatment or drug, the participant's cost is predetermined and fixed. **Coinsurance** means that a participant pays a percentage of the overall cost of the treatment.

For example, a participant visits a physician for a sore throat. The doctor performs a strep test. The total cost of the visit is $125.

- If the participant's medical plan requires a $15 copay for primary care physician visit, he will need to pay $15 out-of-pocket for the visit. The plan will pay the remaining $110 of the claim.
- If the participant's medical plan requires him to pay 10 percent in coinsurance for the visit, he will pay $12.50 for the visit. The plan will pay the remaining $112.50 of the claim.

The use of deductibles, copays and coinsurance paid by those who use services can help keep premiums lower for everyone in the plan. Often, plans use out-of-pocket maximums to limit the total amount an individual would pay for medical care or drugs in a given plan year.

When selecting a plan, it is important to balance how much you will pay in premiums versus how much you could be required to pay out-of-pocket over the course of a year to access medical care.

How Can Participants Help Control the Cost of Healthcare? Every participant can take responsibility for healthcare costs by following a few key guidelines:

- Know your health risks. Consider taking a quick and easy Health Assessment offered by your health plan provider. For more information, see the Health Assessment chapter of this guide.
- Take advantage of preventive care options such as regular physicals, screenings and vaccinations. Preventive care is offered on a zero-cost basis (i.e., no copays or coinsurance) in all of our health plans.
- Commit to the key components of living a healthy life, including diet, exercise and healthy habits.
- Be a wise healthcare consumer when choosing facilities, treatments and diagnostic tests. Examples of healthcare consumerism include opting for generic drugs when available, using mail order prescription services for maintenance drugs and choosing a less costly urgent care facility over an emergency room for non-emergency services.
- Participate in wellness programs like the County's LiveWell program, designed to provide education and information on health and wellness.

Controlling healthcare costs must be a joint effort between the county, healthcare vendors and partners and individual participants.

Medical Coverage Options

The county offers four medical plans to eligible employees, retirees and their dependents.

Open Access Plus-High (OAP-High) Plan, managed by Cigna HealthCare -- This plan allows members to see any licensed provider they choose. Out-of-pocket costs are less when care is provided by a participating provider in the Open Access Plus network. The OAP-High plan offers nationwide access to providers. Participants are encouraged (but not required) to see a primary care physician for routine care. In addition, referrals are not required for specialty care. This plan features a copay structure for in-network office visits and other services. A deductible must be satisfied, followed by coinsurance when care is provided by a non-participating provider outside of the OAP network. When using non-participating providers, participants may be subject to "balance billing." Balance billing is the amount over and above usual and customary charges for services and facilities that a participating provider would have charged.

Point of Service (POS) Plan, managed by CareFirst Blue Cross Blue Shield -- This plan provides access to the BlueChoice HMO network, which primarily covers Northern Virginia, Maryland and Washington, D.C. The POS plan requires the designation of a Primary Care Physician who will assist in the coordination of specialty care. This plan features a copay structure for in-network office visits and other services. A deductible must be satisfied, followed by coinsurance when care is provided by a non-participating POS provider or specialist care is provided without a referral. If there are no physicians within your area, your out-of-pocket costs will be higher. When using non-participating providers,

participants may be subject to "balance billing." Balance billing is the amount over and above usual and customary charges for services and facilities that a participating provider would have charged.

Health Maintenance Organization (HMO), managed by Kaiser Permanente -- This plan provides a fully insured center-based care option. Members receive medical care at a Kaiser Permanente facility within the Washington metropolitan area or at one of the local area hospitals authorized by Kaiser Permanente. Specialists may be located at the Kaiser facility or in private practice. Physician referral is required for specialty care. **Please note**: Retirees and their dependents over the age of 65 are not eligible for Kaiser. The Kaiser Medicare Plus plan is only open to current members who were enrolled in the Medicare plan as of December 31, 2004.

HMO coverage is only available to retirees who live within the Kaiser service areas. Current retirees who move out of the HMO (managed by Kaiser Permanente) service area must change to a qualifying plan within 30 days of the move or coverage will be cancelled.

Open Access Plan-Low (OAP-Low), managed by Cigna HealthCare -- This plan provides a lower-cost premium alternative while still offering comprehensive care through the same national network of providers and facilities utilized by the OAP-High program without the need for referrals. However, this plan uses coinsurance and modest deductibles to help reduce the cost of the plan for participants and the county. Members are protected by out-of-pocket maximums that limit financial exposure for medical costs in the event of a serious injury or illness or those with chronic conditions. Higher deductibles and coinsurance amounts apply when care is provided by a non-participating provider outside of the OAP network. When using non-participating providers, participants may be subject to "balance billing." Balance billing is the amount over and above usual and customary charges for services and facilities that a participating provider would have charged.

The Importance of Participating Providers

Utilizing participating doctors, hospitals and other facilities offers savings not only to the county but also to plan participants. In-network services are provided at negotiated rates that help limit the costs of healthcare services, including doctors and hospitals, as well as outpatient testing, treatment and surgery centers. Dollars are "stretched farther" when participants remain in-network. When participants use non-network providers, the county may pay higher rates for services while participants pay higher deductibles and coinsurance. Participants may also be subject to "balance billing," which is the amount over and above usual and customary charges for services and facilities charged by non-network providers. Balance billing is prohibited when a provider or facility is in-network.

To locate a participating provider, contact the provider's office directly and/or contact the health plan.

Prescription Drug Coverage

Prescription drug coverage is provided through each of the four medical plans. Effective January 1, 2013, the three self-insured programs, including the OAP-High and -Low (managed by Cigna), as well as the POS (managed by CareFirst)

will utilize coinsurance to cover the cost of certain prescription medications. This coverage will feature:

- Deductibles - $50 per individual/$100 per family for prescriptions (this deductible is separate from any general plan deductible for medical services, if applicable)
- Tier-One Drugs (typically generic drugs) - $7 copay
- Tier-Two Drugs (typically brand name drugs for which no generic is available or more costly generics) - 20% coinsurance (maximum $50 per fill per fill at retail pharmacy)
- Tier-Three Drugs (typically more expensive brand-name drugs for which there is a generic or less costly alternative available) - 30% coinsurance (maximum $100 per fill at retail pharmacy)
- Out-of-Pocket Maximum - $1,000 per individual/$2,000 per family (per year)

This new design will help the county keep its prescription drug coverage affordable and sustainable. Participants can further reduce their out-of-pocket expenses for medications while helping the county control the rising impact of prescription expense in its health plans. For example:

- **Ask for generic drugs** which are less expensive versions of brand-name medicines that are produced according to the same U.S. Food and Drug Administration (FDA) standards as their brand-name counterparts with similar effectiveness. If there is not a generic equivalent for your medication, ask your physician if there is a similar medicine in the same class that may be less expensive.
- **Shop around** for the best deal on medicines. Drug pricing can vary by pharmacy. Some pharmacies even match the prices or run "sales" or "specials" on certain medications.
- **Try mail order** for maintenance medications, which are prescriptions to be taken on an ongoing basis over an extended period of time (i.e., blood pressure or high cholesterol.) These might qualify for cost savings when mail order is utilized. Check with your plan vendor:

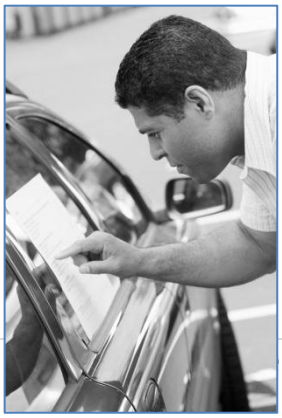
Cigna:	800-835-3784; www.mycigna.com
CareFirst:	800-241-3371; www.carefirst.com
Kaiser Permanente:	301-468-6000; www.kaiserpermanente.org

- **Consider lifestyle changes** that may help reduce the need for medicines. Physical activity, weight loss, improved diet and other healthy habits may reduce your need for some medications.

Choosing the Right Health Plan

Choosing the health plan that is right for you and your family means examining a number of different factors:

- How much does each option cost in terms of monthly premiums?
- What is your family's "health status?" Are there any chronic conditions?
- Does the program require you to choose a primary care physician and are referrals necessary before you can visit a specialist?



- What other out-of-pocket expenses might you incur in addition to monthly premiums (ex. deductibles, copays, coinsurance
- How large is the network of providers offered by the program? Are you better-served by a local network of physicians and hospitals or do you need a larger, national network?

Medical Plans – Benefits at a Glance

The following charts provide general information on the benefits offered by the county's four plans. The enclosed Summaries of Benefit Coverage (SBC) for each coverage option are provided pursuant to the Patient Protection and Affordable Care Act (commonly referred to as "Healthcare Reform.") For more detailed information on each plan, including summary plan descriptions, please refer to materials provided on the Benefits webpage on fairfaxNET.

Benefits at a Glance	**Open Access Plus – High (OAP-High)** **Managed by Cigna HealthCare**	
	In-Network	**Out-of-Network**
Physician Network Area	National Network	
Plan Contact Information	Cigna Customer Service: 800-244-6224 Website: www.Cigna.com; www.myCigna.com	
Primary Care Physician (PCP)	Not required.	
Referrals for Specialty Care	Not required.	
Annual Deductible	$0	$250 individual / $500 family
Yearly Out-of-Pocket Limit	$0	$4000 individual / $8000 family
Office Visits (PCP/ Specialist)	Covered in full after $15 copay for primary care physician; $25 copay for specialist.	Covered at 70% of plan allowance after deductible.
Preventive Care (Refer to Benefits page on fairfaxNET for list of services.)	$0	Children through age 18: 70% of allowed benefit; no deductible. Age 18+: 70% of allowed benefit; after deductible.
Inpatient Hospital Care/Services	$100 per admission copay	Covered at 70% of plan allowance after deductible.
Laboratory & X-Ray	• PCP or Specialist copay in physician's office • Advanced Radiology: $75 copay at radiology centers or outpatient department of hospital.	Covered at 70% of plan allowance after deductible.
Prescription Deductible	$50 individual/$100 family	
Prescription Out-of-Pocket Max	$1000 individual/$2000 family	
Prescription Drugs	Retail (up to 34 day supply) • $7 copay – Generic • 20%– Brand Formulary (max. $50) • 30%– Brand Non-formulary (max. $100) Mail Order (up to 90-day supply) • $14 copay – Generic • 20%– Brand Formulary (max. $100) • 30%–Brand Non-Formulary (max. $200)	Retail (up to 30-day supply): Covered at 70% of allowed benefit Mail Order (up to 90-day supply): Not Covered
Maternity Care	Initial $15 copay for primary care physician or $25 copay for specialist to confirm pregnancy.	Covered at 70% of plan allowance after deductible.
Emergency Treatment	$150 copay for emergency services (waived if admitted for treatment other than observation).	$150 copay for emergency services (waived if admitted for treatment other than observation).
Urgent Care	$25 copay	$25 copay
Mental Health and Substance Abuse Treatment	Inpatient –$100 per admission copay. Outpatient -- $25 copay per visit	Inpatient – Covered at 70% of plan allowance after deductible. Outpatient – Covered at 70% of plan allowance after deductible.
Infertility Coverage • **Refer to Benefits page on fairfaxNET for limitations**	$15 PCP/$25 Specialist copay for office visit; $25 copay for facility visit. Includes IVF, GIFT, ZIFT, etc. $30,000 maximum per calendar year. $100,000 lifetime maximum (combined in-network and out-of-network).	Covered at 70% of plan allowance after deductible. Includes, IVF, GIFT, ZIFT, etc. $30,000 maximum per calendar year. $100,000 lifetime maximum (combined in-network and out-of-network).
TMJ, surgical and non-surgical	Coverage is the same as for other medical conditions. Non-surgical services subject to a $600 lifetime maximum.	Covered at 70% of allowed benefit after deductible. Non-surgical services subject to a $600 lifetime maximum.
Hearing Aids	Max. benefit is $2800 every 36 months (combined in-network and out-of-network)	Max. benefit is $2800 every 36 months (combined in-network and out-of-network)

Benefits at a Glance	**Point of Service (POS)** **Managed by CareFirst BlueCross BlueShield**	
	In-Network	**Out-of-Network**
Physician Network Area	Arlington, Alexandria, Fairfax, Prince William, Loudoun, Fauquier County and City of Falls Church, City of Manassas, City of Manassas Park, Leesburg, the entire state of Maryland and the District of Columbia. Physician Network Area may differ slightly from Service Area; contact Member Services Department for the plan.	
Plan Contact Information	CareFirst Customer Service: 800-628-8549 Website: www.carefirst.com	
Primary Care Physician (PCP)	Yes – Required.	
Referrals for Specialty Care	Yes – Required.	
Annual Deductible	$0	$250 individual / $500 family
Yearly Out-of-Pocket Limit	$0	$4000 individual / $8000 family
Office Visits (PCP/ Specialist)	$10 copay for primary care physician; $15 copay for specialist. Referrals required in-network.	Covered at 70% of allowed benefit after deductible. One routine physical exam/calendar year.
Preventive Care (Refer to Benefits page on fairfaxNET for list of services.)	$0	Children through age 18: 70% of allowed benefit; no deductible. Age 18+: 70% of allowed benefit; after deductible.
Inpatient Hospital Care/Services	$0	Covered at 70% of plan allowance after deductible.
Laboratory & X-Ray	Covered in full at approved radiology/lab centers. $25 copay at approved outpatient dept. of hospital (facility charge waived for therapeutic radiation and chemotherapy).	Covered at 70% of plan allowance after deductible.
Prescription Deductible	$50 individual/$100 family	
Prescription Out-of-Pocket Max	$1000 individual/$2000 family	
Prescription Drugs	Retail (up to 34 day supply) • $7 copay – Generic • 20%– Brand Formulary (max. $50) • 30%– Brand Non-formulary (max. $100) Mail Order (up to 90-day supply) • $14 copay – Generic • 20%– Brand Formulary (max. $100) • 30%–Brand Non-Formulary (max. $200)	Retail (up to 30-day supply): Covered at 70% of allowed benefit Mail Order (up to 90-day supply): Not Covered
Maternity Care	Initial $10 copay for primary care physician or $15 copay for specialist to confirm pregnancy.	Covered at 70% of plan allowance after deductible.
Emergency Treatment	Covered in full after $150 copay for bona fide accidental injury or medical emergency (waived if admitted for treatment other than observation).	Paid as in-network.
Urgent Care	$25 copay	$25 copay for initial care; 70% of allowed benefit after deductible for follow-up care.
Mental Health and Substance Abuse Treatment	Inpatient – $0 Outpatient -- $10 copay per visit	Inpatient – Covered at 70% of plan allowance after deductible. Outpatient – Covered at 70% of plan allowance after deductible.
Infertility Coverage (Refer to Benefits page on fairfaxNET for limitations)	Covered in full for in-vitro fertilization (IVF), up to 3 attempts per live birth. $100,000 lifetime maximum (combined in-network and out-of-network).	Covered at 70% of allowed benefit after deductible for in-vitro fertilization (IVF), up to 3 attempts per live birth. $100,000 lifetime maximum (combined in-network and out-of-network).
TMJ, surgical and non-surgical	Covered in full for pre-surgical x-rays and surgery. Physician: $15 copay Inpatient: $25 copay	Covered at 70% of allowed benefit after deductible for pre-surgical x-rays and surgery.
Hearing Aids	Max. benefit is $2800 every 36 months (combined in-network and out-of-network)	

Benefits at a Glance	Health Maintenance Organization (HMO) Managed by Kaiser Permanente
	In-Network Only
Physician Network Area	Metropolitan Washington D.C., including Northern Virginia and Baltimore areas; includes the City of Fredericksburg, Spotsylvania and Stafford Counties and portions of Caroline, Culpeper, Fauquier, Hanover, Louisa, Orange and Westmoreland Counties. Physician network Area may differ slightly from Service Area, contact Member Services Department for the plan.
Plan Contact Information	Customer Service: 301-468-6000 Website: www.kaiserpermanente.org
Primary Care Physician (PCP)	Yes – required
Referrals for Specialty Care	Yes – required
Annual Deductible	$0
Yearly Out-of-Pocket Limit	$3500 individual / $9400 family
Office Visits (PCP or Specialist)	Covered in full after $10 copay. No charge for children up to age 5.
Preventive Care	Covered in full. Refer to benefits page on FairfaxNET for list of services.
Inpatient Hospital Care/ Doctor's Services	Covered in full.
Laboratory & X-Ray	Covered in full.
Prescription Deductible	$0
Prescription Out-of-Pocket Max	$0
Prescription Drugs	Kaiser pharmacy (up to 30 day supply): $10 copay for generic $20 copay for brand formulary $35 copy for brand non-formulary Community Pharmacy (Up to 30 day supply): $20 copay for generic $40 copay for brand formulary $55 copay for brand non-formulary Mail Order (up to 90 day supply): $16 copay generic $36 copay brand formulary $66 copay brand non-formulary
Maternity Care	Covered in full after $10 copay on first pre-natal visit.
Emergency Treatment	Covered in full after $150 copay per visit. Waived if admitted for treatment other than observation.
Urgent Care	$10 copay per visit
Mental Health Services and Substance Abuse Treatment	Inpatient – Covered in full when medically necessary. Outpatient - $10 individual visit copay; $5 group visit copay.
Infertility Coverage	Coverage for in-vitro fertilization (IVF) for up to 3 completed attempts per lifetime; covered at 50% of allowable charges. $100,000 Benefit Maximum.
TMJ, surgical and non-surgical	Not covered.
Hearing Aids	Covered in full up to maximum. One hearing aid/ear/ every 36 months, $1,000 maximum.
Routine Vision Care	In addition to Davis Vision benefits, eye refraction exam/ ophthalmology visits: $10 copay; eyewear/contact lens discounts also available.

Benefits at a Glance	**Open Access Plus – Low (OAP-Low)** **Managed by Cigna HealthCare**	
	In-Network	**Out-of-Network**
Physician Network Area	National Network	
Plan Contact Information	Cigna Customer Service: 800-244-6224 Website: www.Cigna.com; www.myCigna.com	
Primary Care Physician (PCP)	Not required.	
Referrals for Specialty Care	Not required.	
Annual Deductible	$250 individual/ $500 family	$500 individual/ $1000 family
Yearly Out-of-Pocket Limit	$2000 individual/$4000 family	$4000 individual / $8000 family
Office Visits (PCP/ Specialist)	Covered at 90% after deductible.	Covered at 70% of plan allowance after deductible.
Preventive Care (Refer to Benefits page on fairfaxNET for list of services.)	$0	Children through age 18: 70% of allowed benefit; no deductible. Age 18+: 70% of allowed benefit; after deductible.
Inpatient Hospital Care/Services	Covered at 90% after deductible.	Covered at 70% of plan allowance after deductible.
Laboratory & X-Ray	Covered at 90% after deductible.	Covered at 70% of plan allowance after deductible.
Prescription Deductible	$50 individual/$100 family	
Prescription Out-of-Pocket Max	$1000 individual/$2000 family	
Prescription Drugs	Retail (up to 34 day supply) • $7 copay – Generic • 20%– Brand Formulary (max. $50) • 30%– Brand Non-formulary (max. $100) Mail Order (up to 90-day supply) • $14 copay – Generic • 20%– Brand Formulary (max. $100) • 30%–Brand Non-Formulary (max. $200)	Retail (up to 30-day supply): • Covered at 70% of allowed benefit Mail Order (up to 90-day supply): • Not Covered
Maternity Care	Covered at 90% after deductible.	Covered at 70% of plan allowance after deductible.
Emergency Treatment	$150 copay after deductible for emergency services (waived if admitted for treatment other than observation).	$150 copay after deductible for emergency services (waived if admitted for treatment other than observation).
Urgent Care	$25 copay	$25 copay
Mental Health and Substance Abuse Treatment	Inpatient–Covered at 90% after deductible. Outpatient--Covered at 90% after deductible.	Inpatient–Covered at 70% of plan allowance after deductible. Outpatient–Covered at 70% of plan allowance after deductible.
Infertility Coverage	Not covered.	Not covered.
TMJ, surgical and non-surgical	Not covered.	Not covered.
Hearing Aids	Max. benefit is $2800 every 36 months (combined in-network and out-of-network)	Max. benefit is $2800 every 36 months (combined in-network and out-of-network)

Healthcare Reform

In June 2012, the Supreme Court (the "Court") issued its long-awaited ruling on the Patient Protection and Affordable Care Act (PPACA), paving the way for the continued implementation of the law's provisions. This ruling means that the county will continue its reform implementation which has:

- Provided coverage to eligible dependents up to age 26,
- Offered preventive care on a zero-cost basis to participants (i.e., no copays or coinsurance),
- Removed any annual or lifetime maximums on essential care,
- Participated in the Early Retiree Reimbursement Program that provided over $2.7 million in funds that were used to stabilize premiums,
- Eliminated any restrictions on coverage for those with pre-existing conditions,
- Enhanced our internal and external claims appeals processes, and
- Removed over-the-counter medications from the list of eligible expenses under our flexible spending account programs.

In 2013, participants will see the following changes to the plans:

- Summaries of Benefit Coverage provided to all participants in a format prescribed by Health and Human Services (HHS),
- Disclosure of benefit values on the annual W-2s for employees, and
- Expansion of certain women's healthcare services on a zero-cost basis (i.e., no copay or coinsurance).

In 2014 and beyond, additional changes will go into effect including the opening of the state health insurance exchanges that will provide increased opportunities for those who have been uninsured, under-insured or who need more affordable coverage. The "individual mandate" will also go into effect that requires those who are uninsured to pay a federal "penalty," while premium subsidies will be instituted for lower-income participants. Employers will need to carefully review the impact of new guidelines for essential benefits, requirements for automatically enrolling employees who do not elect coverage at the time of eligibility, the potential for a "Cadillac tax" on benefit plans that exceed a certain level of value, new rules governing retiree medical programs and many more pieces of this complex legislation.

Throughout the upcoming 2013 plan year, the county's benefit staff will focus on:

- An upcoming Request for Proposal effort for our medical, prescription, flexible spending account and health maintenance organization (HMO) benefits that will help us ensure that we have vendors who can partner with us strategically to manage our programs in light of the complex regulatory changes and rising costs in programs,
- Reviewing our systems and procedures to ensure compliance, quality and efficiency of operations, and
- Potential changes in our programs not only to comply with PPACA but also to ensure that we continue to offer flexible and comprehensive benefit programs that help us attract and retain our

workforce. We will focus on ensuring the competitive strength and long-term affordability of our health plans for the county and participants.

Assessing Your Health Risks

Good healthcare doesn't just happen. Employees and their families are encouraged to become more actively engaged in the ongoing management of their health and welfare, using the comprehensive tools provided by the county benefit programs. Educated health decisions can help employees reduce costs and receive better care. Taking an active role in healthcare decisions and partnering with physicians is an integral part of becoming a consumer of healthcare. The county is encouraging all employees and retirees to complete an online Health Assessment offered by all four of our health plans.

A health assessment is an online questionnaire that asks questions about your health and health habits. Here are several reasons to complete an assessment:

Confidentiality is guaranteed	Individual results are kept completely confidential! The county does not receive assessment data at the individual level for anyone who participates.
Identify potential health risks	After you complete your health assessment, you are provided with feedback on your health and suggestions on ways to be healthier. The results of your health assessment will in no way affect your eligibility for our benefit programs or your premiums.
Help manage rising healthcare costs	Aggregate data that is available at the plan level can identify early potential health risks among our employee population. The data allows us to develop programs to address those potential health problems and manage healthcare costs.
There is no cost to participants	Health assessment tools are available to all employees who participate in one of our medical plans at no cost to the participant.

Completing a health assessment is easy. Just go to your health plan's website (identified below), log in (or register) and answer the questions. If you are changing health plans, you may want to wait to take your health assessment until January 1, 2013 in order to maximize the resources and coaching available. Most assessments are completed in 15-20 minutes.

The health assessment tool will ask for certain information such as your height, weight, cholesterol, blood pressure, etc. The exact numbers are not required for completion, but having these numbers helps enhance the final report you receive. You can use results from your most recent annual physical or attend a biometric screening at a county Benefit Fair or Health Screening.

Health Plan	To take a Health Assessment, go to:
Open Access Plus-High (Managed by Cigna)	www.mycigna.com
Point of Service (Managed by CareFirst)	www.carefirst.com/myaccount
Open Access Plus-Low (Managed by Cigna)	www.mycigna.com
Health Maintenance Organization (Managed by Kaiser Permanente)	www.kp.org/register

Tools for Building a Healthier Life

Once you have assessed your health status, risks and needs, we encourage you to leverage the many tools provided by our benefit plans to help you improve your health and quality of life.

Preventive Care at No Cost

Preventive care is a critical tool in the fight against chronic disease in both adults and children. As part of its ongoing commitment to employee health, the county continues to offer preventive care on a zero-cost basis on all health plans. There is no copay, deductible or coinsurance when employees and their dependents receive preventive care services such as annual screenings, physicals and immunizations from a participating physician subject to the terms of each health plan.

Services provided at the time of a well visit or check-up that are not listed as preventive will be considered as standard medical coverage. This means that there may be a cost-share (copay or coinsurance) for those services. Please refer to the plan materials for specific details about coverage.

For a complete listing of preventive care services provided under the health plans, log onto fairfaxNET or contact customer service of the health plan.

Online Tools and Resources

Each health plan provided by Fairfax County offers interactive online tools and resources. These tools assist employees and their dependents to become better consumers of healthcare. Features include the ability to:

- Verify coverage levels and plan benefits
- View claims, track deductibles and out-of-pocket maximums
- Locate participating doctors, hospitals and pharmacies
- Learn about health conditions, expenses, treatments and medications
- Use comparative pricing tools for medical treatments, facilities and prescriptions

Each site offers a secure log-in that enables employees to create their own user IDs and passwords. To register, go to:

www.myCigna.com
www.carefirst.com/myaccount
www.kp.org/register

24-Hour Nurse Support

Speak with a registered nurse anytime day or night. High fever, bad cough, or unexpected allergic reactions are just a few examples of when to contact the 24-hour nurse line. After an intake assessment is conducted by the nurse, they will provide the necessary guidance and direct callers to the most appropriate level of care. Participants can contact their health plan to speak with a nurse.

Disease Management

Employees and their dependents who suffer from a chronic condition (such as asthma, diabetes, heart disease, or low back pain) have the opportunity to enroll in a disease management program.

Participation in disease management programs is voluntary and confidential. These programs are designed to assist those with chronic conditions in creating an action plan to manage symptoms associated with the condition, schedule necessary screenings and improve health.

For more information on the programs offered, contact the health plan or log onto the benefits page fairfaxNET.

Health and Wellness Discounts

Discounts are available on various health and wellness services from all health plans. A few types of services include:

- Health and fitness club memberships
- Alternative therapies/medicines
- Healthy lifestyle products
- Certain dental products or services (in addition to those covered by the county's dental plan)
- Nutrition and weight management programs

For a complete listing of services and vendors, contact the health plan directly. These programs and services are designed to help enhance the health and wellness of participants. There are no claim forms, referrals, or paperwork. To receive the associated discount, inform the provider of the discount program with the health plan.

LiveWell

Retirees and their families are also encouraged to explore the many opportunities to learn more about living a healthy lifestyle and engage in the various wellness events, challenges, seminars and other activities sponsored by the county's LiveWell program.

The LiveWell Workforce Wellness Program is focused on improving retirees' health and well-being, while also serving to curb rising healthcare costs. The program includes reduced membership fees at county RECenters, Weight Watchers discounts, smoking cessation classes, free flu vaccinations and much more. More information on LiveWell is available on fairfaxNET.

Vision Plan

Vision insurance, provided by Davis Vision, is automatically given to all participants who elect coverage under the county's medical programs. The plan offers a nationwide network of more than 33,000 eye care and eyewear providers, including independent optometrists, ophthalmologists and retail providers such as Hour Eyes, For Eyes and Wal-Mart. Be sure to review participating providers prior to your visit.

Premiums for Davis Vision are included in the health insurance premiums deductions. The effective date of coverage is the same as the health insurance benefit. Employees cannot elect the Davis Vision plan without electing a county health plan. For additional information on the vision plan, refer to the below chart, log onto the benefits page of fairfaxNET or contact Davis Vision.

Note: In addition to the coverage provided by Davis Vision, CareFirst, CIGNA and Kaiser Permanente members can receive discounts on vision services and supplies through the discount program highlighted in the Value Added Programs sections of this guide.

Benefits at a Glance	**In-Network**	**Out-of-Network**
Plan Contact Information	Managed by Davis Vision and Provided to All Employees with Medical Coverage 800-208-2112 www.davisvision.com; client control code 4443	
Routine Eye Examination (once every 12 months)	$15 copay (includes eye examination with dilation, as professionally indicated)	Covered up to $40.
Frames (once every 24 months in lieu of contact lenses)	• Davis Vision Designer Collection: Covered in full. • Davis Vision Premier: $25 copay. • Non- Davis Vision Collection (available at all independent and retail network providers): $100 allowance.	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 Lenses	Covered in full.	Covered up to $75.
Trifocal Lenses	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 reimbursements above.
Other Lens Options	Available at discounted fixed fees.	Not covered.
Contact Lenses (once every 12 months in lieu of eyeglasses)		

Benefits at a Glance	In-Network	Out-of-Network
Contact Lens Materials	One pair of standard, soft daily wear; two boxes of planned replacement lenses or 4 boxes of disposables covered in full if from Davis Vision Formulary (available at independent network providers). Elective contact lenses outside of Davis Vision Formulary (available at all independent and retail network providers): $100 allowance.	Covered up to $100.
Contact Lens Fitting Fee with 2 Follow Up Visits	Covered in full after $20 copay 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 for 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% off the provider's usual and customary fees, or a 5% discount on any advertised special.	Not covered.
Low Vision Coverage	Included.	Not included.

Dental Plan

Experts agree that dental wellness is critical to maintaining overall health. The county's dental plan, offered through Delta Dental, provides both in-network and out-of-network benefits to assist participants in achieving good oral health. Through Delta's national PPO and Premier networks, participants can access providers who perform a broad range of covered services including orthodontia. Coverage levels vary according to the services performed. See the accompanying table for a summary of coverage details. For additional information on the plan, log onto fairfaxNET or contact Delta Dental's Member Services.

The plan also includes two important programs designed to encourage participants to keep their teeth and gums in shape. The *Prevention First* program encourages regular preventive visits by providing preventive care and diagnostic services (typically x-rays, exams and cleanings) that do not count against the plan year maximum benefit amount. The *Healthy Smile, Healthy You* program provides additional dental benefits to participants with diabetes and certain cardiac conditions as well as pregnant women.

Retirees who do not currently have dental coverage may not enroll. For additional information on the plan, contact Delta Dental customer service.

In addition to the dental coverage provided by Delta, discounts on dental services or products may be available through your medical plan. See the Benefits webpage on fairfaxNET or contact your medical plan provider for more details.

Benefits at a Glance				
Plan Contact Information	Managed by Delta Dental of Virginia 800-237-6060 www.deltadentalva.com			
Plan Benefit Design	General Plan Information			
Annual Deductible	$50		Limit of 3 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(ren)	
* The amounts listed under the Plan Differential are the deductible and maximum benefits permitted. The in-network and out-of-network deductibles and maximums are not separate and amounts applied to one will apply to the other.				
	In-Network*		Out-of-Network*	Benefit Limitations
COVERAGE	PPO	Premier		
Diagnostic and Preventive Care	100%	100%	80%	Exempt from the deductible. No benefit waiting period.
• Oral exams and cleanings				Twice each in a calendar year.
• Fluoride applications				Once each calendar year under age 19.
• Bitewing x-rays/Vertical bitewing x-rays				Once each calendar year, limited to posterior teeth.
• Full mouth / panelipse x-rays				Limit of one each seven years.
• Space maintainers				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				Retreatment only after 2 years from initial treatment.
• Stainless steel crowns				Limited to primary (baby) teeth for participants under age 14.
• Denture repair and re-cementation of crowns, bridges and dentures				Cost limited to ½ the allowance of a new denture or prosthesis.
• Simple extractions				
Other Basic Dental Care	60%	50%	50%	Deductible applies. No benefit waiting period.
• Oral Surgery				Impactions and other surgical procedures.
• Endodontic services/root canal therapy				Repeat treatment only after 2 years from initial root canal therapy treatment.
• Periodontics services (scaling and root planting, soft tissue and bony surgery, including grafts)				Limitations of 2-3 years apply based on services rendered.
Major Dental Care	60%	50%	50%	Deductible applies. No benefit waiting period.
• Prosthodontics/dentures/bridges				Once every 7 years, subject to age and other limitations.
• Crowns				Once per tooth every 7 years, subject to age and other limitations.
• Implants				Subject to limitations.
• TMJ Non-Surgical Mouth Guards				Subject to limitations.
• Orthodontic Benefits	50%	50%	35%	Deductible applies. Only for dependents under age 19.

2013 Health and Dental Premiums

Retirees pay the full cost of their health and/or dental insurance premiums. 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 55-64			
Years of Service at Retirement	**Subsidy Amount**	**2013 Supple-ment**	**2013 Subsidy Amount**
5-9	$25	$5	$30
10-14	$50	$15	$65
15-19	$125	$30	$155
20-24	$150	$40	$190
25 or more*	$175	$45	$220

*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 with unreduced benefits after 20 years of service.

Monthly Subsidy for Retirees Age 65 and Over			
Years of Service at Retirement	**Subsidy Amount**	**2013 Supple-ment**	**2013 Subsidy Amount**
5-9	$15	$15	$30
10-14	$25	$40	$65
15-19	$100	$55	$155
20-24	$150	$40	$190
25 or more*	$175	$45	$220

*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 with unreduced benefits after 20 years of service.

Retirees can pay their share of the health and/or dental insurance premiums in one of two ways. If possible, the cost will be deducted from the monthly annuity in the month prior to the month of coverage. If the individual does not receive an annuity, or if the retiree's annuity is not large enough to cover the monthly premiums, the retiree must pay their monthly premiums by mailing a personal check (payable to the County of Fairfax) to the Retirement Administration Agency. Personal checks must be received by the Retirement Administration Agency by the 10th of the month to cover the next month's coverage. Failure to make health and dental insurance payments on time may result in cancellation of the retiree's insurance coverage. Please remit personal checks concerning retiree health/dental coverage to:

Retirement Administration Agency
10680 Main Street, Suite 280 Fairfax, VA 22030

Phone: 703-279-8200 or 800-333-1633 Fax: 703-273-3185

Retirees whose retirement annuity has been suspended by the Retirement Administration Agency may pay for the full cost of their benefits by personal check as long as they are eligible to have their retirement benefits restored. If coverage is canceled by the retiree, or if a retiree's coverage is dropped because premiums have not been paid or because the retiree becomes ineligible, the retiree MAY NOT reenroll.

Health, Vision and Dental Insurance Premiums for Retirees January 1, 2013 - December 31, 2013	
CIGNA OAP High + Vision	**Total Monthly Premium Cost (without subsidy)**
Individual	$671.25
Individual with Medicare	$458.60
2 Individuals	$1,308.96
2 Individuals - 1 with Medicare; 1 without	$1,120.86
2 Individuals with Medicare	$908.20
Family	$1,953.27
Family - 1 Medicare	$1,828.31
Family - 2 Medicare	$1,703.35
Family - 3 Medicare	$1,578.39
CareFirst POS + Vision	
Individual	$574.53
Individual with Medicare	$401.24
2 Individuals	$1,129.07
2 Individuals - 1 with Medicare; 1 without	$975.77
2 Individuals with Medicare	$802.46
Family	$1,660.51
Family - 1 Medicare	$1,548.06
Family - 2 Medicare	$1,435.61
Family - 3 Medicare	$1,323.17
Kaiser Permanente HMO + Vision	
Individual	$532.10
Individual with Medicare	$334.49
2 Individuals	$1,036.95
2 Individuals - 1 with Medicare; 1 without	$844.34
2 Individuals with Medicare	$668.15
Family	$1,542.75
CIGNA OAP Low + Vision	
Individual	$439.37
Individual with Medicare	$300.18
2 Individuals	$856.78
2 Individuals - 1 with Medicare; 1 without	$733.66
2 Individuals with Medicare	$594.46
Family	$1,278.59
Family - 1 Medicare	$1,184.07
Family - 2 Medicare	$1,089.55
Family - 3 Medicare	$995.03

Delta Dental PPO	
Individual	$38.24
2 Party	$72.26
Family	$119.10

Group Term Life Insurance

The county offers reduced group term life insurance to retirees who have had the coverage since they retired. Effective January 1, 2013, this coverage will be provided by The Standard Insurance Company, a leading provider of both life and disability insurance across the nation. This plan provides group life insurance with an accelerated death benefit provision. The policy has no cash value from which to borrow.

Benefit Reductions*:* Coverage (and premiums) reduce to 65 percent of the original face value when turning 65 or retirement, whichever comes first. It then reduces to 30 percent of the original face amount at age 70. Both reductions occur the first of the month following the reduction event. Retirees may also reduce their coverage to $12,500.

Accelerated Death Benefit*:* When diagnosed with a terminal illness with a life expectancy of less than 12 months, portions (or the full amount) of the death benefit may be withdrawn. There are no limitations on how to spend the money.

For more information on this benefit, log onto the Benefits page of fairfaxNet or contact HR Central.

Long-Term Care Insurance

The county provides the opportunity to purchase Long Term Care insurance through Prudential. Long-term care is the help or supervision provided for someone with severe cognitive impairment or the inability to perform two of the six activities of daily living: bathing, dressing, eating, transferring, toileting, and continence or when you have a severe cognitive impairment such as Alzheimer's disease. Benefits begin after a single 90-day waiting period. Services may be provided at home, an assisted living facility, nursing home, adult day care or hospice.

Coverage is guaranteed for active retirees who enroll within 30 days of benefit eligibility. If applying for coverage after the initial eligibility period, an enrollment form as well as a medical questionnaire will

need to be completed. Coverage for late enrollees will require approval by Prudential as part of the evidence of insurability (EOI) process.

Retirees, spouses of retirees and surviving spouses of retirees, adult children of retirees, as well as parents or parents-in-law, grandparents or grandparents-in-law of retirees may apply for the coverage. Retirees and family members will need to complete an enrollment form as well as a medical questionnaire. Coverage for retirees and family members will require plan approval.

For more information on this benefit, log onto the Benefits page of fairfaxNet or contact Prudential.

Retirement Benefits

Pension Program

Fairfax County manages three separate defined benefit retirement systems, Retirees', Police Officers' and Uniformed, managed by the Fairfax County Retirement Administration Agency. Questions should be directed to:

Fairfax County Retirement Administration Agency
703-279-8200 (TTY 711)
Monday – Friday; 8:00 a.m. – 4:30 p.m.

Detailed information regarding all three plans is available online at www.fairfaxcounty.gov/retirement/

Deferred Compensation

The Fairfax County Deferred Compensation Plan is managed by T. Rowe Price. This plan provides merit employees with an opportunity to save a portion of their wages for retirement on a pre- or post-tax basis. This is in addition to the regular county retirement plan. The program is governed by Section 457 of the Internal Revenue Code and is designed to complement the county's defined benefit pension plans.

While retirees cannot continue to contribute to the program after they are no longer actively employed, 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, return and fees. Plan design features also include financial planning services and self- directed brokerage arrangements.

For more information on this benefit, log onto the benefits section of fairfaxNet or contact T. Rowe Price.

Building a Plan for 2013

See below for a checklist you can use in ensuring that you understand your benefits and are making the right elections for the coming year.

Health, Vision and Dental Plan

- ✓ Are you enrolled with the best health plan for you/your family?
- ✓ Do you need dental coverage?
- ✓ Do you need health or dental coverage for your spouse and/or dependents?

Group Term Life Insurance

- ✓ Is your beneficiary information up-to-date? It is good practice to complete a new beneficiary designation every two to three years to ensure that information is always current. Beneficiary forms can be downloaded from fairfaxNET. Send completed forms to:

  Fairfax County Department of Human Resources
  Benefits Division
  12000 Government Center Parkway, Suite 270
  Fairfax, VA 22035

Long-Term Care (LTC) Insurance

- ✓ Need LTC coverage to help provide care resources in the event of a serious illness or injury? Coverage may be purchased at any time subject to vendor approval after review of medical questionnaire.

Your Customized Information

- ✓ Do you have the types and levels of coverage that best meet your needs?
- ✓ Are the right members of your household covered?
- ✓ Is your information (name, dependent(s), address, etc.) correct in county records?
- ✓ Are your beneficiary elections for retirement, deferred compensation and group term life programs up-to-date?
- ✓ Do you understand the value of your coverage?

How Do I Enroll in Benefit Programs?

Now that you've gone through your checklist, how do you make sure that your decisions are put into action? During Open Enrollment, retirees are strongly encouraged to enroll, make changes or view their benefits coverage.

Retirees should use the hard copy forms located in the back of this guide to reflect changes in elections. Elections or changes to the Deferred Compensation Plan can be made at any time by contacting T. Rowe Price at 888-457-5770 or logging on to *www.rps.troweprice.com.*

Important Information Regarding Submission of Hard Copy Forms

Please note that forms must be received by the Benefits Division of the county by the due dates specified (generally 30 days after hire or other qualifying event if enrolling outside of the Open Enrollment period.) **For the 2013 Open Enrollment, forms must be received by the Benefits Division by COB Friday, November 16, 2012**. Forms have been included in the back of this guide but may also be downloaded from the Benefits webpage on fairfaxNET or obtained by emailing or calling HR Central at HRCentral@fairfaxcounty.gov or 703-324-3311. Completed forms should be sent to the Benefits Division at the Department of Human Resources, 12000 Government Center Parkway, Suite 270, Fairfax, VA 22035 or faxed to 703-802-8795. If you fax the form, remember to keep a copy of your fax machine's transmission report as documentation that we received the form by the deadline. Forms that are received after applicable deadlines will not be accepted. Do not submit benefits enrollment or change forms to the Retirement Administration Agency as this might delay receipt by the Benefits Division.

Important Notices

Children's and Women's Health Protection

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).

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.

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.

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. These States use funds from their Medicaid or CHIP programs to help people who are eligible for these programs, but also have

access to health insurance through their employer. If you or your children are not eligible for Medicaid or CHIP, you will not be eligible for these premium assistance programs.

If you or your dependents are already enrolled in Medicaid or CHIP and you live in a State listed below, 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 the State if it has a program that might help you pay the premiums for an employer-sponsored plan.

Once it is determined that 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).

If you live in one of the following States, you may be eligible for assistance paying your employer health plan premiums. The following list of States is current as of July 31, 2012. You should contact your State for further information on eligibility.

<table>
<tr><th>ALABAMA – Medicaid</th><th>COLORADO – Medicaid</th></tr>
<tr><td>Website: http://www.medicaid.alabama.gov
Phone: 1-855-692-5447</td><td rowspan="3">Medicaid Website: http://www.colorado.gov/
Medicaid Phone (In state): 1-800-866-3513
Medicaid Phone (Out of state): 1-800-221-3943</td></tr>
<tr><th>ALASKA – Medicaid</th></tr>
<tr><td>Website: http://health.hss.state.ak.us/dpa/programs/medicaid/
Phone (Outside of Anchorage): 1-888-318-8890
Phone (Anchorage): 907-269-6529</td></tr>
<tr><th>ARIZONA – CHIP</th><th>FLORIDA – Medicaid</th></tr>
<tr><td rowspan="2">Website: http://www.azahcccs.gov/applicants

Phone (Outside of Maricopa County): 1-877-764-5437
Phone (Maricopa County): 602-417-5437</td><td>Website: https://www.flmedicaidtplrecovery.com/
Phone: 1-877-357-3268</td></tr>
<tr><th>GEORGIA – Medicaid</th></tr>
<tr><td></td><td>Website: http://dch.georgia.gov/
Click on Programs, then Medicaid, then Health Insurance Premium Payment (HIPP)
Phone: 1-800-869-1150</td></tr>
</table>

IDAHO – Medicaid and CHIP	**MONTANA** – Medicaid
Medicaid Website: www.accesstohealthinsurance.idaho.gov Medicaid Phone: 1-800-926-2588 CHIP Website: www.medicaid.idaho.gov CHIP Phone: 1-800-926-2588	Website: http://medicaidprovider.hhs.mt.gov/clientpages/clientindex.shtml Phone: 1-800-694-3084
INDIANA – Medicaid	**NEBRASKA** – Medicaid
Website: http://www.in.gov/fssa Phone: 1-800-889-9949	Website: www.ACCESSNebraska.ne.gov Phone: 1-800-383-4278
IOWA – Medicaid	**NEVADA** – Medicaid
Website: www.dhs.state.ia.us/hipp/ Phone: 1-888-346-9562	Medicaid Website: http://dwss.nv.gov/ Medicaid Phone: 1-800-992-0900
KANSAS – Medicaid	
Website: http://www.kdheks.gov/hcf/ Phone: 1-800-792-4884	
KENTUCKY – Medicaid	**NEW HAMPSHIRE** – Medicaid
Website: http://chfs.ky.gov/dms/default.htm Phone: 1-800-635-2570	Website: http://www.dhhs.nh.gov/oii/documents/hippapp.pdf Phone: 603-271-5218
LOUISIANA – Medicaid	**NEW JERSEY** – Medicaid and CHIP
Website: http://www.lahipp.dhh.louisiana.gov Phone: 1-888-695-2447	Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/ Medicaid Phone: 1-800-356-1561 CHIP Website: http://www.njfamilycare.org/index.html CHIP Phone: 1-800-701-0710
MAINE – Medicaid	
Website: http://www.maine.gov/dhhs/ofi/public-assistance/index.html Phone: 1-800-977-6740 TTY 1-800-977-6741	
MASSACHUSETTS – Medicaid and CHIP	**NEW YORK** – Medicaid
Website: http://www.mass.gov/MassHealth Phone: 1-800-462-1120	Website: http://www.nyhealth.gov/health_care/medicaid/ Phone: 1-800-541-2831
MINNESOTA – Medicaid	**NORTH CAROLINA** – Medicaid
Website: http://www.dhs.state.mn.us/ Click on Healthcare, then Medical Assistance Phone: 1-800-657-3629	Website: http://www.ncdhhs.gov/dma Phone: 919-855-4100
MISSOURI – Medicaid	**NORTH DAKOTA** – Medicaid
Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005	Website: http://www.nd.gov/dhs/services/medicalserv/medicaid/ Phone: 1-800-755-2604

Health Insurance Portability and Accountability Act (HIPAA)

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) requires that all group plans provide certificates of coverage to individuals who cease to be covered for any reason. The certificates of coverage are to be used by individuals who wish to show that they had group health coverage in order to ease the effect of a new plan's preexisting condition limitation period.

Under HIPAA, a preexisting condition period cannot be longer than 12 months (18 months for late enrollment, reduced by previous periods of creditable coverage). Individuals prove periods of creditable coverage by providing the certificates of coverage to their new plan administrator. Since none of the County's health insurance plans have preexisting condition limitations, you do not need to provide the County with a certificate when joining a County health plan. However, if you are electing coverage mid-year due to a qualifying event, you may be requested to provide a HIPAA certificate to demonstrate the type of coverage with which you were previously enrolled.

Under HIPAA, periods of creditable coverage prior to a 63-day break in coverage may be disregarded in determining whether that previous period of creditable coverage will reduce a preexisting condition limitation period. If you lose coverage under the County and have a break in coverage of 63 days or more before becoming covered by another group, the new plan can disregard all prior creditable coverage under the County plan in applying its preexisting condition limitation. COBRA coverage in most instances may be used until the coverage is available through a new plan.

Special Enrollment Rights: If you are declining coverage in the Medical component of the plan for yourself or your dependents (including your spouse) because of other health insurance or group health plan coverage, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for other coverage (or if the employer stops contributing toward your or your dependents' other coverage). However, you must request enrollment within 30 days after your or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage).

In addition, if you have a new dependent as a result of marriage, birth, adoption or placement for adoption, you may be able to enroll yourself and your dependents. However, you must request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption.

To request special enrollment or obtain more information, contact the Benefits Office at 703-324-3311 or E-Mail: HR-Central@fairfaxcounty.gov.

HIPAA Notice of Privacy Practices – 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: HR-Central @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).

Notice of Patient Protection Disclosure

Fairfax County Government Health Plan generally requires, for POS and HMO, and allows for OAP-High and OAP-Low, the designation of a primary care provider. You have the right to designate any primary care provider who participates in our plan and who is available to accept you or your family members. If you do not designate a primary care provider, the health plan will designate one for you. For information on how to select a primary care provider, and for a list of the participating primary care providers, contact the plan administrator:

Fairfax County
Department of Human Resources
Benefits Division
12000 Government Center Parkway
Suite 270
Fairfax, VA 22035
703-324-3311

For children, you may designate a pediatrician as the primary care provider. You do not need prior authorization from Fairfax County Government Health Plan or from any other person (including a primary care provider) in order to obtain access to obstetrical or gynecological care from a healthcare professional in our network who specializes in obstetrics or gynecology. The healthcare professional, however, may be required to comply with certain procedures including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals. For a list of participating healthcare professionals who specialize in obstetrics or gynecology, contact the plan administrator listed above.

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 the Open Access Plus-High plan (Cigna), Point of Service plan (CareFirst BCBS), HMO plan (Kaiser) and Open Access Plus-Low plan (Cigna) 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 November 15th through December 31st.

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 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 Medicare Part D coverage; or
- Opt out of your current Fairfax County Government Health Plan coverage (which includes prescription drug coverage) and enroll in Medicare Part D coverage. You will not be able to get your Fairfax County Government Health plan coverage back until January 1, 2014 if you opt out of it, unless you become eligible to re-enroll due to a Qualifying Change in Status Event.

You may keep your current Fairfax County Government Health Plan coverage and enroll in Medicare Part D coverage as supplemental prescription drug coverage to your current coverage but you will have to pay premiums for both plans and may not need both types of coverage. You should be certain that you need both types of coverage to meet your prescription drug needs before choosing this option. If you maintain both types of coverage, the primary and secondary payer status of the county's plan and Medicare Part D will be determined the same way it is for Medicare Parts A and B.

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 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 November 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, CareFirst BCBS at 800-628-8549, 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).

Social Security (SSN) Reporting Requirement

A new Mandatory Insurer Reporting Law (Section 111 of Public Law 110-173) requires group health plan insurers, third party administrators, and plan administrators or fiduciaries of self-insured/self-administered group health plans to report, as directed by the Secretary of the Department of Health and Human Services, information that the Secretary requires for purposes of coordination of benefits. Two key elements that are required to be reported are HICNs (or SSNs) and EINs. In order for Medicare to properly coordinate Medicare payments with

other insurance and/or workers' compensation benefits, Medicare relies on the collection of both the HICN (or SSN) and the EIN, as applicable. The law was enacted in late 2007 but became effective in 2009. All participants age 45 or older must provide SSNs in order for the Fairfax County Government Health Plan to meet the requirements of this law. Although it is not required to provide younger dependents' SSNs, it helps the plans correctly process benefits. Individuals who receive ongoing reimbursement for medical care through Workers' Compensation or who receive a settlement, judgment, or award from liability insurance (including self-insurance) will be asked to furnish information concerning their SSNs. For more information about this law, see www.cms.hhs.gov/MandatoryInsRep.

Uniformed Services Employment and Re-Employment Rights Act of 1994

This federal law establishes rights and responsibilities for members of the uniformed services regarding continuation of health or dental benefits and/or medical spending account participation during performance of uniformed service and reinstatement of these benefits upon return from service.

Right to Continue Coverage During Uniformed Service

Employees who have elected health and/or dental coverage and who participate in the medical spending account have the right to elect continuation of coverage for themselves (and their spouse and eligible dependents, if enrolled) while performing service in the uniformed services. Coverage can be continued for the shorter of:

- 24 months, beginning on the date of the employee's absence to perform the uniformed service; or
- The period that begins with the date of the employee's absence to perform the uniformed service and ends on the date the employee either fails to return from service or apply for re-employment.

Employees who are not enrolled in the county's plans do not have the right to initiate such coverage during or upon return from uniformed service.

If an employee performs uniformed service for a period of 30 days or less and elects to continue coverage, s/he will continue to pay the same premium for coverage. If an employee performs uniformed service for a period of 31 days or longer and elects to continue coverage, s/he may be required to pay the employee and employer premium amount, plus an additional 2% to cover administrative costs.

Right to Reinstate Coverage Upon Return to Employment from Uniformed Service

Employees who terminated health and/or dental coverage for themselves and/or their spouse and eligible dependents or who discontinued participation in the medical spending account due to performing uniformed service have the right to reinstate such coverage upon return to employment. No exclusion or waiting period will apply to reinstatement of coverage. However, the county may apply an exclusion or waiting period to any service-connected injury or illness.

Employees with questions regarding how to continue coverage during or reinstate coverage following uniformed service can contact 703-324-3311. For more information regarding ESERRA, visit: www.dol.gov/elaws/vets/userra/ben_heal.asp

For More Information

Vendor Contacts

Plan	Vendor	Phone	Web
Deferred Compensation	T. Rowe Price	888-457-5770	www.rps.troweprice.com
Dental	Delta Dental	800-237-6060	www.deltadentalva.com
Employee Assistance Program (EAP)	INOVA Employee Assistance	800-346-0110	www.inovaeap.com
Group Term Life Insurance	Standard Insurance Company	HR Central: 703-324-3311	See county contacts below
Long-Term Care	Prudential	800-732-0416	www.prudential.com/gtlcweb
Medical Plans			
• OAP – High and OAP – Low	Cigna HealthCare	800-244-6224	www.myCigna.com
• POS	CareFirst BlueCross/BlueShield	800-628-8549	www.carefirst.com/myaccount
• HMO	Kaiser Permanente	301-468-6000	www.kaiserpermanente.org
Vision	Davis Vision	800-208-2112	www.davisvision.com

Contacts at the County

Benefits Division/HR Central

703-324-3311 (TTY 703-222-7314)

http://fairfaxNET.fairfaxcounty.gov/Dept/DHR/Pages/BEN_MainPage.aspx

Retirement Administration Agency

703-279-8200 or 800-333-1633

http://www.fairfaxcounty.gov/retirement/

Fairfax County Government Retiree Benefits Enrollment/Change Form

Once this form is completed, please send it to the Department of Human Resources at 12000 Government Center Parkway, Suite 270, Fairfax, VA 22035 or fax to 703-802-8795. If you fax the form, remember to keep a copy of your fax machine's transmission report as documentation that we received the form by the deadline. Forms that are received after applicable deadlines will not be accepted.

RETIREE NAME _____ SOCIAL SECURITY OR PERSONEL NUMBER _____

HOME PHONE _____ WORK PHONE _____ E-MAIL _____ DATE OF EVENT _____

Why I'm submitting this form (see fairfaxNET for more information):

☐ **Open Enrollment**

☐ **Change in enrollment status of employee or dependent that affects eligibility or cost of coverage:** termination or commencement of benefits-eligible employment, change in worksite, schedule, employer contributions, spouse's open enrollment, etc.

☐ **Change in number of dependents:** birth, adoption, guardianship, marriage, divorce, legal separation, court orders, termination or commencement of Medicaid or SCHIP, drop dependents, etc.

☐ **Other:** Eligibility for Medicare, move from plan's service area. *Only complete sections that are changing.*

Section A. Medical and/or Dental Coverage – *(Select the plan, level of coverage, and tell us about those who should be covered)*

Medical	Individual	2 Party	Family	Number with Medicare	Dental	Individual	2 Party	Family
☐ OAP-High -managed by CIGNA	☐	☐	☐	_____	☐ Delta Dental PPO	☐	☐	☐
☐ POS* - managed by CareFirst	☐	☐	☐	_____	☐ Waive Dental	☐	☐	☐
☐ HMO* – managed by Kaiser	☐	☐	☐	_____	**All medical plan enrollments automatically include vision benefits through Davis Vision.**			
☐ OAP-Low –managed by CIGNA	☐	☐	☐	_____				
☐ Waive medical	*** Choose Primary Care Physician in Enrollment Information Section below**							

Enrollment Information – must be completed for each individual to be covered under health and/or dental coverage

Name (Last, First, MI)	Birthdate	Sex	Primary Care Physician (PCP) Name / ID # (Complete for POS and HMO plans only)	Social Security or Personnel Number	Enroll in Health Plan	Enroll in Dental Plan
Employee					☐	☐
Spouse					☐	☐
Child Relationship:					☐	☐
Child Relationship:					☐	☐
Child Relationship:					☐	☐
Child Relationship:					☐	☐

Note: If adding spouse and/or dependent children, you must forward the marriage certificate and/or birth certificates to Benefits in the Department of Human Resources before your enrollment request will be processed. Dependents not listed above will not be covered. You must notify plan if you will continue to be covered by a second health or dental plan so coordination of benefits may be arranged.

To Remove a Dependent Please remove the dependent listed below from the benefits indicated.

Dependent to be dropped:	Reason for Dropping	Date Occurred:	Drop from:
			☐ Health ☐ Dental ☐ Both health and dental
			☐ Health ☐ Dental ☐ Both health and dental
			☐ Health ☐ Dental ☐ Both health and dental

Revised 8/12

Section B. Group Term Life Insurance (See Fairfax Net for a description of changes that may be made. **To elect a beneficiary other than your estate, complete and return a Beneficiary Election Form.**

Please select one:

☐ Reduce my dependent coverage to $10,000 spouse/$5,000 children

☐ Drop my dependent coverage

☐ Reduce my basic/optional coverage to a total of $12,500 (Note: dependent coverage cannot be higher than $12,500).

☐ I am requesting cancellation of this retiree life coverage. I understand that if I am not picking up this coverage as a re-employed annuitant, I may never have this coverage again.

Acceptance: I hereby apply or waive coverage on behalf of myself and each eligible dependent. I understand that coverage will be provided according to the terms and conditions of the contract between the insurance carrier(s) and my employer. I understand that I must submit my election within 30 days of becoming eligible or during open enrollment and that this coverage is not in effect until my election has been accepted by Human Resources. The effective date for my enrollment as a newly-eligible employee shall be the first of the month after my eligibility date. I further understand that I cannot cancel or change this election unless I experience a Change-in-Status or am entitled to a Special Enrollment Right under HIPAA.

I understand that I must notify the Benefits Office in Human Resources within 30 days of any change in status which would cause any of my covered dependents to cease to be eligible for benefits under the County's health, dental or life insurance plans due to the dependent's death or loss of eligibility. If I fail to notify the Benefits Office in Human Resources by filing the appropriate forms, I will be responsible for any claims and/or premiums paid on behalf of any individual who ceased to be eligible for benefits under the policy. It is my responsibility to keep informed of any changes to the plan that might affect my or my dependent(s) eligibility. The effective date for the change and the documentation that must be submitted are described in the Benefits Summary Handbook.

I also certify that the dependents listed above are eligible to be covered as dependents as described in the Fairfax County Benefits Handbook.

I hereby authorize any physician, hospital or other provider of service to furnish any information, reports or copies of records, related to care or services rendered to me or any of the dependents listed above to the insurance carrier(s) or other third parties who require such information to administer the plan. Such information is to be held confidential. I understand that by completing and signing this enrollment form, I am making a binding election with regard to my benefits and that I am authorizing my employer to make the deductions necessary to pay my share of the cost of coverage. I also authorize subsequent payroll deductions in future plan years unless I notify my employer of a change in my election. See Summary Benefits Handbook for more information.

Retiree Signature: _____ Date: _____

Mail completed form to: Department of Human Resources
12000 Government Center Parkway
Suite 270
Fairfax, Virginia 22035
Or fax to: 703-802-8795

Acknowledgements

The county would like to acknowledge and thank our plan vendors for their contributions to the 2013 employee benefits communications campaign.