

tuneUP YOUR BENEFITS



2012 Enrollment Guide



*Retirees of
Fairfax County Government*

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Welcome to the 2012 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.

Our post-retirement benefits program is just one element of the package designed to ensure the welfare of our retirees as they celebrate their records of public service. In designing our benefit programs, we have sought to provide the right combination of tools to enable retirees to optimize their physical, mental and financial health.

We encourage you to review the county's comprehensive benefit programs every year and to make choices that best suit your needs and the needs of your families. With that in mind, we have developed a "Tune Up Your Benefits" theme for our enrollment materials for 2012. Like your car, your benefits are a well-oiled machine and perform at their best after going through regular tune ups. To keep benefits running at peak performance, we encourage all eligible employees and retirees to review their elections along with these materials and other available information carefully before making new benefits choices for the 2012 plan year.

What This Guide Covers

This guide provides a summary of the benefit programs available to retirees through Fairfax County Government. The information provided should be carefully reviewed.

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

- Providing comprehensive coverage that helps keep retirees and their families physically and financially healthy.
- Maintaining affordable plans for all participants.
- Offering variety in the plan designs to best meet the diverse needs of our population.
- 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.

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, certificates of coverage and documents 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.

Enrollment, Eligibility and Deadlines

Enrollment Opportunities

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 “tune up your benefits” to ensure that elections still meet the needs of participants. Important dates and other Open Enrollment details are posted on FairfaxNet as well as mailed to retirees’ homes.

Eligibility and Enrollment Deadlines

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.

Changes will take effect on the first of the month after receipt of the Health Insurance Election/Change Form, unless another date is required because of a specific qualifying life event. For examples of a qualifying life event, refer to the Glossary section of this guide or log onto the Benefits page on FairfaxNet.

Retirees may choose individual, two-party coverage (employee + one dependent) or family coverage. 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. A birth certificate or legal custody document must be provided when enrolling dependent children.

The county reserves the right to change or terminate the benefit provided or adjust the premium at any time.

Retirees who are not eligible for benefits through the county may find information about individual health insurance coverage from the Commonwealth of Virginia Insurance: <http://www.scc.virginia.gov/division/boi/webpages/inspagedocs/healthinsguide.pdf> **or** <http://www.scc.virginia.gov/division/boi/webpages/inspagedocs/individhealthinscoverage.pdf>.

Benefit Guidelines



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 **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 Retirement Administration Agency showing the effective dates of Part A and Part B coverage. The monthly premium for Medicare Part B will be deducted from their Social Security checks. Retirees must submit a copy of their

Medicare card to the Retirement Administration Agency as soon as it is available – up to three months prior to the effective dates. Submitting a copy of the card in this timely manner will limit the need for any retroactive adjustments and will ensure that claims are paid correctly.

For most FCG health insurance plans, retirees with Medicare are responsible for paying the same deductible, co-payment, 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. Effective January, 2012, 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> and <http://www.medicare.gov/Publications/Pubs/pdf/11219.pdf>.

Medicare Part D

For information on Medicare Part D, refer to the Important Notices from Uncle Sam 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.

If an employee becomes deceased prior to becoming eligible for retirement, his/her survivors are eligible only for continuation coverage under COBRA. Survivors of retirees who become ineligible for coverage may also be eligible for COBRA coverage.

Medical Plan Options

Fairfax County recognizes that everyone's healthcare needs are different and offers a comprehensive benefit package to employees, retirees and their dependents, which includes *four* medical plan options. Medical benefits make routine medical treatment affordable and protect participants 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.

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 nation-wide 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 co-pay structure for in-network office visits and other services. A deductible must be satisfied, followed by co-insurance 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," which is the amount over and above usual and customary charges for services and facilities charged by non-network providers.

Effective January 1, 2012, the following benefit design changes will be made to the CIGNA OAP-High plan:

- Co-pay increase to \$15 per visit to primary care physician; \$25 for specialists;
- Prescription drug retail location co-pays to \$7 generic/\$30 preferred brand/\$50 non-preferred (\$14 generic/\$60 preferred brand/\$100 non-preferred mail order);
- \$75 co-pay on all advanced radiology services; and
- \$100 co-pay for each inpatient hospital admission.

Point of Service (POS) Plan, Managed by CareFirst BlueCross BlueShield -- 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 co-pay structure for in-network office visits and other services. A deductible must be satisfied, followed by co-insurance 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," which is the amount over and above usual and customary charges for services and facilities charged by non-network providers.

Effective January 1, 2012, retirees residing outside of the POS service area may elect to participate in the POS program, but will be responsible for the cost of services at out-of-network levels (including potential balance billing.) If a current retiree moves out of the POS (managed by CareFirst) service area over the course of a year, that participant 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 (including potential balance billing.)

Health Maintenance Organization (HMO), managed by Kaiser Permanente -- This plan provides a fully insured center-based care option through a nationally recognized leader in the HMO market. 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 co-insurance 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 co-insurance 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,” which is the amount over and above usual and customary charges for services and facilities charged by non-network providers.

Choosing the Right Health Plan

Recognizing that employees, retirees and their families have different needs when it comes to maintaining physical and financial health, the county has designed programs to access health care that are comprehensive, flexible and affordable. 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 unique “health status?” Are you dealing with chronic conditions?
- Does the program require you to choose a primary care physician and are referrals necessary before you can visit a specialist?
- What out-of-pocket expenses might you incur in addition to monthly premiums (ex. deductibles, co-pays, and co-insurance?) What is the plan’s out-of-pocket maximum that protect your family in the event of a serious illness, injury or other higher than expected usage of the programs?
- How big is the network of providers offered by the program in the area where you live? Are you well-served by a local network of physicians and hospitals or do you need a larger, national network?

The following charts provide more information on the benefits offered by the county’s four plans.

Medical Plans – Benefits at a Glance

Benefits at a Glance	Open Access Plus – High (OAP-High) Managed by CIGNA HealthCare	
	In-Network	Out-of-Network
Physician Network Area	National	
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	\$3000 individual / \$6000 family
Office Visits (PCP/ Specialist)	Covered in full after \$15 co-pay for primary care physician; \$25 co-pay for specialist.	Covered at 70% of plan allowance after deductible.
Preventive Care (Children and Adults)	Covered in full. Refer to Benefits page on FairfaxNet for list of services.	Children through age 18: 70% of allowed benefit; no deductible. Age 18 and above: 70% of allowed benefit; after deductible. Refer to Benefits page on FairfaxNet for list of services.
Inpatient Hospital Care/ Doctor's Services	Covered in full after \$100 per admission co-pay.	Covered at 70% of plan allowance after deductible.
Laboratory & X-Ray	Covered in full at physician's office after PCP or Specialist co-pay. Advanced Radiology: Covered in full after \$75 co-pay at radiology centers or outpatient department of hospital.	Covered at 70% of plan allowance after deductible.
Prescription Deductible	\$0	
Prescription Out-of-Pocket Max	N/A	
Prescription Drugs	<p><u>Retail (up to 30-day supply):</u> \$7 co-pay for generic \$30 co-pay for brand formulary \$50 co-pay for brand non-formulary</p> <p><u>Mail Order (up to 90-day supply):</u> \$14 co-pay for generic \$60 co-pay for brand formulary \$100 c-opay for brand non-formulary</p>	<p><u>Retail (up to 30-day supply):</u> Covered at 70% of allowed benefit; no deductible</p> <p><u>Mail Order (up to 90-day supply):</u> Not Covered</p>
Maternity Care	Covered in full after initial \$15 co-pay for primary care physician or \$25 co-pay for specialist to confirm pregnancy.	Covered at 70% of plan allowance after deductible.
Emergency Treatment	Covered in full after \$150 co-pay for emergency services (waived if admitted for treatment other than observation).	Covered in full after \$150 co-pay for emergency services (waived if admitted for treatment other than observation).
Urgent Care	Covered in full after \$25 per co-pay (waived if admitted for treatment other than observation).	Covered in full after \$25 per co-pay (waived if admitted for treatment other than observation).
Mental Health and Substance Abuse Treatment	<p><i>Inpatient</i> – Covered in full after \$100 per admission co-pay.</p> <p><i>Outpatient</i> – Covered in full after \$15 co-pay.</p>	<p><i>Inpatient</i> – Covered at 70% of plan allowance after deductible.</p> <p><i>Outpatient</i> – Covered at 70% of plan allowance after deductible.</p>
Infertility Coverage	Covers testing/treatment for underlying medical condition, diagnosis, medical/surgical treatment to restore fertility & artificial insemination. \$15/\$25 co-pay for office visit; \$25 co-pay 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. Covers testing and treatment for underlying medical condition, diagnosis, medical/surgical treatment to restore fertility & artificial insemination. 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 <ul style="list-style-type: none"> Non-surgical services subject to a \$600 lifetime maximum. 	Covered in full after \$15 co-pay for primary care physician; \$25 co-pay for specialist. Inpatient \$100 co-pay per admission. Outpatient Facility covered in full after \$25 co-pay per visit.	Covered at 70% of allowed benefit after deductible.

<i>Benefits at a Glance</i>	Open Access Plus – High (OAP-High) Managed by CIGNA HealthCare	
	In-Network	Out-of-Network
Hearing Aids <ul style="list-style-type: none"> Maximum benefit is \$2800 every 36 months (combined in-network and out-of-network). 	Covered in full.	Covered at 70% of allowed benefit after deductible.
Wigs <ul style="list-style-type: none"> Based on medical necessity \$350 maximum per calendar year 	Covered in full.	Covered at 70% of allowed benefit after deductible.
Dental Care (additional coverage available through Delta Dental plan – separate premium required)	Routine care not covered.	
Routine Vision Care	Vision benefits provided through Davis Vision.	

Notes:

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	\$3000 individual/\$6000 family
Office Visits (PCP/Specialist)	Covered in full after \$10 co-pay for primary care physician; \$15 co-pay for specialist. Referrals required in-network.	Covered at 70% of allowed benefit after deductible. One routine physical exam/calendar year.
Preventive Care <ul style="list-style-type: none">• Children and Adults	Covered in full. Refer to benefits page on FairfaxNet for list of services.	Children through age 17: 70% of allowed benefit no deductible. Age 18 and above: 70% of allowed benefit; after deductible. Refer to benefits page on FairfaxNet for list of services.
Inpatient Hospital Care/Doctor's Services	Covered in full.	Covered at 70% of allowed benefit after deductible.
Laboratory & X-Ray	Covered in full at approved radiology/lab centers. \$25 co-pay at approved outpatient dept. of hospital (facility charge waived for therapeutic radiation and chemotherapy).	Covered at 70% of allowed benefit after deductible.
Prescription Deductible	\$0	
Prescription Out-of-Pocket Max	\$0	
Prescription Drugs	<i>Retail (up to 34-day supply):</i> \$10 co-pay for generic \$20 co-pay for brand formulary \$40 co-pay for brand non-formulary <i>Mail Order (up to 90-day supply):</i> \$20 co-pay for generic \$40 co-pay for brand formulary \$80 co-pay for brand non-formulary	<i>Retail (up to 34-day supply):</i> Not Covered <i>Mail Order (up to 90-day supply):</i> Not Covered
Maternity Care	Covered in full after initial \$10 co-pay for primary care physician or \$15 co-pay for specialist to confirm pregnancy.	Covered at 70% of allowed benefit after deductible.
Emergency Treatment	Covered in full after \$150 co-pay for bona fide accidental injury or medical emergency (waived if admitted for treatment other than observation).	Benefits provided in-network only.
Urgent Care	\$25 co-pay per visit co-pay	Initial Care: Covered in-network; Follow up Care: Covered at 70% of allowed benefit after deductible.
Mental Health Services and Substance Abuse Treatment	<i>Inpatient</i> – Covered in full. <i>Outpatient</i> – Covered in full after \$10 co-pay.	<i>Inpatient</i> – Covered at 70% of plan allowance after deductible. <i>Outpatient</i> – Covered at 70% of plan allowance after deductible.
Infertility Coverage	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.	Covered at 70% of allowed benefit after deductible for pre-surgical x-rays and surgery.

Benefits at a Glance	Point of Service (POS) Managed by CareFirst BlueCross BlueShield	
	In-Network	Out-of-Network
	Physician: \$15 co-pay Inpatient: \$25 co-pay	
Hearing Aids <ul style="list-style-type: none"> Maximum benefit is \$2800 every 36 months (combined in-network and out-of-network). 	Covered in full up to \$2800 maximum per 36 months (combined in-network and out-of-network).	Covered at 70% of allowed benefit after deductible. Maximum benefit is \$2800 every 36 months (combined in-network and out-of-network).
Wigs <ul style="list-style-type: none"> Based on medical necessity \$350 maximum per calendar year 	Covered in full.	Covered at 70% of allowed benefit after deductible.
Dental Care (add'l coverage available through Delta Dental plan – separate premium required)	Discounts on services by participating dentists.	Routine care not covered.
Routine Vision Care	Vision benefits provided through Davis Vision.	

Notes:

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 co-pay. No charge for children up to age 5.
Preventive Care • Children and Adults	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	<p><i>Kaiser pharmacy (up to 30 day supply):</i> \$10 co-pay for generic \$20 co-pay for brand formulary \$35 co-pay for brand non-formulary</p> <p><i>Community Pharmacy (Up to 30 day supply):</i> \$20 co-pay for generic \$40 co-pay for brand formulary \$55 co-pay for brand non-formulary</p> <p><i>Mail Order (up to 90 day supply):</i> \$16 co-pay generic \$36 co-pay brand formulary \$66 co-pay brand non-formulary</p>
Maternity Care	Covered in full after \$10 co-pay on first pre-natal visit.
Emergency Treatment	Covered in full after \$150 co-pay per visit. Waived if admitted for treatment other than observation.
Urgent Care	\$10 co-pay per visit
Mental Health Services and Substance Abuse Treatment	<p><i>Inpatient</i> – Covered in full when medically necessary.</p> <p><i>Outpatient</i> - \$10 individual visit co-pay; \$5 group visit co-pay.</p>
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.

Benefits at a Glance	Health Maintenance Organization (HMO) Managed by Kaiser Permanente	
In-Network Only		
Hearing Aids <ul style="list-style-type: none"> • One hearing aid/ear/ every 36 months, \$1,000 maximum. 		Covered in full up to maximum
Wigs		Not covered.
Dental Care (additional coverage available through Delta Dental plan – separate premium required)		Discounts on services.
Routine Vision Care		In addition to Davis Vision benefits, eye refraction exam/ ophthalmology visits: \$10 co-pay; eyewear/contact lens discounts also available.

Notes:

Benefits at a Glance	Open Access Plus – Low (OAP-Low) Managed by CIGNA HealthCare	
	In-Network	Out-of-Network
Physician Network Area	National	
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	\$1250 individual/ \$2500 family	\$3000 individual/ \$6000 family
Office Visits (PCP/ Specialist)	Covered at 90% after deductible.	Covered at 70% of plan allowance after deductible.
Preventive Care <ul style="list-style-type: none"> Children and Adults 	Covered in full. Refer to benefits page on FairfaxNet for list of services.	Children through age 18: 70% of allowed benefit; no deductible. Age 18 and above: 70% of allowed benefit; after deductible. Refer to Benefits page on FairfaxNet for list of services.
Inpatient Hospital Care / Doctor's 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 <ul style="list-style-type: none"> Applies to retail and home delivery 	\$50 Individual / \$100 Family	
Prescription Out-of-Pocket Max	\$1000 Individual / \$2000 Family	
Prescription Drugs	<i>Retail (up to 30-day supply):</i> \$5 co-pay for generic 20% for brand formulary (maximum \$50) 30% for brand non-formulary (maximum \$100) <i>Mail Order (up to 90-day supply):</i> \$10 co-pay for generic 20% for brand formulary (maximum \$100) 30% for brand non-formulary (maximum \$200)	<i>Retail (up to 30-day supply):</i> Not Covered <i>Mail Order (up to 90-day supply):</i> Not Covered
Maternity Care	Covered at 90% after deductible.	Covered at 70% of plan allowance after deductible.
Emergency Treatment	\$150 co-pay after deductible for emergency services (co-pay waived if admitted for treatment other than observation).	\$150 co-pay after deductible for emergency services (co-pay waived if admitted for treatment other than observation).
Urgent Care	\$25 co-pay after deductible (co-pay waived if admitted for treatment other than observation).	\$25 co-pay after deductible (co-pay waived if admitted for treatment other than observation).
Mental Health and Substance Abuse Treatment	<i>Inpatient</i> – Covered at 90% after deductible. <i>Outpatient</i> – Covered at 90% after deductible.	<i>Inpatient</i> – Covered at 70% of plan allowance after deductible. <i>Outpatient</i> – Covered at 70% of plan allowance after deductible.
Infertility Coverage	Not covered.	Not covered.
TMJ, surgical and non-surgical	Not covered.	Not covered.

Benefits at a Glance	Open Access Plus – Low (OAP-Low) Managed by CIGNA HealthCare	
	In-Network	Out-of-Network
Hearing Aids <ul style="list-style-type: none"> Maximum benefit is \$2800 every 36 months (combined in-network and out-of-network). 	Covered at 90% after deductible.	Covered at 70% of allowed benefit after deductible.
Wigs <ul style="list-style-type: none"> Based on medical necessity \$350 maximum per calendar year 	Covered at 90% after deductible.	Covered at 70% of allowed benefit after deductible.
Dental Care (additional coverage available through Delta Dental plan-separate premium required)	Routine care not covered.	Routine care not covered.
Routine Vision Care	Vision benefits provided through Davis Vision.	

Notes:

Health Care Reform

On March 23, 2010, the Patient Protection and Affordable Care Act (the PPACA,) a sweeping piece of health care reform legislation designed to overhaul health care delivery and accessibility was signed into law by President Obama. A companion bill, the Health Care and Education Reconciliation Act (HCERA) was enacted to fine-tune the PPACA was signed on March 30, 2010. The Department of Human Resources is continually assessing the impact of the legislation on programs for county employees and retirees. Additional information regarding the impact of healthcare reform on the county's medical programs will be posted on FairfaxNet as it becomes available.



Maximizing Benefits

Good health care doesn't just happen. Retirees 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.

Good health decisions can help you reduce costs and get better care. A good decision takes into account:

- The benefits of each option.
- The risks of each option.
- The costs of each option.
- Individual needs and wants.

Taking an active role in health care decisions and partnering with physicians is an integral part of becoming a consumer of health care. Refer to the Health and Wellness Guide for more information on achieving optimum health.

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 on-going commitment to employee and retiree health, the county continues to offer preventive care on a zero-cost basis on all health plans. There is no co-pay (or other cost sharing such as a deductible or co-insurance) when participants 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 (co-pay or co-insurance) 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 participants and their dependents to become better consumers of health care. 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; and
- Learn about health conditions, expenses, treatments and medications.

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

www.mycigna.com

www.carefirst.com/myaccount

www.kp.org/register

The Importance of Participating Providers

Utilizing participating doctors, hospitals and other facilities offers savings to not only the county, but also to plan participants. In-network services are provided at negotiated rates that help limit the costs of health care services, including doctors and hospitals, as well as outpatient testing, treatment and surgery centers. Dollars are “stretched further” when participants remain in-network. When participants use non-participating providers, the county may pay higher rates for services while participants pay higher deductibles and co-insurance. 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.

Emergency Room, Urgent Care, Convenience Care and Physician’s Offices: Know Before You Go

One of the most important steps county retirees and their dependents can take to control health care costs and premiums is to seek the most appropriate level of care. Emergency rooms (ER) provide immediate specialized care to people with serious, often life-threatening issues. However, many people often use the ER for conditions that are much less serious. Treatment of non-emergency conditions in the ER costs hundreds of dollars more than treatment at an urgent care center, convenience care clinic, or physician’s office. The American College of Emergency Physicians provides a list of warning signs that indicate a medical emergency that warrants a visit to the ER:

- Chest or upper abdominal pain or pressure
- Difficulty breathing, shortness of breath
- Fainting, sudden dizziness or weakness



- Changes in vision
- Confusion or changes in mental status
- Sudden or severe pain
- Uncontrolled bleeding
- Severe or persistent vomiting or diarrhea
- Suicidal feelings
- Difficulty speaking
- Unusual abdominal pain

Always go to the emergency room when directed by a physician!

Walk-in clinics are often called "minor emergency," "urgent care," or "immediate care" centers. These facilities deal with all kinds of health problems and are often open in the evenings and on weekends. In many locations, appointments are not required. These types of clinics can be a great option for:

- Abdominal Pain
- Cuts/Stitches
- Strains/Sprains
- Minor infections (ear, eye, sinus)
- Vomiting or Diarrhea
- Respiratory problems
- Sports physicals and vaccinations

Lowering Prescription Costs



Generic medicines are less expensive versions of brand-name medicines. Generic equivalents are made according to the same U.S. Food and Drug Administration (FDA) standards as brand-name drugs. Generics have the same quality, strength, purity, and stability as their more expensive brand names.

Generic equivalents are not available for every brand-name medicine. If there is not an equivalent, ask the prescribing physician if there is a similar medicine in the same class that may be less expensive or that has a generic equivalent.

Shop around for the best deal on medicines. The retail cost can vary widely from pharmacy to pharmacy. Some pharmacies match the price that other pharmacies charge. In addition, pharmacies often run “sales” or “specials” on certain medications.

Consider mail order for maintenance medications. Maintenance medications are prescriptions to be taken on an ongoing basis over an extended period of time (such as for conditions like blood pressure or cholesterol.) The county health plans offer a cost savings when mail order is utilized. For more information on mail order pharmacy, contact:

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

Take action. Many chronic illnesses, including diabetes, high blood pressure and low back pain, require fewer medicines with the increase of physical activity, weight loss and improved diet. Counseling, support groups, and other therapies may help with illnesses such as depression. Lifestyle changes may help reduce the need for medicines.

Value Added Programs

All health plans provided by the county offer a series of value-added programs to participants at no extra cost including:

- 24-hour nurse support
- Disease Management
- Health and Wellness Discounts

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

Retirees 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 create 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. **Please note:** Discount programs are not a benefit under the medical plan. There are no claim forms, referrals, or paperwork. These programs and services are designed to help enhance the health and wellness of participants. To receive the associated discount, inform the provider of the discount program with the health plan.

Vision Plan



Vision insurance is provided by Davis Vision. Coverage is automatic 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, including Hour Eyes, For Eyes and Wal-Mart. Be sure to review participating providers prior to your visit.

Yearly routine eye examinations are provided (after \$15 co-pay) and there is partial coverage for eyeglasses or contact lenses. For additional information on the vision plan, refer to the below chart, log onto the benefits page of FairfaxNet or contact Davis Vision.

Premiums for Davis Vision are included with the health insurance premium deductions. The effective date of coverage is the same as the health insurance benefit. Participants cannot elect the Davis Vision plan without electing a county health plan.

In addition to the coverage provided by Davis, CareFirst, CIGNA and Kaiser 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	Vision	
	Managed by Davis Vision and Provided to All Participants with Medical Coverage	
	In-Network	Out-of-Network
Plan Contact Information	800-208-2112 www.davisvision.com ; client control code 4443	
Routine Eye Examination (once every 12 months)	Covered in full after \$15 co-pay. Eye examination with dilation, as professionally indicated, included.	Covered up to \$40.
Frames (once every 24 months in lieu of contact lenses)	Davis Vision Designer Collection (available at independent network providers): Covered in full. Davis Vision Premier Collection (available at independent network providers): \$25 co-pay. Outside 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.

Benefits at a Glance	Vision Managed by Davis Vision and Provided to All Participants with Medical Coverage	
	In-Network	Out-of-Network
Contact Lenses (once every 12 months in lieu of eyeglasses)		
Contact Lens Materials	One pair of standard, soft daily wear; two boxes of planned replacement lenses or 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 co-pay for Formulary contact lenses.	Covered up to \$40.
Medically Necessary Contact Lenses (with prior approval)	Covered in full.	Covered up to \$225.
Additional Features		
One-Year Eyeglass Breakage Warranty	Included for all spectacle lenses, Davis Vision Collection frames and retailer supplied frames.	Not included.
Lens 1-2-3!®	Included.	N/A
Membership		
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

The Benefits Division is pleased to announce that Delta Dental will continue to be the county's dental vendor in 2012. Through the Request for Proposal (RFP) process, a Selection Advisory Committee (SAC) was created to represent employees and retirees. The committee carefully reviewed numerous proposals and determined Delta Dental best met the needs of the county's diverse workforce.

The county's new contract with Delta Dental provides a number of attractive enhancements designed to assist participants in maintaining oral health. The following services have been added to the county's dental program effective January 1, 2012:

- Composite (e.g., white) fillings on posterior teeth;
- Vertical bitewing x-rays;
- Implants; and
- Non-surgical mouth guards for participants who suffer from Temporomandibular Joint disorders (TMJ).

Experts agree that **dental wellness** is critical to maintaining overall health. Effective January 1, 2012, the county's new Delta Dental plan will include two important programs designed to encourage participants to keep their teeth and gums in shape. First, the Prevention First program encourages regular preventive visits. With the addition of this program, preventive care and diagnostic services



(typically, x-rays, exams and cleanings) will **no longer** count against the plan year maximum benefit amount. Second, the Healthy Smile, Healthy You program provides additional dental benefits to participants with diabetes and certain cardiac conditions as well as pregnant women.

The table below outlines the coverage details. For additional information on the plan, log onto FairfaxNet or contact Delta Dental's Member Services.

In addition to the dental coverage provided by Delta, a discount dental plan is offered through CareFirst. Discounts ranging from 20% - 40% are available from participating dentists. For more information on this program, or to see a list of dentists, log onto the CareFirst member services website.

CIGNA members can receive discounts on dental products through the Healthy Rewards discount program. For a complete list of Healthy Rewards vendors and programs, visit mycigna.com or call 1-800-870-3470.

A discount dental plan is provided to Kaiser members through Dominion Dental Services USA, Inc. For information on charges and services, log onto FairfaxNet, or contact Dominion Dental Services at 888-518-5338 Monday – Friday from 7:30 a.m. – 6:00 p.m. Eastern.

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

Benefits at a Glance	Dental Managed by Delta Dental of Virginia			
Plan Contact Information	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	\$2000	Per enrollee, per calendar year. Preventive care expenses do not count toward the annual benefit maximum.		
Orthodontic Lifetime Maximum	\$2000	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.
<ul style="list-style-type: none"> • Oral exams and cleanings • Fluoride applications • Bitewing x-rays/Vertical bitewing x-rays • Full mouth / panoramic x-rays • Space maintainers • Sealants • Healthy Smile, Healthy You® Program 				Twice each in a calendar year. Once each calendar year under age 19. Once each calendar year, limited to posterior teeth. Limit of one each seven years. Under the age of 14. Under the age of 19, with limitations 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.
<ul style="list-style-type: none"> • Amalgam (silver) and composite (white) fillings • Stainless steel crowns 				Retreatment only after 2 years from initial treatment. Limited to primary (baby) teeth for participants under age 14.

Benefits at a Glance	Dental Managed by Delta Dental of Virginia			
<ul style="list-style-type: none"> Denture repair and re-cementation of crowns, bridges and dentures Simple extractions 				Cost limited to ½ the allowance of a new denture or prosthesis.
Other Basic Dental Care	60%	50%	50%	Deductible applies. No benefit waiting period.
<ul style="list-style-type: none"> Oral Surgery Endodontic services/root canal therapy Periodontic services (scaling and root planing, soft tissue and bony surgery, including grafts) 				Impactions and other surgical procedures. Repeat treatment only after 2 years from initial root canal therapy treatment. Limitations of 2-3 years apply based on services rendered.
Major Dental Care	60%	50%	50%	Deductible applies. No benefit waiting period.
<ul style="list-style-type: none"> Prosthodontics/dentures/bridges Crowns Implants TMJ Non-Surgical Mouth Guards 				Once every 7 years, subject to age and other limitations. Once per tooth every 7 years, subject to age and other limitations. Subject to limitations.
<ul style="list-style-type: none"> Orthodontic Benefits 	50%	50%	35%	Deductible applies. Only for dependents under age 19.

2012 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.*

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.

What Makes Up a Premium?

No one likes to see their health insurance premiums increase from one year to the next, but understanding what is driving those increases may help.

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.

Components of a Premium. Administrative expenses are fixed costs the county pays to the health insurance companies to manage enrollment, process claims and contract with medical providers. Claims, however, vary from month to month based on health care services actually used. Reserves protect the plans against claims volatility and ensure adequate cash flow. In addition, government regulations require that the county set aside sufficient assets toward future retiree medical expenses.

Determining the amount that must be available to cover all of these health plan expenses requires the combined expertise of the county's benefits and budget staff as well as input from each of the health plan vendors and from consultants. Optimally, premiums are set for the coming year to cover the full cost of the program.

Premium Drivers. There are several factors that can impact premiums:

- Higher or lower than expected general claims expense: This means that claims for the overall population were higher or lower than predicted, often as a result of factors like the severity of a flu season.
- More specific individual claims: While past experience is used to estimate the number of serious health incidents that will be experienced by participants, it isn't an exact science. Swings in overall claims volume can be impacted by individual health problems because of a serious accident, illness, or even premature birth.
- Migration: This is the unexpected movement of plan participants from one plan to another during open enrollment or as new hires.



How Does the County Cushion the Impact of Premium Increases for Retirees? Premiums are set to cover the true cost of offering these benefits. So, how does the county cushion premium increases for retirees? First, for qualifying retirees, the county offers a monthly subsidy that is based upon years of service and helps offset medical premiums. Second, in determining retiree premiums for the coming year, the county aggregates expected costs for all participants. In that way, retirees, who can experience higher medical costs in later years, benefit from the claims experience of a larger population, providing lower premiums than would have been set based upon a smaller pool of only retired participants.

Finally, plan designs are constantly reviewed to ensure there is a balance between offering comprehensive services and keeping the program as cost-effective as possible for participants.

Premiums may also be impacted by federal and state mandates and regulatory changes, new reimbursement agreements for providers, facilities or prescription drugs and more. Health Care Reform, for example, is expected to increase claims over the next several years between 2 and 5 percent. County staff monitors these developments carefully and will keep participants updated on changes, particularly concerning potential health care reform and other legislative changes.

How Can Participants Affect Premiums? Every participant, including retirees and their dependents, can take responsibility for health care costs and focus on preventive care and wellness:

- Are you taking the steps to live a healthy life, including diet, exercise and healthy habits?
- Are you taking advantage of preventive care options such as regular physicals, screenings and vaccinations?
- Are you spending health care dollars wisely, effectively and efficiently when choosing facilities, treatments and diagnostic tests? Examples of cost savings mechanisms could 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 when regular physician's offices are unavailable.

Controlling health care costs is a partnership between the county, health care vendors and partners and individual participants.

**Health, Vision and Dental Insurance Premiums for Retirees
January 1, 2012 – December 31, 2012**

OAP – HIGH + VISION (administered by CIGNA)	TOTAL MONTHLY PREMIUM COST (without subsidy)
Individual	\$590.89
Individual with Medicare	\$403.70
2 Individuals	\$1,152.25
2 Individuals – 1 with Medicare; 1 without	\$986.67
2 Individuals with Medicare	\$799.47
Family	\$1,719.43
Family – 1 Medicare	\$1,609.43
Family – 2 Medicare	\$1,499.43
Family – 3 Medicare	\$1,389.43
POS + VISION (administered by CareFirst)	
Individual	\$537.95
Individual with Medicare	\$375.69
2 Individuals	\$1,057.18
2 Individuals – 1 with Medicare; 1 without	\$913.64
2 Individuals with Medicare	\$751.37
Family	\$1,554.78
Family – 1 Medicare	\$1,449.49
Family – 2 Medicare	\$1,344.20
Family – 3 Medicare	\$1,238.92
HMO + VISION (administered by Kaiser Permanente)	
Individual	\$489.96
Individual with Medicare*	\$308.00
2 Individuals	\$954.83
2 Individuals – 1 with Medicare; 1 without	\$777.48
2 Individuals with Medicare*	\$615.24
Family	\$1,420.58
OAP – LOW + VISION (administered by CIGNA)	
Individual	\$395.12
Individual with Medicare	\$269.95
2 Individuals	\$770.49
2 Individuals – 1 with Medicare; 1 without	\$659.77
2 Individuals with Medicare	\$534.59
Family	\$1,149.81
Family – 1 Medicare	\$1,064.81
Family – 2 Medicare	\$979.81
Family – 3 Medicare	\$894.81
Delta Dental PPO**	
Individual	\$38.24
2 Party	\$72.26
Family	\$119.10

* only available to retirees already in Kaiser Medicare Plus

**only available to retirees who have maintained dental coverage since retirement

Group Term Life Insurance

The county offers reduced group term life insurance to retirees. 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 occurs the first of the month following the reduction event.

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

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 staff at 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.

Benefits Tune Up Checklist

Checklists are often handy in making sure we do everything required for maintaining our automobiles. 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 still 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?
- ✓ Complete beneficiary forms and send to Benefits, DHR, 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.

Administrative Tune Up

- ✓ You have the types and levels of coverage that best meet your needs.
- ✓ The right members of your household are covered.
- ✓ Your information (name, dependents, address, etc.) is correct with the Retirement Administration Agency.
- ✓ Ensure that your beneficiary elections for retirement, deferred compensation and group term life programs are up-to-date.
- ✓ You understand the value of your coverage.
- ✓ You can change your asset allocations and beneficiary in the county's Deferred Compensation Plan at any time during the year.

Glossary of Terms

Allowed Benefit: The maximum dollar amount allowed for services covered, regardless of the actual charge.

Appeal: A protest filed by a member or a health care provider regarding a coverage decision.

Authorization: A contractual requirement that the provider or member notify and obtain approval for certain services.

Co-insurance: A percentage of charges that members pay for covered services.

Coordination of Benefits: A provision which determines the order of benefit when a member has health care coverage under more than one plan.

Co-payment: A fixed dollar amount that is paid for certain covered services.

Deductible: A dollar amount of an incurred expense that needs to be paid before your plan pays benefits.

Dependent: A member who is covered under the plan as a spouse or eligible child.

Merit Employee: A merit employee is someone hired under the competitive system defined in the Merit System Ordinance found in Code of Fairfax County Article 1, Chapter 3.

Out-of-Pocket Maximum: The maximum amount an employee will have to pay out of their own pocket before services are completely covered at 100% by the plan.

Participating Providers: A doctor, hospital, pharmacy or other facility that has an established contract with a health plan.

Qualifying Life Event: A change in life status including but not limited to:

- marriage
- divorce
- birth of a child

that allows participants to make benefit plan changes outside of the annual open enrollment. Retirees may drop dependents at any time without a qualifying life event.

Election/Change Form

Fairfax County Department of Human Resources

HEALTH INSURANCE ELECTION/CHANGE FORM

Benefits Open Enrollment – October 17-November 17, 2011

(Changes Effective January 1, 2012)

Complete this form ONLY IF MAKING A CHANGE TO YOUR CURRENT COVERAGE OPTIONS

Retiree Information (Please Print):

Retiree's Name _____ Social Security _____

Retiree's Date of Birth _____

Street Address _____

City _____ State _____ Zip _____

Home Phone _____ Cell Phone _____ Email _____

I Currently Have:

- OAP – High + Vision (administered by CIGNA)
- POS + Vision (administered by CareFirst)
- HMO + Vision (administered by Kaiser)
- OAP – Low + Vision (administered by CIGNA)

I currently have coverage for:

- 1 Individual 2 Individuals Family

How many with Medicare? _____

My Election for 2012

- OAP-High + Vision (administered by CIGNA)
 - POS + Vision (administered by CareFirst)
- POS Primary Care Doctor's Name/Code _____
- HMO + Vision (administered by Kaiser*)
 - OAP -Low + Vision (administered by CIGNA)

I hereby acknowledge receipt of the **Open Enrollment Materials** from Fairfax County with new election options for health insurance for 2012. **Please Note: Forms are only required if you are making changes to your current elections.** New premium rate will take effect with deductions in the December 2011 payroll. All changes are effective January 1, 2012.

Signature _____ Date _____

* Kaiser coverage is not available if you or your spouse are over the age of 65.
New Kaiser enrollees for 2012 MUST contact RAA to receive a Kaiser enrollment form.

Complete the Information Below
If you are Requesting Coverage for More than 1 Individual

All insured members must be listed below by name, and include date of birth, Social Security Number and their relationship to the applicant.

Additionally, if you have elected the POS plan, you must also include a Primary Care Physician name and Code for each covered family member.

LAST NAME	FIRST NAME	MI	DATE OF BIRTH M/D/YEAR	RELATIONSHIP TO APPLICANT	PRIMARY CARE PHYSICIAN* Only designate PCP if you are electing the POS – (CareFirst)	PCP CODE* Only if you are electing POS – (CareFirst)	COVERED BY MEDICARE? YES/NO
_____				Retiree			
Social Security Number: _____							
_____				Spouse (if applicable)			
Social Security Number: _____							
_____				<input type="checkbox"/> Son <input type="checkbox"/> Daughter			
Social Security Number: _____							
_____				<input type="checkbox"/> Son <input type="checkbox"/> Daughter			
Social Security Number: _____							
_____				<input type="checkbox"/> Son <input type="checkbox"/> Daughter			
Social Security Number: _____							
_____				<input type="checkbox"/> Son <input type="checkbox"/> Daughter			
Social Security Number: _____							

**Only designate a PCP and Code if you are electing the Point of Service (POS) option administered by CareFirst.*

If you are NOT making changes to your coverage from 2011, you do NOT need to complete and return this form.

Fairfax County Department of Human Resources

12000 Government Center Parkway, Suite 270, Fairfax, VA 22035

703-324-3311 ~ 703-222-7314 (TTY) ~ FAX 703-802-8795

Important Notices from Uncle Sam

Notice of Privacy Practices (HIPAA)

FAIRFAX COUNTY GOVERNMENT HEALTH PLANS AND ITS AFFILIATED ENTITIES Effective April 14, 2003

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW IT CAREFULLY.

THE PRIVACY OF YOUR MEDICAL INFORMATION IS IMPORTANT TO US.

The following entities, affiliated with FAIRFAX COUNTY GOVERNMENT, are covered by this notice:

This notice applies to the privacy practices of the health plans listed below. As affiliated (related) entities, we may share your protected health

information, and the protected health information of others on your insurance policy as needed for payment or health care operations.

- CareFirst BlueCross BlueShield POS
- Kaiser Permanente HMO
- CIGNA HealthCare Plans OAP-High
- CIGNA HealthCare Plan OAP-Low
- Delta Dental PPO
- Prudential (Long Term Care)
- FBMC (Medical Spending Account)
- INOVA (Employee Assistance Program)

Our Legal Duty

This Notice describes our privacy practices, which include how we might use, disclose (share or give out), collect, handle, and protect our members' protected health information. We are required by certain federal and state laws to maintain the privacy of your protected health information. We must follow the privacy practices that are described in this notice while it is in effect. This notice takes effect April 14, 2003, and is not intended to amend any prior notice of Fairfax County Government Health Plan privacy practices.

information that we maintain, including protected health information we created or received before we made the changes. If we make a significant change in our privacy practices, we will change this notice and send the new notice to our health plan subscribers within sixty days of the effective date of the change.

We reserve the right to change our privacy practices and the terms of this notice at any time, as long as law permits these changes. We reserve the right to make the changes in our

You may request a copy of our notice at any time. For more information about our privacy practices, or for additional copies of this notice, please contact us using the information listed at the end of this notice.

Privacy practices and the new terms of our notice effective for all protected health

Uses and Disclosures of Medical Information

Primary Uses and Disclosures of Protected Health Information

We use and disclose protected health information about you for payment and health care operations. The federal health care privacy regulations generally do not “preempt” (or take precedence over) state privacy or other applicable laws that provide individuals greater privacy protections. As a result, to the extent state law applies, state privacy laws, or other federal laws, rather than the federal HIPAA (Health Insurance Portability and Accountability Act) privacy regulations, might impose a privacy standard under which we will be required to operate. For example, where such laws have been enacted, we will follow more stringent state privacy laws that relate to uses and disclosures of the protected health information concerning HIV or AIDS, mental health, substance abuse/chemical dependency, genetic testing, and reproductive rights. In addition to these state law requirements, we also may use or disclose protected health information in the following situations:

Payment: We may use and disclose your protected health information for all activities that are included within the definition of “payment” as written in the federal privacy regulations. For example, we might use and disclose your protected health information to pay claims for services provided to you by doctors, hospitals, pharmacies and others for services delivered to you that are covered by your health plan. We might also use your information to determine your eligibility for benefits, to coordinate benefits, to examine medical necessity, to obtain premiums, and to issue explanations of benefits to the person who subscribes to the health plan in which you participate.

Health Care Operations: We may use and disclose your protected health information for all activities that are included within the definition of “health care operations” as defined in the federal privacy regulations. For example, we might use and disclose your protected health information to determine our premiums for your health plan, to conduct quality assessment and improvement activities, to engage in care coordination or case management, and to manage our business.

Business Associates: In connection with our payment and health care operations activities, we contract with individuals and entities (called “business associates”) to perform various functions on our behalf or to provide certain types of services (such as member service support, utilization management, subrogation, or pharmacy benefit management). To perform these functions or to provide the services, our business associates will receive, create, maintain, use, or disclose protected health information, but only after we require the business associates to agree in writing to contract terms designed to appropriately safeguard your information.

Other Covered Entities. In addition, we may use or disclose your protected health information to assist health care providers in connection with *their* treatment or payment activities, or to assist other covered entities in connection with certain of *their* health care operations. For example, we may disclose your protected health information to a health care provider when needed by the provider to render treatment to you, and we may disclose protected health information to another covered entity to conduct health care operations in the area of quality assurance and improvement activities or accreditation, certification, licensing or credentialing.

Other Possible Uses and Disclosures of Protected Health Information

The following is a description of other possible ways in which we might (and are permitted to) use and/or disclose your protected health information.

To You or with Your Authorization: We must disclose your protected health information to you, as described in the Individual Rights section of this notice. You may give us written authorization to use your protected health information or to disclose it to anyone for any purpose not listed on this notice. If you give us

an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures that we made as permitted by your authorization while it was in effect. Without your written authorization, we may not use or disclose your protected health information for any reason except those described in this notice.

Disclosures to the Secretary of the U.S. Department of Health and Human Services: We are required to disclose your protected health information to the Secretary of the U.S. Department of Health and Human Services when the Secretary is investigating or determining our compliance with the federal privacy regulations.

To Plan Sponsors: Where permitted by law, we may disclose your protected health information to the plan sponsor of your group health plan to permit the plan sponsor to perform plan administration functions. For example, a plan sponsor may contact us seeking information to evaluate future changes to your benefit plan. We also may disclose summary health information (this type of information is defined in the federal privacy regulations) about the enrollees in your group health plan to the plan sponsor to obtain premium bids for the health insurance coverage offered through your group health plan or to decide whether to modify, amend or terminate your group health plan.

To Family and Friends: If you agree (or, if you are unavailable to agree, such as in a medical emergency situation), we may disclose your protected health information to a family member, friend or other person to the extent necessary to help with your health care or with payment for your health care.

Underwriting: We may receive your protected health information for underwriting, premium rating or other activities relating to the creation, renewal or replacement of a contract of health insurance or health benefits. We will not use or further disclose this protected health information received under these circumstances for any other purpose, except as required by law, unless and until you enter into a contract of health insurance or health benefits with us.

Health Oversight Activities: We may disclose your protected health information to a health oversight agency for activities authorized by law, such as: audits; investigations; inspections; licensure; or civil, administrative, or criminal proceedings or actions. Oversight agencies seeking this information include government agencies that oversee: (i.) the health care system; (ii) government benefit programs; (iii) other government regulatory programs; and (iv) compliance with civil rights laws.

Abuse or Neglect: We may disclose your protected health information to appropriate authorities if we reasonably believe that you may be a possible victim of abuse, neglect, domestic violence or other crimes.

To Prevent a Serious Threat to Health or Safety: Consistent with certain federal or state laws, we may disclose your protected health information if we believe that the disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public.

Coroners, Medical Examiners, Funeral Directors, and Organ Donation: We may disclose protected health information to a coroner or medical examiner for purposes of identifying you after you die, determining your cause of death or for the coroner or medical examiner to perform other duties authorized by law. We may also disclose, as authorized by law, information to funeral directors so they may carry out their duties on your behalf. Further, we might disclose protected health information to organizations that handle organ, eye, or tissue donation and transplantation.

Research: We may disclose your protected health information to researchers when an institutional review board or privacy board has: (1) reviewed the research proposal and established protocols to ensure the privacy of the information; and (2) approved the research.

Inmates: If you are an inmate of a correctional institution, we may disclose your protected health information to the correctional institution or to a law enforcement official for: (1) the institution to provide health care to you; (2) your health or safety or the health or safety of others; or (3) the safety and security of the correctional institution.

Workers' Compensation: We may disclose your protected health information to comply with workers' compensation laws and other similar programs that provide benefits for work-related injuries or illnesses.

Public Health and Safety: We may use or disclose your protected health information to the extent necessary to avert a serious and imminent threat to your health or safety or the health or safety of others.

Required by Law: We may use or disclose your protected health information when we are required to do so by law. For example, we must disclose your protected health information to the U.S. Department of Health and Human Services upon their request for purposes of determining whether we are in compliance with federal privacy laws.

Legal Process and Proceedings: We may disclose your protected health information in response to a court or administrative order, subpoena, discovery request, or other lawful process, under certain circumstances. Under limited circumstances, such as a court order, warrant or grand jury subpoena, we may disclose your protected health information to law enforcement officials.

Law Enforcement: We may disclose to a law enforcement official limited protected health information of a suspect, fugitive, material witness, crime victim, or missing person. We may disclose protected health information where necessary to assist law enforcement officials to capture an individual who has admitted to participation in a crime or has escaped from lawful custody.

Military and National Security: We may disclose to military authorities the protected health information of Armed Forces personnel under certain circumstances. We may disclose to federal officials protected health information required for lawful intelligence, counterintelligence, and other national security activities.

Other Uses and Disclosures of Your Protected Health Information: Other uses and disclosures of your protected health information that are not described above will be made only with your written authorization. If you provide us with such authorization, you may revoke the authorization in writing, and this revocation will be effective for future uses and disclosures of protected health information. However, the revocation will not be effective for information that we have already used or disclosed in reliance on your authorization.

Individual Rights

Access: You have the right to look at or get copies of your protected health information contained in a designated record set, with limited exceptions. You may request that we provide copies in a format other than photocopies. We will use the format you request unless we cannot reasonably do so. You must make a request in writing to obtain access to your protected health information. You may obtain a form to request access by using the contact information listed at the end of this notice. You also may request access by sending a letter to the address at the end of this notice. If you request copies, we might charge you a reasonable fee for each page, and postage if you want the copies mailed to you. If you request an alternative format, we might charge a cost-based fee for providing your protected health information in that format. If you prefer, we will prepare a summary or an explanation of your protected health information, but we may charge a fee to do so.

We may deny your request to inspect and copy your protected health information in certain limited circumstances. Under certain conditions, our denial will not be reviewable. If this event occurs, we will inform

you in our denial that the decision is not reviewable. If you are denied access to your information and the denial is subject to review, you may request that the denial be reviewed. A licensed health care professional chosen by us will review the request and the denial. The person performing this review will not be the same person who denied your initial request.

Disclosure Accounting: You have the right to receive a list of instances in which we or our business associates disclosed your protected health information for purposes other than treatment, payment, health care operations and certain other activities, after April 14, 2003. We will provide you with the date on which we made the disclosure, the name of the person or entity to which we disclosed your protected health information, a description of the protected health information we disclosed, the reason for the disclosure, and certain other information. If you request this list more than once in a 12-month period, we might charge you a reasonable, cost-based fee for responding to these additional requests.

You may request an accounting by submitting your request in writing using the information listed at the end of this notice. Your request may be for disclosures made up to 6 years before the date of your request, but in no event, for disclosures made before April 14, 2003.

Restriction Requests: You have the right to request that we place additional restrictions on our use or disclosure of your protected health information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in an emergency). Any agreement that we might make to a request for additional restrictions must be in writing and signed by a person authorized to make such an agreement on our behalf. We will not be liable for uses and disclosures made outside of the requested restriction unless our agreement to restrict is in writing. We are permitted to end our agreement to the requested restriction by notifying you in writing.

You may request a restriction by writing to us using the information listed at the end of this notice. In your request tell us: (1) the information of which you want to limit our use and disclosure; and (2) how you want to limit our use and/or disclosure of the information.

Confidential Communication: If you believe that a disclosure of all or part of your protected health information may endanger you, you have the right to request that we communicate with you in confidence about your protected health information. This means that you may request that we send you information by alternative means, or to an alternate location. We must accommodate your request if: it is reasonable, specifies the alternative means or alternate location, and specifies how payment issues (premiums and claims) will be handled. You may request a Confidential Communication by writing to us using the information listed at the end of this notice.

Amendment: You have the right to request that we amend your protected health information. Your request must be in writing and it must explain why the information should be amended. We may deny your request if we did not create the information you want amended or for certain other reasons. If we deny your request, we will provide you with a written explanation. You may respond with a statement of disagreement to be appended to the information you wanted amended. If we accept your request to amend the information, we will make reasonable efforts to inform others, including people you name, of the amendment and to include the changes in any future disclosures of that information.

Electronic Notice: Even if you agree to receive this notice on our web site, or by electronic mail (e-mail), you are entitled to receive a paper copy as well. Please contact us using the information listed at the end of this notice to obtain this notice in written form. If the e-mail transmission has failed, and we are aware of the failure, then we will provide a paper copy of this notice to you.

Questions and Complaints

Information on Fairfax County Government's Health Plan's Privacy Practices: If you want more information about our privacy practices or have questions or concerns, you may call the member service number on the back of your insurance card or you may contact us at the address below.

Filing a Complaint: If you are concerned that we may have violated your privacy rights, or you disagree with a decision we made about your individual rights, you may use the contact information at the end of this notice to complain to us. You may also submit a written complaint to the U.S. Department of Health and Human Services (DHHS) at the address below.

We support your right to protect the privacy of your protected health and financial information. We will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services

Contact Information

HIPAA Contact

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

Fairfax County HIPAA Compliance Manager

Fairfax County Government Center
12000 Government Center Parkway, Suite 552
Fairfax, VA 22035
703-324-4136 — TTY 703-968-0217
www.fairfaxcounty.gov/hipaa/privacy_office_officer.asp

Region III, Office for Civil Rights

U.S. Department of Health and Human Services
150 S. Independence Mall West, Suite 372
Public Leger Building
Philadelphia, PA 19106-9111
215-861-4441 — Hotline 800-368-1019
FAX: 215-861-4431 — TDD 215-861-4440

General COBRA Notice

CONTINUATION COVERAGE RIGHTS UNDER COBRA

Introduction

You are receiving this notice because you have recently become covered under the Fairfax County Employee's health and/or dental plan (the Plan). This notice contains important information about your rights to COBRA continuation coverage, which is a temporary extension of coverage under the Plan. This notice generally explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect the right to receive it.

The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage can become available to you when you would otherwise lose your group health coverage. It can also become available to other members of your family who are covered under the Plan when they would otherwise lose their group health coverage. This notice gives only a summary of your COBRA continuation rights. For additional information about your rights and obligations under the Plan and under federal law, you should either review the Plan's Summary Plan Description or contact the Plan Administrator.

The Plan Administrator is:

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

The Plan Administrator is responsible for administering COBRA continuation coverage.

What is COBRA Continuation Coverage?

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

If you are an employee, you will become a qualified beneficiary if you lose your coverage under the Plan because either one of the following qualifying events happens:

- Your hours of employment are reduced, or
- Your employment ends for any reason other than your gross misconduct.

If you are the spouse of an employee, you will become a qualified beneficiary if you lose your coverage under the Plan because any of the following qualifying events happens:

- Your spouse dies;

- Your spouse's hours of employment are reduced;
- Your spouse's employment ends for any reason other than his or her gross misconduct;
- Your spouse becomes entitled to Medicare benefits (under Part A, Part B, or both); or
- You become divorced or legally separated from your spouse.

Your dependent children will become qualified beneficiaries if they lose coverage under the Plan because any of the following qualifying events happens:

- The parent-employee dies;
- The parent-employee's hours of employment are reduced;
- The parent-employee's employment ends for any reason other than his or her gross misconduct;
- The parent-employee becomes entitled to Medicare benefits (Part A, Part B, or both);
- The parents become divorced or legally separated; or
- The child stops being eligible for coverage under the plan as a "dependent child."

When is COBRA Coverage Available?

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

You Must Give Notice of Some Qualifying Events

For the other qualifying events (divorce or legal separation of the employee and spouse or a dependent child's losing eligibility for coverage as a dependent child), you must notify the Plan Administrator within 60 days after the qualifying event occurs. You must provide this notice to: COBRA Administrator, Benefits Division, Department of Human Resources, 12000 Government Center Parkway, Suite 270, Fairfax, VA 22035. If the qualifying event is a divorce, a copy of the first and last page of the divorce decree (showing the parties involved and the effective date of the divorce) must be attached. For legal separations, a notarized separation agreement signed by both parties must be attached. If a child is losing their status as a dependent before age 26, documentation of new group coverage through employer group must be attached.

How is COBRA Coverage Provided?

Once the Plan Administrator receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. Covered employees may elect COBRA continuation coverage on behalf of their spouses, and parents may elect COBRA continuation coverage on behalf of their children.

COBRA continuation coverage is a temporary continuation of coverage. When the qualifying event is the death of the employee, the employee's becoming entitled to Medicare benefits (under Part A, Part B, or both), your divorce or legal separation, or a dependent child's losing eligibility as a dependent child, COBRA continuation coverage lasts for up to a total of 36 months. When the qualifying event is the end of employment or reduction of an employee's hours of employment, and the employee became entitled to Medicare benefits less than 18 months before the qualifying event, COBRA continuation coverage for qualified beneficiaries other than the employee lasts until 36 months after the date of Medicare entitlement. For example, if a covered employee becomes entitled to Medicare 8 months before the date on which his employment terminates, COBRA continuation coverage for his spouse and children can last up to 36 months after the date of Medicare entitlement, which is equal to 28 months after the date of the qualifying event (36 months minus 8 months). Otherwise, when the qualifying event

is the end of employment or reduction of the employee's hours of employment, COBRA continuation coverage generally lasts for only up to a total of 18 months. There are two ways in which this 18-month period of COBRA continuation coverage can be extended.

Disability Extension of 18-Month Period of Continuation Coverage

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

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

A copy of the Social Security Administration's disability determination letter must be attached.

Second Qualifying Event Extension of 18-Month Period of Continuation Coverage

If your family experiences another qualifying event while receiving 18 months of COBRA continuation coverage, the spouse and dependent children in your family can get up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months, if notice of the second qualifying event is properly given to the Plan. This extension may be available to the spouse and dependent children receiving continuation coverage if the employee or former employee dies, becomes entitled to Medicare benefits (under Part A, Part B, or both), or gets divorced or legally separated, or if the dependent child stops being eligible under the Plan as a dependent child, but only if the event would have caused the spouse or dependent child to lose coverage under the Plan had the first qualifying event not occurred. In all of these cases, you must notify the Plan Administrator of the second qualifying events within 60 days of the second qualifying event. This notice must be sent to:

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

If the qualifying event is a divorce, a copy of the first and last page of the divorce decree (showing the parties involved and the effective date of the divorce) must be attached. For legal separations, a notarized separation agreement signed by both parties must be attached. If a child is losing his or her status as a dependent before age 26, documentation of new group coverage through employer group must be attached. If the former employee has enrolled in Medicare, a copy of the former employee's Medicare card must be attached.

If You Have Questions

Questions concerning your Plan or your COBRA continuation coverage rights should be addressed to:

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

You may also contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA). Address and phone numbers of Regional and District EBSA Offices are available through the EBSA website: www.dol.gov/ebsa.

Keep Your Plan Informed of Address Changes

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

Plan Contact Information

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

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, 2012 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.

For 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.

For 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).

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

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.

Notice of Opportunity to Enroll – Extension of Dependent Coverage to Age 26

Individuals whose coverage ended, or who were denied coverage (or were not eligible for coverage), because the availability of dependent coverage of children ended before attainment of age 26 are eligible to enroll in the Fairfax County Government Health Plan. Individuals may request enrollment for such children for 30 days from the date of notice. Enrollment will be effective retroactively to January 1, 2011. For more information contact the plan administrator:

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

Notice Lifetime Maximum No Longer Applies and Enrollment Opportunity

The lifetime maximum on the dollar value of benefits under the Fairfax County Government Health Plan no longer applies. Individuals whose coverage ended by reason of reaching a lifetime limit maximum the plan are eligible to enroll in the plan. Individuals have 30 days from the date of this notice to request enrollment. For more information contact the plan administrator:

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

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 health care professional in our network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals. For a list of participating health care professionals who specialize in obstetrics or gynecology, contact the plan administrator:

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

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.

Medicaid and the Children's Health Insurance Program (CHIP) Offer Free or Low-Cost Health Coverage to Children and Families

If you are eligible for health coverage from your employer, but are unable to afford the premiums, some states have premium assistance programs that can help pay for coverage. These states use funds from their Medicaid or CHIP programs to help people who are eligible for employer-sponsored health coverage, but need assistance in paying their health premiums.

If you or your dependents are already enrolled in Medicaid or CHIP and you live in a state listed at the web address 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 by dialing **1-877-KIDS NOW** or visit them online at 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, your employer's health plan is required to permit you and your dependents to enroll in the plan – as long as you

and your dependents are eligible, but not already enrolled in the employer's plan. This is called a "special enrollment" opportunity, and **you must request coverage within 60 days of being determined eligible for premium assistance.**

If you live in one of the following states, identified on the U.S. Department of Health and Human Services Centers for Medicare & Medicaid Services website www.cms.hhs.gov, you may be eligible for assistance paying for your employer health plan premiums. You should contact your state for further information on eligibility.

Notice About the Early Retiree Reinsurance Program

You are a plan participant, or are being offered the opportunity to enroll as a plan participant, in an employment-based health plan that is certified for participation in the Early Retiree Reinsurance Program. The Early Retiree Reinsurance Program is a Federal program that was established under the Affordable Care Act. Under the Early Retiree Reinsurance Program, the Federal government reimburses a plan sponsor of an employment-based health plan for some of the costs of healthcare benefits paid on behalf of, or by, early retirees and certain family members of retirees participating in the employment-based plan. By law, the program expires on January 1, 2014.

Under the Early Retiree Reinsurance Program, your plan sponsor *may choose* to use any reimbursements it receives from this program to reduce or offset increases in plan participants' premium contributions, co-payments, deductibles, co-insurance, or other out-of-pocket costs. If the plan sponsor *chooses* to use the Early Retiree Reinsurance Program reimbursements in this way, you, as a plan participant, may experience changes that may be advantageous to you, in your health plan coverage terms and conditions, for so long as the reimbursements under this program are available and this plan sponsor chooses to use the reimbursements for this purpose. A plan sponsor may also use the Early Retiree Reinsurance Program reimbursements to reduce or offset increases in its own costs for maintaining your health benefits coverage, which may increase the likelihood that it will continue to offer health benefits coverage to its retiree and employees and their families.

If you have received this notice by e-mail, you are responsible for providing a copy of this notice to your family members who are participants in this plan.

Benefit Plan 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
Flexible Spending Accounts	FBMC	800-342-8017	www.myfbmc.com
Group Term Life Insurance	Minnesota Life*	HR Central: 703-324-3311	See county contacts below
Long Term Care	Prudential	800-732-0416	www.prudential.com/gtlcweb
Long Term Disability	CIGNA Group Insurance*	HR Central: 703-324-3311	See county contacts below
Medical Plans			
<ul style="list-style-type: none"> • OAP – High and OAP – Low 	CIGNA HealthCare	800-244-6224	www.mycigna.com
<ul style="list-style-type: none"> • POS 	CareFirst BlueCross/BlueShield	800-628-8549	www.carefirst.com/myaccount
<ul style="list-style-type: none"> • HMO 	Kaiser Permanente	301-468-6000	www.kaiserpermanente.org
Vision	Davis Vision	800-208-2112	www.davisvision.com

*At the time this guide was printed, Group Term Life and Long Term Disability were undergoing a vendor and plan design reevaluation process as part of the county’s regularly scheduled procurement process. Information on new vendors or design changes, if applicable, will be announced in early 2012. For information on these programs, please contact HR Central at 703-324-3311 (TTY 703-222-7314).

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/>

Acknowledgement

The county would like to acknowledge and thank our plan vendors for their contributions to the 2012 employee benefits communications campaign.

