Fairfax County Government

Your Retiree Benefits, Medicare & More

Empower, Educate, Engage

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Cigna 90% and 80% Co-Insurance Plans

Retirees Eligible for Medicare

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

Are You New to Medicare?

- Participants enrolled in one of the Cigna managed Co-Insurance Plans, who become newly eligible for Medicare, whether due to age or disability, will transition to the Cigna RX PDP Plan. This is Fairfax County Government's Group Part D Pharmacy Plan. A separate card will be issued for the Medicare participant and can be used to access pharmacy benefits.
- The new Medicare participant, retiree or dependent, may be required to meet a pharmacy deductible in the new plan. Medical and RX deductibles re-set.
- After Medicare eligibility, the participant must create a new online ID on MyCigna.com
- Any non-Medicare eligible dependents will remain on Cigna's Medical and RX Plans and will be issued their own subscriber number(s) for accessing care.

Special guidelines apply when retirees enroll in two-party or family plans where one (or more) individual is eligible for Medicare and others under the same plan are not. The individual eligible for Medicare will be given their own record in the Cigna system and will be required to meet their own deductible. Any participant enrolled under the same plan (whether it is the retiree or covered dependent) who is not eligible for Medicare will also be required to meet a separate deductible. Fairfax County Government has adjusted the applicable premium to offset any cost burden on these families.

Cigna Open Access Plus (OAP) 90% and 80% Co-Insurance Plans

Both of the Cigna managed Co-Insurance Plans offer in- and out-of-network coverage and access to the Open Access Plus (OAP) Network. No referrals or PCP selection is required and preventive services are covered at 100%. All other covered medical services are subject to a deductible. (A deductible is the amount you pay each year for most eligible medical services before your health plan begins to share in the cost.) After satisfying the deductible, participants are responsible for a co-insurance, or a percentage of the bill. Participants in the 90% Co-Insurance Plan would be responsible for 10% of the negotiated rate for services they receive in-network. A medical service, from an in-network provider, with a negotiated rate of $100 would have a co-insurance of 10%, or $10 owed by you.

For a lower premium, and slightly higher deductible, the 80% Co-Insurance Plan is available. After meeting an annual deductible, participants are responsible for a 20% co-insurance for in-network services. A medical service, from an in-network provider, with a negotiated rate of $100 would have a co-insurance of 20%, or $20 owed by you.

In both plans, participants continue to pay co-insurances until they reach the out-of-pocket maximum. A Pharmacy Plan with separate deductible is included.

Couples or families, made-up of a combination of participants who are Medicare eligible and those who are not, may enroll in the Co-Insurance Plans. Participants who are not eligible for Medicare may enroll in one of the Co-Insurance Plans while their Medicare eligible family member may enroll in one of the Cigna managed 90% or 80% Co-Insurance Plans as secondary coverage or the new Cigna True Choice Core Medicare Advantage Plan.

The Co-Insurance plans are also open to couples or families made-up of all Medicare eligible participants.

Co-Insurance Plans and Coordination with Medicare

If you have coverage in one of the county's Co-Insurance plans and Medicare, Medicare becomes the primary payer of claims. The Fairfax County Government (FCG) health plan becomes the secondary "payer."

When there is more than one potential payer, there are coordination of benefits rules to decide who pays first. The first or "primary payer" pays what it owes on your bills first and then sends the rest to the second or "secondary payer." In some cases, there may also be a third payer.

Medicare's primary payment does offset costs of some services, but does not eliminate all out-of-pocket costs to the participant. You will always be responsible for your co-insurances and deductibles. If Cigna's normal liability is equal to or less than Medicare's payment, Cigna does not make an additional payment as the secondary payer.

Whether Medicare pays first depends on a number of considerations, including those listed below. However, please keep in mind that these descriptions do not cover every situation.

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

Cigna RX PDP Plan for Medicare Eligible Participants

Medicare eligible participants enrolled in the Cigna 90% or 80% Co-Insurance plans will be enrolled in the Cigna RX PDP Plan, the Group Part D Prescription Drug Plan (formerly known as HealthSpring). Participants not eligible for Medicare will remain under the traditional pharmacy plan.

Medicare Advantage Plans

Retirees Eligible for Medicare

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

What is a Medicare Advantage Plan?

Medicare Advantage Plans are types of Medicare health plans offered by a private company that contracts with Medicare to provide all your Part A and Part B benefits. These types of plans are often referred to as Medicare Part C Plans. If you're enrolled in a Medicare Advantage Plan, most Medicare services are covered through the plan. Your Medicare services aren't paid for by Original Medicare.

Medicare Advantage Plans do not replace Medicare and are not a supplement. A Medicare Advantage plan works differently than a Medicare supplemental plan or Medi-gap Plan.

Know the As, Bs, Cs and Ds of Medicare

Part A	Part B	Part C (A+B)	Part D
Hospital Insurance	Medical Insurance	Medicare Advantage	Prescription Drug
Hospital stays Skilled nursing facility stays Home health care Hospice care	Doctor's services Outpatient care Diagnostic tests Preventive services Laboratory services Durable medical equipment	Combines Parts A & B Commonly includes supplemental benefits like hearing, vision, and dental May or may not include prescription coverage	Help lower prescription drug costs All plans must offer at least a standard coverage set by Medicare

What is a PPO?

PPO stands for "preferred provider organization". A PPO is a type of health plan that contracts with medical providers, such as hospitals and doctors, to create a network of participating providers. You pay less if you use providers that belong to the plan's network. The Cigna True Choice Core Medicare Advantage Plan and the United Healthcare Group Medicare Advantage Plan are both PPOs.

What is an HMO?

A Health Maintenance Organization, or HMO, is a plan type that limits participants to consulting with only in-network doctors. Typically participants in this plan must select a primary care physician and need referrals to seek care from specialists in the network. The Kaiser Medicare Advantage Plan is an HMO.

New Medicare Advantage Plans are Fully Insured Medical Plans

A fully-insured medical plan is a traditional plan structure where the employer, or group, pays a commercial insurer to provide coverage for its members. In this type of plan, premiums and provisions of the plan are dictated by the insurer and approved by the Center for Medicare and Medicaid Services (CMS). Unlike the current plans managed by Cigna, which are self-insured, the plan rules for our new Medicare Advantage Plans are dictated by Medicare and the carrier. There is no process of appeal through Fairfax County Government to overturn decisions or to request coverage for denied expenses.

Medicare Part D Plan Enrollment

As you explore all of the options available to you, it is important to note that Centers for Medicare Services does not allow individuals to be enrolled in more than one Part D Drug Plan at a time. The Medicare Advantage Plans, and the Cigna managed Co-Insurance Plans offered by Fairfax County Government to Medicare eligible retirees, include a Part D prescription plan. The Co-Insurance Plans, the Cigna True Choice Core Medicare Advantage Plan and the United Healthcare Group Medicare Advantage Plan all include the Cigna RX PDP Plan, Fairfax County Government's Group Part D Prescription Plan (formerly known as HealthSpring). The Kaiser Permanente plan offered to Medicare eligible retirees is a Medicare Advantage plan and also has a Part D prescription plan included.

When a Medicare eligible retiree enrolls in an outside Part D prescription plan or other Medicare plan that includes Part D coverage, Fairfax County Government receives a notification from CMS of their double enrollment. This notification requires Fairfax County to terminate the retiree's coverage effective the first of the following month. The retiree loses their county-sponsored medical plan with no option to re-enroll and will no longer receive their subsidy.

If you are currently, or soon to be, enrolled in Medicare and enrolled in a Fairfax County Government medical plan and if you enroll in any other plan that offers Part D coverage, your county medical plan will be cancelled. It is important to remember, as a retiree, once any county coverage is cancelled, coverage is cancelled permanently. There is no option to re-enroll in the future.

Physical Address Required

CMS requires a physical address for anyone enrolled in Medicare and in a Group Medicare Advantage, or Group Part D Prescription Drug Plan. The Benefits Division can maintain your desired P.O. Box for mailings but will need a physical address on file to ensure compliance with Medicare. Always ensure you keep your address up-to-date with both the Retirement Systems and the Benefits Division in the Department of Human Resources. Failure to inform us of your move could impact your coverage.

Retro-Active Enrollment in Medicare and Medicare Advantage Plans

The Centers for Medicare Services (CMS) does not permit retroactive enrollment under any circumstance. This regulation is strictly adhered to and no exceptions are granted. So what does this mean for you:

If you or a dependent become Medicare eligible and wish to enroll in one of the offered Medicare Advantage Plans, proof of Medicare enrollment and the required Retiree Change Form must be submitted to the Benefits Division prior to the first of the month you are eligible for Medicare. Requests and documentation received past the first of the month could leave you without coverage.

Note: If you lose any of the offered coverages, for any reason, there is no opportunity to re-elect that coverage at a later date and any break in medical coverage with FCG will mean loss of your Retiree Subsidy.

Two-Party and Family Plans

Special guidelines apply when retirees and their families enroll in plans where one or more individuals are eligible for Medicare and others are not.

Families composed of a blend of both Medicare eligible and non-Medicare eligible participants can enroll in the 90% and 80% Co-Insurance Plans with the Cigna True Choice Core Medicare Advantage Plan or the Kaiser Permanente HMO with the Kaiser Permanente Medicare Advantage Plan.

When a family has a blend of Medicare eligible participants and non-Medicare eligible participants, those enrolled in Medicare can elect the Cigna True Choice Core Medicare Advantage Plan. The other members of the family who are not eligible for Medicare would be enrolled in either the 90% or 80% Co-Insurance Plans.

The United Healthcare Group Medicare Advantage Plan (PPO) is only open to enrollment for Medicare eligible retirees as individuals or in the Two-Party and Family tiers when all members are enrolled in Medicare.

Example: Maria, who is under 65 and not eligible for Medicare, is a Fairfax County Government retiree currently enrolled in the Cigna 80% Co-Insurance Plan. Maria is enrolled in the Two-Party tier and is covering her spouse Walter. Walter is also a Fairfax County retiree and Medicare eligible. Walter is interested in enrolling in one of the new Medicare Advantage Plans. Maria and Walter have the following options:

- Maria and Walter maintain their Two-Party coverage, 1 with Medicare and 1 without, in the Cigna managed 80% Co-Insurance Plan. For Maria, Cigna remains the primary payer for medical services and her enrollment in the traditional pharmacy plan continues. For Walter, Cigna becomes the secondary payer (Medicare is the primary payer) and he enrolled in the Cigna RX PDP Plan, Fairfax County Government's Group Part D Prescriptions Plan for Medicare eligible participants.
- Maria and Walter maintain their Two-Party coverage but split their plan enrollment in the Cigna plans. Maria maintains her enrollment in the Cigna managed 80% Plan and completes the Retiree Open Enrollment Form enrolling Walter in the Cigna True Choice Core Medicare Advantage Plan. Maria cannot enroll in the Cigna True Choice Core Medicare Advantage Plan because she is not Medicare eligible.

- Maria maintains her coverage in the Cigna managed 80% Co-Insurance Plan, but Walter wants to enroll in the United Healthcare Group Medicare Advantage Plan. The United Healthcare Plan is only available to participants who are Medicare eligible and cannot be combined with any other plan. Because he is an eligible retiree, who has had continuous coverage under a Fairfax County Government medical plan, Walter can choose to enroll in the United Healthcare Plan as an individual. Both Maria and Walter complete their Retiree Open Enrollment Forms and return them to the Benefits Division before the deadline. Covered Dependents, who are not eligible Fairfax County Retirees on their own, would not have this option. In that case, the Medicare eligible family member would not have the option of enrolling in the new United Healthcare Medicare Advantage Plan.

- During Open Enrollment for Plan Year 2022, Walter decides to re-enroll in the Cigna managed 80% Co-Insurance Plan with Maria again. Both Maria and Walter complete their Retiree Open Enrollment Forms and return them to the Benefits Division before the deadline.

Qualifying Events

Qualifying Events are special circumstances, like changes in your family status or a change in a dependents eligibility, that allow you the opportunity to change benefit elections during the plan year. The change requested must be on account of, and consistent with, the qualifying event, and must be requested **within 30 days** of the qualifying event.

To change your benefits due to a qualifying event, you must contact the Benefits Division and complete the required Retiree Change Form. It is important to note for Retirees who are eligible for Medicare and are enrolled in one of the offered Medicare Advantage Plans, that no retro-active changes are permitted.

- Example #1: Fred, a Fairfax County Government retiree enrolled in the Cigna True Choice Core Medicare Advantage Plan, gets married on October 30th. Fred contacts the Benefits Division on the following Monday, November 2nd. His new spouse cannot be added to Fred's current plan until December 1st, the first of the month following his request to enroll his new spouse as a result of a qualifying event.

- Example #2: Jane is a Medicare eligible Fairfax County Government retiree enrolled in the United Healthcare Group Medicare Advantage Plan. Jane's spouse, Ricardo is retiring from his employer in June. Ricardo is not Medicare eligible. Ricardo's retirement and loss of coverage is a qualifying event. As a result, Jane can add Ricardo to her medical plan the first of the month following his event, provided Jane contacts the Benefits Division within 30 calendar days and provides verifying documentation. Because Ricardo is not Medicare eligible, he cannot be enrolled in a Medicare Advantage Plan. Jane can complete the Retiree Benefits Change Form enrolling in one of the Cigna managed plans (Cigna True Choice Core Medicare Advantage Plan, 90% or 80% Co-Insurance Plans) or the Kaiser Permanente Plans.

	CIGNA OAP 90% Co-Insurance Plan		CIGNA OAP 80% Co-Insu	
	Non-Medicare and Medicare Eligible Participants. Can be combined with Cigna Medicare Advantage Plan.		Non-Medicare and Medicare Eligi Can be combined with Cigna Medica	
	In-Network	Out-of-Network	In-Network	O
Primary Care Physician (PCP)	Plan pays 90% co-insurance after plan deductible is met	Plan pays 70% co-insurance after plan deductible is met	Plan pays 80% co-insurance after plan deductible is met	Plan pa after pl
Specialty Care	Plan pays 90% co-insurance after plan deductible is met	Plan pays 70% co-insurance after plan deductible is met	Plan pays 80% co-insurance after plan deductible is met	Plan pa after pl
Annual Deductible	$350 Individual $700 Family	$700 Individual $1,400 Family	$500 Individual $1,000 Family	$
Annual Out-of-Pocket Limit	$2,500 Individual $5,000 Family	$5,000 Individual $10,000 Family	$3,000 Individual $6,000 Family	$
Preventive Care - All Ages Routine Preventive Care, Immunizations, Mammogram, PAP, PSA Tests	Plan Pays 100%	Ages 18 and above: Plan pays70% co-insurance after deductible is met	Plan Pays 100%	Ages pays70 d
Inpatient Hospital Facility	Plan pays 90% co-insurance after plan deductible is met	Plan pays 70% co-insurance after plan deductible is met	Plan pays 80% co-insurance after plan deductible is met	Plan pa after pl
Outpatient Hospital Facility	Plan pays 90% co-insurance after plan deductible is met	Plan pays 70% co-insurance after plan deductible is met	Plan pays 80% co-insurance after plan deductible is met	Plan pa after pl
Outpatient Professional Service	Plan pays 90% co-insurance after plan deductible is met	Plan pays 70% co-insurance after plan deductible is met	Plan pays 80% co-insurance after plan deductible is met	Plan pa after pl
Chiropractic Care	Plan pays 90% co-insurance after plan deductible is met	Plan pays 70% co-insurance after plan deductible is met. Max 12 visits per year.	Plan pays 80% co-insurance after plan deductible is met	Plan pa after pl Max
Hearing Aids	Plan pays 90% co-insurance after plan deductible is met	Plan pays 90% co-insurance after plan deductible is met	Plan pays 80% co-insurance after plan deductible is met	Plan pa after pl
	Max benefit is $3,000 every 24 months	Max benefit is $3,000 every 24 months	Max benefit is $3,000 every 24 months	Max e
Emergency Room	Plan pays 90% co-insurance after plan deductible is met	Plan pays 90% co-insurance after plan deductible is met	Plan pays 80% co-insurance after plan deductible is met	Plan pa after pl
Urgent Care Facility	Plan pays 90% co-insurance after plan deductible is met	Plan pays 90% co-insurance after plan deductible is met	Plan pays 80% co-insurance after plan deductible is met	Plan pa after pl
Mental Health & Substance Abuse Treatment (In-Patient)	Plan pays 90% co-insurance after plan deductible is met	Plan pays 70% co-insurance after plan deductible is met	Plan pays 80% co-insurance after plan deductible is met	Plan pa after pl

*Participants in the Cigna True Choice Core and United Healthcare Group Medicare Advan
the same cost share as long as the provider participates in Medicare and accepts and will bill
unless it is an emergency. For more information on the Me

Cigna True Choice Core Medicare Advantage Pl
United Healthcare Group Medicare Advantage
Kaiser Permanente Medicare Advantage Plan

Cigna RX Medicare Part D Plan included in these plans.

rance Plan	Cigna True Choice Core Medicare Advantage PPO	United Healthcare Group Medicare Advantage Plan (PPO)	Kaiser Permanente HMO Medicare Advantage Plan
ble Participants. re Advantage Plan.	Medicare Eligible Participants Only. Includes Cigna RX (PDP) Plan	Medicare Eligible Participants Only. Includes Cigna RX (PDP) Plan	Medicare Eligible participants, see Kaiser Medicare Advantage Plan
ut-of-Network	In- and Out-of Network*	In- and Out-of Network*	In-Network - Local
ys 60% co-insurance lan deductible is met	$5 per visit	$5 per visit	$10 PCP co-pay No Charge for Children under 5
ys 60% co-insurance lan deductible is met	$5 per visit	$5 per visit	$10 PCP co-pay
1,000 Individual $2,000 Family	None	None	$0
6,000 Individual $12,000 Family	$1,500 each Individual covered	$1,500 each Individual covered	$3,400 per Individual
18 and above: Plan 0% co-insurance after eductible is met	Medicare Covered Preventive Care Plan pays 100%	Medicare Covered Preventive Care Plan pays 100%	No Charge
ys 60% co-insurance lan deductible is met	$0 per Admission	$0 per Admission	No Charge
ys 60% co-insurance lan deductible is met	$0	$0	No Charge
ys 60% co-insurance lan deductible is met	Outpatient Surgery $0 Non-Surgical $10 copay	$0	Covered services include telehealth visits such as video chats and telephonic visits. You pay nothing.
ys 60% co-insurance an deductible is met. 12 visits per year.	Medicare Covered $10 per visit	Medicare Covered $10 per visit	Covered services include manual manipulation of the spine to correct subluxation. You pay $10 per visit.
ys 80% co-insurance lan deductible is met benefit is $3,000 very 24 months	$2,800 maximum allowance Benefit available every 36 months	$2,800 maximum allowance Benefit available every 36 months	You pay nothing for one hearing aid for each ear, every 36 months, limited to $1,000 benefit maximum.
ys 80% co-insurance lan deductible is met	$120 per visit, waived if admitted within 24 hours (Worldwide, $50,000 maximum benefit)	$120 per visit, waived if admitted within 24 hours (Worldwide)	$50 per visit (co-pay waived if admitted other than observation)
ys 80% co-insurance lan deductible is met	$10 per visit , waived if admitted within 24 hours	$10 per visit , waived if admitted within 24 hours (Worldwide)	$10 visit
ys 60% co-insurance lan deductible is met	$0 per Admission (lifetime maximum of 190 days)	$0 per Admission	Pay Nothing per Benefit Period, for a Medicare covered stay in a network hospital, Benefit Period begins on the first day of inpatient stay and ends when patient has been discharged for 60 consecutive calendar days.

tage Plans can access doctors, specialists and hospitals in or out of our network for the plan. If your doctor is not in the network, he or she may choose not to treat you dicare Advantage Plans contact the carrier directly.

an (PPO)	(888) 281-7867
Plan (PPO)	(866) 859-5402
	(888) 777-5536

Refer to the information on the Cigna Rx PDP plan

Preferred Pharmacy – up to 60 day supply
$10 Preferred Generic
$10 Generic or Preferred Brand
$10 Non-preferred Brand or Specialty

Standard Pharmacy – up to 60 day supply
$15 Preferred Generic
$15 Generic or Preferred Brand
$15 Non-preferred Brand or Specialty

OON Pharmacy – up to 30 day supply
$7.50 Preferred Generic
$7.50 Generic or Preferred Brand
$7.50 Non-preferred Brand or Specialty

Mail Order – 90 day supply
$5 All Covered Tiers

Cigna True Choice Core Medicare Advantage Plan

With Cigna's True Choice Core Medicare Advantage PPO plan, participants have the freedom of choice with access to care, when and where they need it. The Cigna True Choice Core Medicare Advantage plan covers retirees for annual physicals and other necessary screenings, lowering the risk of associated diseases and medical conditions.

For more details, see the plan At-A-Glance for Medicare Eligible Retirees or call Cigna Customer Service at (888) 281-7867 (TTY 711). Customer Service is available 8 a.m. – 8 p.m. local time, 7 days a week.

Plan Highlights

- National PPO with the option of using in-network or out of network providers, as long as they participate in Medicare and accept the plan.
- Low co-pays, no annual deductible and a $1,500 annual out-of-pocket maximum.
- This plan includes the Cigna RX (PDP) Plan. See page 12 in this guide for additional details.
- Clinical support programs that focus on behavioral health, chronic care, heart health and more.
- 24-hour Health Information Line. Nurse Advocates are available by phone 24 hours a day, seven days a week, to answer your questions in a confidential and convenient service.
- **Participants in the Cigna True Choice Core Medicare Advantage Plan are not required to see an in-network doctor. To find out more, search our online Provider Directory at www.CignaMedicare.com/group/MAresources or call Cigna Customer Service at (888) 281-7867.**

Your Wellbeing

Cigna Medicare Advantage Rewards encourages you to take an active role in your health. Incentive based activities including completion of your annual 360 Exam and additional health screenings like: HbA1c, Diabetic Retinal Eye Exam, Mammogram and Colonoscopy Screenings.

If you're enrolled in a health plan through Cigna, you're eligible to participate in Healthy Rewards! Find health and wellbeing vendors that Cigna has partnered with to provide discounts to individuals. Healthy Rewards discount programs include: hearing aids and exams, nutrition experts, fitness club memberships, home delivered meals, and more.

Participants in the Cigna True Choice Core Medicare Advantage Plan are not eligible to earn Motivate*Me* Rewards.

Additional Benefits

- Telehealth services that let you talk with a doctor by phone or video for non-emergency care. Available 24/7/365 – even on weekends and holidays – from wherever you are.
- Silver&Fit Fitness program is a $0 member cost share program at a national network of fitness facilities, including YMCA, 24 Hour Fitness and Curves. One-on-One Silver&Fit Healthy Aging Coaching, home fitness kits are also included.
- Home Delivered Meals Program that helps make your transition back home more comfortable after an inpatient hospital or skilled nursing facility stay.

The United Healthcare Group Medicare Advantage plan offers a way to help members to connect to the care they need. Plan benefits and features include help finding a doctor, getting a ride to appointments, or talking to a nurse 24/7.

For more details, see the plan At-A-Glance for Medicare Eligible Retirees or call United Healthcare Customer Service at (866) 859-5402. Customer Service is available 8 a.m. – 8 p.m. local time, 7 days a week.

Plan Highlights

- National PPO with coverage for visiting doctors, clinics, and hospitals. No referrals needed to see specialist
- Low co-pays, no annual deductible and a $1,500 annual out-of-pocket maximum.
- This plan includes the Cigna RX (PDP) Plan. See page 12 in this guide for additional details.
- With Virtual Visits, you're able to live video chat with a doctor or behavioral health specialist from your computer, tablet or smartphone anytime, day or night.
- This plan lets you visit doctors, specialists and hospitals in or out of our network for the same cost share, as long as the provider participates in Medicare and accepts the plan.
- **Even though you are not required to see a network doctor, your doctor may already be part of our network. To find out, search our online Provider Directory at www.UHCRetiree.com/fairfax or call United Healthcare Customer Service at (866) 859-5402.**

Your Wellbeing

Renew by United Healthcare is a health and wellness experience that helps empower you to take charge of your wellbeing every day. It provides a wide variety of useful resources and activities, including brain games, healthy recipes, learning courses, fitness activities and more. Plus, you may be eligible to earn rewards by completing certain health care activities such as your annual physical or wellness visit.

The United Healthcare Group Medicare Advantage Plan offers SilverSneakers. Participants in this wellbeing program have access to over 17,000 fitness centers, on-demand fitness videos, healthy living discounts, and a fitness app designed for seniors.

Participants in the United Healthcare Group Medicare Advantage Plan are not eligible to earn Motivate*Me* Rewards.

Additional Benefits

- With United Healthcare HouseCalls, participants receive yearly check-ups at home to help stay up-to-date on thier health between regular doctor's visits at no extra cost.
- With United Healthcare Hearing, you can receive a hearing exam and have access to a wide selection of name-brand and private-labeled custom-programmed hearing aids at significant savings.
- A post-discharge meal delivery program provides freshly-made meals to your home after you have been discharged from the hospital or skilled nursing facility, at no additional cost.

Cigna RX Medicare (PDP) Plan

Understanding your Medicare Part D plan

The Cigna RX (PDP) Plan is the new name for Fairfax County Government's Group Part D Prescription Plan, formerly known as HealthSpring. This is the pharmacy plan included with the Cigna True Choice Core Medicare Advantage Plan, United Healthcare Group Medicare Advantage Plan, and the Cigna managed 90% and 80% Co-Insurance Plans for Medicare eligible participants.

A few important things to know about the Cigna RX (PDP) Plan:

- Medicare defines the types of drugs included in Part D plans based on the medical and pharmacy needs of seniors.
- Some drugs and other items may not be covered by your Medicare plan – cosmetics, over the counter medications, vitamins, erectile dysfunction, and cough and cold drugs.
- Some drugs and supplies are covered by Medicare Part B, not your Part D plan. Medicare requires certain medications and durable medical equipment (such as diabetic test strips, lancets, and wheelchairs) be covered under Medicare Part B. Even if you buy these items at a pharmacy, they may not be covered by your pharmacy plan.
- Your Rx plan uses a drug list with four cost-sharing tiers, or coverage levels.
  - **Tier 1** Preferred Generic Drugs
  - **Tier 2** Preferred Brand Drugs
  - **Tier 3** Non-Preferred Generic & Brand Drugs
  - **Tier 4** Specialty Drugs Generic & Brand (limited to 30 day supply)
- If you are unsure how your drug will be covered, call Cigna Customer Service and speak to a representative at (800) 835-3784.
- Centers for Medicare Services (CMS) does not allow individuals to be enrolled in more than one Part D Drug Plan at a time. If you or your Medicare eligible covered dependent enroll in an outside Part D Prescription Plan, your enrollment in both Fairfax County Government's pharmacy and medical plan will be canceled with no option of future enrollment.

Cigna RX (PDP) Plan		
	Retail (30-day supply)	Home Delivery (90-day supply)
Deductible	$75	$75
Out-of-Pocket Maximum	$2,000	$2,000
Generic Drugs	You pay $7	You pay $14
Preferred brand drugs	You pay 20% ($50 max)	You pay 20% ($100 max)
Non-preferred brand drugs	You pay 30% ($100 max)	You pay 30% ($200 max)
Specialty drugs - limited to 30 day supply	You pay 30% ($100 max) per prescription	Not available – Specialty drugs only available up to 30-day supply
What you pay in the coverage gap	Once you reach $4,130 in total drug costs you move into the Coverage Gap stage. **You will pay the same copays as your Initial Coverage or same as standard Part D.**	
Catastrophic coverage	Once you reach the $6,550 true out-of-pocket limit, you will pay the lesser of Standard Part D catastrophic or gap coverage. (Standard Part D catastrophic is greater of 5% coinsurance or $3.70 for generic drugs or $9.20 for brand drugs for the remainder of the year). **You will pay the same copays as your Initial Coverage or same as standard Part D.**	

For all participants, this plan is a local medical center based HMO or Health Maintenance Organization for the Mid-Atlantic region. Participants pay co-pays for in-network services at Kaiser facilities only. From medical care to specialty treatment and wellness programs, most participant services are handled at one location. You don't even have to stop at the pharmacy on the way home. There is one on-site. With Kaiser, there are no out-of-network services allowed. PCP designation and referrals are required.

This plan is eligible for families that are made-up of participants who are eligible for Medicare and those who are not. Participants eligible for Medicare are enrolled in Kaiser's Medicare Advantage Plan, participants who are not eligible for Medicare remain enrolled in Kaiser's traditional HMO. Note: Kaiser Medicare Advantage Plan does not include all of their facilities. Check your zip code before you enroll.

Plan Highlights

- Includes 24 one-way rides for nonemergency medical appointments at Kaiser Permanente medical centers and contracted facilities at no cost.
- You pay $0 for Silver&Fit®. This includes a no-cost membership at a participating fitness facility near you and the opportunity to select up to 3 home fitness kits.
- You have flexible options to get care beyond the doctor's office — and you can manage your care anytime with the Kaiser Permanente app or at kp.org.

Kaiser Permanente's Member Services can be contacted at (888) 777-5536, TTY 711 or by visiting Kaiser Permanente online at kp.org.

Service Area Expansion in Virginia: Stafford, Spotsylvania, and Fredericksburg City

- Starting on January 1, 2021, the Medicare Advantage service area will include Stafford and Spotsylvania counties and Fredericksburg City in Virginia.
- We will also be adding zip codes to Charles and Frederick counties in Maryland to close some gaps in our service area. We cover these zips already in the adjoining county.
- Charles County: 20607, 20613, 20645
- Frederick County: 20842, 20871, 21757, 21776, 21787, 21791
- Enrollment in these areas is for effective dates on and after 1/1/2021

Important Coverage Information

Retirees Eligible for Medicare

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

It is recommended that participants apply for Medicare at the earliest opportunity, 90 days before their eligible birth month or qualified disability date, to ensure thier coverage is in effect on time.

Continuous Coverage Requirement

The County requires retirees to maintain continuous coverage in Fairfax County Government (FCG) Life, Health and/or Dental plans. After retirement, if you lose any of these coverages, for any reason, there is no opportunity to re-elect that coverage at a later date. Also note that any break in medical coverage with FCG will mean loss of your Retiree Subsidy.

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

Changing Coverage

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

Coverage for Surviving Spouses

Surviving spouses of deceased retirees may continue health and/or dental insurance coverage until they remarry.

Surviving Spouses are contacted by the Benefits Division upon notification of the retiree's death. To maintain enrollment in the benefits, Surviving Spouses must complete an election form and review payment options within 30 calendar days of the retiree's death.

Due to Medicare's rules regarding retroactive enrollment, Surviving Spouses who are Medicare eligible will need to complete all required paperwork and submit it to the Benefits Division before the last day of the month during which the retiree died. If no action is taken, coverage for a Surviving Spouse will end on the last day of the month in which the retiree died.

If a retiree or dependent with coverage dies or remarries, please contact the Benefits Division as soon as possible so that premiums can be adjusted.

Adult Dependents, Children over 18

Children can stay on your health plans through the end of the month they turn 26, even if they marry, move out of your home, go to school or get a job. When your dependent turns 26 and is no longer eligible, they will receive a COBRA Notice allowing them the option to continue coverage. This process requires no notification from you; however, dependents will not be automatically removed from Dependent Life Insurance. Also, note that our plans do not cover spouses or dependents of adult children.

Dependents over the age of 18 who are removed from a benefit plan cannot be re-enrolled mid-year as a result of their own qualifying event, i.e. losing coverage through their employer. Qualifying events are special circumstances in employment, benefit eligibility or status for employees and their spouses only. Children over the age of 18 can be added during Open Enrollment, providing they meet all other eligibility criteria.

Health Insurance Orders

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

Address Changes

When moving, remember to update your address with the Benefits Division. The address maintained by us is reported to all benefit vendors. To update your address, you must complete the appropriate form and return it to the Benefits Division.

Note: A change in address could impact coverage for participants in our Kaiser Permanente HMO and Kaiser Medicare Advantage Plan.

Paying Your Premium

The retiree portion of the benefit premium is paid in one of two ways: 1. The premium, less the subsidy, will be deducted from the monthly annuity in the month prior to the month of coverage; 2. If the individual does not receive an annuity, or if the retiree's check does not cover the full cost of the monthly premium, the retiree must pay the amount by automatic deduction, ACH, from your personal checking account. The Benefits Division takes this deduction on the 3rd of the month for that month's coverage. Personal checks and lump sum payments will **not** be accepted.

Sharing Healthcare Information

The Benefits Division cannot share personal healthcare information or enrollment details with anyone other than the retiree. To protect the privacy of our retirees, spouses, dependents, family members and other parties, the Benefits Division will not provide details regarding benefit enrollment or healthcare to any third party.

A retiree must provide permission in advance, before any details can be shared with a family member and any changes requested by someone other than the retiree, will only be granted after review, and approval of, a legal Power or Attorney or other legal document submitted to the Benefits Division. Privacy guidelines apply in all circumstances, even if both participants are current or former county employees.

End-Stage Renal Disease (ESRD)

ESRD is a medical condition in which a person's kidneys cease functioning on a permanent basis. Plan participants may become entitled to Medicare due to ESRD but Medicare will be the secondary payer to our group health plans for a coordination period of 30 months. As a result, any participant with ESRD who becomes Medicare eligible is prohibited from enrolling in one of the three offered Medicare Advantage Plans and will be automatically enrolled in the Cigna managed 80% Co-Insurance Plan.

2021 Medical and Dental Premiums

Benefit Plan Options	Total Monthly Premium (without subsidy) for Medical, RX, and Vision combined
Cigna OAP 90% Co-Insurance Plan - Non-Medicare and Medicare Participants	
Individual	$761.10
Individual with Medicare	$532.63
2 Individuals	$1,495.44
2 Individuals - 1 with Medicare, 1 without	$1,292.31
2 Individuals - 1 with True Choice Core Medicare Advantage Plan, 1 without	$1,152.72
2 Individuals with Medicare	$1,064.81
Family	$2,199.58
Family - 1 with Medicare	$2,053.00
Family - 1 with True Choice Core Medicare Advantage Plan (PPO)	$1,838.39
Family - 2 with Medicare	$1,904.21
Family - 2 with True Choice Core Medicare Advantage Plan (PPO)	$1,545.76
Family - 3 with Medicare	$1,755.43
Cigna OAP 80% Co-Insurance Plan - Non-Medicare and Medicare Participants	
Individual	$564.09
Individual with Medicare	$391.02
2 Individuals	$1,099.69
2 Individuals - 1 with Medicare, 1 without	$951.48
2 Individuals - 1 with True Choice Core Medicare Advantage Plan, 1 without	$955.71
2 Individuals with Medicare	$773.12
Family	$1,641.28
Family - 1 with Medicare	$1,534.92
Family - 1 with True Choice Core Medicare Advantage Plan (PPO)	$1,464.06
Family - 2 with Medicare	$1,413.80
Family - 2 with True Choice Core Medicare Advantage Plan (PPO)	$1,348.75
Family - 3 with Medicare	$1,292.68
Kaiser Permanente HMO Plans - Non-Medicare and Medicare Participants	
Individual	$668.65
Individual with Medicare	$306.87
2 Individuals	$1,303.00
2 Individuals - 1 with Medicare, 1 without	$974.10
2 Individuals with Medicare	$612.32
Family	$1,938.67
Family - 1 with Medicare	$1,587.57
Family - 2 with Medicare	$1,269.55
Family - 3 with Medicare	$951.53
Cigna True Choice Core Medicare Advantage Plan (PPO) - Medicare Participants Only	
Individual	$393.04
2 Individuals	$784.66
Family with 3 on Medicare	$1,177.70
United Healthcare Group Medicare Advantage Plan (PPO) - Medicare Participants Only	
Individual	$423.00
2 Individuals	$844.58
Family with 3 on Medicare	$1,267.58
Delta Dental PPO	
Individual	$43.53
2 Individuals	$82.24
Family	$135.53