Fairfax County Government

2021 Retiree Benefits Guide

Empower, Educate, Engage

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

Open Enrollment November 2 - 30, 2020

Medical Plans

In keeping with our long-term strategy, the Cigna managed **Co-Pay Plan** will be closing to all participants on December 31, 2020. Participants are encouraged to attend virtual education sessions and review all materials provided to select a new plan.

Those currently enrolled in the Cigna managed Co-Pay Plan, who take no action during the Open Enrollment Period, will be mapped to the Cigna managed 90% Co-Insurance Plan effective January 1, 2021.

With the exception of Kaiser participants, all retirees will receive new medical cards for plan year 2021, even if no plan change is made. Medicare eligible retirees, not enrolled in Kaiser, will also receive a new Part D Pharmacy Plan card from the Cigna RX PDP Plan (formerly HealthSpring). Expect to receive new cards in late December.

Premium Increases for Plan Year 2021:

2021 Premium Increases	
Cigna 90% Co-Insurance Plan	2%
Cigna 80% Co-Insurance Plan	6%
Cigna MyChoice CDHP	4%
Kaiser Permanente HMO	No Increase

Changes to Cigna managed 90% and 80% Co-Insurance Plans:

Effective January 1, 2021 the Hearing Aid Benefit for Cigna managed plans will increase. The new hearing aid allowance will be $3,000, after the plan deductible is met, every twenty-four months.

Outside of the Hearing Aid Benefit enhancement, there will be no significant medical plan or coverage changes for plan year 2021. Deductibles, co-insurances and major coverages will remain the same. Remember, pharmacy formularies can change every year, so check your medications to see if there has been a change in the level they are paid.

*HealthSpring is now **Cigna RX PDP Plan***

Effective January 1, 2021 Fairfax County Government's Part D Prescription Plan currently referred to as HealthSpring, will have a new name. The Cigna RX (PDP) Plan is similar to the plan offered to Medicare eligible participants in 2020. All Medicare eligible participants will be issued new cards to access benefits. This pharmacy plan will be paired with Cigna and United Healthcare plans.

Changes to Kaiser Permanente HMO Plan

The In-Network HMO Tier (Option 1) standard optical benefit has been restructured to a dollar discount to improve member understanding of the benefit. In lieu of a 25% discount on glasses and contact lenses, the restructured optical benefit is $75 off the retail price of a pair of glasses or $25 off the retail price of an order of contact lenses.

New for 2021, Medicare Advantage Plans:

Effective January 1, 2021, Medicare eligible retirees can elect to enroll in our new line-up of Medicare Advantage Plans.

Medicare Advantage Plan coverage for families composed of both Medicare eligible and non-Medicare eligible participants is available only 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. See notes below:

- 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.
- 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 or one of the Cigna managed Co-Insurance Plans as secondary coverage. The members of the family who are not eligible for Medicare would be enrolled in either the 90% or 80% Co-Insurance Plans.

Are you interested in one of the new Medicare Advantage Plans? Remember, as long as a retiree maintains enrollment in a county offered medical plan, they can elect a plan offered during Open Enrollment and then change plan enrollment again during the following year's Open Enrollment. *As an example, an eligible retiree can enroll in the United Healthcare Group Medicare Advantage Plan for 2021 and then change enrollment to the Cigna 90% Co-Insurance Plan for plan year 2022 during the next Open Enrollment.*

The *new* Medicare Advantage Plans include their own incentive reward plans and participants will not be eligible for Motivate*Me*.

See the Medicare Advantage sections of this guide, or the updated rates page, for more details.

Health Savings Accounts (HSAs)

Retirees, under 65, who are not eligible for Medicare, and enroll in the MyChoice CDHP Plan can contribute personal funds to a Health Savings Account and then claim contributions on their tax return to reduce taxable income. Retirees enrolled in individual plans can contribute $3,600 and $7,200 for those enrolled in two-party or family plans. All participants over the age of 55 can contribute an additional $1,000 per year. See the MyChoice section for more details.

If you choose to be enrolled in the MyChoice CDHP Plan along with a medical plan outside of Fairfax County Government (i.e. coverage under a spouse's employer or a new employer) you are **NOT** eligible to contribute to a Health Savings Account.

Note: By waiting to claim Social Security and go on Medicare you are provided a lump sum of retroactive benefits going back six months. You will also be retroactively enrolled in Medicare, going back six months. This enrollment makes you ineligible to participate in a Health Savings Account during that six month period.

Vision Care Program

As a reminder effective January 1, 2020, Fairfax County Government added new vendor partner, **EyeMed**. For Plan Year 2021, there will be a slight increase in the vision premium. This cost is bundled with the medical premiums.

Medical Plans

Plan Options for 2021

In keeping with our long-term strategy, the Cigna managed **Co-Pay Plan** will be closing to all participants on December 31, 2020. Current Co-Pay Plan participants will be mapped to the Cigna managed 90% Co-Insurance Plan but are encouraged to attend virtual education workshops and review available materials to select and enroll in a new plan.

For the 2021 plan year, the county will continue to offer three self-insured plans managed by Cigna, a fully insured HMO managed by Kaiser Permanente, and a Kaiser Medicare Advantage Plan to retirees and their families. New for 2021, we have added two Medicare Advantage Plans.

Kaiser Permanente HMO

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.

Kaiser Permanente's Customer Service can be contacted Monday through Friday from 7:00 am to 5:30 pm at (301) 468-6000, TTY (301) 879-6380 or by visiting Kaiser Permanente online at kp.org.

Cigna MyChoice CDHP Plan

The MyChoice Plan is a Consumer Driven Health Plan (CDHP), or a High Deductible Health Plan (HDHP), and is not open to any participant who is eligible for Medicare.

In this plan, participants are required to meet an annual deductible prior to the plan covering medical services and prescriptions. The in-network deductible for 2021 is $1,400 for individuals and $2,800 for plans covering two or more people (the entire Two-Party or Family deductible must be met before the plan pays). The annual deductible in the MyChoice Plan is combined for both medical services and prescription drugs and after the deductible has been met, participants are responsible for 10% of the allowable amount for in-network services.

Participants in the MyChoice CDHP Plan, have access to the Open Access Plus, or OAP, national network and pay co-insurances until they reach the out-of-pocket maximum. This plan does not require participants to select a Primary Care Physician (PCP) or receive a referral before seeking specialty care.

While the benefits are greater for in-network services, participants in the MyChoice Plan can receive services from out-of-network providers after meeting the out-of-network annual deductible. This allows participants to see any licensed provider they choose.

Cigna Customer Service is available 24/7 at (800) Cigna24 or (800) 244-6224 or online at MyCigna.com.

The MyChoice CDHP Plan is the only plan offered by Fairfax County Government that qualifies you to contribute to a Health Savings Account (HSA). It is important to note:

- For plan year 2021 the IRS contribution maximum is $3,600 for individuals and $7,200 for those enrolled in a two-party or family plan.
- Fairfax County Government does **not** contribute to retiree HSAs.
- Individual contributions to HSAs must be made directly to HSA Bank and cannot be made through Fairfax County Government or the Retirement Systems' payroll for retirees.
- If you choose to be enrolled in the MyChoice Plan along with another medical plan, you are **NOT** eligible to contribute to a Health Savings Account.
- Note: By waiting to claim Social Security and go on Medicare you are provided a lump sum of retroactive benefits going back to six months. You will also be retroactively enrolled in Medicare, going back six months. This enrollment makes you ineligible to participate in a Health Savings Account during that six month period.

For more information concerning Health Savings Accounts, please contact HSA Bank at (800) 357-6246.

Retiree Subsidies

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

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

Cigna 90% and 80% Co-Insurance Plans

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.

Are You New to Medicare?

- Participants who become newly eligible for Medicare, whether due to age or disability, will transition to the Cigna RX PDP Plan, 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 participants 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.

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 a type of Medicare health plan 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 prescriptions 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 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 the Center for Medicare and Medicaid Services (CMS) does not allow individuals to be enrolled in more than one Part D Drug Plan at a time. The NEW 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 or 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 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

The Centers for Medicare Services (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.

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 is 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 lose 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 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 15 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, search our online Provider Directory 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 include 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.

United Healthcare Group Medicare Advanage Plan

The United Healthcare 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 visitng 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 15 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 well-being 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 your 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 (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 (888) 281-7867.
- 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 $7/$14
Preferred brand drugs	You pay 20% ($50 max)	You pay 20% ($50 max)
Non-preferred brand drugs	You pay 30% ($100 max)	You pay 30% ($100 max)
Specialty drugs - limited to 30 day supply	You pay 30% ($100 max) per prescription	You pay 30% ($100 max) per prescription
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.**	

Medicare Advantage Plan Must Knows

- You must be enrolled in Medicare Part A and Part B to participate.
- You still get complete Part A and Part B coverage through the plan.
- You're still in the Medicare Program and you still have Medicare rights and protections.
- Your out-of-pocket costs may be lower in a Medicare Advantage Plan. If so, this option may be more cost effective for you.
- You can't buy and don't need Medigap or Medicare Supplemental Plan if you are enrolled in a Medicare Advantage Plan.
- You can only join a plan at certain times during the year. In most cases, you're enrolled in a plan for a year.
- You can join a Medicare Advantage Plan even if you have a pre-existing condition .
- You can check with the plan before you get a service to find out if it's covered and what your costs may be.
- Go to a doctor, other health care provider, facility, or supplier that belongs to the plan's network, so your services are covered and your costs are less.
- Providers can join or leave a plan's provider network anytime during the year. Your plan can also change the providers in the network anytime during the year. If this happens, you may need to choose a new provider.
- Medicare Advantage Plans can't charge more than Original Medicare for certain services like chemotherapy, dialysis, and skilled nursing facility care.
- Medicare Advantage Plans have a yearly limit on your out-of-pocket costs for medical services. Once you reach this limit, you'll pay nothing for covered services. Each plan can have a different limit, and the limit can change each year. You should consider this when choosing a plan.

For more information on the Medicare Advantage Plan offered to Fairfax County retirees, contact our vendor partners from 8 am to 8 pm, Monday through Friday:

Cigna True Choice Core Medicare Advantage Plan (PPO)	(888) 281-7867
United Healthcare Group Medicare Advantage Plan (PPO)	(866) 859-5402
Kaiser Permanente Medicare Advantage Plan	(888) 777-5536

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 your 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 Medicare Advantage Plan.

Paying Your Premium

The retiree portion of the benefit premiums 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.

MotivateMe

Total Wellbeing Program 2021

Earn up to $200 per year

	GOAL TYPE	DESCRIPTION	AWARD TYPE	AMOUNT
REQUIRED	ANNUAL PHYSICAL: SUBSCRIBER	A preventive exam with a primary care provider, including lab work.	Required for Cigna members Must be up to date, per Kaiser Permanente guidelines	Combined $100 BOTH are REQUIRED to earn additional rewards
REQUIRED	HEALTH ASSESSMENT: SUBSCRIBER	A confidential questionnaire about your wellbeing and health behaviors.	Required annually for Cigna and Kaiser Permanente members	
SPOUSE	ANNUAL PHYSICAL: SPOUSE	A preventive exam with a primary care provider, including lab work. The subscriber earns the rewards.	One per year	$25
SPOUSE	HEALTH ASSESSMENT: SPOUSE	Completion of the health assessment by a spouse covered under a Fairfax County health plan. The subscriber earns the rewards.	One per year	$25
SCREENING	CANCER SCREENINGS	Choice of 1 screening per year: -Colon cancer screening -Cervical cancer screening -Prostate cancer screening -Mammogram	One per year	$30
COACHING	TELEPHONIC HEALTH COACHING	Make progress toward a health goal, or achieve them with telephonic coaching, through Cigna and Kaiser Permanente.	Make progress toward one health goal per year. Achieve one health goal per year, in partnership with your coach.	$10 $30
ONLINE	OMADA	Complete at least 16 lessons of the Omada program.	One per year	$25
SELF	DENTAL EXAM*	Visit your dentist for a dental/oral examination.	Two per year	$10 each
SELF	VISION EXAM*	Visit an optometrist, ophthalmologist or other eye health professional for a vision exam.	One per year	$5
SELF	LIVEWELL WORKSHOPS & WEBINARS*	Participate in live classes, sponsored by LiveWell, online webinars or in-person workshops.	Workshops: 2 per year Webinars: 2 per year	$10 each $5 each
SELF	TOBACCO FREE PLEDGE*	Attest to being tobacco free (including smoking, vaping, smokeless tobacco, etc.).	One per year	$5

SELF REPORTED*

QUESTIONS? 703.324.4556, LIVEWELL@FAIRFAXCOUNTY.GOV

Motivate*Me* Retiree FAQ's

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

How does Motivate*Me* work?
Cigna subscribers track and manage their rewards through **mycigna.com**. Cigna participants are required to complete a physical with a primary care provider and Cigna's online health assessment annually to receive any rewards. **All activities must be completed AND posted on mycigna.com by December 31, 2021. Documentation must be received by LiveWell by December 31, 2021.** Kaiser Permanente subscribers must track their rewards using a paper "passport". The passport can be obtained by emailing LiveWell. Kaiser participants are required to complete Kaiser's total health assessment at **kp.org** every year. Annual physical and biometric screening results must also be up to date in Kaiser's medical portal to meet the physical requirement. **The completed "passport" must be scanned and emailed to LiveWell@fairfaxcounty.gov by December 31, 2021. Passports can also be mailed or delivered in-person to the LiveWell office at 12000 Government Center Parkway, Suite 270, Fairfax, VA 22035. All passports must be received by December 31, 2021.**

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

Who can participate in Motivate*Me*?
Fairfax County Government employees and retirees who are over the age of 18 and subscribe to a County health plan (Cigna 80%, 90%, MyChoice, Kaiser Permanente) are eligible to participate and earn rewards. **Participants in the Cigna Medicare Advantage plan or UnitedHealthcare (UHC) Medicare Advantage plan have access to their own wellness and incentive programs, and do NOT have access to Motivate*Me*.**

What activities are required to earn rewards?
There are two requirements to earn rewards. Participants must have an annual physical **AND** complete their health plan's online health assessment during the calendar year. **Points must be posted to the Motivate*Me* portal by December 31, 2021 or rewards will not be given.** Additional points and activities can be completed or tracked before the requirements are completed, but points will not be awarded until the physical and health assessment are completed and posted. Items marked with an asterisk* are self-reported, through the Motivate*Me* portal or passport. Participants can earn up to $200 per year.

Does a Medicare physical count toward the Motivate*Me* annual physical exam requirement?
Yes. Please send your explanation of benefits (EOB) showing your name, exam type, and date of exam to **LiveWell@fairfaxcounty.gov** by December 31. The Medicare physical or an annual physical that is billed through Cigna or Kaiser will qualify the annual physical requirement.

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

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

When, and how, do I receive my Motivate*Me* rewards?
Retirees will receive their rewards in their pension check within the first quarter of the following year.

Who can I contact with questions?
Please email **LiveWell@fairfaxcounty.gov** or call the LiveWell Coordinator at 703.324.4556.

LiveWell
Empower • Educate • Engage

Vision Insurance

Vision benefits are so much more than an eye exam. They help you save money, stay healthy and see everything life has to offer. Retirees who maintain enrollment in a Fairfax County Government medical plan are automatically enrolled in a Vision Care Program with EyeMed. You're on the INSIGHT Network.

Plan Contacts

For a complete list of in-network providers near you, use our Enhanced Provider Locator on eyemed.com or call (866) 804-0982.

Additional discounts

40% OFF
Complete pair of prescription eyeglasses

20% OFF
Non-prescription sunglasses

20% OFF
Remaining balance beyond plan coverage

These discounts are not insured benefits and are for in-network providers only

Take a sneak peek before enrolling

- You're on the INSIGHT Network
- For a complete list of in-network providers near you, use our Enhanced Provider Locator on eyemed.com or call 1.866.804.0982.
- For LASIK providers, call 1.877.5LASER6.

SUMMARY OF BENEFITS

Vision Care Services	In-Network Member Cost	Out-of-Network Reimbursement
Exam With Dilation as Necessary	$0 Co-pay	Up to $40
Retinal Imaging	Up to $39	N/A
Frames	$0 Co-pay, $150 Allowance, 20% off balance over $150	Up to $50
Standard Plastic Lenses		
Single Vision	$0 Co-pay	Up to $50
Bifocal	$0 Co-pay	Up to $75
Trifocal	$0 Co-pay	Up to $100
Lenticular	$0 Co-pay	Up to $150
Standard Progressive Lens	$50 Co-pay	Up to $75
Premium Progressive Lens[Δ]	$80 Co-pay - $175 Co-pay	
Tier 1	$80 Co-pay	Up to $75
Tier 2	$90 Co-pay	Up to $75
Tier 3	$105 Co-pay	Up to $75
Tier 4	$175 Co-pay	Up to $75
Lens Options		
UV Treatment	$12 Co-pay	Up to $5
Tint (Solid and Gradient)	$12 Co-pay	Up to $5
Standard Plastic Scratch Coating	$0 Co-pay	Up to $5
Standard Polycarbonate	$30 Co-pay	Up to $5
Standard Polycarbonate–Kids under 19	$0 Co-pay	Up to $5
Standard Anti-Reflective Coating	$0 Co-pay	Up to $5
Premium Anti-Reflective Coating	$0 Co-pay	Up to $5
Photochromic/Transitions	$65	Up to $5
Polarized	20% off retail	N/A
Other Add-Ons and Services	20% off retail	N/A
Contact Lens Fit and Follow-Up (Contact lens fit and follow up visits are available once a comprehensive eye exam has been completed)		
Standard Contact Lens Fit & Follow-Up	Up to $40	N/A
Premium Contact Lens Fit & Follow-Up	10% off retail price	N/A
Contact Lenses (Contact lens allowance includes materials only.)		
Conventional	$0 Co-pay, $150 Allowance, 15% off balance over $150	Up to $140
Disposable	$0 Co-pay, $150 Allowance; plus balance over $150	Up to $140
Medically Necessary	$0 Co-pay, paid-in-full	Up to $225
Laser Vision Correction		
LASIK or PRK from U.S. Laser Network	15% off the retail price or 5% off the promotional price	N/A
Hearing Care		
Hearing Health Care from Amplifon Hearing Network	40% off hearing exams and a low price guarantee on discounted hearing aids	N/A
Frequency		
Examination	Once every 12 months	
Lenses	Once every 12 months	
Contacts	Once every 12 months	
Frame	Once every 12 months	

Dental Insurance

Enrolled retirees continue to have dental coverage with Delta Dental of Virginia. As the nation's leading provider of dental insurance, Delta Dental of Virginia make it easy to protect your smile and keep it healthy, with access to botht the PPO and Premier network of dentists nationwide.

For a full plan summary visit the Fairfax County Benefits Summary on the public website: https://www.fairfaxcounty.gov/hr/fairfax-county-benefits-summary

Plan Contacts

If you have questions or concerns about services you need or have received; or if you have questions about a claim or a bill you can contact Delta Dental's Member Services at (800) 237- 6060 or (877) 287-9039 or visit Delta Dental of Virginia online at Deltadentalva.com.

DELTA DENTAL®

Delta Dental PPO plus Premier™

Benefits for Fairfax County Government
Group Number: 600050
Effective Date: January 1, 2021

Annual Deductible *(Applies to Basic, Major, and Orthodontic Services)*	$50 per person; $150 per family, per calendar year
Annual Maximum	$2,000 per enrollee, per calendar year
Orthodontic Lifetime Maximum	$2,000 per person
Prevention First	Visits to the dentist for Diagnostic and Preventive Services will not count against the Annual Maximum.
Healthy Smile, Healthy You® Program	Your plan provides additional cleanings and/or application of topical fluoride to enrollees with specific health conditions such as pregnancy, diabetes, high-risk cardiac conditions or who are undergoing cancer treatment via chemotherapy and/or radiation. Enrollment in the ***Healthy Smile, Healthy You*** **Program** is simple. Visit DeltaDentalVA.com to print an enrollment form.

Coverage	Coinsurances			Benefit Limitations
	In-Network		Out-of-Network	
	PPO	Premier		
Diagnostic and Preventive Services	100%	100%	80%	
• Oral exams				Twice in a calendar year.
• Regular/Periodontal cleanings				Limited to four in a calendar year (maximum of 2 regular cleanings).
• Fluoride applications				Twice in a calendar year for enrollees under the age of 19.
• Bitewing X-rays				Bitewing X-rays are limited to once in a calendar year limited to a maximum of 4 films or a set (7-8 films) of vertical bitewings.
• Full mouth/panelipse X-rays				Once in a 5-year period.
• Sealants				One application per tooth in a 60-month period for enrollees under the age of 19 on non-carious, non-restored 1st and 2nd permanent molars.
• Space maintainers				Once per quadrant per arch for enrollees under the age of 14.

Group Term Life Insurance

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

Benefit Reductions

Coverage reduces to 65% of the original face value when you turn 65 or retire, whichever comes first. Coverage then reduces to 30% of the original face amount at age 70. Reductions in coverage take effect the first of the month following the reduction event. Retirees may reduce their coverage to a flat $12,500 at any time.

Upon turning age 80, a retired member who has continued coverage will have the following options:

- If the amount of Basic Life Insurance is $12,500 or less, the member may keep the full amount of Life Insurance, and Fairfax County will pay the entire cost of insurance.
- If the amount of Basic Life Insurance is greater than $12,500, the member may keep the full amount of Basic and Optional Life Insurance. Fairfax County Government will pay the cost of the Basic Life Insurance and the retiree will pay the cost of the Optional Life Insurance; OR the retiree can elect to reduce the amount of coverage to $12,500 and the full cost will be paid for by Fairfax County Government.

Dependent Life Insurance

Employees who elected, and maintained, dependent life insurance coverage can continue that same coverage into retirement. Dependent Life insurance cannot exceed the amount in effect for the retiree. If you are currently enrolled in Option 2 or Option 3 of the Dependent Life Insurance with a Life Insurance benefit for yourself of under $12,500 or, a scheduled reduction which decreases the coverage below $12,500, dependent life insurance will be reduced to $10,000.

	Spouse	Child	Rate/Month
Option 1	$10,000	$5,000	$1.32
Option 2	$15,000	$10,000	$2.64
Option 3	$25,000	$15,000	$5.30

Plan Contacts

Contact The Standard's customer service line at 800-628-8600 or visit them online.

Additionally, The Standard provides a dedicated Help Desk Representative. The Care Advocate is available to assist with life insurance related issues. To reach our Representative call (703) 324-3351 or email her directly at lonna.owens@standard.com.

2021 Retiree Open Enrollment Meetings

Virtual, Retiree Open Enrollment Meetings

Sessions are open to all Fairfax County employees, retirees, and their families.

Participants are encouraged to attend as many sessions as they would like, along with Retiree Open Enrollment Meetings offered in November.

Use the web links and/or phone number and code associated with each session to attend. Registration is not required.

Additional resources can be found on our public site:

https://www.fairfaxcounty.gov/hr/fairfax-county-benefits-summary

Date	Time	Access Online	Access by Phone	Code
Monday, November 2nd	11 am	https://zoom.us/j/98869800160	(866) 434-5269	801348
Wednesday, November 4th	1 pm	https://zoom.us/j/93805866652	(877) 336-1839	379049
Thursday, November 5th	4 pm	https://zoom.us/j/95709500031	(877) 336-1839	379049
Tuesday, November 10th	11 am	https://zoom.us/j/96515658590	(866) 434-5269	801348
Thursday, November 12th	1 pm	https://zoom.us/j/94995659982	(866) 434-5269	801348
Thursday, November 12th	7 pm	https://zoom.us/j/92019841956	(866) 434-5269	801348
Tuesday, November 17th	4 pm	https://zoom.us/j/91275726426	(877) 336-1839	379049
Thursday, November 19th	11 am	https://zoom.us/j/95169559295	(866) 434-5269	801348
Monday, November 23rd	1 pm	https://zoom.us/j/98900078870	(877) 336-1839	379049
Monday, November 23rd	7 pm	https://zoom.us/j/93295688297	(877) 336-1839	379049

In-Person, Retiree Open Enrollment Meetings

Protecting the health and safety of our employees, retirees and citizens is a top priority, only two in-person Retiree Open Enrollment Meetings will be offered. Both meetings will be held in the Board Auditorium of the Government Center and pre-registration is required, no walk-ins will be admitted.

Sign-up at: https://www.signupgenius.com/go/20f0b4aaba92fa1fb6-general

Social distancing guidelines will be in place, and face coverings will be required. Space is limited and no one will be admitted without prior registration, including spouses, family members, and guests.

To limit contact, no additional materials will be available. Please bring the presentation included in this packet with you.

Thursday, November 5th	11 am
Monday, November 16th	11 am

Who to Contact

General Assistance

Benefits & LiveWell	HR Central	(703) 324-3311	hrcentral@fairfaxcounty.gov

Cigna managed Medical Plans

Vendor Partner	Cigna	(800) 244-6224	www.mycigna.com
For participants 65+	True Choice Core Plan	(888) 281-7867	www.mycigna.com
On-Site Help Desk	Keisha Lewis	(703) 324-2446	keisha.lewis@cigna.com

Cigna RX Medicare PDP Plan (formerly HealthSpring)

Home Delivery RX	Cigna	(800) 835-3784	www.mycigna.com
RX for participants 65+	Cigna RX PDP	(800) 558-9562	

Deferred Compensation/457(b) managed by T. Rowe Price

On-Site Help Desk	Marie Canterbury	(703) 324-4995	Fairfax457@troweprice.com
On-Site Help Desk	Kelli Parris	(703) 324-4995	Fairfax457@troweprice.com
Vendor Partner	T. Rowe Price	(888) 457-5770	rps.troweprice.com

Dental Plan

Vendor Partner	Delta Dental	(800) 237-6060	www.deltadentalva.com

Health Savings Accounts

Vendor Partner	HSA Bank	(800) 357-6246	www.mycigna.com or www.hsabank.com

Kaiser Permanente

Vendor Partner	Kaiser Permanente	(301) 468-6000	www.kp.org
Participants 65+	Kaiser Medicare Advantage	(888) 777-5536	www.kp.org

Life Insurance and Long Term Disability

On-Site Help Desk	Lonna Owens	(703) 324-3351	lonna.owens@standard.com
Vendor Partner	The Standard	(800) 628-8600	www.standard.com

United Healthcare Group Medicare Advantage Plan

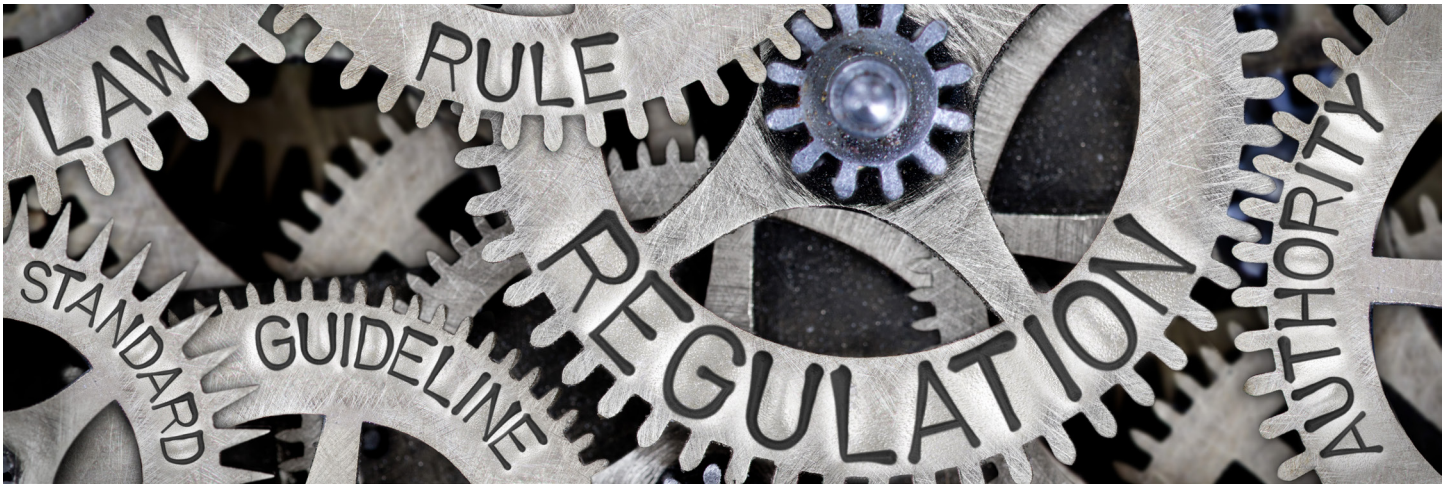
Vendor Partner	Member Services	(866) 859-5402	www.UHCRetiree.com/fairfax

Vision Care Program

Member Services	EyeMed	(866) 800-5457	www.eyemed.com

Miscellaneous, Non-DHR Contacts

Defined Benefit/Pension	Retirement Systems	(703) 279-8200	retirementquestions@fairfaxcounty.gov
Medicare	Medicare	(800) 633-4227	www.medicare.gov



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

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

Genetic Information Nondiscrimination Act (GINA)

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

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

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

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

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

Health Insurance Portability and Accountability Act (HIPAA)

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

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

FEDERALLY MANDATED NOTICES CONTINUED

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

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

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

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

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

Prescription Drug Coverage and Medicare

NOTICE OF CREDITABLE COVERAGE

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

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

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

1. Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.
2. Fairfax County Government has determined that the prescription drug coverage offered by all of the Cigna plans offered by the County and the Kaiser HMO are, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

When Can You Join A Medicare Drug Plan?

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

FEDERALLY MANDATED NOTICES CONTINUED

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

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

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

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

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

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

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

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

More Information About This Notice or Your Current Prescription Drug Coverage

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

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

More Information About Your Options Under Medicare Prescription Drug Coverage

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

For more information about Medicare prescription drug coverage:

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

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

2021 Medical and Dental Premiums

Benefit Plan Options	Total Monthly Premium (without subsidy) for Medical, RX, and Vision combined
Cigna MyChoice Plan - Non-Medicare Participants Only	
Individual	$494.06
2 Individuals	$963.01
Family	$1,437.40
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