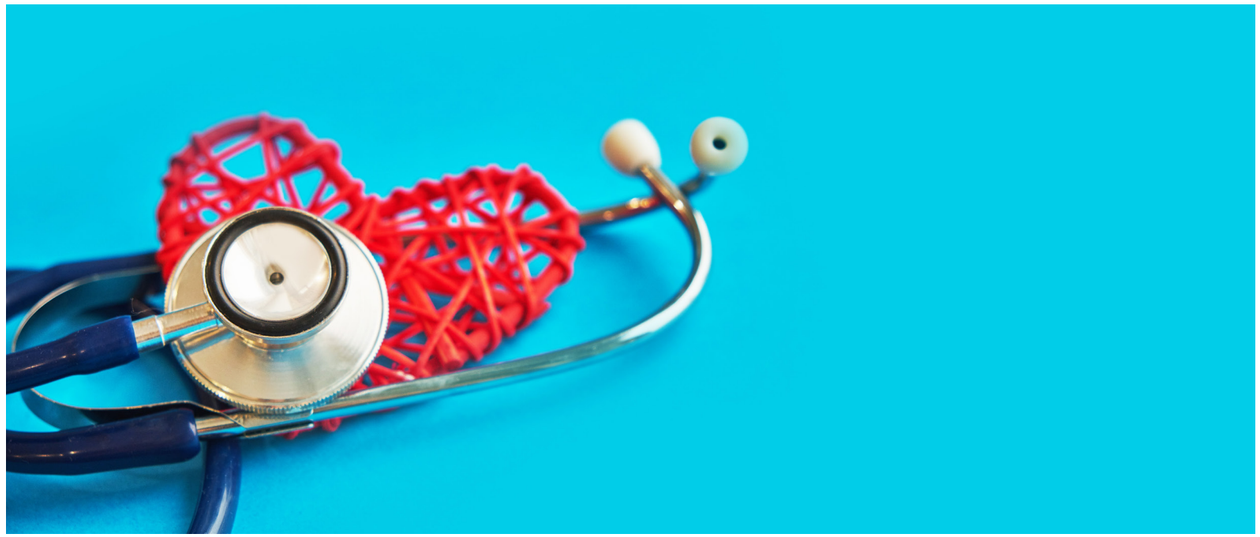
Cigna RX (PDP) Plan - Group Medicare Part D Plan

	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% ($200 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.**	

- 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.

Additional Benefit Highlights for the New Medicare Advantage Plans

Description	Cigna True Choice Core Medicare Advantage Plan	United Healthcare Group Medicare Advantage Plan
Diagnostic Radiology Advanced Radiology	$0 10%	10%
Outpatient Therapy Services: Occupational, Physical, Speech/ Language Therapies, Cardiac and Pulmonary Rehab.	$10 per visit	$10 per visit
Durable Medical Equipment	10%	10%
Diabetic Supplies	$0	$0
Home Health Services	$0	$0
Telemedicine	$5	$5
Post Discharge Meal Delivery	Included. Up to14 nutritional meals delivered to your home immediately following an inpatient discharge for acute inpatient care.	Included. Up to 3 meals a day for a 4-week period immediately following an inpatient discharge with case manager referral
Incentive Program	Yes	Yes
Wellness/Exercise Program	Silver and Fit	Silver Sneakers



2021 Retiree At-A-Glance

Plans for Medicare Eligible Particpants

- In keeping with our long-term strategy, the Cigna Co-Pay plan will be closing to all participants on December 31, 2020.

- 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.

- 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. Requests and documentation received past the first of the month could leave you without coverage.

- 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 and any break in medical coverage with FCG will mean loss of your Retiree Subsidy.

- 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: The Centers for Medicare Services (CMS) requires a physical address for anyone enrolled in Medicare and in a Group Medicare Advantage or Part D Prescription Drug Plans and that the Kaiser Medicare Advantage Plan does not include all of their facilities. Check your zip code before you enroll.

- End-Stage Renal Disease, or ESRD, is a medical condition in which a person's kidneys cease functioning on a permanent basis. Plan participants may become entitled to Medicare based on ESRD. In this case, 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.

	CIGNA OAP 90% Co-Insurance Plan		CIGNA OAP 80% Co-Insurance Plan		Cigna True Choice Core Medicare Advantage PPO	United Healthcare Group Medicare Advantage Plan (PPO)	Kaiser Permanente HMO Medicare Advantage Plan
	Non-Medicare and Medicare Eligible Participants. Can be combined with Cigna Medicare Advantage Plan.		Non-Medicare and Medicare Eligible Participants. Can be combined with Cigna Medicare 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
	In-Network	Out-of-Network	In-Network	Out-of-Network	In- and Out-of Network*	In- and Out-of Network*	In-Network - Local
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 pays 60% co-insurance after plan deductible is met	$5 per visit	$5 per visit	$10 PCP co-pay No Charge for Children under 5
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 pays 60% co-insurance after plan deductible is met	$5 per visit	$5 per visit	$10 PCP co-pay
Annual Deductible	$350 Individual $700 Family	$700 Individual $1,400 Family	$500 Individual $1,000 Family	$1,000 Individual $2,000 Family	None	None	$0
Annual Out-of-Pocket Limit	$2,500 Individual $5,000 Family	$5,000 Individual $10,000 Family	$3,000 Individual $6,000 Family	$6,000 Individual $12,000 Family	$1,500 each Individual covered	$1,500 each Individual covered	$3,400 per Individual
Preventive Care - All Ages Routine Preventive Care, Immunizations, Mammogram, PAP, PSA Tests	Plan Pays 100%	Ages 18 and above: Plan pays 70% co-insurance after deductible is met	Plan Pays 100%	Ages 18 and above: Plan pays 60% co-insurance after deductible is met	Medicare Covered Preventive Care Plan pays 100%	Medicare Covered Preventive Care Plan pays 100%	No Charge
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 pays 60% co-insurance after plan deductible is met	$0 per Admission	$0 per Admission	No Charge
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 pays 60% co-insurance after plan deductible is met	$0	$0	No Charge
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 pays 60% co-insurance after plan 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.
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 pays 60% co-insurance after plan deductible is met. Max 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.
Hearing Aids	Plan pays 90% co-insurance after plan deductible is met Max benefit is $3,000 every 24 months	Plan pays 90% co-insurance after plan deductible is met Max benefit is $3,000 every 24 months	Plan pays 80% co-insurance after plan deductible is met Max benefit is $3,000 every 24 months	Plan pays 80% co-insurance after plan deductible is met Max benefit is $3,000 every 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.
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 pays 80% co-insurance after plan 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)
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 pays 80% co-insurance after plan deductible is met	$10 per visit , waived if admitted within 24 hours	$10 per visit , waived if admitted within 24 hours (Worldwide)	$10 visit
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 pays 60% co-insurance after plan 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.

Cigna RX Medicare Part D Plan included in these plans. Refer to the information on the Cigna Rx PDP plan

*Participants in the Cigna True Choice Core and United Healthcare Group Medicare Advantage Plans can access doctors, specialists and hospitals in or out of our network for the same cost share as long as the provider participates in Medicare and will bill the plan. If your doctor is not in the network, he or she may choose not to treat you unless it is an emergency. For more information on the Medicare Advantage Plans contact the carrier directly.

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

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