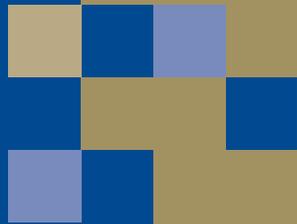


FAIRFAX COUNTY PUBLIC SCHOOLS

Interim Edition
Expires January, 2014

2014 Retiree

Benefits HANDBOOK



About This Handbook

This handbook provides an overview of the benefit plans and programs offered to retirees of Fairfax County Public Schools (FCPS). If you need more information or would like to talk to someone about your benefits, contact information is available for all programs on the following page of this handbook.

“Welcome to the FCPS retiree benefits program!

FCPS is proud to offer a comprehensive and competitive benefits package designed to meet the needs of its retirees following career employment.



In addition to first rate retirement benefits, many retirees are eligible to continue participation in the FCPS medical, dental, life, and long-term care insurance plans. Whether you are already retired or considering retirement, this handbook will help you understand the benefits for which you may be eligible, as well as important provisions you should be aware of when planning for your retirement.

On behalf of FCPS, I want to thank you for your years of dedicated service. We wish you the very best in your retirement years.”

Phyllis Pajardo, Ed. D.

Assistant Superintendent of Human Resources

Your Benefits Contacts

If you have questions about your benefits or need forms or information, contact:

HEALTH CARE PLANS

Aetna Dental (DPPO and DMO)	www.ih-aetna.com/fcps	877-238-6200	8 am–6 pm M–F
Aetna/Innovation Health	www.ih-aetna.com/fcps	888-236-6249	8 am–6 pm M–F
CareFirst BlueChoice Advantage	www.carefirst.com/fcps	800-296-0724	8 am–9 pm M–F
Kaiser Permanente HMO	www.my.kp.org/mida/fcps	800-777-7902	7:30 am–5:30pm M–F
Express Scripts (Prescription drug plan for Aetna/Innovation Health and CareFirst members)	www.express-scripts.com	866-815-0003	Available 24/7

RETIREMENT OFFICES

Educational Employees' Supplementary Retirement System of Fairfax County (ERFC)	www.fcps.edu , search "ERFC"	703-426-3900 800-426-4208	8 am–4:30 pm M–F
Virginia Retirement System (VRS)	www.varetire.org	888-827-3847 (VA-RETIR)	8:30 am–5 pm M–F
Fairfax County Employees' Retirement System (FCERS)	www.fairfaxcounty.gov/retirement	703-279-8200 800-333-1633	8 am–4:30 pm M–F

457(b) & 403(b) RETIREMENT SAVINGS PLANS

Great-West Retirement Services—457(b) Plan	www.GWRS.com/fcps	877-449-FCPS (3277)	9 am–8 pm M–F
Tax-Deferred Account-403(b)	See vendor list on page 43.		

LIFE INSURANCE

ERFC Members – Minnesota Life	www.varetire.org www.fcps.edu —search "Life Insurance" on the Employee Benefits website.	571-423-3200, option 3	8 am–4:30 pm M–F
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LONG-TERM CARE INSURANCE

CNA	www.ltcbenefits.com	800-528-4582	8 am–6 pm M–F
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FEDERAL GOVERNMENT RESOURCES

Centers for Medicare and Medicaid Services	www.cms.hhs.gov	800-Medicare or 800-633-4227	7 am–7 pm M–F
Social Security Administration	www.ssa.gov	800-772-1213	7 am–7 pm M–F

FCPS RESOURCES

Office of Benefit Services	HRBenefitQuestions@fcps.edu	571-423-3200, option 3	8 am–4:30 pm M–F
Human Resources (HR) Client Services	HRQuestions@fcps.edu	571-423-3000 800-831-4331, extension 3000	8 am–4:30 pm M–F

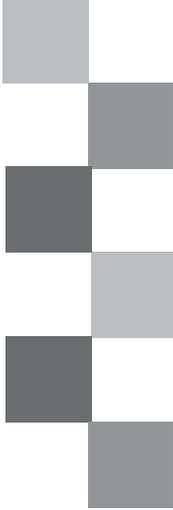


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This handbook is not intended to be a comprehensive reference and should be reviewed in conjunction with other FCPS benefits materials. In the event of any conflict between official benefit plan documents, benefit contracts, and this handbook, the official information will govern. FCPS reserves the right to modify and/or discontinue any of these plans.

FCPS Retiree Benefits-at-a-Glance

This chart outlines your benefits and references the pages in this handbook where you can find more information about each program. Detailed information is also available on the FCPS Retiree Benefits website: Go to www.fcps.edu, click on **Employees** and look for **Benefits** under **Retirees**.

Medical and Vision Plans (available to eligible retirees)

Benefit	Description	More Information
Aetna/Innovation Health	A preferred provider plan that uses the strengths of two organizations, Aetna and Inova Health Systems. In addition to Inova facilities, the plan has a strong national network of physicians, hospitals and ancillary health care providers. Vision benefits will be included with your medical coverage through EyeMed. This plan is available to both non-Medicare and Medicare-eligible retirees.	Page 8
CareFirst BlueChoice Advantage	This plan functions as both a point-of-Service (POS) and a preferred provider organization (PPO) plan. The plan uses the BlueChoice Advantage network for in-network benefits as well as BlueCard PPO providers when care is delivered outside of the CareFirst service area. Vision benefits will be included with your medical coverage through Davis Vision. This plan is available to only non-Medicare eligible retirees/dependents.	Page 9
Kaiser Permanente Signature HMO	This health maintenance organization (HMO) plan provides care at Kaiser Permanente facilities located throughout Northern Virginia, Maryland, and the District of Columbia. Care received outside of this area is not covered except for emergencies. This plan includes prescription coverage through Kaiser and vision plan benefits through both UHC Vision and Kaiser. This plan is available to retirees who reside within the Kaiser Permanente/Kaiser Medicare service area.	Page 10
Express Scripts, Inc.	This is the prescription drug plan for Aetna/Innovation Health and CareFirst participants.	Page 14

Dental Plans (available to eligible retirees)

Aetna Dental DPPO	Under this dental preferred provider organization (DPPO) plan, your benefits are greater if you see a dentist in the Aetna network. You may see any out-of-network dentist, but you will pay more.	Page 20
Aetna Dental DMO	Under a dental maintenance organization (DMO) plan, you must select a participating primary care dentist. You must receive your dental care from that dentist, unless that dentist refers you to a specialist. You must use dentists who are in the DMO network.	Page 20

Long-Term Care Insurance

Benefit	Description	More Information
Long-Term Care Insurance	This plan provides for nursing home or assisted living coverage at group rates for you, your spouse, parents, parents-in-law, grandparents, and grandparents-in-law (if you so elect and approved by CNA). You pay the full cost. Premium payments are made directly to CNA.	Page 25

Life Insurance

VRS Member Group Term Life Insurance	Basic life insurance continues upon retirement at no cost. Coverage reductions occur each year after retirement, until the value reaches 25% of the original amount. Optional/dependent coverage may be continued until you reach age 80. You pay the full premium for optional and dependent coverage.	Page 28
FCERS Member Group Term Life Insurance	Basic insurance continues upon retirement at no cost to you. Coverage reductions occur when you retire, upon reaching age 65, and age 70. Optional/dependent coverage may be continued—you pay the full premium for optional and dependent coverage.	Page 28

Deferred Compensation–457(b) plan and Tax-Deferred Account (TDA)–403(b)

Deferred Compensation–457(b) and Tax-Deferred Account (TDA)–403(b)	These plans allow you to save for retirement through payroll deduction while working. Contributions to your 403(b) and 457(b) end at retirement. If you are rehired into a temporary hourly position, such as a substitute teacher, you can contribute to a 403(b) through payroll deduction. Please note that if you retire and re-employ in a temporary hourly or substitute teacher position, you may not be approved for distributions from your accounts, such as rollovers or cash withdrawals.	Page 29
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FCPS-Sponsored Defined Benefit Retirement Plans

Virginia Retirement System (VRS)	This plan is for former full-time educational, administrative, and support employees. The monthly retirement check is payable on the first of the month for the previous month.	Page 30
Educational Employees' Supplementary Retirement System of Fairfax County (ERFC)	This plan is for former full-time educational, administrative, and support employees. If you were hired before July 1, 2001, you are in the <i>ERFC Legacy</i> plan. If you were hired on or after July 1, 2001, you are in the <i>ERFC 2001</i> plan. The monthly retirement check is payable on the last day of the month.	Page 30
Fairfax County Employees' Retirement System (FCERS)	This plan is for former full-time and part-time custodial, food service, maintenance, and transportation employees and less-than-full-time educational, administrative, and support employees. The monthly retirement check is payable on the last day of the month.	Page 30

Important Information for the Year You Retire

HR Retiree Services

Have a question? You can get your answer three ways:

1. E-mail us at HRBenefitQuestions@fcps.edu
2. Visit us online at www.fcps.edu, click on **Employees**, and look for **Benefits** under **Retirees**
3. Or call HR Client Services at 571-423-3000 or 800-831-4331, ext. 8172.

You and your dependents may continue your participation in FCPS medical and dental plans if you meet the eligibility requirements stated on the next page.

At the time you retire, your health care insurance coverage will continue:

- Through the end of August if you retire in June, July or August.
- Through the last month of employment if you retire in any other month.

If you or any covered dependents are age 65 or older at the time of retirement, you must elect Medicare parts A & B when you become eligible. Medicare will become your primary coverage and FCPS' medical plan will become secondary.

Premium Payment

As a retiree, you are responsible for the full premium (minus any FCPS subsidies) if you decide to continue to participate in FCPS health plans. FCPS deducts your health plan premiums from your monthly pension payment. If your annuity is insufficient from which to deduct premiums, FCPS will send you coupons, showing the premium you must pay each month.

Address Changes

You must keep your address updated with ERFC/VRS and/or FCERS in order to receive information from the Office of Benefit Services after you retire. Contact information for both retirement agencies is on the "Your Benefits Contacts" page opposite the Table of Contents in this handbook.

Aetna/Innovation Health Members

Aetna/Innovation Health is a preferred provider that uses the strengths of two organizations, Aetna and Inova Health Systems. In addition to Inova facilities, the plan has a strong national network of physicians, hospitals and ancillary health care providers. This plan is available to both non-Medicare and Medicare-eligible retirees.

CareFirst BlueChoice Advantage Members

When you retire and reach age 65, you can no longer participate in the CareFirst BlueChoice Advantage plan. You will be transferred automatically to the Aetna/Innovation Health plan unless you elect to enroll in the Kaiser Permanente Medicare Plus plan (if you reside within Kaiser's service area).

Kaiser Permanente Members

Retirees must live in the Kaiser Permanente local service area to retain coverage. If you do not, you must change plans. Your health plan coverage as a retiree is identical to your coverage as an active employee until you become eligible for Medicare. Not all Kaiser service areas are available to Medicare eligible retirees. Go to www.kp.org or call Kaiser for more details.

FSAs at Retirement

Your flexible spending account benefit plan(s) will end on the same schedule as your health insurance.

For expenses incurred in plan year 2014, you have until March 31 of the calendar year following your termination to submit claims for eligible expenses.

Remember that FSA claims must be **incurred before your coverage ends (i.e. employment)**.

Health Care Benefits in Retirement

FCPS Subsidies

If you are a retiree age 55 or older (or if you retire due to a disability), FCPS provides a subsidy toward the cost of your FCPS medical coverage. The subsidy reduces the cost of your medical coverage. The subsidy schedules for VRS/ERFC and FCERS members are available on p. 22. As a retiree, you do not pay your health plan contributions on a pre-tax basis as you did as an active employee. Eligibility

In order to be eligible for FCPS medical and/or dental benefits in retirement, you must meet the following criteria;

- Have been enrolled in the type of coverage (medical, dental or both) for sixty (60) consecutive months immediately prior to retirement;
- Be eligible for normal, early or disability retirement benefits, and elect to commence your pension benefits at the time you terminate employment with FCPS;
- Indicate your election to continue benefits prior to retirement; and
- Elect Medicare Parts A and B, if you and/or your spouse are age 65 or older.

If you meet the above eligibility and choose not to enroll in the health plans by the effective date of your retirement, you and your dependents **will not** have the option to enroll as a retiree at a later date unless you are a DHO participant as described below.

Deferred Health Option

If you meet the eligibility for retiree health care benefits described above *and* you were hired prior to July 1, 2005, at termination of employment you have a one-time election opportunity to participate in the Deferred Health Option (DHO). The DHO program creates a safety net for **married individuals** who elect not to enroll in an FCPS medical and/or dental plan when they retire, but wish to maintain their eligibility for future enrollment in the retiree health plans.

By paying a monthly premium, DHO participants retain the right to enroll in FCPS retiree medical and/or dental coverage at a later date, if the DHO participant loses health coverage due to the **death** of, or **divorce** from, their spouse.

The DHO participant must not be eligible to continue their late/former spouse's health insurance plan (including COBRA continuation coverage). Additionally, the DHO participant may enroll only in the type of health insurance plan that they lost.

For example, if a DHO participant loses dental coverage as a result of death or divorce, the participant may elect FCPS retiree dental coverage. Once enrolled in an FCPS retiree medical and/or dental plan, the individual will be subject to all applicable rules for FCPS participants.

For more information about DHO, refer to p. 23 of the handbook.

DHO is not available to you if you were hired on or after July 1, 2005.



Additional documentation required to make changes to your benefits may include:

- Divorce decree (applicable pages)
- Letter from your spouse's or dependent's HR Department or insurance plan explaining circumstances regarding a significant cost change, coverage curtailment, or a change in coverage
- Letter from your spouse's or dependent's employer or open enrollment notice indicating enrollment dates and effective date
- Court order requiring you to cover a child or an order requiring someone else to provide coverage for your dependent
- Copy of your Medicare card or Medicare/ Medicaid letter

Changing Your Health Benefits

If you are eligible for retiree health care benefits, you may elect to continue health coverage at the time of retirement, provided you meet the eligibility criteria described on page 5.

You may add eligible dependents or change plans during Open Enrollment, usually held in the fall of each year. Changes made during Open Enrollment take effect January 1 of the following year.

As a retiree, you may cancel your health benefits or remove a dependent at any time; however, the change will not take effect until the **first of the month** after the Office of Benefit Services receives your form. **Once you cancel your health insurance coverage as a retiree, you and your dependents generally will NOT have the option to enroll at a later date. However, re-enrollment may be permitted in the following circumstances:**

- Your spouse is an active FCPS employee and you continue to be covered by an FCPS health plan through their eligibility; or
- You are re-employed with FCPS and continue coverage in FCPS health plans as an active employee.
- No break in coverage can occur.

Status Changes or Qualifying Events

You must notify the Office of Benefit Services within 30 calendar days of a status change or qualifying event.

If you have a qualifying event and wish to change coverage, you must inform the Office of Benefit Services about a status change by completing and submitting a change form, which is available on the FCPS Retiree Benefits website: Go to www.fcps.edu, click on **Employees**, and look for **Benefits** under **Retirees**; or by calling the FCPS Office of Benefit Services at 571-423-3200, option 3.

If you are requesting to add a dependent, you must also provide the required documentation demonstrating change in eligibility.

If you fail to notify FCPS within the 30-day period, you may not add the dependent until Open Enrollment.

Dependent Eligibility & Required Documentation for FCPS Health Plan Coverage

FCPS requires documentation demonstrating all insured dependents meet eligibility criteria. You have **30 calendar days** from a qualifying event to complete and submit your medical and dental plan enrollment forms along with applicable documentation from the chart below to verify your dependent's eligibility before coverage will become effective.

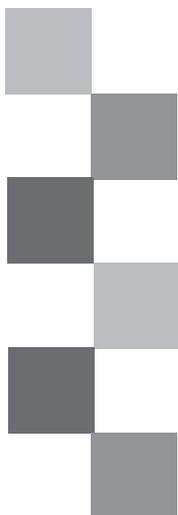
Dependents	Eligibility Definition	Documentation Required
Spouse	A member of the opposite sex to whom you are legally married as defined by U.S. federal tax law	Photocopy of the front page of the employee's most recent federal tax return that includes the employee's spouse (you may remove all financial information) AND Photocopy of marriage certificate
Biological Child*	The biological son or daughter of the retiree	Photocopy of birth certificate showing employee's name
Adopted Child*	The adopted son or daughter of the retiree or a child placed for adoption	Photocopy of an Final Adoption Decree or an Interlocutory Decree of Adoption with the presiding judge's signature and seal; OR Photocopy of the child's birth certificate showing the employee as the adopting parent
Stepchild of a Current Marriage*	The stepson or stepdaughter of the retiree	Photocopy of birth certificate showing employee's spouse's name; AND Photocopy of marriage certificate showing the employee and child's parent's name
Child under Legal Guardianship*	Child for whom the retiree has been appointed legal guardian	Photocopy of the final court order, with the presiding judge's signature and seal, affirming the employee as the child's legal guardian
Child under Legal Custody*	Child for whom the retiree has been granted legal custody	Photocopy of the court order of custody with the presiding judge's signature and date, affirming the child's placement in legal custody of the named employee
Foster Child*	Certain eligible foster children	Photocopy of the certified foster care documents with the name of the child and the name of the employee
Disabled Child	Child age 26 or older who is wholly dependent on the retiree for support and maintenance due to a disability that occurred prior to age 26	Photocopy of birth certificate showing employee's name as mother or father (this only verifies dependent eligibility - your health carrier determines the disability status of the child) AND Completed <i>Disability Certification</i> form that has been approved by the carrier

*Children must be under age 26, unless disabled.

Examples of **ineligible individuals** include: former spouse; former spouse's child not biologically related to you (exceptions may apply with applicable court orders); child age 26 or older unless they are disabled and dependent on you for support as defined above.

If the source document is not in English, you must have the document translated prior to supplying it to the Office of Benefits Services.

Document copies can typically be obtained in the locality where the birth or marriage occurred, or via the following websites. Fees will likely apply. www.vitalchek.com or www.vitalrec.com; www.irs.gov/taxtopics/tc156.html (for copy of tax return).



Medical Plans

FCPS offers three medical plans that include prescription and vision benefits:

- **Aetna/Innovation Health**
- **CareFirst BlueChoice Advantage**
- **Kaiser Permanente**

Aetna/Innovation Health

Aetna/Innovation Health is a preferred provider plan that uses the strengths of two organizations, Aetna and Inova Health Systems. In addition to Inova facilities, the plan has a strong national network of physicians, hospitals and ancillary health care providers.

This plan is available to both non-Medicare and Medicare-eligible retirees.

Summary Plan

A *Summary Plan Document* describes the provisions and features of a benefit plan, including eligibility, coverage, employee rights, and appeals procedures.

Plan Highlights

- You do not have to choose a Primary Care Provider (PCP).
- You are not required to obtain referrals to specialists.
- Registered nurses staff a 24-7 medical advice service to answer your health care questions.
- You pay a copayment for most office visits.
- For services not considered office visits, most in-network services are covered at 90 percent of the plan allowance. The remaining 10 percent is the coinsurance amount for which you are responsible.
- Vision benefits will be provided through Aetna Vision Preferred, in partnership with the EyeMed vision network.

To find network providers and review both the Summary of Benefits and Coverage and the Summary Plan Booklet, visit the Aetna/Innovation Health website at www.ih-aetna.com/fcps or call Member Services at 888-236-6249.

CareFirst BlueChoice Advantage

CareFirst BlueChoice Advantage functions as both a POS and PPO plan. The plan uses both the BlueChoice Advantage network for in-network benefits as well as BlueCard PPO providers when care is delivered **outside** of the CareFirst area.

This plan is available to only non-Medicare eligible retirees/dependents.

Plan Highlights

- You do not have to choose a PCP.
- You are not required to obtain referrals to specialists.
- Registered nurses staff a 24-7 medical advice service to answer your health care questions.
- You pay a copayment for most office visits.
- Most in-network services not considered office visits are covered at 90 percent of the plan allowance. The remaining 10 percent is the coinsurance amount for which you are responsible.
- Vision benefits will be provided through CareFirst's partnership with Davis Vision.

To find network providers and review both the Summary of Benefits and Coverage and the Summary Plan Booklet, visit the CareFirst website at www.carefirst.com/fcps or call Member Services at 800-296-0724.

Contact your health plan to ...

- *Clarify your benefits*
- *Ask questions about services and costs*
- *Request an identification card if you have not received one or if you need a replacement*
- *Obtain information about providers*
- *Make a complaint or file an appeal*

Aetna/Innovation Health

Medical: **888-236-6249**

Vision (EyeMed): **877-973-3238**

CareFirst BlueChoice Advantage

Medical: **800-296-0724**

Vision (Davis Vision): **888-343-3462**

Kaiser Permanente

800-777-7902

Express Scripts (CareFirst members)

866-815-0003

Kaiser Service Area

The Kaiser service area for FCPS retirees includes Northern Virginia, Maryland, and Washington, DC. Kaiser Permanente Medicare members have a different service area than non-Medicare members.

Details on service areas are available at www.my.kp.org/mida/fcps or contact Kaiser member services at 800-777-7902.

Kaiser Permanente Signature HMO

This plan provides a wide range of integrated preventive care and health assessments, including outpatient services, laboratory, radiology, pharmacy, and health education to its members. You must reside in Kaiser's service area to retain coverage in this plan.

This plan is available to retirees who reside within the Kaiser Permanente/Kaiser Medicare service area.

Plan Highlights

- You **must have a referral** from your primary care physician to see a specialist.
- You may receive care at any Kaiser medical facility in the local area. Some Kaiser facilities serve as urgent care centers for non-life threatening after-hours emergencies.
- Care and services not directly managed by Kaiser Permanente are not covered, except for emergency services received out of the area.

Additional Services and Programs

- A 24-hour *Medical Advice and Appointment Line*, which is available by calling 703-359-7878 or 800-777-7904.
- Kaiser offers online features that provide secure access to your health information. You can:
 - » View lab results
 - » E-mail your doctor's office
 - » Schedule and view future appointments
 - » Obtain health care reminders
 - » View information on ongoing health conditions
 - » View immunization records
 - » Act for a family member (proxy)

To use these online services, complete a registration form on www.my.kp.org/mida/fcps: Click **Register Now** under Members sign on and follow the instructions.

- *Live Well Be Well*—a free health education program, which includes classes on managing high blood pressure, diabetes, back pain, etc. available on www.kplivewellbewell.org/
- Discounts on health club memberships, acupuncture, chiropractic care, and massage therapy.

To review the Summary of Benefits and Coverage and the Evidence of Coverage, visit the Kaiser's website at www.my.kp.org/mida/fcps.

Vision Services

Beginning in 2014, Participants have access to an annual \$150 allowance for frames, lenses and contact lenses obtained through Kaiser Permanente optical centers.

Kaiser Permanente Prescription Drug Plan

Kaiser Permanente manages its own retail and mail service pharmacy plan and uses a drug formulary—a list of preferred medications and drugs that its health care professionals use to prescribe. Prescription refills may be requested through the member website, as well as through *EZ Refill*, a 24-hour refill line.

Kaiser Permanente Prescription Copayments

Kaiser Pharmacy* (up to a 60-day supply)

Generic	\$ 15
Formulary Brand	\$ 25
Non-Formulary Brand	\$ 40

Retail Pharmacy* (up to a 60-day supply)

Generic	\$ 20
Formulary Brand	\$ 45
Non-Formulary Brand	\$ 60

Mail (90-day supply)

Generic	\$ 13
Formulary Brand	\$ 23
Non-Formulary Brand	\$ 38

* For a 90-day supply, regular copayments are increased by 1.5 times.

Kaiser Permanente Medicare Plus Copayments

Note: Both brand and generic drugs have the same copayments under the Medicare Plus plan.

Kaiser Pharmacy (up to a 60-day supply)	\$ 15
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Retail Pharmacy (up to a 60-day supply)	\$ 25
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Mail Order (90-day supply for maintenance medications; 60-day supply for non-maintenance medications)	\$ 10
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Aetna/Innovation Health		
	In-Network You Pay	Out-of-Network You Pay
Annual Deductible (Individual/Family)	None	\$250/\$500 (all services subject to deductible unless otherwise noted)
Out-of-Pocket Maximum	\$500 Individual/\$1,000 Family (excludes copays and deductibles)	\$1,500 Individual/\$3,000 Family (excludes copays and deductibles)
Office Visits—Primary Care & Specialist	\$20 copay	30% of plan allowance
Inpatient Physician Services	10% of plan allowance	30% of plan allowance
Routine Exams & Immunizations	\$20 copay	30% of plan allowance
Lab and X-ray	Outpatient—Covered in full at network radiology or laboratory centers; Inpatient—10% of plan allowance	30% of plan allowance
Emergency Room Care (Must be a bonafide emergency to be covered)	\$50 copay (waived if admitted), then 10% of plan allowance	\$50 copay (waived if admitted), then 10% of plan allowance
Maternity Care	\$20 copay first visit, then covered in full	30% of plan allowance
Well Baby Care	\$20 copay	30% of plan allowance
Outpatient Surgical and Ambulatory Care	10% of plan allowance	30% of plan allowance
Inpatient Hospital Admission	\$100/admission copay, then 10% of plan allowance	\$100/admission copay, then 30% of plan allowance
Durable Medical Equipment	10% of plan allowance	30% of plan allowance
Physical Therapy (Outpatient)	\$20 copay, 90-visit maximum, per condition/therapy, per calendar year	30% of plan allowance, 90-visit maximum, per condition/therapy, per calendar year
Chiropractic Care	\$20 copay	30% of plan allowance
Mental Health and Substance Abuse	Outpatient—10% of plan allowance; Inpatient—\$100/admission copay, then 10% of plan allowance	Outpatient—30% of plan allowance; Inpatient—\$100/admission copay, then 30% of plan allowance
Prescription Drugs	Provided by Express Scripts for Aetna/Innovation Health members	
Vision	Provided by Aetna Vision Preferred in partnership with EyeMed. Vision plan includes coverage for frames, lenses (or contact lenses) and eye exams.	

Note: FCPS plans are considered "grandfathered" under the Patient Protection and Affordable Care Act. As permitted by the Act, grandfathered health plans can preserve certain basic health coverage that was already in effect when the law was enacted.

CareFirst BlueChoice Advantage In-Network You Pay	Out-of-Network You Pay	Kaiser Permanente
None	\$250/\$500 (all services subject to deductible unless otherwise noted)	None
\$250 Individual/\$500 Family (excludes copays)	\$1,500 Individual/\$3,000 Family (excludes copays)	\$3,500/Individual; \$9,400/Family
\$20 copay	30% of plan allowance	\$15 copay
10% of plan allowance	30% of plan allowance	Covered in full
\$20 copay	30% of plan allowance	Covered in full
Outpatient—Covered in full at network radiology or laboratory centers; Inpatient—10% of plan allowance	30% of plan allowance	Covered in full
\$50 copay (waived if admitted), then 10% of plan allowance	\$50 copay (waived if admitted), then 10% of plan allowance	Covered in full after \$75 copay (waived if admitted)
\$20 copay first visit, then covered in full	30% of plan allowance	Covered in full after diagnosis
\$20 copay	30% of plan allowance	Covered in full for age 5 and under
10% of plan allowance	30% of plan allowance	\$15 copay
\$100/admission copay, then 10% of plan allowance	\$100/admission copay, then 30% of plan allowance	\$100/admission copay, then covered in full
10% of plan allowance	30% of plan allowance	Covered in full (includes prostheses and orthotics)
\$20 copay, 90-visit maximum, per condition/therapy, per calendar year	30% of plan allowance, 90-visit maximum, per condition/therapy, per calendar year	Covered in full, short-term duration; \$15 copay
\$20 copay	30% of plan allowance	Not covered
Outpatient—10% of plan allowance; Inpatient—\$100/admission copay, then 10% of plan allowance	Outpatient—30% of plan allowance; Inpatient—\$100/admission copay, then 30% of plan allowance	Outpatient—\$15 copay; Inpatient—\$100/admission copay, then covered in full
Provided by Express Scripts for CareFirst members		Kaiser Rx
Provided by Davis Vision plan. Vision plan includes coverage for frames, lenses (or contact lenses) and eye exams.		\$150 annual allowance for frames, lenses and or contact lenses.

Express Scripts—Pharmacy Benefit Manager for Aetna/Innovation Health and CareFirst Members

Express Scripts

Your copayment is 20% of the cost of the drug (subject to the minimum and maximum copayments below).

Retail Pharmacy (per 34 day supply)

Generic	\$ 7	minimum (or cost of drug prior to coinsurance, if less)
	\$ 25	maximum

Brand	\$ 15	minimum
	\$ 25	maximum

Retail Pharmacy (90-day supply) (not available for specialty drugs)

Generic	\$ 21	minimum (or cost of drug prior to coinsurance, if less)
	\$ 75	maximum

Brand	\$ 45	minimum
	\$ 75	maximum

Mail/Home Delivery (90-day supply)

Generic	\$ 14	minimum (or cost of drug prior to coinsurance, if less)
	\$ 50	maximum

Brand	\$ 30	minimum
	\$ 50	maximum

Annual out-of-pocket prescription maximum: Individual, \$1,500; Family, \$3,000. (These out-of-pocket expenses do not include ancillary amounts or additional charges.)

Plan Highlights

The Express Scripts prescription drug program offers services through a network of 61,000 participating pharmacies, including major chains and retail pharmacies, a specialty pharmacy, and a mail service pharmacy.

UNDER THE ESI PHARMACY PROGRAM:

- You complete a *Prescription Mail Order* form and begin saving immediately on your maintenance prescriptions.
- You may fill up to a 1-month supply of a maintenance prescription drug 2 times from a local participating pharmacy.
- **Before you can refill your prescription, you must use 75 percent of your medication if obtained from your local pharmacy or 60 percent of your medication if obtained from the home delivery program.**
- Details about your coverage are available in the *Summary Plan Document*: go to www.fcps.edu, click on **Employees**, and look for **Benefits** under Retirees. This document is updated regularly and contains additional details about **Specialty Medications, Prior Authorization, Step Therapy, and Drug Quantity Limits**.
- Visit www.express-scripts.com for more information.

VACATION OVERRIDE

If you are going on vacation and need more than a 1-month supply of your medication, ask your pharmacist to call the Pharmacy Help Line and request a vacation override. This will allow you to fill your next prescription early.

Additional Services and Programs

- *Price Check* is an online feature that allows you to find out what you will pay for a specific drug.
- Express Scripts provides automated order notifications and refill reminders to its members who elect this service.

Express Scripts Program Guidelines

PRIOR AUTHORIZATION

This is a list of drugs that requires proof of medical necessity before the plan will pay for a prescription for these drugs.

The purpose of prior authorization is to prevent misuse and off-label use of expensive and potentially dangerous drugs. Prior to issuing a prescription on the Prior Authorization list, your doctor's office should call the ESI Prior Authorization department at 800-417-8164 or fax in the *Prior Authorization Medication Request* form (available by calling ESI Customer Service or visiting www.express-scripts.com/services/physicians/pa/). The physician must complete, sign, and fax the form to 800-357-9577.

STEP THERAPY

This is a program for people who take selected prescription drugs regularly to treat an ongoing medical condition. The program is an approach to getting you the prescription drugs you need with safety, cost, and most importantly, your health in mind. It allows you and your family to receive the most effective and affordable treatment.

In Step Therapy, the covered drugs you take are organized in a series of "steps," with your doctor approving and writing your prescription(s). The program usually starts with generic drugs as the first step. The first step allows you to begin or continue treatment with safe, effective prescription drugs that are also affordable. Your copay is generally the lowest with a first-step drug. Brand-name drugs are usually covered in the second step.

If you have tried a first-step drug unsuccessfully or your doctor decides one is not appropriate for medical reasons, ask your doctor's office to call the ESI Prior Authorization department at 800-417-8164 or fax in the *Prior Authorization Medication Request* form (available by calling ESI Customer Service or visiting www.express-scripts.com/services/physicians/pa/). The physician must complete, sign, and fax the form to 800-357-9577.

If Express Scripts approves the prior authorization request, the second-step drug will be covered by the plan. If this is a brand-name drug, you will have a higher copay.

If you have previously taken a second-step drug but have not had the prescription filled within 130 days, upon the next fill of that medication you will be required to start with the first-step drug, unless your doctor provides ESI with documentation that you should only take the second-step drug.

Accredo is ESI's home or office delivery service for retirees who use specialty oral or injectable medications. After an initial 34-day supply of a specialty medication is filled at a network pharmacy, the plan covers the medication only through the Specialty Care Pharmacy managed by Accredo. You receive a maximum 1 month's supply each time you refill your prescription. Call Accredo at 877-ACCREDO (222-7336).

Generic drugs are copies of brand-name drugs whose patents have expired.**A generic drug is:**

- Effective—Contains the same active ingredients and comes in the same strengths as the original brand drug that you commonly see advertised.
- Safe—Meets strict requirements for quality and purity from the U.S. Food and Drug Administration.
- Less Expensive—Costs about half as much as a brand drug to produce because the companies that make generics do not spend large sums on research and advertising—and the savings are passed on to you in the form of a lower copayment.

GENERIC PREFERRED PROGRAM

When you fill a prescription the pharmacy will determine if a generic drug is available.

1. If a generic is not in stock, you may choose either to wait until the pharmacy has the generic in stock, visit another pharmacy, or pay the brand copay.
2. If a generic drug is available and you choose the brand name drug, you will pay the brand copayment plus an ancillary amount in addition to the copayment. This ancillary amount is the price difference between the generic drug and the brand drug.

You will not pay the ancillary amount if:

- Your physician documents a medical need for the brand drug in writing, and Express Scripts concurs with the medical necessity for a brand.

HOME DELIVERY PROGRAM

Express Scripts has a Home Delivery Program that helps CareFirst members save money on maintenance medications—or any prescribed drug that you take for more than 2 months.

If your doctor has diagnosed you with a chronic condition, such as diabetes, high blood pressure, arthritis, or high cholesterol, you are probably taking maintenance medications—prescription drugs for ongoing medical conditions.

Using home delivery for your maintenance medications saves you money on copayments. Basically, you get a 3-month supply of your prescription drug for what you would have spent on a 2-month supply at a retail pharmacy.

When you begin taking a new maintenance medication, you should obtain 2 prescriptions from your physician:

1. A prescription for a 30-day supply, which you should have filled at your local pharmacy so you can take your medication while your first order is being processed at mail order.
2. A prescription for a 90-day supply, with 3 refills (if appropriate) that you should mail to Express Scripts as soon as you fill your local pharmacy prescription from #1 above. You should use a *Prescription Mail Order* form, which is available by calling Express Scripts Customer Service at 866-815-0003 or by calling the FCPS Client Services at 571-423-3000.

You will receive your prescription approximately 2-3 weeks after Express Scripts receives your prescription or refill request.

With Home Delivery:

- Two registered pharmacists check every new prescription.
- Your medication arrives in a plain, weather-resistant package.
- You receive free home delivery of your medication.
- Pharmacists are available 24 hours/day to answer your questions.
- You may order refills by phone, by mail, or on the Express Scripts website.
- You receive automated order notifications and reminders.

Ordering Refills

Order refills of your Home Delivery prescriptions by:

- Registering on the Express Scripts website at www.express-scripts.com
- Calling Express Scripts Customer Service at 866-815-0003
- Mailing the refill request using the form enclosed with your previous order

Prescription Examples

Your physician prescribes Effexor and allows you to buy the generic venlafaxine:

SCENARIO # 1

You choose to use the home delivery program:

- Complete the Home Delivery form. Allow 2–3 weeks for delivery on a new prescription.
- Choose the generic equivalent venlafaxine.
- Pay \$14 for a 3-month supply of the generic.

SCENARIO # 2

You choose to fill your Rx at a local pharmacy:

- Choose the generic venlafaxine and fill your prescription twice at a local pharmacy. You pay \$7 for each fill. On your third fill, you choose to continue to use the local pharmacy and begin to pay \$17 for up to a 34-day supply (\$7 + \$10 additional charge for receiving the third fill of a generic medication at a local pharmacy).
- Pay \$31 for a 3-month supply of the generic.

SCENARIO # 3

You choose the brand and fill your Rx at a local pharmacy:

- Choose the brand Effexor and fill your prescription twice at a local pharmacy. You pay \$217.16 for each fill (\$25 copay, plus \$192.16 ancillary charge).
- Or pay \$510.76 for a 3-month supply of the brand-name drug at retail (\$75 copay, plus \$435.76 ancillary charge).

In other words...

SCENARIO # 1

Fill generic at mail order:

Fill #1 - 90 day supply of venlafaxine

Your cost **\$14**

SCENARIO # 2

Fill generic at local pharmacy:

Fill #1 - 90 day supply of venlafaxine

Your cost **\$21**

SCENARIO # 3

Fill brand name at local pharmacy instead of choosing generic:

Fill - 34 day supply of Effexor XR (\$25 brand name copayment + ancillary charge)

Your cost (per fill) **\$217.16**

Total cost for 3 month supply **\$14**

Total cost for 3 month supply **\$21**

Total cost **\$510.70**
(Fill a 90-day supply at one time)

The examples above are for illustrative purposes only. Prescription drug prices are subject to market cost changes.

Medicare Part A

Medicare Part A—Hospital Coverage pays for care in a hospital, skilled nursing facility, home health care, and/or hospice care.

Most retirees do not pay for Medicare Part A coverage; you have already paid for it as part of your Social Security taxes while you were working.

Medicare Part B

Medicare Part B—Medical insurance helps pay for doctors, outpatient hospital care, and other medical services.

You pay a monthly premium to Social Security when you enroll in Medicare Part B.

Creditable Coverage

FCPS provides an annual notice (pp. 35–36) stating that FCPS prescription coverage is creditable coverage. Please keep this notice so you can provide documentation of continuous creditable coverage if you later decide to enroll in a Medicare Rx plan.

For more information about Medicare Rx and communications from CMS, visit www.cms.hhs.gov or call 1-800-Medicare (1-800-633-4227).

Becoming Eligible for Medicare

Medicare is a federal medical insurance program for people age 65 or older, those under age 65 (when certified as eligible by Social Security) and those any age with end-stage renal disease. Find more information at www.medicare.gov.

You are typically eligible for Medicare on the first day of the month you turn 65. Disabled individuals may qualify prior to age 65. Your Medicare eligibility date may not be the same as your Social Security eligibility date. Contact Social Security three months before you turn 65 to initiate Medicare coverage.

Medicare Enrollment

Once you receive your Medicare card, make a copy and send it to:

**FCPS, Department of Human Resources, Office of Benefit Services,
8115 Gatehouse Road, Suite 2700, Falls Church, VA 22042**

Your Medicare initial enrollment period begins 3 months before you turn 65 and ends 3 months after. If you miss this deadline, you must wait until the Medicare General Enrollment Period, held January 1 through March 31 each year. If you do not enroll during your initial enrollment period, you may incur a penalty that will increase your monthly premium as long as you have Medicare coverage (see *Exceptions to Medicare Enrollment and Coverage* below).

All FCPS retiree medical plans require retirees, spouses, and their dependents to enroll in Medicare Parts A and B when they become eligible for Medicare (exceptions indicated below). Medicare is generally the primary coverage for a retiree and/or spouse age 65 or older who has medical benefits through FCPS. Medicare enrollees generally receive the same level of coverage, but **Medicare pays first**. Your FCPS retiree medical plan becomes your secondary coverage.

As an FCPS retiree eligible for Medicare, you can enroll either in the CareFirst Blue Preferred PPO or Kaiser Permanente Medicare Plus plans (provided you reside in the Kaiser Permanente Medicare service area).

Exceptions to Medicare Enrollment and Coverage

- If you are retired and covered by your spouse who continues to work for FCPS, you do not need to enroll in Medicare when you become eligible. As a dependent of an active employee, your FCPS coverage remains primary. Prior to your spouse's retirement, you should obtain a form from Medicare that FCPS will complete to verify your enrollment in the active plan.
- This rule applies only if your spouse is covered through FCPS as an active employee. If you or your spouse is retired and re-employed as a substitute teacher or a non-benefits-eligible employee, your benefits are provided as a retiree and you must elect Medicare coverage.
- You must elect Medicare if you are retired, working for another employer, and eligible for Medicare. Since you are covered by FCPS as a retiree, your Medicare benefits will pay as primary, and FCPS benefits pay as secondary.
- If you retire on June 30 your employee coverage will continue through August 31; however, Medicare becomes your primary plan effective July 1.

Aetna/Innovation Health and CareFirst BlueChoice Advantage

- If you are enrolled in the FCPS Aetna/Innovation Health or CareFirst BlueChoice Advantage plans, when you become eligible for Medicare FCPS **will automatically enroll you** in the Medicare supplemental plan. If you are covered by the BlueChoice Advantage plan, FCPS will transfer you and your dependents to the Aetna/Innovation Health plan.
- If you do not want to participate in the Aetna/Innovation Health plan, you may elect to enroll in Kaiser Permanente Medicare Plus plan (subject to service area restrictions described below).
- **You may not elect the CareFirst BlueChoice Advantage plan once you are eligible for Medicare.**

Kaiser Permanente Medicare Plus

- If you want to continue with Kaiser when you become eligible for Medicare, you must take action to enroll in the Kaiser Permanente Medicare Plus plan. Medicare's rules do not allow for automatic enrollment in the Medicare Plus Plan.
- If you are age 65 or older, contact Kaiser Permanente for the Medicare Plus form and return the form to FCPS DHR, Office of Benefit Services.
- Under Medicare Plus, Kaiser Permanente generally provides all your medical care. You may also use your Medicare coverage to see health care providers not affiliated with Kaiser.
- Enrollment in the Kaiser Medicare Plus plan is subject to federal government guidelines that **require residence in the plan's Medicare service area**. You must live—and your Social Security address must be—in the Kaiser Medicare service area, which may be different than the Kaiser Permanente Service area. Therefore, submitting an application does not guarantee your enrollment in Kaiser's Medicare Plus plan. You should contact Kaiser Permanente's customer service unit at 301-468-6000 to ensure that your residential zip code is in the service area.

Medicare Rx (Medicare Part D)

Your FCPS prescription coverage—either with Express Scripts (for Aetna/Innovation Health members) or Kaiser Permanente—is currently more comprehensive than Medicare Part D provisions and meets the Centers for Medicare and Medicaid Services (CMS) creditable coverage requirements.

- If you elect to participate in either the Aetna/Innovation Health or Kaiser Medicare Plus plans, you automatically have prescription drug coverage with Express Scripts or Kaiser Permanente. You are not required to enroll in a Medicare Rx plan. **Enrollment in a separate Medicare Rx plan will cause your FCPS prescription drug coverage to be canceled.**
- If you choose to enroll in a Medicare Rx plan and later cancel that coverage, you will be eligible to resume prescription drug coverage under an FCPS plan if you provide FCPS with a Medicare prescription drug coverage termination notice within 30 days of termination.

When Medicare Is Your Primary Coverage

Medicare is the primary payer for a retiree or spouse age 65 or older who has retiree health benefits through FCPS. Your FCPS retiree health plan becomes your secondary coverage.

Medicare is also the primary payer for certain individuals under age 65 with disabilities. If you are a retiree under age 65 and eligible for Medicare, you must elect Medicare coverage; FCPS' medical plan will pay as secondary.

Medicare Part D

Medicare Part D is a prescription drug plan available to Medicare-eligible individuals. If you elect Medicare Part D, you pay a monthly premium directly to the plan with which you are enrolled. You are not required to enroll in a Medicare D plan—all FCPS health plans contain prescription drug benefits.

Dental Plans

FCPS offers you a choice of two dental plans: Aetna Dental Preferred Provider Organization (DPPO) or Aetna Dental Maintenance Organization (DMO)

You can elect dental benefits separately from medical benefits.

Aetna Dental Preferred Provider Organization

Plan Highlights

- Coverage includes preventive care, basic care, and major services. You do not have to choose a primary care dentist.
- You can receive care from either an in-network or out-of-network dentist. You pay more when you receive care from out-of-network providers.
- The plan has a wide choice of in-network dentists.
- You pay a coinsurance based on an allowable charge. Network dentists must accept the Aetna negotiated fees and are not allowed to charge more.
- Certain orthodontic procedures are covered for treatment that begins prior to a child turning 19.
- There is an annual maximum on covered services which renews each year. Orthodontic services are subject to a lifetime maximum.

Aetna Dental Maintenance Organization

Plan Highlights

- You must select a primary care dentist and receive all your dental care from that dentist, unless that dentist refers you to a specialist. You may change your primary care dentist at any time.
- This is a lower cost plan with a more limited network of providers. Call your dentist to ensure that they are in the Aetna DMO network.
- You may only use dentists who are part of the Aetna DMO network; **out-of-network providers are not covered under this plan.**
- Most preventative dental services are covered at 100%. Other services will require you to pay a copayment per service.
- There are no deductibles and no dollar annual maximums, although limitations may apply to certain procedures.
- If you are moving and want to find a DMO provider in your new area, call Aetna customer service.
- Orthodontia is covered regardless of age. Services must be provided by a DMO-covered provider.

Dental Plan Comparison

	DPPO In-Network you pay	Out-of-Network you pay***	DMO In-Network you pay
Deductible	None	\$50 individual, \$150 family	None
Orthodontic Deductible	None	\$50	None
Preventive & Diagnostic	Covered in full	10%	Covered in full
Basic Restorative	20%	30%	Varies by service
Major Restorative	50%	60%	Varies by service (see fee schedule)
Orthodontia	50%**	60%**	\$2,300 copay
Annual Maximum (not including orthodontia)†	\$1,500	\$1,200	None
Orthodontia Lifetime Maximum*†	\$1,500	\$1,000	One treatment plan

*Orthodontic benefits limited to one treatment plan. Patient responsible for amounts above orthodontia lifetime maximum.

**Dependent children under age 19 only.

***In addition to coinsurance, you pay any amount in excess of usual, customary, and reasonable fees.

† Limits are combined across in and out of network.

Pretreatment Authorization Under the Aetna DPPO or DMO

Aetna Dental suggests that you obtain a pretreatment authorization for any treatment plan that is expected to exceed \$350. The pretreatment authorization will tell you whether the service is covered, as well as reasonable and customary fees.

- Your dentist submits the treatment plan to Aetna Dental, including the list of services to be performed with dental codes, the itemized cost of each service, and the estimated duration of treatment. Aetna Dental then sends an authorization form with Aetna's estimated payment to you and your dentist.
- Actual benefits are determined according to the fee allowance that exists at the time the service is actually performed.
- Dental expenses may be denied if treatment is not appropriate for the participant's condition. Additional payments may be required if any portion of the fees exceeds the allowance for a procedure.

Additional Benefits through Aetna

Aetna also offers access to discounts on fitness and alternative health care services and products.

As an Aetna member, you have access to discounts on fitness services at independent health clubs and on home exercise equipment and videos through GlobalFit.

Aetna's alternative health care programs offer discounts on health-related services from chiropractors, acupuncturists, massage therapists, and nutritional counselors and on the purchase of vitamins, nutritional supplements, and other health-related products through participating retailers.

Simply show your Aetna Dental ID card to participating professionals and retailers. Additional information about these discounts and participating vendors can be found at www.aetna.com.

Details about your coverage are available in the Summary Plan Document on the Aetna/Innovation Health website. Go to www.ih-aetna.com/fcps for plan documents or to search for participating providers.

To get help with your dental benefits ...

Call Aetna Dental Customer Service at 877-238-6200 to:

- Ask questions to clarify your benefits
- Ask questions about services and costs
- Request an identification card if you have not received one or if you need a replacement
- Obtain information about providers
- Make a complaint or file an appeal

VRS Years of Service	Monthly Health Credit
15	\$ 60
16	\$ 64
17	\$ 68
18	\$ 72
19	\$ 76
20	\$ 80
21	\$ 84
22	\$ 88
23	\$ 92
24	\$ 96
25	\$ 100
26	\$ 104
27	\$ 108
28	\$ 112
29	\$ 116
30	\$ 120
31	\$ 124
32	\$ 128
33	\$ 132
34	\$ 136
35	\$ 140

Medical Plan Subsidies

If you are eligible and elect to continue FCPS medical coverage into retirement, FCPS pays a subsidy toward the cost of your medical coverage if you are age 55 or older (or if approved for disability retirement). This subsidy reduces the premium amount you pay for your FCPS medical coverage.

Educational Employees' Supplementary Retirement System

If you are a member of ERFC, FCPS provides a \$100 per month subsidy toward your medical premium. The subsidy does not apply to dental benefits. If you are under the age of 55 and receive disability retirement benefits, you also may receive the subsidy. FCPS applies the subsidy on the first day of the month following the month in which you turn age 55. The FCPS medical subsidy ends upon your death and does not transfer to surviving dependents who remain covered by an FCPS medical plan.

← Virginia Retirement System

VRS provides a monthly health credit to retirees with at least 15 years of service. You do not have to be enrolled in an FCPS health plan to receive this reimbursement. The Virginia General Assembly sets the amount for each year of service you have with VRS. The credit is currently \$4 per year of service. The VRS credit ends upon your death and does not transfer to any surviving dependents.

To receive the credit, you must complete a *Request for Health Insurance Credit* form (VRS-45) and submit it to VRS in order to verify that you are purchasing medical insurance (including Medicare Part B premiums). The health insurance credit amount is reflected in your monthly VRS benefit and is not subject to federal or state taxes.

Fairfax County Employees' Retirement System

FCPS provides a subsidy to FCERS members based on years of service. FCPS applies the subsidy for FCERS retirees on the first of the month in which you turn age 55. The FCPS subsidy ends upon your death, at which time your surviving dependents no longer receive your medical subsidy.

If you retired from FCERS **before** July 1, 2004, **and** you participated in an FCPS medical plan before that date, you receive at least \$100 per month in subsidy. Your subsidy may be above \$100 if you have more years of service as shown below:

Subsidy (Retired and enrolled before July 1, 2004)		
Years of Service	Under Age 65	Age 65 & Over (Medicare)
Less than 15	\$100	\$100
15–19	\$125	\$100
20–24	\$150	\$150
25 or more	\$175	\$175

If you retired from FCERS on or **after** July 1, 2004, or if you enrolled in an FCPS medical plan on or after July 1, 2004, FCPS provides a subsidy based on your years of service according to the following schedule:

Subsidy (Retired or enrolled on or after July 1, 2004)		
Years of Service	Under Age 65	Age 65 & Over (Medicare)
5–9	\$ 25	\$ 15
10–14	\$ 50	\$ 25
15–19	\$125	\$100
20–24	\$150	\$150
25 or more	\$175	\$175

Deferred Health Option for Retirees

The Deferred Health Option (DHO) creates a safety net for retirees who do not elect to continue enrollment in an FCPS health and/or dental plan when they retire, but wish to maintain their eligibility for future enrollment in the plan(s).

If you are eligible to retain health care benefits into retirement (requirements on page 5) and you were hired prior to July 1, 2005, you have a one-time election opportunity to participate in the DHO when you retire.

By paying a monthly premium, DHO gives an eligible retiree and their dependents the right to enroll in FCPS retiree medical and/or dental coverage at a later date, if the DHO participant loses health and/or dental coverage due to the death of a spouse or divorce.

An eligible individual may only enroll in the type of plan coverage they lost as a result of the death of or divorce from a spouse. For example, **if an enrolled DHO member loses dental coverage as a result of death or divorce**, the member may only elect FCPS retiree dental coverage. Additionally, if you are permitted to continue on your former spouse's plan, such as through COBRA Continuation Coverage, you are not eligible for DHO enrollment. Loss of coverage for other reasons (such as retirement from a second career) does not allow a DHO participant to re-join an FCPS retiree health care plan.

DHO is not available to you if you were hired on or after July 1, 2005.

How to Enroll

To participate in the DHO program, you must elect this option at time of retirement. and have met the criteria for continued coverage as a retiree. If you do not, you will not be provided with another opportunity to enroll. This option is available only to employees who were hired before July 1, 2005.

Your retirement counselor will provide you with the form needed in order to enroll in the DHO plan and authorize premium deductions from your retirement annuity.

Future Communications—Annual Notification

Prior to the start of each calendar year, DHO participants will receive notification of the monthly premium amount due for the upcoming calendar year. The letter shall be mailed to the individual's last known address, so it is critical to maintain a current address with FCPS. Please also provide FCPS with your email address so that communications can be sent electronically.

Amount of Payment

The cost of DHO participation is adjusted each year by the cost of living adjustment, provided to ERFC retirees.

Enrollment

All enrollment communications should be either sent by mail to:

**Fairfax County Public Schools
Department of Human Resources
Office of Benefit Services
Gatehouse Administration Center I
8115 Gatehouse Road, Suite 2700
Falls Church, VA 22042**

OR faxed to:

**Fairfax County Public Schools
Department of Human Resources
Office of Benefit Services**

(Fax) 571-423-5000

OR emailed to:

HRBenefitsEnrollment@fcps.edu



DHO participants must elect to pay premiums via deduction from their ERFC or FCERS annuity payments unless such annuity is insufficient from which to take a deduction. In this case, the participant will be provided instructions on how to remit payment. Disenrollment will occur if the participant fails to make payments timely. Once DHO coverage is cancelled, it may not be reinstated.

Election to Join Retiree Medical and/or Dental Plan Upon Death of Spouse or Divorce

If a DHO participant becomes widowed or divorced, the participant may elect to be covered by an FCPS medical or dental plan. In order to elect coverage, the DHO participant must:

- Have lost coverage due to death of your spouse or divorce;
- Be married to the same individual as when you elected DHO;
- Not be eligible for medical and/or dental coverage under the former spouse's plan (including COBRA coverage);
- Have been enrolled in the same line of coverage for which enrollment is being requested (i.e., in order to request enrollment in an FCPS medical plan, you must have been enrolled in your former spouse's medical plan).
- Request enrollment in an FCPS plan with 30 days of the event or loss of coverage;
- Provide evidence satisfactory to FCPS that employer-provided medical and/or dental coverage had been in effect and that you are no longer permitted to be enrolled in said coverage due to the event.

Enrollment paperwork and required premium payments must be received or postmarked within 30 days of the loss of coverage. Upon timely receipt of the above, the DHO participant will be enrolled in an FCPS retiree medical and/or dental plan the first day of the month following the loss of coverage. An individual who does not meet the criteria outlined above will not be permitted to enroll in FCPS retiree medical and/or dental coverage.

Once enrolled, the individual will become subject to the same rules with respect to payment, etc., as all other FCPS retiree health and/or dental plan participants.

Long-Term Care Insurance

Long-Term Care helps you pay for the care you need if you ever suffer from a chronic illness or disability that makes you unable to care for yourself for an extended period of time. Long-Term Care Insurance is managed by CNA.

Plan Highlights

DAILY FACILITY CARE BENEFIT

Pays the actual cost of services you receive, up to the amount elected, for care in the following facilities:

- Nursing homes
- Assisted living facilities
- Hospice facilities

DAILY COMMUNITY-BASED CARE BENEFIT

Pays the actual cost of services you receive, up to the amount elected, for care in the following settings:

- Your own home
- Adult day care facility

You can choose either 60% or 100% of the Daily Facility Care Benefit.

LIFETIME MAXIMUM BENEFIT

This is the total amount of insurance you purchase. It is the total available pool of money you can use to pay for long-term care services.

INFLATION PROTECTION

To keep up with inflation, long-term care insurance offers you a chance to increase your coverage without providing evidence of insurability (called “guaranteed issue”).

- **Guaranteed Benefit Increase**—Every 3 years, CNA will offer you the chance to increase your Daily Facility Care and Lifetime Maximum Benefits. Premiums for increased coverage will be based on your age on the effective date of the offer and will be at least equal to a compound 5 percent rate of increase. Actively-at-work employees and their spouses are guaranteed acceptance, regardless of whether a previous offer was rejected. All other participants are guaranteed acceptance, as long as the participant continues to accept offers to increase coverage.

Or you may have the option to purchase:

- **Lifetime Compound Automatic Benefit Increase**—This inflation protection feature automatically increases your benefits by 5 percent (compounded each year) without increasing your premiums. Increases continue, even while receiving benefits, unless premium payments stop for any reason (except waiver of premium).

Eligibility

You are eligible to request enrollment in the Long-Term Care plan if you are a benefits-eligible retiree.

You may also request coverage for your spouse, parents, parents-in-law, grandparents or grandparents-in-law. Evidence of insurability is required.

Employees who were enrolled in the Long-Term Care plan may continue coverage on a direct-pay basis upon retirement or termination of employment.



Enrollment

To enroll, retirees and their family members must submit evidence of insurability and be approved by CNA before coverage will begin. To request enrollment in the Long-Term Care plan, visit CNA online for enrollment information at www.ltcbenefits.com. The password is "FCPS". Your coverage starts on the first day of the month after your application has been approved.

You may cancel your coverage at any time. You may request a change to your benefit at any time during the year, as long as you are not receiving a benefit or are in the qualification period. The request must be approved by CNA.

When you enroll in Long-Term Care, you will elect your desired benefit levels. You can choose from the following options:

Daily Benefit Amount (Facility)	Daily Community-Based Care Benefit	Lifetime Maximum Benefit (3-year option)	Lifetime Maximum Benefit (5-year option)
\$100	\$60 or \$100	\$109,500	\$182,500
\$200	\$120 or \$200	\$219,000	\$365,000
\$250	\$150 or \$250	\$273,750	\$456,250

Premiums are based on:

- Age on the effective date of coverage
- Choice of Daily Benefit Amount (\$100, \$200, or \$250)
- Choice of Daily Community-Based Care Benefit (60% or 100%)
- Choice of Lifetime Maximum Benefits (3-year or 5-year)
- Choice of Inflation Protection - Guaranteed Benefit Increase or Automatic Benefit Increase Option

Qualifying for Benefits

You qualify to receive benefits when a licensed health care practitioner has certified that either of the following conditions exists and is likely to last more than the plan waiting period of 90 calendar days:

- You are unable to perform two of the following six activities of daily living: Bathing, dressing, eating, maintaining continence, transferring, and toileting;

OR

- You have a cognitive impairment (confusion, memory or orientation problems, lack of reasoning or judgment) that causes safety concerns for you or another person.

After you satisfy the waiting period, your premiums will be waived while you are receiving benefits.

Exclusions

Exclusions help keep the cost of the plan affordable. Your plan will not pay benefits for the following:

- Long-term care that results from war.
- Long-term care covered by Workers' Compensation or other group insurance.
- Long-term care normally provided without charge.
- Care in a facility that primarily treats substance abuse or mental illness.
- Long-term care received outside the United States.
- Services covered by Medicare (except for application of a deductible or coinsurance).

Additional Features

Bed Reservation—Pays the Daily Facility Care Benefit up to 21 days per year, to hold your place in a nursing home or other facility, if you need to be away temporarily.

Caregiver Benefit—This benefit makes a cash payment equal to 10 times your Daily Facility Care Benefit each year when you receive unpaid care. This benefit is payable in addition to the Home-Based Care Benefit.

Future Benefit Guarantee (Nonforfeiture)—There may come a time when you either cannot or no longer want to continue paying premiums. If you stop paying premiums after having coverage for at least 3 years, the Future Benefit Guarantee keeps your daily benefits the same, but reduces your lifetime maximum benefit. Your reduced lifetime maximum benefit equals the total premiums paid or 30 times the Daily Facility Care Benefit, whichever is higher, less any benefits paid.

Restoration of the Lifetime Maximum Benefit—This feature restores your Lifetime Maximum Benefit if you have received LTC benefits but have not received medical care or treatment for 5 consecutive years for a condition requiring Long-Term Care services.

When you retire, You are eligible to continue most of your life insurance coverage. You may convert any portion of your basic and/or optional life insurance that did not continue as a retiree to an individual plan. You must request this coverage within 31 days of the date your group coverage ends.

FCERS members should contact the FCPS Office of Benefit Services at 571-423-3200 to request a conversion form.

VRS/ERFC members should contact ERFC at 703-426-3900.

Life Insurance for Retirees

Life Insurance for VRS & ERFC Members

If you are a member of VRS, your basic group life insurance benefit continues at no cost to you, provided you meet the age and service requirements for normal retirement or have been approved for disability retirement.

Minnesota Life, the VRS group life insurance provider, bases the amount of your basic group life insurance on your annual salary at the time of your retirement. If you have 20 or more years of service, your life insurance at retirement will be equal to twice the highest annual salary you earned during your career. Your basic life insurance begins to reduce January 1 of the first full year after retirement at a rate of 25 percent per year, until it is valued at 25 percent of your coverage amount at retirement.

You may continue a portion of your optional group life insurance coverage for yourself, your spouse, and your dependents into retirement if you were covered continuously under the optional plan during the 60 months immediately preceding your retirement. You must elect optional coverage within 31 days of terminating service in a VRS-covered position, and you will make payment directly to Minnesota Life. Optional and dependent life insurance amounts reduce 25% each year upon attainment of ages 65, 70, and 75. Optional and dependent life coverage ends at age 80.

VRS members continue to have access to accelerated death benefits for life insurance. Accidental death and dismemberment benefits end upon retirement.

Life Insurance for FCERS Members

If you are a member of FCERS, your basic life insurance benefit continues at no cost to you after retirement. Upon retirement or when you turn age 65 (whichever is earlier), your life insurance coverage will reduce to 65 percent of your original coverage. Coverage will reduce again to 50 percent of your original coverage when you reach age 70. Reductions will occur on the first of the month following or coinciding with retirement, or when you reach specified ages.

FCERS members may continue optional coverage at retirement provided you were covered during the 60 months immediately preceding your retirement. Optional life follows the same reduction schedule as the basic coverage. Premium amounts adjust accordingly.

FCERS members continue to have access to accelerated death benefits for life insurance. Accidental death and dismemberment benefits end upon retirement.

Changing Beneficiaries

If you are a VRS participant, you should notify ERFC if you want to change beneficiaries. If you are a member of FCERS, contact the FCPS Office of Benefit Services to change beneficiaries.

Other FCPS Benefits at Retirement

Tax-Deferred Retirement Savings Plans: 457(b) and 403(b)

Contributions to the Deferred Compensation–457(b) plan and Tax-Deferred Account–403(b) end upon retirement.

If you are rehired into a temporary hourly position, such as a substitute teacher, you are eligible to contribute to a 403(b) through payroll deduction. **If in retirement you are re-employed in a temporary hourly position, you may not be approved for distributions such as rollovers or cash withdrawals from your 403(b) or 457(b) account.**

If you are a 12-month employee and receive an annual leave payout, your tax-deferred contribution(s) will automatically be deducted from that payment unless you stop your contribution(s) prior to that payout. You should contact your 403(b) and/or the 457(b) investment provider for advice about your account.

To improve service to you and comply with IRS 403(b) regulations, FCPS has partnered with TSA Consulting Group (TSACG) as our third-party administrator. TSACG is responsible for evaluating and approving distribution and withdrawal transactions (to include cash withdrawals, rollovers, loans, and hardship withdrawals). You will initiate all distribution transactions through TSACG. You may request distributions by completing the necessary forms obtained from your investment product provider, attaching them to a *Transaction Routing Request Form*, and submitting all completed documents to TSACG for evaluation and approval. The *Transaction Routing Request* form can be found on the TSACG website at www.tsacg.com/employee_services/transaction_procedures.htm.

Participants in the 457(b) should contact Great West Retirement Services for distribution information at (800) 701-8255 or on the Great West website at www.qwrs.com/.

Federal tax law generally requires that plan participants receive an annual required minimum distribution (RMD) no later than April 1 of the year following the year you turn age 70½ or, in the year you retire from FCPS, whichever is later. Contact your investment provider(s) for further details.

Long-Term Disability

Your eligibility for long-term disability benefits generally ends upon your retirement. However, if you are currently collecting a long-term disability benefit (LTD), contact Liberty Mutual to determine how your retirement benefit will impact your LTD benefit. If you elect to continue your medical or dental benefits, you should also contact the Office of Benefit Services regarding the amount of your contribution if you continue your FCPS medical coverage.

Credit Union

You may continue to be a member of the Apple Federal Credit Union after you retire. For more information, call 703-788-4800.

Keep in Touch

Be sure to keep your address up-to-date with FCPS. Benefit terms and conditions may change in the future; to ensure FCPS can contact you, please notify your retirement agency if you change your address.

Leave Benefits

ANNUAL LEAVE

The Office of Payroll Management automatically pays all funds due to you for unused annual leave approximately one to two pay periods after your last regular paycheck.

SICK LEAVE

ERFC Legacy Plan & FCERS—Any unused sick leave accrued through your retirement date is applied as additional retirement service credit if you are a *vested* member of the *ERFC Legacy* plan or FCERS. No monetary payout occurs for unused sick leave.

FCPS regulations allow you to transfer a portion of your sick leave to another Virginia school system. If you will become employed by another Virginia school system within 60 days of retirement, you may elect to transfer a portion of your sick leave to that system and convert your remaining sick leave balance to retirement service credit. See *Regulation 4819* for more details.

ERFC 2001—Sick leave conversion does not apply to members of *ERFC 2001* (employees who were hired on or after July 1, 2001). *ERFC 2001* members do not receive service credit, nor do they receive a monetary payout for unused sick leave.

VRS-Only Members (Not Enrolled in ERFC)—VRS-only members do not receive additional service credit for unused sick leave. Instead, you are eligible for a sick leave payout at a rate of \$1.25 per hour of unused sick leave.

Your Retirement Checks

VRS, ERFC, and FCERS require you to sign up for direct deposit of your retirement benefits. Be sure to contact your retirement plan(s) if you change banks or account numbers.

VRS Retirement Checks—Your retirement date is the first day of the month in which you choose to retire. VRS makes deposits on the first business day of the month or on the last business day of the preceding month if the first day of the month falls on a holiday or weekend. If VRS receives your retirement application at least 90 days before your retirement date, you will receive your first check on the first of the month following the month you last contributed to VRS. Your retirement benefit is payable on the first of the month for the previous month.

ERFC Retirement Checks—Your effective retirement date is always the first day of the month in which you choose to retire. You receive your monthly retirement payment on the last day of the month.

FCERS Retirement Checks—You will receive your retirement payment on the last working day of the month. You receive your first check at the end of the first full month in which you make no contributions to FCERS. You receive your monthly retirement payment on the last day of the month.

Legislation Applicable to FCPS Health Plans

Your FCPS benefits comply with all federal mandates that govern public sector benefit plans. To obtain more information about the requirements of these legislative acts, please refer to the following:

Social Security (SSN) Reporting Requirement

Public Law 110-173 requires FCPS' health plans to report participants' Social Security Numbers (SSNs) in order to coordinate benefits with Medicare or other insurance benefits. All participants (employees, retirees and dependents) age 45 or older must provide SSNs in order for FCPS health plans to meet the requirements of this law. All participants who are receiving kidney dialysis or have received a kidney transplant, as well as all participants under age 45 who have Medicare, are also required to report SSNs. For more details on this legislation, you may go to www.cms.hhs.gov/MandatoryInsRep.

COBRA—Maintaining Health Coverage for You or Your Family

COBRA continuation coverage is a way to extend your plan coverage when it would otherwise end due to a status change or qualifying event (see list below). FCPS must offer COBRA continuation coverage to each person who is a qualified beneficiary, or someone who will lose coverage under the plan due to a qualifying event. Depending on the type of qualifying event, you, your spouse, and your dependent children may be qualified beneficiaries.

Generally, each COBRA-qualified beneficiary is required to pay the entire cost of COBRA continuation coverage, not to exceed 102 percent of the cost to the group health plan (150 percent in the case of an extension of COBRA continuation coverage due to a disability).

The following information explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect the right to receive it. This is only a summary of your COBRA continuation coverage rights.

As a **former employee**, you become a qualified beneficiary if you lose your coverage under the plan because your employment ends for any reason other than gross misconduct. In this event, COBRA continuation coverage lasts a maximum of 18 months.



COBRA Q & A

If you have questions about your COBRA continuation coverage, you should contact the plan administrator or you may contact the nearest regional or district office of the U.S. Department of Labor Employee Benefits Security Administration (EBSA).

The plan administrator may be contacted at FCPS, Office of Benefit Services, 8115 Gatehouse Road, Suite 2700, Falls Church, VA 22042
Phone: 571-423-3200

Addresses and phone numbers of regional and district EBSA offices are available through the EBSA website at www.dol.gov/ebsa.

Your **eligible dependent(s)** (spouse and/or dependent children) become qualified beneficiaries if they lose coverage under the plan because any of the following qualifying events occurs:

- Your employment ends for any reason other than your gross misconduct.
- You and your spouse divorce.
- Your child loses eligibility for coverage under the plan's definition of "dependent child."
- You die.

When the qualifying event is your death, your divorce, or your child loses eligibility as a dependent child, COBRA continuation coverage lasts for up to 36 months.

How Long COBRA Continuation Coverage Lasts

When the qualifying event is the end of employment, COBRA continuation coverage lasts for up to 18 months, (or 29 months if you have a ruling from the Social Security Administration that you became disabled within the first 60 days of COBRA coverage). In the event of a disability, you must send a copy of the Social Security ruling letter to the FCPS Office of Benefit Services within 60 days of receipt, but prior to the expiration of the 18-month period of COBRA coverage.

The plan will offer COBRA continuation coverage to qualified beneficiaries only after the plan administrator has been notified that a qualifying event has occurred. When the qualifying event is the end of your employment or your death, the plan administrator is automatically notified.

For the other qualifying events (your divorce or your child loses eligibility for coverage as a dependent child), you must notify the plan administrator. The plan requires you to notify the plan administrator within 60 days of the date the qualified beneficiary loses coverage due to the qualifying event.

You must send written notice to the FCPS Office of Benefit Services. In addition, you must provide documentation supporting the event.

Examples:

- If you divorce, you must send a copy of the divorce decree (applicable pages).
- If your spouse loses eligibility for coverage, you must send documentation supporting the loss of eligibility.

Once the plan administrator receives notice that a qualifying event has occurred, FCPS will offer COBRA continuation coverage to each qualified beneficiary. For each qualified beneficiary who elects it, COBRA continuation coverage will begin on the date plan coverage would otherwise have been lost, provided all applicable premiums have been paid.

Mental Health Parity & Addiction Equity Act

The Mental Health Parity and Addiction Equity Act of 2008 prohibits group health plans that offer mental health and substance use disorder benefits from creating more restrictive financial requirements or treatment limitations for mental health and substance use disorder services than those offered for medical and surgical benefits. Plan participants may not be required to pay more in deductibles, copayments, coinsurance, and out-of-pocket expenses for mental health and substance abuse benefits than those imposed by the plan's medical/surgical benefits.

The law also requires that health plans not impose any limits on the frequency of treatment, the number of visits, the days of coverage, or other similar limits for mental health/substance abuse benefits that are more restrictive than those imposed on medical/surgical benefits. If a health plan offers out-of-network medical/surgical benefits, it also must offer out-of-network mental health/substance abuse benefits.

Genetic Information Nondiscrimination Act (GINA)

GINA prohibits 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.

Health Insurance Portability & Accountability Act

The Health Insurance Portability and Accountability Act (HIPAA) of 1996 limits pre-existing condition exclusions, permits special enrollment when certain life or work events occur, prohibits discrimination against employees, retirees, and dependents based on their health status, and guarantees availability and renewability of health coverage to certain individuals. The Act also establishes standards to assure that individuals' health information is properly protected while allowing the flow of health information needed to provide and promote high quality health care and to protect the public's health and well being.

Under HIPAA, a pre-existing period cannot be longer than 12 months (18 months for late enrollment, reduced

by previous periods of creditable coverage). An individual receives credit for previous coverage that occurred without a break in coverage of 63 days or more. (A break in coverage of 63 days or more is not credited against a pre-existing condition exclusion period.)

HIPAA requires group health plans to offer special enrollment opportunities without having to wait until the plan's next regular open enrollment period. A special enrollment opportunity occurs if a person becomes a new dependent through marriage, birth, adoption, or placement for adoption.

Retirees must request enrollment of eligible dependents within 30 days of the loss of coverage or life event triggering the special enrollment. Loss of dependent eligibility for Medicaid or State Children's Health Insurance Programs (CHIP) also results in a special enrollment opportunity; enrollment must be requested within 60 days of the event in this instance.

HIPAA privacy and security rules legally obligate group health plans to:

- Maintain the privacy of your medical information.
- Provide you with a Notice of the health plan's privacy practices with respect to your medical information and to abide by the terms of the Notice.

The Health Information Technology for Economic and Clinical Health (HITECH) Act expanded and strengthened the privacy and security provisions of HIPAA. Effective September 2009, covered entities must notify affected members and the U.S. Department of Health and Human Services following a breach of unsecured protected health information.

FCPS Office of Equity & Compliance

The Office of Equity & Compliance is responsible for overseeing HIPAA compliance for FCPS. An individual may make a complaint in writing to the privacy officer or a designee in the Office of Equity & Compliance.

For more information, visit www.fcps.edu, click on **Employees**, and look for **Workplace Issues**.

Women’s Health & Cancer Rights Act

If you had or are going to have a mastectomy, you may be entitled to certain benefits under the Women’s Health and Cancer Rights Act of 1998 (WHCRA). For individuals receiving mastectomy-related benefits, coverage will be provided (per consultation with the attending physician and the patient), for:

- All stages of reconstruction of the breast on which the mastectomy is performed.
- Surgery and reconstruction of the other breast to produce a symmetrical appearance.
- Prosthesis and treatment of physical complications of the mastectomy, including lymphedema.

These benefits are provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under the plan.

MASTECTOMY BENEFITS

Benefits provided in connection with a mastectomy are subject to the plans’ regular deductibles and copayments. For more information, refer to the *Summary Plan Documents* for each of the medical plan providers, available on www.fcps.edu, click on **Employees**, and look for **Benefits** under **Retirees**.

Newborns’ & Mothers’ Health Protection Act

The Newborns’ and Mothers’ Health Protection Act of 1996 provides protections on the length of time mothers and their newborn infants may stay in the hospital following childbirth. Generally, group health plans and health insurers may not restrict benefits for a hospital stay in connection with childbirth to less than 48 hours (or 96 hours following a cesarean section). The law allows an attending provider, in consultation with the mother, to authorize an earlier discharge. To ensure that the exception does not result in early discharges that might harm the health of the mother or newborn, a group health plan or health insurer may not reduce the compensation of the attending providers because they provide care to a covered individual in accordance to the Act, nor provide incentives to induce the attending providers to provide care in a manner inconsistent with the Act.

Patient Protection & Affordable Care Act

Disclosure of Grandfather Status

FCPS believes its health insurance plans are considered “grandfathered health plans” under the Patient Protection and Affordable Care Act (PPACA). As permitted by the PPACA, grandfathered health plans can preserve certain basic health coverage that was already in effect when that law was enacted. Being a grandfathered health plan means that your CareFirst POS and PPO plans, and Kaiser Permanente HMO plan, may not include certain consumer protections of the PPACA that apply to other plans, for example, the requirement for the provision of preventive health services without any cost sharing. However, grandfathered health plans must comply with certain other consumer protections in the PPACA, for example, the elimination of lifetime limits on essential benefits.

Questions regarding which protections apply and which protections do not apply to a grandfathered health plan and what might cause a plan to change from grandfathered health plan status may be directed to the plan administrator at the Office of Benefit Services, 8115 Gatehouse Road, Suite 2700, Falls Church, VA 22042, phone: 571-423-3200.

You may also contact the U.S. Department of Health and Human Services at www.healthcare.gov.

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

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

If you or your dependents are already enrolled in Medicaid or CHIP and you live in Virginia, you may contact the Virginia Medicaid and CHIP program offices to find out if premium assistance is available:

Medicaid website: www.dmas.virginia.gov

Medicaid Phone: 800-432-5924

CHIP website: www.famis.org

CHIP phone: 866-873-2647

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 may contact your State Medicaid or CHIP office: Dial **877-KIDS NOW**, or log on to www.insurekidsnow.gov to find out how to apply. If you qualify, you can ask the State if it has a program that might help you pay the premiums for an employer-sponsored plan.

Once it is determined that your dependents are eligible for premium assistance under Medicaid or CHIP, your former employer’s health plan may be required to permit your dependents to enroll in the plan—as long as your dependents are eligible. This is called a “special enrollment” opportunity, and **you must request coverage within 60 days of being determined eligible for premium assistance.**

Many other states offer assistance paying your health plan premiums. You should contact your State for further information on eligibility. To see a listing of States that offer premium assistance programs, or for more information on special enrollment rights, you may contact either:

U.S. Department of Labor, Employee Benefits Security Administration
www.dol.gov/ebsa

866-444-EBSA (3272)

U.S. Department of Health & Human Services
Centers for Medicare & Medicaid Services
www.cms.hhs.gov

877-267-2323, x 61565



Glossary & Acronyms

Ancillary Amount—A supplemental charge added to the cost of a prescription drug when a participant elects a brand name drug and a generic is available.

Brand-Name (Advertised) Drug—A drug protected by a patent issued to the original maker of the drug. A patent prohibits other companies from manufacturing the drug as long as the patent remains in effect. Because of this exclusivity, brand-name drugs are more expensive than generic equivalent drugs.

Copay/Copayment—The flat dollar amount you pay for certain health care services and supplies.

Deductible—The amount you pay before your plan pays benefits. This usually applies to out-of-network benefits.

DMO—Dental Maintenance Organization—A dental plan that uses a network of participating dental providers to provide services. The plan generally has no deductibles and fixed copayments for most services.

DPPO—Dental Preferred Provider Organization—A dental plan that contracts with primary and specialty care dentists to provide comprehensive dental services. Out-of-network services are usually covered.

Dependent Child—Your biological child, legally adopted child (or one for whom you have legal guardianship or legal custody), a child who has been placed for adoption with you, or a legally recognized stepchild or foster child who is under age 26. A child over age 26 who depends on you for support due to a handicap or disability that occurred prior to age 26 and who has been approved by the health plan as disabled, is also a dependent child.

Family—You and two or more dependents.

Formulary—A list of preferred drugs selected by pharmacy managers based on effectiveness and cost.

Generic Drugs/Generic Equivalent—Drugs equivalent in therapeutic power to brand-name originals because they contain identical active ingredients at the same dosage. These drugs are available after a patent expires.

HMO—Health Maintenance Organization—An organized health care delivery system that emphasizes preventive care.

In-Network—Care you receive in accordance with plan rules from a health care provider who participates in the network of health care providers for your plan.

Lifetime Maximum—A limit on the amount that can be paid from a plan or the number of times a plan will pay for a specified procedure.

LTC—Long-Term Care—An insurance plan that covers eligible nursing home or at-home assistance for daily living activities.

Minifamily—You and one dependent (either your spouse or dependent child).

Network—A group of providers contracted to provide service to health plan members.

Open Enrollment—A period of time in the fall when you may change health plans or add a dependent for the next calendar year.

Out-of-Network—Services received in accordance with plan rules from a health care provider who is not an in-network provider for your plan.

Out-of-Pocket—The amount of money you pay in addition to your premium payments. This is usually the sum coinsurance amounts that you pay for health care. Copayments and deductibles are not included in your out-of-pocket expenses.

POS/PPO—Point of Service and Preferred Provider Organization—A type of managed care plan that contracts with a network of medical and dental providers. The FCPS plans do not require a referral prior to receiving medical care or seeing a specialist. Out-of-network benefits are available, subject to higher out-of-pocket expenses.

Premium—The amount of money paid to fund insurance benefits. The employer and employee usually each pay a portion of the premium.

PCP—Primary Care Physician—A physician who specializes in general, internal medicine, or pediatrics and coordinates medical care and may provide referrals for specialty care.

Prior Authorization—A list of drugs that require proof of medical necessity before a prescription for these drugs will be paid by the plan. The purpose of prior authorization is to prevent misuse and the off-label use of expensive and potentially dangerous drugs.

Status Change or Qualifying Event—An event that changes your eligibility status or that of your dependents. These events include the birth or adoption of a child, marriage, divorce, death of a spouse or child, a change in the marital status of a dependent under the age of 26, a dependent turning age 26 or a change in a dependent's employment status.

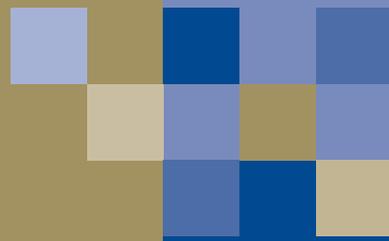
Specialty Medications—A home or office delivery service for members who use specialty medications. After an initial 34-day supply of a specialty medication is filled at a network pharmacy, the medication is covered through the Specialty Care Pharmacy managed by Accredo.

Step Therapy—A protocol designed to ensure that you receive the most clinically appropriate medication for your condition. In most cases, Express Scripts will guide you to use more cost-effective first-line drugs when medically appropriate before more costly second-line drugs are covered.

Fairfax County Public Schools
Karen Garza, Superintendent

Department of Human Resources
Phyllis Pajardo, Assistant Superintendent

Office of Benefit Services
De Hawley Brown, Director



Department of Human Resources
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Fairfax County Public Schools

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