Fairfax County
PUBLIC SCHOOLS
ENGAGE • INSPIRE • THRIVE

2017

Employee Benefits Handbook






Your Benefits Contacts

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

HEALTH PLANS			
Aetna Dental (DPPO and DMO/DNO)	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	http://my.kp.org/fcps/	**800-777-7902**	**7:30 am–5:30 pm M–F**
CVS Caremark (Effective 1/1/17) (Prescription drug plan for Aetna/ Innovation Health and CareFirst members)	http://info.caremark.com/fcps	**888-217-4161**	**Available 24/7**
Express Scripts (Through 12/31/16) (Prescription drug plan for Aetna/ Innovation Health and CareFirst members)	www.express-scripts.com/fcps	**866-815-0003**	**Available 24/7**
EMPLOYEE ASSISTANCE PROGRAM			
Guidance Resources by ComPsych	www.guidanceresources.com	**855-355-9097**	**Available 24/7**
FLEXIBLE SPENDING ACCOUNTS			
Automatic Data Processing (ADP)	https://myspendingaccount.adp.com	**866-871-0773**	**8 am–8 pm M–F**
RETIREMENT PLANS			
Virginia Retirement System (VRS)	www.varetire.org	**888-827-3847 (VA-RETIR)**	**8:30 am–4 pm M–F**
Educational Employees' Supplementary Retirement System of Fairfax County (ERFC)	www.fcps.edu, **search "ERFC"**	**703-426-3900 844-758-3793**	**8 am–4:30 pm M–F**
ICMA-RC (Third-party administrator for the VRS Hybrid Defined Contribution Component)	Investor ServicesCommonwealthofVA@ icmarc.org	**1-877-327-5261 1-VRS-DC-PLAN1**	**8:30 am–5 pm M–F**
Fairfax County Employees' Retirement System (FCERS)	http://www.fairfaxcounty.gov/ retirement/schools.htm http://www. fairfaxcounty.gov/retirement/schools. htm	**703-279-8200 800-333-1633**	**8 am–4:30 pm M–F**
457(b) & 403(b) RETIREMENT SAVINGS PLANS			
EMPOWER Retirement - 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 28.**		
LIFE INSURANCE			
ERFC Members – Minnesota Life	www.varetire.org	**1-800-441-2258**	**8:30 am–4 pm M–F**
FCERS Members – Minnesota Life	www.fcps.edu, search "Life Insurance"	**571-423-3200, opt. 1 or 2**	**8 am–4:30 pm M–F**
LEAVE PROGRAMS			
Liberty Mutual—Short-Term and Long-Term Disability and Workers' Compensation Claims	https://www.fcps.edu/Disability-Benefits	**1-800-524-0740**	**Available 24/7**
Virginia Workers' Compensation Commission (VWCC)	**1000 DMV Drive Richmond, VA 23220**	**877-664-2566 804-367-9740 (Fax)**	**8:30 am–4:45 pm M–F**
FCPS RESOURCES			
Human Resources (HR) Client Services	HRConnection@fcps.edu	**571-423-3000 800-831-4331**	**8 am–4:30 pm M–F**
Office of Benefit Services: • **Employee Insurance and Financial Programs** • **Disability & Leave** • **Workers' Compensation**	HRConnection@fcps.edu	**571-423-3200, then** • **option 3** • **option 1** • **option 2**	**8 am–4:30 pm M–F**
Employee Assistance Program	EAPQuestions@fcps.edu	**n/a**	**8 am–4:30 pm M–F**
Employee Wellness	HRWellness@fcps.edu	**n/a**	**8 am–4:30 pm M–F**

Table of Contents

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.

Eligibility and Enrollment

The 30-Day* Rule

If you are a new employee, you must enroll for medical, dental, optional life, and FSA benefits within **30 calendar days*** of your date of hire. Once the 30 days* has elapsed, enrollment is permitted only for qualifying events.

If you are a current employee, you have **30 calendar days*** from the date of a status change or qualifying event to change your medical, dental, life insurance, and FSA benefits.

The requested change must be consistent with the event.

If You Are a New Employee

All full-time and part-time employees in authorized** positions are eligible to participate in the FCPS benefit programs described in this handbook. You have **30 calendar days*** from your date of hire to complete your medical, dental, and flexible spending account (FSA) enrollment forms. Medical and dental elections are made while completing the required Onboarding process. Please note the following:

- FCPS offers several retirement plans; your membership is determined by your job category and status.
- If your contract or work schedule is less than 50 percent of full time, you are not eligible to participate in the retirement, life insurance, and long-term disability programs.
- If both you and your spouse are benefits eligible employees, you may be eligible for reduced contribution rates for your health benefits. You must take action by completing the "Two Employee Discount Form within 30 calendar days of your date of hire. See the Spousal Rates listed in the premium charts published each year.

All newly-hired benefit-eligible employees participate in the FCPS New Employee Onboarding program where you will receive detailed information about your benefit programs.

Your participation in the health, dental, and life insurance programs takes effect on the first day of the month following your date of hire, provided you make your election within 30 calendar days* of your hire date. If you will be requesting medical or dental coverage for your dependent(s), you must also submit documentation to verify their eligibility. (See page 3 for the list of required documents). If you submit your election and documentation after the payroll deadline for that pay period, you will have make-up deduction(s) in a future paycheck.

Your participation in the FSA program takes effect on the first day of the month **after** your FSA Enrollment form has been received by the Office of Benefit Services.

If You Are a Current Employee

You may enroll, add, or cancel coverage for yourself or your dependents, or change your health benefits and FSA participation during the annual **Open Enrollment (usually held in the fall of each year).** Changes made during Open Enrollment take effect January 1 of the following calendar year. If adding dependents, you must submit applicable documentation to verify your dependent's eligibility. See page 3 for required documents.

At any other time during the year, you may only enroll, add, or cancel coverage for yourself (or your dependents) or change your health coverage and FSA participation if you experience a status change or qualifying event (See pages 4-6). The requested change must be consistent with the event.

*If an employee misses the 30 calendar day enrollment window but is still within 60 calendar days of the status change or qualifying event, he or she may request an appeal. See page 6.
**Temporary/hourly employees who meet the Affordable Care Act (ACA) definition of full-time employee (30+ hours per week) are also eligible for health benefits.

Dependent Eligibility Definitions & Required Documentation for FCPS Health Plan Coverage

FCPS requires documentation demonstrating all dependents meet the eligibility criteria for coverage under the plans. You have **30 calendar days** from your hire/re-hire date (or date of status change or qualifying event) to submit your enrollment forms and applicable documentation; coverage for dependents does not become effective until documentation is received and verified.

Dependents	Eligibility Definition	Documentation Required
Spouse	A person to whom you are legally married	Photocopy of the first page of employee's most recent IRS Form 1040 that includes the employee's spouse (you may remove all financial information) *Note: not required if married in same year as being added to plan AND Photocopy of marriage certificate
Biological Child*	A biological son or daughter of the employee	Photocopy of birth certificate showing employee's name
Adopted Child*	An adopted son or daughter of the employee or a child placed for adoption	Photocopy of the 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*	A stepson or stepdaughter of the employee	Photocopy of birth certificate showing employee's spouse's name as mother or father AND Photocopy of marriage certificate showing the employee and spouse's name
Child under Legal Guardianship*	A child for whom the employee 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*	A child for whom the employee 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	A child age 26 or older who is wholly dependent on the employee 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 Disability Certification form(s) submitted directly to health carriers

*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 these websites.Fees will likely apply. www.vitalchek.com or www.vitalrec.com; www.irs.gov/taxtopics/tc156.html (for copy of tax return).

When to Change, Add, or Cancel Your Benefits for Status Changes or Qualifying Events

You must notify the Office of Benefit Services to change your benefits enrollment within **30 calendar days* of a status change or qualifying event that affects your medical, dental, life insurance, and/or Flexible Spending Account (FSA).**

Section 125 of the Internal Revenue Code outlines status changes or qualifying events that permit mid-year coverage changes to employee benefit plans. The following events are examples of eligible status changes or qualifying events:

- Marriage: Within 30 calendar days of the date of marriage, you must:

  – request to add your spouse to your coverage, or
  – request to cancel your coverage (in order to be added by your new spouse to their coverage)
- Divorce: Within 60 calendar days of the date of divorce, you must:

  –request to remove your former spouse from your coverage

  You may not drop coverage for a spouse if you are legally separated; however, you must drop your former spouse and any ineligible stepchildren upon your divorce.
- Birth or adoption. If you notify the Office of Benefit Services within **30 calendar days,** your child's medical benefits become effective on the date of birth, date of adoption (or date placed for adoption). As an adoptive parent, you do not have to wait until the adoption is final to add your child to your health plan.
- Becoming the legal guardian of a child.
- A court order requiring you to cover a child or an order requiring someone else to cover your dependent.
- Death of a spouse or child.
- Spouse's or other dependent's change in employment status that affects their eligibility for medical and/or dental benefits (or their employer's open enrollment).
- Beginning or returning from an unpaid leave of absence.
- Loss of health coverage.
- Significant increase or reduction in hours.
- Dependent reaching age 26
- A significant cost change, coverage curtailment, improvement, new option, or a change in coverage under your spouse's or dependent's plan.
- A move that causes loss of eligibility to participate in your HMO plan.
- Entitlement to or loss of Medicare or Medicaid.

How to Change Your Coverage

IRS rules state that the health care election changes must be on account of, and correspond to, a change in status that affects eligibility under the health plan. Paperwork must be received by the Office of Benefit Services within **30 calendar days*** of your status change or qualifying event.

It is your responsibility to inform the Office of Benefit Services about a status change by completing an enrollment and change form, which is available under the Benefit Forms section of the FCPS Benefits website or by calling Human Resources (HR) Client Services. You must also provide the required documentation to request the change in coverage.

Additional required documentation may include:

- Divorce decree (applicable pages)
- Letter from your spouse's or dependent's employer or open enrollment notice that includes enrollment dates and effective date
- Letter from your spouse's or dependent's HR Department or insurance plan with insurance cancellation date
- Letter from your spouse's or dependent's HR Department or insurance plan explaining circumstances regarding a significant cost change, coverage curtailment, improvement, new option, or change in coverage for your dependent
- Copy of your letter from Medicare/ Medicaid.

*If an employee misses the 30 calendar day enrollment window but is still within 60 calendar days of the status change or qualifying event, he or she may request an appeal. See page 6.

**Sixty (60) days in the event of divorce

If you fail to notify the Office of Benefit Services within the **30 calendar day*** period, you may not enroll, cancel, or change coverage until the next Open Enrollment. Changes made to your coverage during Open Enrollment become effective January 1 of the following calendar year.

If you miss the **30 calendar day*** deadline for a status change or qualifying event that results in the cancellation of coverage or a reduction in your employee contribution (such as a divorce or your dependent child turns 26), FCPS will not refund your excess contributions.

Adding or Removing a Family Member • 30-day deadline

- If you marry, you may change your enrollment from Individual to Minifamily or Family. You may also cancel coverage if you are being added to your new spouse's coverage.
- If you divorce, you must remove your former spouse from your coverage. Once you are divorced, your former spouse no longer qualifies for FCPS health insurance, unless he/she qualifies for, and elects COBRA continuation coverage
  You may also enroll in coverage if you are losing coverage under your ex-spouse. Please note that separation is not a legal event in Virginia, and you cannot drop or add your spouse due to a separation.
- If you have a baby, adopt a baby, or gain legal guardianship of a child, you can add the new dependent and change your level of coverage.
- If you have a baby, you may enroll in the Dependent Day Care Flexible Spending Account (FSA) plan.
- If your child turns age 26 they are no longer eligible for FCPS coverage as a dependent. Coverage ends at the end of the month in which they turn age 26, unless certified as disabled by your health/dental plan.

In addition to submitting an enrollment and change form, you must also provide documentation of the event as described on the form.

- To facilitate compliance with federal mandates relating to health plans, you are requested to provide Social Security Numbers of all eligible dependents when adding them to your plans.

Please note:. If both you and your spouse are both FCPS employees, you may not be covered as both an employee and dependent under FCPS plans. Additionally you may not cover your children as dependents of both employees.

Qualifying Event Examples:

1. You are married February 14 (the life event), and you request to add your spouse to your health plan on March 6 (within 30 days). Your spouse's coverage takes effect the first day of the month following the qualifying event (March 1), and your payroll deduction will change for March coverage..

2. You have a baby on March 17 (the life event), and you add your baby to your health plan on April 1 (within 30 days). Because this is a HIPAA special enrollment event, you are also eligible to add your spouse and/or other eligible dependent children within 30 days of the date of birth (the qualifying event).
   - Coverage for your newborn takes effect on the date of birth (March 17).
   - Coverage for your spouse/other eligible dependents takes effect on the 1st day of the month following the qualifying event (April 1).
   - If adding the baby to your plan results in a change in tier (i.e., you are converting Individual to Minifamily, or Minifamily to or Family coverage), your premiums will change effective March 1. If you are also adding a spouse and/or other dependent children to your health plan due to the birth of a child, their coverage, and any changePremiums will change again on April 1 if your enrollment shifts from from Minifamily to Family, will take effect April 1.
3. A baby is placed with you for adoption on October 24, and you add your baby to your health plan on October 30. Your baby's coverage takes effect October 24. If you are converting to Minifamily or Family coverage, your premiums will change effective October 1.

*If an employee misses the 30 calendar day enrollment window but is still within 60 calendar days of the status change or qualifying event, he or she may request an appeal. See page 6.

**Sixty (60) days in the event of divorce

Employment Changes • 30 calendar-day deadline

You are eligible to enroll, change or cancel your FCPS coverage within 30 calendar days of the following events, provided the change requested is consistent with the qualifying event:

- You are enrolled in a health plan with your spouse's employer and your spouse loses coverage,
- Your spouse changes jobs and you join your spouse's employer's plan,
- Your spouse's or dependent's employer has a benefits open enrollment period that does not coincide with the FCPS enrollment period,
- You return to active employment from a leave of absence or retirement and are eligible for benefits. Please note: optional benefits (such as health, dental, optional life and flexible spending accounts do not reinstate automatically). **You must take action to enroll within 30 calendar days* of your status change.**

Requesting an Appeal

If you miss the 30 calendar day enrollment window but are still within 60 calendar days of your status change or qualifying event, you may request an appeal. You must submit a signed, written statement explaining your circumstance as well as your completed paperwork to the Office of Benefit Services before the 60th day of the qualifying event.

Coordination of Benefits

When both spouses work, each person may be covered by their employer's health plan, as well as their spouse's health plan. Coordination of benefits determines which group health care plan pays benefits first. The secondary health plan may then pay additional benefits.

Health insurers follow a common set of guidelines to determine which plan pays first and which plan pays second for family members. Your employer's group health care plan is always primary for you as an employee.

Example:

If your birthday is January 14, and your spouse's birthday is April 10, your group health plan is the primary plan for you and your dependents, but is the secondary plan for your spouse.

If you are married, and both you and your spouse cover your dependent children, the plan that covers the parent whose birthday falls first in the calendar year is usually primary for any dependent children.

Other factors that can change which plan pays first include eligibility for Medicare, court decrees or custody arrangements, the length of time you are covered, and whether you are an employee or retiree. See your plan's Summary Plan Document for more details.

Preexisting Conditions

None of the medical plans offered by FCPS will deny you or your qualified dependents coverage because of a preexisting condition. Some waiting periods or frequency limitations will apply under the dental plans.

Public Law 110-173 requires FCPS' health plans to report participant's Social Security Numbers (SSNs) in order to coordinate benefits with Medicare or other insurance benefits. All participants (employees 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.

*If an employee misses the 30 calendar day enrollment window but is still within 60 calendar days of the status change or qualifying event, he or she may request an appeal.

Health Plans

Medical Plans

FCPS offers three medical plans, which 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.

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 an annual deductible before the plan begins to pay.
- You pay a copayment for in-network covered office visits.
- Preventive care is covered at 100% for checkups, screenings, vaccines, prenatal care and more when provided in network.
- 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 are 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.

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 service area.

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 an annual deductible before the plan begins to pay.
- You pay a copayment for most in-network services.
- Preventive care is covered at 100% for checkups, screenings, vaccines, prenatal care and more when provided in network.
- Vision benefits are 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.

CVS Caremark provides prescription drug benefits for Aetna/Innovation Health and CareFirst members. (See page 9 for details.)

Kaiser Permanente

Kaiser Permanente is an HMO plan that allows you to access Kaiser Permanente facilities and providers in the local service area.

Plan Highlights

- 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.

All services must be provided by Kaiser Permanente physicians unless referred to an external provider by KP.

- You pay a copayment for most in-network office visits.
- You **must have a referral** from your primary care physician to see a specialist.
- Preventive care is covered at 100% for checkups, screenings, vaccines, prenatal care and more when provided in network.
- A 24-hour Medical Advice and Appointment Line
- You may receive care at any Kaiser medical facility in the local area. Some Kaiser facilities include urgent care centers for non-life threatening after-hours emergencies.
- Care and services not directly managed by Kaiser Permanente are not covered, except for out-of-area emergencies.
- Prescription drugs may be obtained at a Kaiser Permanente.
- Participants are eligible for a 25% discount on frames and lenses, and a 15% discount on contact lenses when obtained at a Kaiser Permanente optical facility. This discount is in addition to the annual $150 vision benefit allowance.
- Live Well Be Well is a free health education program that includes classes on managing high blood pressure, diabetes, back pain, etc.

To review the Summary of Benefits and Coverage and the Evidence of Coverage visit Kaiser's website at http://my.kp.org/fcps for more information.

Kaiser Permanente Prescription Drug Program

Copayments only.

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

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

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

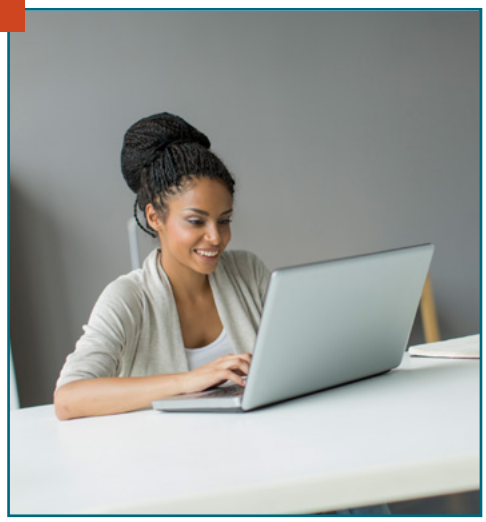
Generic	$ 20
Formulary Brand	$ 45
Non-Formulary Brand	$ 60

Mail (90-day supply)

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

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

For more detailed information on FCPS health plans (Aetna/Innovation Health, CareFirst BlueChoice Advantage, and Kaiser Permanente), visit www.fcps.edu/, search "Medical Insurance".



Contact Information for Your Benefits Questions

Call the toll-free numbers below to:

- Clarify your benefits
- Ask service and cost questions
- Request a new/replacement ID card
- 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

CVS Caremark (effective January 1, 2017)
(Aetna/Innovation Health and CareFirst members)
888-217-4161

Express Scripts (through December 31, 2016)
(Aetna/Innovation Health and CareFirst members)
866-815-0003

Pharmacy Benefits Program for Aetna/ Innovation Health and CareFirst Members

Your prescription drug plan, administered by CVS Caremark, provides access to a network of more than 64,000 retail pharmacies and home delivery. The amount you pay for your covered medications depends on the type of medication (generic, brand, or specialty) and where you fill your prescriptions.

Your Coinsurance or Copayments*		
Participating Retail Network Pharmacy for short-term (or acute) medications	**Generic**	**Brand**
Up to a 30-day supply	$7	20% of cost of drug; Maximum $50
More than a 30-day supply up to 60-day supply	$14	20% of cost of drug; Maximum $100
More than a 60-day supply up to 90-day supply	$21	20% of cost of drug; Maximum $150
CVS Mail Service (home delivery) or **CVS Retail Pharmacy** for long-term (or maintainence) medications	**Generic**	**Brand**
Up to a 90-day supply	$14	20% of cost of drug Maximum $100
CVS Speciality Pharmacy for specialty medications	**Generic**	**Brand**
Up to a 30-day supply Note: Maintainence speciality medications must be filled through CVS Specialty after the initial fill.	$7	20% of cost of drug; Maximum $50

*If the cost of the medication is less than the minimum copayment, you will pay the lower amount.

Out-of-Pocket Maximums

Once your pharmacy out-of-pocket expense reaches the specified levels below, the Plan will pay covered charges at 100% for the remainder of the calendar year.

Individual: $1,500 **Family:** $3,000

Formulary

Your coverage under CVS Caremark is based on a formulary—a preferred list of covered medications. Your formulary offers a wide selection of generic and brand-name prescription drugs chosen based on clinical and

cost effectiveness. To view the current formulary, visit http://info.caremark.com/fcps.

Preventive Medications

Certain preventive medications, including women's contraceptives, will be provided at zero copay. Additionally, several preventive over-the-counter (OTC) products will also be provided at no copay as long as you have a prescription and the recommended criteria are met. Generally these items are drugs and vitamins recommended for specific age, gender and risk categories.

For more detailed information, visit http://info.caremark.com/fcps.

Drug or Category (prescription required)	Criteria
Aspirin (to prevent cardiovascular events)	Men ages 45 to 79 years and women ages 55 to 79 years
Oral Fluoride	Children older than 6 months of age through 5 years old
Folic Acid	Women through age 50 years
Iron Supplements	Children ages 6 to 12 months who are at risk for iron deficiency anemia
Smoking Cessation	Men and Women ages > 18 who use tobacco products
Colonoscopy Prep	Men and women between ages 50 and 75; limited to two prescriptions per year
Vitamin D	Men and Women ages ≥ 65 who are at increased risk for falls
Women's Contraceptives • Barrier contraceptives • Hormonal contraceptives • Implantable medications (provided through your medical plan) • OTC Barrier contraceptive methods	Women through age 50 years

Filling Your Presciptions

Using a participating retail network pharmacy for short-term (or acute) medications

For short-term medication needs, please present your CVS Caremark member ID card and written prescription at a participating retail pharmacy.

Using a CVS retail Pharmacy for maintenance medications

You have the option of filling prescriptions for long-term or maintainence medications (up to a 90-day supply) at a CVS retail Pharmacy. You will need to present your CVS Caremark member ID card.

Using home delivery from the CVS Caremark Mail Service

For long-term medication needs, CVS Mail Service or CVS retail Pharmacy offer the best value for the prescription drugs you take regularly to treat ongoing conditions. You can receive a 90-day supply of your maintenance medications delivered safely and conveniently to your home. If you would prefer to pick up your prescriptions, you also have the option of filling your 90-day prescriptions at a CVS retail Pharmacy.

Using a participating non-CVS retail Pharmacy for maintenance medications

You also have the option of filling prescriptions for long-term medication needs at a participating retail pharmacy. You will, however, pay a higher cost than using a CVS retail Pharmacy or the CVS Mail Service.

Using CVS Specialty Pharmacy for specialty medications

CVS Specialty Pharmacy, an online prescription management system, allows you to have your specialty medication delivered to your home or available for pickup at a CVS retail Pharmacy. Maintenance specialty medications must be filled through CVS Specialty Pharmacy after the initial fill.

Note: Before you can refill your prescription, you must use 75% of your medication.

Utilization Management Programs

To promote safety along with appropriate and cost-effective use of prescription medications, the plan includes several utilization management programs.

Generics Preferred Program (Automatic Generic Substitution)

If your doctor prescribes a brand-name drug when an equivalent generic drug is available, your prescription will automatically be filled with the FDA-approved generic drug. However, if your doctor indicates the prescription must be "dispensed as written" (DAW), the brand-name drug will be provided but you will pay the generic coinsurance PLUS the full difference in cost between the brand- name drug and the generic equivalent. This additional amount is known as an ancillary fee.

Prior Authorization

Prescriptions for certain medications require a prior authorization, also known as a coverage review, before they can be covered by the plan. If your prescription requires a prior authorization, your doctor must submit a request for coverage review for approval. This is to ensure that the medication is clinically appropriate in accordance with recommended treatment or prescribing guidelines.

Step Therapy

The Step Therapy program helps assure that you get the most affordable treatment while keeping safety and cost in mind. With step therapy, you typically start with a generic drug before a brand-name drug is approved. If you are not able to use the generic drug, brand-name drugs are covered in the second step.

For more information

Details about your coverage can be found in Your Pharmacy Benefits Handbook, at www.fcps.edu, search keywords "Medical Insurance." To get additional information about estimated medication costs, participating pharmacies, covered drugs and more, visit http://info.caremark.com/fcps or call CVS Caremark toll-free at 1-888-217-4161.

Make utilizing your prescription benefit even easier, by downloading the free, CVS Pharmacy mobile app!

The *CVS Pharmacy mobile application* allows you to conveniently order refills, receive shipping notifications, access your prescription history, and set medication and treatment reminders. For participants utilizing CVS Specialty Pharmacy, there is also a *CVS Specialty app*, which provides users with the same features, resources, and tools.

Both applications are available for free download from your preferred mobile app store.

Dental Plans

FCPS offers you a choice of two Aetna dental plans:

- Dental Preferred Provider Organization (DPPO)
- (Dental Network Only DNO)*

You can elect dental benefits separately from medical benefits.

Aetna Dental Preferred Provider Organization (DPPO)

Plan Highlights

- Coverage includes preventive care, basic care, and major services. You **do not have to choose a primary care dentist.**
- This plan has a wide choice of in-network dentists.
- 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.
- You pay 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 20.

The plan pays 50 percent of the cost of orthodontia if you are obtaining treatment from an in-network dentist and 40 percent of the cost if you are using an out-of-network dentist up to a lifetime maximum.

Aetna Dental Network Only (DNO)

Plan Highlights

- When you enroll you must select a primary care dentist who will perform all your dental care, unless that dentist refers you to a specialist. You may change your primary care dentist at any time and must call by the 15th of the month for the change to be effective the 1st of the following month.
- The Aetna DNO plan is a lower cost plan that has a more limited network of providers. Before enrolling, call your dentist to ensure that they are in the network.
- You may only use dentists who are part of the Aetna DNO network; **out-of-network providers are not covered under this plan.**
- Most preventative dental services are covered at 100 percent. Other dental 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 check for a DNO network in your new area, call Aetna customer service.
- Orthodontia is covered regardless of age. Services must be provided by a DNO-covered provider.

Find a network provider for the Aetna DPPO and DNO plans at www.ih-aetna.com/fcps. Details about your coverage are available in the Aetna Dental Summary Plan Documents on the Aetna/Innovation Health website at www.ih-aetna.com/fcps.

Pretreatment Authorization Under the DPPO or DNO

Aetna Dental suggests that prior to services being rendered, you obtain a pretreatment authorization for any non-emergency treatment plan that is expected to exceed $350 to determine whether the service is covered, as well as reasonable and customary fees. To obtain a pretreatment authorization:

- 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.

Discounts on Other Services

As an Aetna/Innovation Health or Aetna Dental member, you also have access to discounted 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/Innovation Health or Aetna Dental ID card to participating professionals and retailers. Additional information about discounts and participating vendors can be found at www.ih-aetna.com/fcps.

Quick Answers for Basic Dental Questions

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

Dental Plan Comparison	DPPO In-Network you pay	Out-of-Network*** you pay	DNO 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 benefit summary)
Orthodontia	50%**	60%**	$ 2,300†
Annual Maximum‡ (not including orthodontia)	$ 1,500	$ 1,200	None
Orthodontia Lifetime‡ Maximum*	$ 1,500	$ 1,000	n/a

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

**Dependent children under age 20 only.

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

†Amount includes orthodontia treatment, screening exam, diagnostic records and retainer

‡Limits are combined across in- and out-of-network for DPPO only.

Employee Wellness

Wellness at FCPS

The mission of the wellness program is to promote initiatives that enhance the overall health and well-being of FCPS employees. Wellness initiatives are based on scientific evidence and provide health information and fitness strategies to inspire healthy lifestyles and lower health risks.

The program is administered through the Office of Benefit Services in the Department of Human Resources. Each FCPS worksite has a designated wellness liaison who assists with the dissemination of information and coordination of wellness initiatives for their site.

FCPS has been recognized by the American Heart Association and awarded its Gold Award as a "Fit Friendly" company since 2009.

Wellness Initiatives

Flu Clinics

Onsite flu clinics are coordinated every fall to offer FCPS employees an easy and convenient means to obtain a free flu immunization. Employee Wellness works in conjunction with the site wellness liaisons to coordinate flu clinic logistics. Flu clinics are also offered at the open enrollment open houses and may be accessed by FCPS employees. Retirees and family members 18 years and older may receive a flu immunization for $28.

Health Fairs/Health Screenings

Employee Wellness sponsors health fairs and health events throughout the year and offers free consultations for sites upon request to assist with coordinating their own health events to encourage employee wellness.

HR Wellness Talks

Employee Wellness can provide talks, workshops, webinars, and health exhibits for small and large groups upon request. Sites can choose from a variety of wellness and health topics, ranging from heart health to stress strategies, fitness, nutrition, and more. To request a wellness talk, email HRWellness@fcps.edu.

FCPS Get Active

Employee Wellness sponsors web-based fitness challenges that are open to all FCPS employees. The focus of these challenges is to reduce health risks and promote a heart-healthy lifestyle. Participants may choose to form teams at their site or participate on their own. Each participant registers for the challenge and pledges to adhere to designated fitness and nutrition goals, such as exercising 30 minutes a day, 5 days a week. Participants will receive email updates throughout the challenge, providing information on interactive fitness, nutrition, and stress management.

Fitness challenge participants are eligible to have their names placed in weekly random prize drawings for health-related prizes. Fitness challenges are open to all employees, irrespective of physical limitations.

Fitness Classes

FCPS employees age 18 and older can access the Gatehouse Administration Center fitness facility for free after signing the participation agreement form found on the FCPS intranet website. Go to http://fcpsnet.fcps.edu, click on "Building Services", then "Fitness Center". The fitness center offers a series of Heartline fitness equipment, as well as treadmills, elliptical machines, and spinning bikes. There are also fee-based fitness classes offered by private instructors (See the fitness center website for a schedule of classes).

Individual FCPS sites can also coordinate after-work fitness classes with private fitness instructors if they follow the guidelines in *Regulation 8420: Community Use*. If your site would like information on how to coordinate a workplace fitness class, email HRWellness@fcps.edu.

Earn a $100 Wellness Incentive!

As part of the strategic plan, FCPS has made an ongoing commitment to support employee health and well-being. Employees participating in an FCPS health plan will have an opportunity to earn a $100 wellness incentive for completing their health vendor's online health assessment (HA) between January 1, 2017, and September 20, 2017.

The HA is a questionnaire related to different aspects of general health and well-being that is easy to complete in about 15-20 minutes. It provides a snapshot of your current health status and includes a wellness score so you can become familiar with any potential health risks and strategies to help reduce them. Your individualized health report may also include information on how to obtain health coaching and/or receive other health or wellness programs that are offered through your health plan.

The HA is confidential! Only you and your health plan receive the individual information. Your health-related information is not shared with FCPS in compliance with state and federal privacy laws.

For more information, visit the Employee Wellness website on the FCPS intranet, search keywords "health assessment".

Vendor Websites:

- Aetna: www.ih-aetna.com/fcps
- CareFirst: www.carefirst.com/fcps
- Kaiser: https://my.kp.org/fcps/

Wellness Website

Visit the Employee Wellness website for information and resources on topics ranging from planning a pregnancy to lowering stress or starting a worksite walking program.

Questions?
Email HRWellness@fcps.edu.

Continued Focus on Disease Management

In 2017, there will be an increased focus on disease management programs (DM) through all of the health plans. DM programs are designed to help people with certain chronic disease conditions better manage their health and decrease complications by coordinating the delivery of high quality care. DM programs do not replace your doctor's care or advice. Since chronic disease conditions are one of the highest drivers of health care costs for FCPS, these programs can also help to save you and the plan money.

Your insurance plan may identify you to participate in a DM program through a physician referral, medical claims or when you take your annual health assessment survey. If identified, a registered nurse or other health professional would contact you by phone or mail to engage in one-on-one support telephonically or to participate in online health coaching programs. They can help you monitor your condition, answer your questions and provide personalized care. You will choose whether you want to access the program and/or how often you would like to be contacted. There is no cost to you for accessing resources through the DM program.

Participation in DM programs is confidential and is done strictly through your insurance plan. FCPS does not receive any identifiable health information in accordance with state and federal privacy laws.

We hope you will take advantage of this opportunity to obtain these valuable health resources.

Employee Assistance Program

The Employee Assistance Program (EAP) is available to all benefits-eligible FCPS employees and their household members to help when you are experiencing personal issues or concerns.

Guidance Resources' services include referrals for free and confidential counseling (4 sessions); unlimited telephonic financial and legal consultations; work/life support to help with research and referrals and telephonic wellness coaching. There is also a resource-rich website with tip sheets, blogs, communities and more. Participation in this program, including the nature of your concerns and any referrals, is confidential.

For more information about Guidance Resources, call the Office of Benefit Services at 571-423-3200 or visit the EAP website.

Contact Your EAP

There are three ways to access your GuidanceResources benefits:

- Call 1-855-355-9097. You'll speak to a counseling professional who will listen to your concerns and can guide you to the appropriate services you require.
- Visit GuidanceResources online at www.guidanceresources.com and enter your organization ID: **FCPS**. Once you enter the website, you will be able to create your own username and password.
- You can also access Guidance Resources from your smart phone or tablet by downloading the *Guidance Now* app from your preferred app store.

Flexible Spending Accounts

FCPS offers two Flexible Spending Accounts (FSAs): the Health Care FSA and Dependent Day Care FSA. These accounts allow you way to put aside pre-tax money to help cover eligible medical, dental, and vision expenses, as well as work-related child and adult day care expenses.

Using an FSA reduces your income taxes by deducting money from your pay before taxes are calculated. The end result is that you pay less in taxes and increase your spendable income, potentially saving hundreds of dollars a year. Typically, participation in an FSA is effective for an entire calendar year. Each year:

1. You determine how much you want to contribute into one or both accounts (up to $2,550 into the Health Care FSA, and up to $5,000 into the Dependent Day Care FSA).
2. The amount you designate is taken out of your paycheck pre-tax and placed in the FSA account(s).
   - For monthly-paid employees, deductions are taken 10 months of the year (January–June, and September–December).
   - For bi-weekly-paid employees, deductions are taken over 20 pay periods. No deductions are taken in July and August and the first pay period of September.
3. You use that money to reimburse yourself for eligible out-of pocket expenses.

Money placed in a Health Care FSA can only be used to claim health care expenses, not dependent day care expenses. Likewise, a Dependent Day Care FSA can only reimburse expenses related to day care for eligible dependents.

Eligibility & Enrollment

As a new employee, your FSA becomes effective on the first day of the month following the month your enrollment form is received by the Office of Benefit Services, provided the form is submitted within 30 calendar days of your date of hire into a benefits-eligible position. If you do not enroll as a new employee, you may enroll during annual open enrollment—typically held every fall. Otherwise, you can only enroll within 30 calendar days after a qualifying event such as marriage, birth, divorce, or loss of dependent eligibility. **You must re-enroll each year.**

Reimbursements through Direct Deposit

All participants in the FSA program are automatically enrolled in direct deposit for their reimbursements. Direct deposit is a condition of FSA plan enrollment. Your direct deposit information on file for deposit of your net pay with FCPS will be transmitted to ADP, the flexible benefit plan administrator for FCPS. Participants who would like to update their banking information throughout the year for their FSA program reimbursements can do so by setting up an account through ADP at: https://myspendingaccount.adp.com.

Health Care FSA

This FSA is for setting aside money for qualified expenses not covered by your health plans. You may use the Health Care FSA for health care expenses that are considered eligible deductions on your federal income tax return. This also applies to health care expenses incurred by any dependent you claim on your federal tax return.

You can participate in the Health Care FSA even if you do not participate in an FCPS health plan.

Examples of **eligible expenses** include:

- Copayments for covered expenses
- Prescription drugs or prescription drug copays
- Deductibles
- Contact lenses and eyeglasses
- Braces
- Out-of-pocket expenses paid to doctors, dentists, surgeons, chiropractors, osteopaths, psychiatrists, psychologists, and Christian Science practitioners
- Out-of-pocket expenses for hospital services, nursing services, laboratory fees, and

radiology services
- Acupuncture treatments
- Inpatient treatment at a center for alcohol or drug addiction
- Smoking-cessation programs and prescribed drugs to help nicotine withdrawal
- Dentures, hearing aids, crutches, wheelchairs, and guide dogs for the blind or deaf
- Fees in excess of reasonable and customary amounts allowed by your insurance

Examples of **ineligible expenses** include:

- Over-the-counter medications, unless issued as a prescription and documented by your physician
- Health plan premiums, including COBRA premiums
- Long-term care premiums
- Health club dues
- Physical treatments unrelated to a specific health problem and prescribed by your physician, such as massage
- Cosmetic surgery or cosmetic dental procedures
- Prescription drugs for cosmetic purposes
- Dietary supplements and vitamins
- Cosmetics
- Sunblock
- Toiletries (e.g., toothpaste, lotions)

For a more complete listing of eligible medical expenses, please refer to IRS Publication 502.

Contribution Amounts

To determine how much to contribute, make a list of the expected out-of-pocket medical expenses for you and your dependents for the upcoming calendar year. For example, if you always exceed your deductible, include the deductible amount in your calculation. You can set aside between $120 and $2,550 each year. A Contribution Planning Worksheet can be found on ADP's website: https://myspendingaccount.adp.com.

Reimbursement Claims Submission

As you incur medical expenses that are not covered or (partially covered) by your insurance, submit a copy of the Explanation of Benefits or provider's invoice to the FSA plan administrator, who will then reimburse you by direct deposit. You can also submit your FSA claims online via ADP's secure website.

Dependent Day Care FSA

This FSA is designed to help you pay for eligible day care expenses for your child(ren) and other qualifying family members while you and your spouse (if married) are working.

Qualifying Dependents

Money placed in this FSA can be used to pay for day care expenses for:

- Your dependent child who is under age 13 when care is provided
- Your spouse who is not physically or mentally able to care for themselves and lived with you for more than half the year
- A person claimed as your dependent who is not physically or mentally able to care for themselves and lived with you for more than half the year

See IRS Publication 503 for more information on qualifying dependents.

Eligible Expenses & Providers

Examples of **eligible expenses** include:

- After-school care
- Babysitting fees
- Adult and child day care services
- In-home care/au pair services
- Nursery and preschool
- Summer day camps

Eligible day care providers include:

- Day care centers that meet local regulations, provide care for more than six nonresidents and receive fees for such services.
- Babysitters or companions, including your relatives (your children must be age 19 or over) whom you do not claim as exemptions on your federal income tax return.

IRS Publication 503 or a tax advisor can provide more detailed information about eligible expenses. You cannot receive reimbursement for

a dependent day care expense if you itemized the expense as a deduction on your tax return, or if dependent day care was provided by an individual you could claim as a dependent on your tax return.

Contribution Amounts

To determine how much to contribute, consider how much you paid in day care expenses last year and any increases or changes for the upcoming year. The minimum annual election amount is $120. Each year, you can set aside up to:

- $5,000 if you are a single parent or married and filing taxes jointly
- $2,500 per person if you are married and filing taxes separately

Deciding Between a Dependent Day Care FSA & the Federal Tax Credit

If you have eligible dependent day care expenses, you must choose between using a Dependent Day Care FSA and the federal tax credit. The federal tax credit allows you to deduct a percentage of eligible expenses from your taxes (up to $3,000 for one dependent and $6,000 for two or more dependents). Your income and personal tax status will determine which is more beneficial, so check with a tax advisor before choosing either option.

Reimbursement Claims Submission

Submit a copy of the invoice from your day care provider or ask your provider to sign the bottom of the reimbursement form. Be sure the form indicates the individuals for whom services were provided and the dates of service. Reimbursement forms may be obtained on the Forms page of the FCPS Benefits website or by calling the FSA administrator. You can also submit your FSA claims online.

$500 Annual Carryover

Participants in the Health Care FSA are able to carryover $500 in unused funds to the following plan year.

Example: Employee elects $1000 for the 2015 plan year but only uses $400. Participant elects $300 for the 2016 plan year. Employee will carryover $500 from the 2015 plan year to the 2016 thereby having a total amount of $800 to use for the 2016 plan year. Participant will forfeit $100 for the 2015 plan year.

The carryover provision applies to participants even if they do not elect to participant in the FSA program the following year.

The carryover funds are not available to the participant until after the claims filing deadline of March 31st each year.

Per federal guidelines, this carryover provision option is not available for the Dependent Day Care FSA.

Questions About FSAs?

For enrollment/claims questions:

Automatic Data Processing (ADP)
P.O. Box 34700,
Louisville, KY 40232
1-800-871-0773, M–F, 8 am–8 pm
Fax: 1-866-643-2219
https://myspendingaccount.adp.com

Claims Submission Deadlines

Your FSA funds are subject to use-or-lose rules. Be conservative when calculating how much money to contribute for the year because any money left over in your FSA account, over the $500 carryover provision for the Health Care FSA, will be forfeited and, by law, cannot be returned to you.

For all employees and former employees: The filing deadline for FSA claims incurred in the current plan year will be March 31 following the plan year. Example: the claims filing deadline for the 2017 plan year is March 31, 2018.

Preparing for Retirement

Health Care Benefits in Retirement

You and your dependents may continue your participation in FCPS medical and dental plans if you meet the eligibility requirements below.

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.

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 or are eligible for Medicare due to disability.

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.

Deferred Health Option

If you meet the eligibility criteria 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 may elect FCPS retiree medical and/or dental coverage if he/she loses similar coverage for the following reasons:

- death of spouse
- divorce or legal separation (in states where permitted)
- termination of employment (or termination of spouse's employment) that results in a change in eligibility
- significant increase in cost of coverage (qualifying increase amounts are still being defined)
- loss of eligibility under spouse's health and/or dental plan (such as becoming eligible for Medicare).

The DHO participant must not be eligible to continue their late/former spouse's health insurance plan (including COBRA Continuation Coverage). 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.

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

Premium Payment

When your active health insurance coverage ends, 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 retirement payment if your monthly pension payment is sufficient to cover the premium(s). Otherwise, 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 Contact" page opposite the Table of Contents in this handbook.

FSAs at Retirement

Your flexible spending account benefit plan will end on the same schedule as health insurance (described on page 19). The last day you may submit claims for your FSA is March 31 of the year following your retirement. However, you must incur the eligible expenses prior to termination of employment.

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 become Medicare-eligible due to age or disability, you can no longer participate in CareFirst BlueChoice Advantage. You will be required to enroll in the Aetna/ Innovation Health or Kaiser Medicare Plus Plan (if you reside in Kaiser's Medicare service area).

Kaiser Permanente Members

Retired members of Kaiser Permanente must reside in the local service area to retain coverage with Kaiser Permanente. If you do not reside in Kaiser's service area (or Kaiser's Medicare service area), you must change plans in order to retain health care coverage with FCPS.

Other than the Kaiser service area rule, your health plan coverage as a retiree is identical to your coverage as an active employee until you become eligible for Medicare. Visit the Kaiser website at http://my.kp.org/fcps/ or contact Kaiser directly for more details.

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. Subsidy schedules are available in the Retiree Benefits Handbook. As a retiree, you do not pay your health plan contributions on a pre-tax basis as you did as an employee. Contact your tax advisor for information about the tax status impact of your contributions.

Enrolling in Medicare

FCPS requires retirees and spouses who are eligible for Medicare to elect and maintain Medicare Parts A and B in order to maintain health coverage under an FCPS medical plan. This applies to retirees and spouses who will be turning age 65 as well as retirees or covered dependents who are eligible for Medicare due to disability.

If you are a CareFirst member, it is strongly recommended that you change plans during the Open Enrollment prior to you and/or your spouse's 65th birthday. Once eligible for Medicare, you will be required to switch to either Aetna or Kaiser, and you will not be able to transfer any money paid towards the deductible to your new plan.

To learn more about Medicare and your FCPS health benefits, please read "Becoming Eligible for Medicare" on the FCPS website.

For further health plan details, see the Summary Plan Documents, which are posted on each medical and dental vendor's website. See pages 7-11 (medical) and 12-13 (dental) for the website addresses.

Life Insurance

Life Insurance for VRS Members

If you are a monthly paid full-time instructional, administrative, or support employee, you are likely a member of the Virginia Retirement System (VRS). As an active member of VRS you receive life insurance as well as accidental death and dismemberment benefits. VRS sponsors and insures this plan through the Minnesota Life Insurance Company.

Basic Group Life Insurance

- You are automatically enrolled for coverage of 2 times your annual salary (rounded to the next highest thousand).
- You and FCPS share the cost for basic life insurance.

Optional Group Life Insurance

You may purchase additional life insurance at group rates for you, your spouse, and your dependents up to age 21 (or age 25 if they are full-time students). You can:

- Insure yourself for 1, 2, 3, or 4 times your salary (rounded to the next higher $1,000), up to a maximum of $750,000.
- Insure your spouse for half of the amount of your coverage, up to a maximum of $375,000.
- Insure your children over 14 days of age in increments of $10,000, $20,000, or $30,000, depending on the level of coverage you select for yourself.

VRS bases premiums for optional coverage for you and your spouse on each individual's age and the amount of coverage. Age-related premium rate changes occur once a year on July 1.

Evidence of insurability is required if applying for certain levels of coverage.

Rate tables can be found on the VRS website: www.varetire.org. You pay all costs for optional life insurance.

Enrollment

Optional life insurance for the employee is a guaranteed benefit (subject to plan maximums) if you enroll **within 31 calendar days of your hire date.** You may apply for optional coverage after 31 calendar days, but evidence of insurability will be required. VRS guarantees coverage equal to one-half your salary for your spouse. Evidence of insurability is required for higher levels of coverage.

Coverage Period

You may continue your optional life insurance if you retire. You must have been enrolled for 60 months before leaving service and elect continuation of coverage within 31 calendar days of leaving service.

Accidental Death & Dismemberment (AD&D) Benefits

Both basic and optional group life benefits provide AD&D coverage. AD&D provides additional coverage if you should die or lose your sight or limbs due to accidental causes.

- If you should die in an accident, your benefit generally would be twice what it would be if you were to die of natural causes.
- If you are in an accident, you would receive prorated or partial benefits according to the loss experienced.

Life Insurance for FCERS Members

If you are a benefits-eligible custodial, food service, maintenance, or transportation employee; or a less-than-full-time educational, administrative, or support employee, you are likely a member of the Fairfax County Employees' Retirement System (FCERS). As an active member of FCERS you receive life insurance as well as accidental death and dismemberment benefits. FCPS sponsors and insures this plan through Minnesota Life Insurance Company. Employees who work less than 50 percent of a normal scheduled work week (less than 15 hours per week for food service) are not eligible for life insurance.

Basic Group Life Insurance

- You automatically are covered for 1 times your annual salary, rounded to the next higher $1,000.*
- FCPS pays the full cost for this coverage as long as you are actively at work.
- You may continue coverage while you are on leave-without-pay or long-term disability, but you will be responsible for the full premium.

* Separate provisions apply for Leadership Team members.

Optional Group Life Insurance

You may purchase additional life insurance at group rates for you, your spouse, and your dependent children (from the age of 10 days up to age 21, or age 25 if they are full-time students). You may choose from several options:

- You may elect optional coverage for yourself of 1 or 2 times your salary, rounded to the next higher $1,000.
- You may elect dependent life coverage in the following options:
  Low option: Spouse $5,000; Child(ren) $2,000.
  High option: Spouse $10,000; Child(ren) $5,000.

A Note About Optional Life Insurance

Optional life insurance is a guaranteed benefit (subject to plan maximums) if you enroll within 30 days of your hire date. You may apply at any time, but the benefit will not be guaranteed.

You pay all costs for optional and dependent life insurance. Rate tables are available in the FCERS Group Life Plan brochure on the FCPS Benefits website. Go to www.fcps.edu, search "Life Insurance".

Accidental Death & Dismemberment Benefits (AD&D)

Both basic and optional group life benefits provide AD&D coverage. AD&D provides additional coverage if you should die or lose sight or limbs due to accidental causes.

- If you should die in an accident, your benefit generally would be twice what it would be if you were to die of natural causes.
- If you are in an accident, you will receive, prorated or partial benefits according to the loss experienced in the accident.

Saving for Your Future—
Your FCPS-Sponsored Retirement Plans

FCPS provides its employees the financial security of defined benefit retirement plans at the end of their working career. A defined benefit program provides a retirement benefit that is calculated based on several factors, including your age, years of service and average final compensation.

FCPS participates in three different, mandatory pension plans for its benefit eligible employees. The system(s) in which you are enrolled is based on your position with FCPS, as described in more detail below.

Virginia Retirement System (VRS) and Educational Employees' and Supplementary Retirement System of Fairfax County (ERFC)

Full-time educational, administrative, and support employees

Virginia Retirement System (VRS)

The Virginia Retirement System (VRS) is a mandatory defined benefit program sponsored by the Commonwealth of Virginia. After five years of eligible service, you become vested in this system.

- **Employees hired before July 1, 2010 and vested as of January 1, 2013, are covered under VRS Plan 1.** Plan 1 members are eligible for normal (unreduced) retirement benefits at age 50 with 30 years of service, or at age 65 with 5 years of service. For more details about Plan 1, visit the VRS website.
- **Employees hired on or after July 1, 2010 (or your VRS membership date is before July 1, 2010, and you were not vested as of January 1, 2013) are covered under VRS Plan 2.** Plan 2 members are eligible for normal (unreduced) retirement benefits at normal Social Security retirement age with at least five years of creditable service, or when the combination of the employee's age and years of creditable service total 90 or more. For more details about Plan 2, visit the VRS website.
- **Employees hired on or after January 1, 2014, with no previous VRS service credit, are covered under the VRS Hybrid Retirement Plan.** A hybrid retirement plan combines the features of a defined *benefit* plan and a defined *contribution* plan, which provides a retirement benefit based on employee contributions and employer match to the plan and the investment performance of those contributions. You contribute a *mandatory* 1% of creditable compensation each month, and FCPS contributes a mandatory 1% match. The first 1% of *voluntary* contributions will be matched with a 1% contribution by FCPS. Each additional 0.5% member contribution (up to 4%) will be matched by FCPS with a 0.25% contribution (up to 2.5%).

  Hybrid plan members are eligible for normal (unreduced) retirement benefits at normal Social Security retirement age with at least five years of creditable service, or when the combination of the employee's age and years of creditable service total 90 or more. For more details about the VRS Hybrid Plan, visit the VRS website.

You and FCPS share in the cost of funding your VRS retirement benefit, regardless of plan membership, with FCPS contributing the majority of these costs.

Vested Contributions

Members are always 100% vested in their own contributions.

For the defined contribution component, upon leaving employment, Hybrid members are eligible to receive distribution of a percentage of the employer contributions, subject to vesting restrictions.

- After two years, members are 50% vested and may withdraw 50% of employer contributions.
- After three years, members are 75% vested and may withdraw 75% of employer contributions.
- After four or more years, employees are 100% vested and may withdraw 100% of employer contributions.

For More Information

In order to make the best decisions relating to your retirement planning, you are encouraged to create an online myVRS account on the VRS website at: www.varetire.org. Select the "myVRS" logo from the "Members" tab, which will take you to the Registration page and follow the instructions. The system offers secure features for interacting with VRS such as viewing and tracking your service credit and member contributions and creating future retirement benefit estimates using live data from your file.

Educational Employees' Supplementary Retirement System of Fairfax County (ERFC)

The Educational Employees' Supplementary Retirement System of Fairfax County (ERFC) is a mandatory defined benefit program sponsored by FCPS. The plan is designed to supplement VRS and Social Security. After five years of eligible service, you become vested in this system. You and FCPS share in the cost of funding your retirement benefit.

If you were hired on or after July 1, 2001, you are covered under the *ERFC 2001 Plan*. If you were hired prior to July 1, 2001, you are covered under the *ERFC Legacy Plan*.

New enrollees in the ERFC system will receive an email confirmation of your enrollment in the ERFC Retirement system. Members establish their own online ERFCDirect account for direct and secure access to personal retirement information. ERFCDirect allows members to designate beneficiaries for ERFC benefits. Completion of the VRS Beneficiary Designation Form is optional.

Go to www.fcps.edu and search "ERFC" for more information and plan booklets.

Fairfax County Employees' Retirement System (FCERS)

For full-time and part-time custodial, food service, maintenance, and transportation employees and part-time educational, administrative, and support employees

The Fairfax County Employees' Retirement System (FCERS) is a mandatory defined benefit program sponsored by Fairfax County. After five years of eligible service, you become vested in this system.

Employees hired on or after January 1, 2013, who are covered under the FCERS plan must elect membership in Plan C or Plan D within 30 calendar days of date of hire. This election is irrevocable. If you do not elect a plan within the first 30 days of employment, you are automatically enrolled in Plan C.

Employees hired before January 1, 2013, who are covered under the FCERS plan are members in Plan A or Plan B.

Plan A and C members contribute a lower amount of their salary (4%) than Plan B and D members (5.33%). This means Plan A and C members receive a slightly lower benefit at retirement while Plan B and Plan D members receive a higher benefit at retirement.

Plan A and B members are eligible to receive normal retirement benefits as early as age 50 with 30 years of service; when age and years of service (including sick leave) total 80; or at age 65 with five or more years of service. Plan C and D members are eligible to receive normal retirement benefits as early as age 55 with 30 years of service; when age and years of service (including sick leave) total 85; or at age 65 with five or more years of service.

For additional information, contact FCERS at 703-279-8200, or e-mail your questions to retirementquestions@fairfaxcounty.gov.

Determining the right time to retire and selecting your benefit payment options are very personal, important decisions. FCPS encourages you to starting planning early by reviewing your available options and seeking the advice of a professional financial planner or tax advisor who can help you align your FCPS retirement benefits with your other savings plans and retirement goals.

Saving for Your Future—

457(b) & 403(b) Retirement Savings Plans

Financial experts suggest that you plan for retirement income that includes your pension, Social Security, and your own personal savings. You can enhance your financial future by participating in the voluntary retirement savings plans sponsored by FCPS.

FCPS offers both a **deferred compensation–457(b) plan** and a **tax-deferred account (TDA)–403(b) plan** to help you save for your future and meet your retirement savings goals.

Both plans allow you to save now—by setting aside your salary on a pre-tax basis and withdrawing your contributions and earnings later in life. You do not pay federal or state taxes on the portion of your salary you contribute to these plans, or the earnings on your contributions, until you withdraw the funds.

Each year, the IRS sets limits on the amount you may contribute to 403(b) and 457(b) plans. The Office of Benefit Services will post these limits online when available. Tax laws allow eligible employees to contribute up to the annual IRS maximum to each plan—potentially doubling your annual contribution to your retirement savings.

You may enroll in these programs at any time. Payroll deductions generally start after the month in which you enroll.

Deferred Compensation—457(b) Plan

All benefits-eligible full-time and part-time employees may enroll in the 457(b) plan. The plan is not available to temporary, hourly employees.

A 457(b) plan:

- Has no 10 percent early distribution penalty.
- Offers a generous catch-up provision for unused deferrals—up to 2 times the standard deferral limit—for unused deferrals during 1 or more of the 3 calendar years that end prior to the year you are eligible for unreduced normal retirement.

The 457(b) plan offers a number of no-load and load-waived mutual fund investment options, as well as a fixed interest investment option. It's easy to enroll either online at www.gwrs.com/fcps or by calling EMPOWER Retirement 877-449-FCPS (3277).

Tax-Deferred Account—403(b) Plan

All employees, including substitute teachers and other temporary, hourly employees, are immediately eligible to participate and save for retirement with the Tax-Deferred Account (TDA) plan, also known as a 403(b) plan. The 403(b) plan offers best-in-class mutual funds and group annuity products across a broad spectrum of investment options.

To enroll in the 403(b) plan and to establish an account with one of the authorized providers, visit any of the providers' websites. These sites offer easy online enrollment and salary reduction processes. You may only contribute to one vendor at a time, but you may have balances with more than one provider. The most current list of authorized providers, including contact information, is available on the 403(b) Approved Providers page on the FCPS website. Investing in a 403(b) plan may seem complex. When you meet with a 403(b) provider, you should ask about:

- Types of investment options
- Minimum contribution requirements
- Transfer of money between investment options
- Fees, including withdrawal, transfer, sales (load), surrender, etc.
- Expenses (e.g., annual account maintenance, annual fund expenses)
- Catch-up provisions
- Early withdrawal penalties
- Changing your investment strategy at a later time
- Track record of investments you are considering

To improve service to you and comply with IRS 403(b) regulations, FCPS has partnered with TSA Consulting Group (TSACG) to work with

you and your FCPS-authorized 403(b) vendor to simplify transactions on your account, such as loans, hardship withdrawals, rollovers, transfers, exchanges, and distributions.

See *FCPS Regulation 4750* for established policies that enable you to increase or decrease your contribution, or change from one authorized 403(b) provider to another.

Most importantly, take the time to read any materials you receive and make sure you do your homework before you invest.

You are entirely responsible for managing the investment of your 403(b) account.

FCPS has granted permission to certain 403(b) providers to offer investment products to you. However, you should do your own research so that you can choose the provider that is right for you. The providers available today are not guaranteed to be available in the future.

It is important to note that monies contributed to the 457(b) and 403(b) plans are intended for retirement. Once contributed, you are restricted on how you may withdraw monies from the account(s) while employed. Be sure you read and understand these provisions before you invest.

Find forms, documents, and other information on the FCPS Benefits website: Go to www.fcps.edu, click on "Current Employees".

FCPS 403(b) Universal Availability Notice

What is a 403(b) plan?

A 403(b) plan is a tax-deferred retirement savings plan available to employees of public educational institutions and certain tax-exempt organizations. A 403(b) plan allows you to make pretax contributions by convenient payroll deduction and save that money for your retirement.

403(b) plans were created to encourage long-term savings. Distributions generally are available only when you reach age 59 ½, leave your job, upon death or disability. However, distributions can also be available in the event of financial hardship. Bear in mind that distributions before age 59 ½ might be subject to federal restrictions and a 10% federal tax penalty.

Short-term needs can sometimes be met by nontaxable loans. This type of loan makes it possible for you to access your account without permanently reducing your balance. Though you should remember that defaulted loan amounts will be taxed as ordinary income and might be subject to a 10% penalty if you are under age 59 ½.

Why contribute to a 403(b) plan?

Participating in your plan can provide a number of benefits, including:

- **Lower taxes today–**You contribute before income taxes are withheld, which means you're taxed on a smaller amount. This can reduce your current income tax bill. For example, if your federal marginal income tax rate is 25 percent and you contribute $100 a month to a 403(b) plan, you've reduced your federal income taxes by roughly $25. In effect, your $100 contribution costs you only $75. The tax savings increases with the size of your 403(b) contribution.
- **Tax-deferred growth and compounding interest–**In a 403(b) plan, your interest and earnings accrue tax deferred. That means interest on your interest also grows tax deferred. The compounding interest can allow your account to grow more quickly than saving in a taxable account, where interest and earnings are generally taxed each year.
- **You take the initiative–**Contributing to a 403(b) retirement savings plan can help you take control of your future. Other sources of retirement income, including state pension plans and, if applicable, Social Security, rarely replace a person's final salary upon retirement. That's why it's up to you to make sure you'll have enough money for retirement.

Contributions made to the plan are invested as you direct, based upon your elections among the investments available under the plan. Loans and distributions from the plan are subject to requirements under the plan and under the investment product that you select.

Am I eligible to participate?

All employees including temporary hourly and substitute teachers are eligible to participate.

What is the maximum amount I can contribute?

The IRS limits the annual contributions you can make to a 403(b) plan. For 2016, you can contribute the lesser of 100 percent of your taxable income or:

- Under Age 50 $18,000
- Age 50 and older $24,000

Limits are adjusted each year. See *IRS Publication 571* for more information.

When can I enroll?

You can enroll in the plan immediately upon your date of hire or anytime after your date of hire, as long as you are an employee of Fairfax County Public Schools. For investment provider contacts, please visit the FCPS Benefits website.

When are my elective deferral contributions effective?

After completing the online enrollment requirements, your elected deferral percentage will begin the first day of the following month or as soon as administratively possible. Completed

online enrollments must be entered by the twentieth of the month to be effective on the first day of the following month.

Can I change or stop my elective deferral contributions?

You may change or revoke your elective deferral contributions anytime during the plan year. Online salary reduction agreements for new enrollments, changes, or stops entered by the twentieth of any given month will become effective on the first of the following month.

For general questions, contact the Office of Benefit Services at 571-423-3200. For additional information about participation, investment options, and more, please contact the investment providers directly.

VALIC
804-897-5042
www.valic.com/fcps

TIAA-CREF
703-460-7100
www.tiaa-cref.org/fcps

EMPOWER RETIREMENT
(formerly Great-West Financial)
877-449-FCPS (3277)
www.gwrs.com/fcps

Find forms, documents, and other information on the FCPS Benefits website: Go to www.fcps.edu, click on "Current Employees".

Integrated Disability Management

The Integrated Disability Management (IDM) program replaces all or part of your salary if you are unable to work due to a serious illness or injury, by coordinating benefits through Short-Term Disability, Long-Term Disability, Workers' Compensation (if the condition is work-related), and sick and/or annual leave. No cost is associated with your participation in the Short-Term Disability (STD) program and Workers' Compensation (WC); however, a minimal cost is associated with the Long-Term Disability (LTD) program. For complete IDM program details and eligibility rules, refer to the IDM Handbook on the FCPS Benefits website.

How the IDM Program Works

If you are absent from work due to an illness or injury or have been diagnosed with a serious illness, you **must** keep Liberty Mutual, the program administrator, and your principal or supervisor informed of when you expect to return to work (if you are able to provide information). If you have been released to return to work, but are not fully recovered from your injury or illness, you may be placed in a temporary, alternate duty capacity for up to 60 calendar days; Liberty Mutual will coordinate with your worksite. If this occurs, you must keep in contact with Liberty Mutual about your progress toward full recovery to ensure that all necessary information to compensate you for any lost wages has been documented and forwarded to Liberty Mutual.

Short-Term Disability (STD)

If an employee sustains a personal illness, injury, has been diagnosed with a serious health condition, or is going to serve as an organ donor, FCPS will provide salary replacement through the short-term disability (STD) program, if the employee has been disabled for more than 20 continuous workdays (for organ donors the 20 workday elimination period is waived). After that time, the employee will automatically be transferred to the STD program if he or she has been working with Liberty Mutual (the program administrator) and the absence is medically necessary. After an elimination period of 20 consecutive workdays, this plan replaces your income for up to five months if you are disabled, and your claim is approved.

Your Benefits During STD

When you are approved for STD benefits, you will be receiving payments through the FCPS payroll process. This means that FCPS continues its contribution for optional benefits—medical, dental, and life insurance—and for the retirement plan for a maximum of 5 months. You also continue to earn retirement service credit. However, you do not accrue additional sick or annual leave while you are receiving STD benefit pay.

Eligibility

All employees hired before July 1, 2010, are automatically enrolled on the first day of the month after their hire date. All employees hired on or after July 1, 2010, are enrolled on the first of the month after 12 calendar months of service from date of employment or re-employment.

Short-Term Disability Benefits

As a result of your STD benefits claim approval, you have two options to choose from to receive your STD benefit pay, after the 20 workday elimination period. Beginning on Day 21, you may elect to receive:

- 90% of your current salary without use of any of your accrued sick and/or annual accrued leave. This option maintains your accrued leave balances after use of your leave for the 20 work day elimination period.
- 100% of your current salary with use of any/all available accrued sick and/or annual leave. After exhausting the sick and/or annual leave balances to receive 100%, your STD pay will then convert to 90% of pay until all rights to STD pay have been exhausted.

While employees are receiving STD benefits, employees and FCPS will continue to make payments for voluntary benefits and for the retirement plan. As long as medically certified, these benefits are paid for a maximum of five months. Employees also continue to receive

retirement credit. However, employees do not accrue additional sick, personal, or annual leave while they are approved for STD benefits.

Non-worked summer months do not count for eligibility nor are benefits paid during non-working periods, ex. spring, winter, and holiday breaks, etc.

Example: If you are a 10-month employee and you begin the STD program on June 6, the months of July and August are not counted toward your elimination period, nor are benefits paid during these nonworked periods.

If you become seriously ill or injured

Immediately notify your supervisor that you will be away from work. Call Liberty Mutual at 800-524-0740 to report your injury or illness:

- On the fifth consecutive absence in a month.
- On your fifth absence in a month for the same medical condition.
- If you are diagnosed with a serious illness or injury.

Liberty Mutual will deny any claim filed more than 5 workdays after the beginning of the disability if you do not provide this notice, but you may appeal the denial provided you have a valid reason for late filing.

In case of emergency, go or be taken to the emergency room. Emergency treatment is for a sudden life-threatening occurrence demanding immediate medical attention. You or someone on your behalf should call Liberty Mutual to report as much information as possible about the injury/illness.

If you do not call within these time frames, your claim will be denied. You may write an appeal detailing why you did not follow the STD plan guidelines in order for your claim to be reconsidered for benefits.

Your Information Is Confidential

All medical and personal information you or your physician supplies is confidential and protected from unauthorized use or disclosure by Liberty Mutual. Certain claims may require the use of a separate, written authorization form. When Liberty Mutual sends you forms, sign and return them as quickly as possible so there is no delay in processing your claim.

To ensure payments reach you in a timely manner, notify Liberty Mutual and FCPS of any address or phone number changes.

Long-Term Disability (LTD)

If employees are receiving payment from the short-term disability (STD) program and the claim is approaching the end of the five-month STD period, Liberty Mutual will automatically transition the short-term disability claim to the long-term disability (LTD) program to determine if they are eligible to collect additional benefits.

Premium Cost

Employees pay for the LTD program through post tax deductions. Premiums are deducted from an employee's earnings each pay period. The amount deducted can be viewed in UConnect or on your most recent Pay Advice.

Long-Term Disability Benefits

The program pays 66 2/3% of pay if employees continue to be disabled after 180 days (5 months), which coincides with the end of STD payments. While employees are receiving LTD benefits, they are not required to pay the cost for LTD. The deduction automatically begins again once an employee returns to work.

Employees may continue to participate in the health insurance, dental insurance, and other optional benefit programs if the plans allow such participation. Employees must pay the premium cost for these benefits.

Workers' Compensation

If an employee is injured on the job or has sustained an occupational illness, the employee may be eligible to receive workers' compensation benefits. Benefits available through workers' compensation include payment for medical expenses and salary replacement if the employee is disabled for more than 7 calendar days as a result of the compensable occupational illness and/or injury.

Eligibility

All new employees are automatically enrolled in the workers' compensation program on the first day of work.

If a workplace injury/illness occurs:

- And is life-threatening or limb-threatening injury, seek immediate medical attention!
- For non-life/limb-threatening medical services, refer to the Workers' Compensation Provider Panel list to choose a provider and make an appointment with the panel provider.
- Call Liberty Mutual immediately (or as soon as possible) at 1-800-524-0740 to report the injury and/or illness. Liberty Mutual is available to take the call and provide assistance 24 hours per day, 7 days per week. If there is an emergency and you are unable to call, someone else may call for you. Be sure to provide Liberty Mutual the physician's name.
- Medical expenses and prescription costs related to your approved workers' compensation claim will be paid by Liberty Mutual. You are not responsible for paying co-payments, consultation fees, or fees for visits to an approved workers' compensation provider panel physician or facility. If the physician or facility requires you to pay for the office visit, you should refer them to Liberty Mutual.
- If your medical condition requires specialty care, your workers' compensation provider panel physician will make the referral. Please ensure that Liberty Mutual is aware of this specialty physician.
- If you choose to use a physician who is not approved by Liberty Mutual, you will be responsible for payment of the services rendered upon the direction of the physician.

Leave Programs

Family & Medical Leave Act

If you have been actively employed with FCPS for the previous 12 months, and have worked a minimum of 1,250 hours, you may be eligible for leave under the Family and Medical Leave Act (FMLA). FMLA allows up to 12 weeks of unpaid leave during a 12-month rolling period for a serious personal illness or injury, the birth or adoption of a child or placement of a foster child, or the care of a seriously ill spouse, child, or parent. If you are approved for short-term disability (STD) or Workers' Compensation, FCPS automatically tracks FMLA when your claim begins and you are absent from work.

FMLA regulations also permit a spouse, son, daughter, parent, or next of kin to take up to 26 weeks of leave to care for a member of the Armed Forces or National Guard or Reserves, who is undergoing medical treatment, recuperation, or therapy for a serious injury or illness. In addition, the Act also permits an employee to take FMLA leave for "any qualifying exigency" arising out of the fact that the spouse, son, daughter, or parent of the employee has been called to active duty or has been notified of an impending call or order to active duty.

Your Pregnancy

Under the Integrated Disability Management (IDM) program, FCPS regards the recovery period from delivery from a pregnancy the same as illnesses or injuries that prevent you from performing your normal work duties with FCPS. In applying this standard, each absence and ability to return to work is evaluated on its own facts and circumstances.

You should contact Liberty Mutual at least 30 days prior to your due date to report your claim. You also must call when your baby is born to start your 20-workday elimination period. You also should contact Liberty Mutual if your doctor orders bed rest any time during your pregnancy.

Generally, a 6-week recovery is medically supported for a regular delivery, and an 8-week recovery is medically supported for a cesarean delivery. In addition, if you have at least 12 months of FCPS service, you may be eligible for leave under FMLA, which provides up to 12 weeks of leave in a 12-month period. The 12 weeks of FMLA start on the first workday after delivery or on the first workday of bed rest, according to your physician's order and Liberty Mutual approval.

A representative from the FCPS Disability and Leaves unit will contact you to discuss your options if you need or desire more time off, including taking an additional absence without pay through your work location (30 days or less), participating in a remaining FMLA, or taking an unpaid leave of absence greater than 30 days. You need to add your baby to your FCPS benefits and you must do so within 30 days of the birth or adoption even if you currently have family coverage.

For more information about maternity and/or paternity-related leave, view the IDM Handbook on the FCPS Benefits website or attend an Expecting Parents Workshop.

Your baby is not automatically enrolled for medical insurance.

Regardless of whether you will be covering your baby under an FCPS medical plan or other plan, you must contact the benefits office of the plan in which you will be enrolling your child in order to add the baby to your policy.

FCPS requires you enroll your baby within **30 calendar days** of the date of birth; contact the Office of Benefit Services to obtain the appropriate enrollment form or go to: www.fcps.edu, search "Benefits".

Leaves of Absence

FCPS provides two types of long-term (30 days or more), unpaid leaves of absence (LOA) to help you meet your personal and professional needs—**designated** and **nondesignated.** For school-based employees, a request **must** be submitted by **March 1** preceding the school year you wish to take an LOA.

A **designated** LOA is provided for specific purposes, and FCPS requires related documentation supporting your LOA. You need not have worked for FCPS for a specified time period prior to requesting this type of LOA. You may request a designated LOA for any of the following reasons:

- Child care
- A personal or family illness
- Hardship
- Military active duty
- Student teaching, internships, or a professional certification if you are obtaining your initial teacher license or a license in a critical field
- A professional certification for nonteaching employees related to your position

A **nondesignated** LOA is available to you after 5 consecutive years of working for FCPS If approved, you may take any number of nondesignated LOAs during your FCPS career. Eligibility for each successive LOA requires 5 years of active service from the date of your return to active employment from any prior designated or nondesignated LOA.

An LOA does not extend past 24 months, although FCPS can allow extensions under certain circumstances, such as military and child care. Before you take an LOA, you should find out how it may affect your retirement and benefits. If you need additional information or assistance on the types of leaves available, eligibility, and the application process, email Disability and Leaves at disabilityandleaves@fcps.edu.

Your Benefits & LOA

While on an approved LOA, you have the option to make changes to your current benefits to include dropping coverage and/or dependent(s) within **30 calendar days** of the first day of approved leave. During an LOA, you may be required to pay for your elected benefits by personal check or money order, if you do not receive a check from FCPS while on an upaid LOA and/or you have exhausted your leave balance(s). If you participate in the Flexible Spending Account program(s), you will not be covered for the periods in which no payroll deductions occur, unless you have elected to continue these benefits on a direct pay basis.

To Maintain Your Benefits During LOA

You must elect to continue optional benefits during an LOA. You pay the full premium (the employee and employer portions) of your benefits while you are on an LOA. FCPS must receive an Initial Premium Invoice and payment no later than 30 calendar days after the date that you were approved for your LOA. The Office of Payroll Management will then send you an insurance coverage billing letter and future payment coupons indicating the amount you must pay for your benefits and the due dates.

Your Benefits Upon Return from LOA

FCPS automatically reinstates your mandatory benefits when you return to work—retirement, basic life insurance, STD, LTD, and Workers' Compensation.

You must re-enroll in optional benefits—medical and dental, flexible spending accounts, optional life insurance, long-term care insurance, and deferred compensation plans, upon your return to work.

These benefits are reinstated if you submit your enrollment forms within 30 calendar days of your return to work. If you do not submit your enrollment forms within 30 calendar days of your return to work, you are not able to enroll for optional benefits, including medical and dental insurance, until the next open enrollment period. Call HR Client Services at 571-423-3000 for enrollment forms or visit the Benefit Forms section of the FCPS Benefits website.

Sick Leave

All employees assigned a specific number of contract days or workdays—and those who were hired prior to July 1, 1996, and are paid hourly—are eligible for sick leave. Sick leave can be accrued and credited as long as you are in a paid status. There is no limit on the accumulation of sick leave from one year to the next.

You may use sick leave for:

- Personal illness or injury.
- The care of ill immediate family members.
- Bereavement leave for up to 5 days for immediate family members upon request.

To use sick leave, complete a Leave Request form from your time and attendance processor and submit it to your principal or program manager, who approves your sick leave use. Sick leave is not available for use until the pay period after it is accrued.

Monthly Paid or Biweekly Paid Employees Working 12 Months—You accrue sick leave at a rate of .0538 per hour for every hour worked, for an accrual of approximately 14 days per year.

Monthly Paid Employees Working Less Than 12 Months—You accrue sick leave at a rate of .0632 per hour for every hour worked. If your workdays are 208–260, this results in an accrual of approximately 13 days; 190–203 workdays results in an accrual of approximately 12 days; and 183–188 workdays results in an accrual of approximately 11 days.

Regulation 4819—Leave and Leaves of Absence: Sick Leave—Effective July 1, 2013, all new hires and re-hires with a break in service of greater than one year will be granted up to three days of sick leave before they begin to accrue or earn it. All other employees must accrue or earn sick leave balances before they are available for use. After the first year of new employment or re-employment all employees must accrue or earn sick leave balances before the funds are available.

For more information concerning the modifications to the requirements of sick leave, go to www.fcps.edu, search keywords "Time Away from Work".

Sick Leave & Retirement

ERFC Legacy & FCERS Members

FCPS converts sick leave accrued by **vested** *ERFC Legacy* **or FCERS members** to retirement service credit upon termination. Neither vested nor non-vested members are entitled to a monetary payout of unused sick leave.

ERFC 2001 Members

Accrued sick leave for *ERFC 2001* members is not converted to retirement service credit.

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 payment at a rate of $1.25 per hour of unused sick leave.

Reciprocity of Sick Leave

You may transfer up to 60 days of accumulated sick leave between public school divisions within Virginia, if the separation from one division occurred within the 12-month period prior to employment with the other school division or if a written request is submitted within the 12-month period after separation from the other district.

An unlimited number of accumulated sick leave days are reciprocal between FCPS and Fairfax County government if both positions are eligible to earn sick leave, if there was no break in employment, and if you resigned from one of the positions. See *Regulation 4819* for more information about sick leave.

Personal Leave

FCPS allows less-than-12-month employees to use up to 5 days of sick leave as personal leave. Personal leave not used in one contract or work year is not carried over to the next contract or work year.

Annual Leave

Twelve-month employees accrue annual leave beginning with 13 days per year in the first year of service. FCPS adds 1 additional day of annual leave for each year of service between the first and thirteenth years to reach a maximum of 26 days per year.

Example:
You accrue 14 days of leave in your second year of service and 15 days of leave in your third year of service.

Annual leave is not available for use until the pay period after it is earned. To use your annual leave, complete a Leave Request form in advance and submit it to your principal or program manager, who approves your annual leave use.

During your first 10 years of 12-month employment, you may accumulate up to a maximum of 30 days of annual leave. Beginning in the eleventh year of continuous 12-month employment, you may accumulate up to a maximum of 40 days of annual leave. At the end of each new fiscal year on June 30, FCPS converts unused annual leave in excess of the limits to sick leave.

If you move from a less-than-12-month position to a 12-month position, you will begin accruing annual leave based on the total years of service you have with FCPS at the time of your transfer. If you terminate employment or move from an annual leave-eligible position to one that does not accrue annual leave, you are paid for your accumulated annual leave.

Annual leave may be used on days when unscheduled liberal leave policy is in effect and schools are closed due to inclement weather or other emergencies.

Reciprocity of Annual Leave

Accumulated annual leave is reciprocal between FCPS and the Fairfax County government if there is no break in employment when you move between organizations. See *Regulation 4813* for more information about annual leave.

Paid Nonworkdays

FCPS pays bus drivers and transportation attendants for nonworkdays during winter and spring breaks, federal, and local holidays, and teacher workdays. Those hired before July 1, 2005, receive approximately 19–21 paid nonworkdays a year. Those hired after July 1, 2005, and those who migrated to the *2006 Salary Plan* receive approximately 6 paid non-workdays a year.

Holidays

The list below contains the standard holidays recognized by FCPS.

Regulation 1344 and *Regulation 4421* list which of the following days are paid and unpaid for various employee categories. The current school calendars are at www.fcps.edu.

- New Year's Day
- Martin Luther King, Jr.'s birthday
- Inauguration day (every 4th year)
- George Washington's birthday
- Spring Break (except 12-month employees)
- Memorial Day
- Independence Day
- Labor Day
- Columbus Day
- Thanksgiving Day and the following Friday
- Winter Break (except 12-month employees)
- Christmas Eve
- Christmas Day
- New Year's Eve

Generally, holidays are observed on the day designated as the federal holiday. If a holiday falls on a Saturday, it usually is observed on the Friday before the actual holiday. If a holiday falls on a Sunday, it usually is observed the Monday after the actual holiday.

Legislation Applicable to FCPS Health Plans

Your FCPS benefits comply with all federal mandates governing public sector employee plans. For more information about the requirements of these legislative acts, refer to the following:

FCPS Policy Regarding Use of Social Security Numbers for Health Coverage Enrollment

Patient Protection and Affordable Care Act

The Patient Protection and Affordable Care Act requires employers to report to the IRS Social Security numbers (SSNs) for all individuals, including spouses and dependent children enrolled in employer-sponsored medical plans (IRC Section 6055). This information will assist the IRS in determining compliance with the Individual and Employers Mandates.

Medicare, Medicaid, and SCHIP Extension Act of 2007

Medicare, Medicaid, and SCHIP Extension Act of 2007, 42 U.S.C. 1395y (b) (7) & (8), mandates employers to submit SSNs of all medical plan enrollees who are age 45 and over or who are Medicare eligible regardless of age to the Center for Medicare and Medicaid Services.

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 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 may be 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 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 an employee, you become a qualified beneficiary if you lose your coverage under the plan because:

- Your employment status changes to a non-benefits eligible position
- You lose eligibility due to reduction in hours during the preceding measurement period (12-month period during which an employee's average weekly hours worked will be measured to determine eligibility for coverage)
- Your employment ends for any reason other than gross misconduct

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

- Your employment status changes to a non-benefits eligible position
- You lose eligibility due to reduction in hours during the preceding measurement period (12-month period during which an employee's average weekly hours worked will be measured to determine eligibility for coverage).
- 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 as a "dependent child"
- You die

How long does COBRA coverage last?

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.

When the qualifying event is the end of employment or a change in your employment

status, 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 prior to or 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 a change in your employment status, 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. Once the plan administrator receives notice that a qualifying event has occurred, FCPS will offer COBRA continuation coverage to each of the qualified beneficiaries. For each qualified beneficiary who elects COBRA, coverage will begin on the date that plan coverage would otherwise have been lost.

Examples:

- If you divorce, you must send a copy of the first and last pages of the divorce decree. You must also provide your former spouse's mailing address.
- If your dependent child becomes eligible for coverage under another plan, you must send documentation supporting the change in eligibility.

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

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

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

Important Notice from Fairfax County Public Schools (FCPS) About Your Prescription Drug Coverage and Medicare

Please read this notice carefully as it has information about your current prescription drug coverage with FCPS and about your options under Medicare's prescription drug coverage. This information can help you decide whether or not you want to join a Medicare drug plan. Information about where to get help making these decisions is at the end of this notice.

1. Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.

2. FCPS has determined that the prescription drug coverage offered by the FCPS plan is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and, therefore, is considered Creditable Coverage.

Because your existing coverage is Creditable Coverage, you may keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

You can join a Medicare drug plan when you first become eligible for Medicare and each year from October 15 through December 7.

However, if you lose your current creditable prescription drug coverage, through no fault of your own, you will be eligible for a 2-month Special Enrollment Period (SEP) to join a Medicare drug plan.

If you decide to join a Medicare drug plan, your FCPS coverage will be affected. (This notice contains more information about what happens to your current coverage if you join a Medicare drug plan.)

If you decide to enroll in the Medicare prescription drug plan, you will be dropped from your current prescription drug plan through FCPS. You will be able to reenroll in FCPS prescription drug coverage if you provide FCPS with a Medicare drug plan termination notice within 30 days of termination.

You should also know that if you drop or lose your current coverage with FCPS and don't join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later.

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

For more information about this notice or your current prescription drug coverage:

Call the Office of Benefit Services at 571-423-3200. **NOTE:** You will receive this notice each year. You will also receive it before the next period during which you can join a Medicare drug plan and if this coverage through FCPS changes. You may also request a copy of this notice at any time.

For more information about your options under Medicare prescription drug coverage:

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

For more information about Medicare prescription drug coverage:

• Visit www.medicare.gov.

• Call your State Health Insurance Assistance Program (see the inside back cover of your copy of the Medicare & You handbook for their telephone number) for personalized help.

• Call 800-MEDICARE (800-633-4227). TTY users should call 877-486-2048.

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

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.

Break Time for Nursing Mothers

In recognition of the well documented health advantages of breastfeeding for infants and mothers, and in conjunction with section 4207 of the Patient Protection and Affordable Care Act (also known as Health Care Reform), FCPS provides a supportive environment to enable lactating employees reasonable break times and private, non-restroom locations, to express milk during the workday for the first year of the child's life.

Find the Lactation Toolkit in the Wellness section of the FCPS Benefits website. Please e-mail lactationquestions@fcps.edu with questions regarding this program.

Women's Health & Cancer Rights Act

If you have 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.
- Prostheses 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. 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 medical plan provider, available on the FCPS Benefits website.

Find forms, documents, and other information on the FCPS Benefits website: Go to www.fcps.edu, click on "Current Employees".

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 applied to 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.

Uniformed Services Employment & Readjustment Rights Act (USERRA)

USERRA is a federal law that protects civilian job rights as well as health and pension benefits for veterans and members of Reserve components.

Individuals who take a leave of absence from FCPS to perform military duty may elect to continue FCPS medical and dental benefits. If military service is expected to last more than 30 days, the service member may continue health benefits for up to 24 months.

For military service of less than 31 days, health care coverage is provided as if the service member had remained employed.

Employees who choose to terminate health care coverage due to commencement of military service have the right to reinstate their health care coverage within 30 days of return to work with FCPS. For more information regarding USERRA, visit www.dol.gov/compliance/laws/comp-userra.htm.

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 & Accountability Act (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 an individual with other health insurance loses that coverage, or if a person becomes a new dependent through marriage, birth, adoption, or placement of adoption. Employees or dependents must request enrollment within 30 days of the loss of coverage or life event triggering the special enrollment.

Loss of 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 plan 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. Dept. of Health and Human Services following a breach of unsecured protected health information.

FCPS Office of Equity & Employee Relations is responsible for overseeing HIPAA compliance for FCPS. An individual may make a complaint in writing to the privacy office or a designee in the Office of Equity & Employee Relations. For more information, go to www.fcps.edu and search "HIPAA."

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

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

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

Medicaid website:
www.coverva.org/programs_premium_assistance.cfm
Medicaid Phone: 1-800-432-5924

CHIP website:
www.coverva.org/programs_premium_assistance.cfm
CHIP phone: 1-866-873-2647

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, contact your state Medicaid or CHIP office or dial 1-877-KIDS NOW or www.insurekidsnow.gov to find out how to apply. If you qualify, ask your state if it has a program that might help you pay the premiums for an employer-sponsored plan.

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

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

1-866-444-EBSA (3272)

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

1-877-267-2323, option 4, ext. 61565

Find forms, documents, and other information on the FCPS Benefits website:
Go to www.fcps.edu, click on "Current Employees".

New Health Insurance Marketplace Coverage Options and Your Health Coverage

Form Approved
OMB No. 1210-0149
(expires 1-31-2017)

PART A: General Information

When key parts of the health care law take effect in 2014, there will be a new way to buy health insurance: the Health Insurance Marketplace. To assist you as you evaluate options for you and your family, this notice provides some basic information about the new Marketplace and employment-based health coverage offered by your employer.

What is the Health Insurance Marketplace?

The Marketplace is designed to help you find health insurance that meets your needs and fits your budget. The Marketplace offers "one-stop shopping" to find and compare private health insurance options. You may also be eligible for a new kind of tax credit that lowers your monthly premium right away. Open enrollment for health insurance coverage through the Marketplace begins in October 2013 for coverage starting as early as January 1, 2014.

Can I Save Money on my Health Insurance Premiums in the Marketplace?

You may qualify to save money and lower your monthly premium, but only if your employer does not offer coverage, or offers coverage that doesn't meet certain standards. The savings on your premium that you're eligible for depends on your household income.

Does Employer Health Coverage Affect Eligibility for Premium Savings through the Marketplace?

Yes. If you have an offer of health coverage from your employer that meets certain standards, you will not be eligible for a tax credit through the Marketplace and may wish to enroll in your employer's health plan. However, you may be eligible for a tax credit that lowers your monthly premium, or a reduction in certain cost-sharing if your employer does not offer coverage to you at all or does not offer coverage that meets certain standards. If the cost of a plan from your employer that would cover you (and not any other members of your family) is more than 9.5% of your household income for the year, or if the coverage your employer provides does not meet the "minimum value" standard set by the Affordable Care Act, you may be eligible for a tax credit.[1]

Note: If you purchase a health plan through the Marketplace instead of accepting health coverage offered by your employer, then you may lose the employer contribution (if any) to the employer-offered coverage. Also, this employer contribution -as well as your employee contribution to employer-offered coverage- is often excluded from income for Federal and State income tax purposes. Your payments for coverage through the Marketplace are made on an after-tax basis.

How Can I Get More Information?

For more information about your coverage offered by your employer, please check your summary plan description or contact Office of Benefit Services at 571-423-3200, option 3 or go online to www.fcps.edu and search "medical insurance".

The Marketplace can help you evaluate your coverage options, including your eligibility for coverage through the Marketplace and its cost. Please visit **HealthCare.gov** for more information, including an online application for health insurance coverage and contact information for a Health Insurance Marketplace in your area.

[1] An employer-sponsored health plan meets the "minimum value standard" if the plan's share of the total allowed benefit costs covered by the plan is no less than 60 percent of such costs.

PART B: Information About Health Coverage Offered by Your Employer

This section contains information about any health coverage offered by your employer. If you decide to complete an application for coverage in the Marketplace, you will be asked to provide this information. This information is numbered to correspond to the Marketplace application.

3. Employer name Fairfax County Public Schools	4. Employer Identification Number (EIN) 54-0805373	
5. Employer address 8115 Gatehouse Road	6. Employer phone number 571-423-3000	
7. City Falls Church	8. State VA	9. ZIP code 22042
10. Who can we contact about employee health coverage at this job? Department of Human Resources. Office of Benefit Services		
11. Phone number (if different from above) 571-423-3200, option 3	12. Email address HRConnection@fcps.edu	

Here is some basic information about health coverage offered by this employer:

- As your employer, we offer a health plan to:
  - ☐ All employees. Eligible employees are:
  - ☒ Some employees. Eligible employees are:
    All full-time and part-time employees in authorized positions who are eligible to participate in FCPS benefit programs and those working the minimum required number of hours.
- With respect to dependents:
  - ☒ We do offer coverage. Eligible dependents are:
    The eligible employee's spouse and child(ren), as defined in the Fairfax County Public Schools Employee Benefits Handbook
  - ☐ We do not offer coverage.

☒ If checked, this coverage meets the minimum value standard, and the cost of this coverage to you is intended to be affordable, based on employee wages.

** Even if your employer intends your coverage to be affordable, you may still be eligible for a premium discount through the Marketplace. The Marketplace will use your household income, along with other factors, to determine whether you may be eligible for a premium discount. If, for example, your wages vary from week to week (perhaps you are an hourly employee or you work on a commission basis), if you are newly employed mid-year, or if you have other income losses, you may still qualify for a premium discount.

If you decide to shop for coverage in the Marketplace, **HealthCare.gov** will guide you through the process. Here's the employer information you'll enter when you visit **HealthCare.gov** to find out if you can get a tax credit to lower your monthly premiums.

Glossary & Acronyms

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

Biweekly Paid Employee—Full-time and part-time custodial, food service, maintenance, transportation, and less-than full-time instructional and administrative employees. These employees are generally eligible for the FCERS retirement plan and the FCERS life insurance plan.

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.

Case Manager—A registered nurse who gathers medical information from your physician(s) and may authorize the replacement of wages during a period of disability.

Copay or Copayment—The 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.

Deferred Compensation—457(b)—A plan that allows you to save more now—by setting aside your salary on a pre-tax basis—and withdrawing your contributions and earnings later in life.

DHO—Deferred Health Option—A program that began on January 1, 2007, for retirees at the point of retirement to retain potential future health plan eligibility.

DNO — Dental Network Only—
A dental plan that uses a network of participating dental provicders 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 covered.

Dependent Day Care Flexible Spending Account—A flexible spending account for day care expenses that are incurred while you are at work. This account allows you to reimburse yourself with pretax dollars for eligible dependent day care expenses.

EAP—Employee Assistance Program—
A program assists employees and their household members in dealing with personal problems (i.e., marital, financial, legal, emotional or family-related issues, or substance/alcohol abuse) that may be adversely affecting the employee's performance, health and well-being. EAP services generally include assessment, short-term counseling and work-life balance referrals.

Elimination Period—The 20-continuous-workday period during which you are waiting for the beginning of benefit payments under the STD plan. When calculating the elimination period, the program administrator may elect to count absences that are nonconsecutive if they are related to the same health condition and can be confirmed as absences by your health care provider. Nonconsecutive absences apply only if you have not returned to work for 2 full calendar months.

ERFC—Educational Employees' Supplementary Retirement System of Fairfax County—
A mandatory retirement program for full-time educational, administrative, and support employees (monthly paid). You are a member of *ERFC Legacy* if you were hired before July 1, 2001. You are a member of *ERFC 2001* if you were hired on or after July 1, 2001.

Family—You and two or more dependents.

FCERS—Fairfax County Employees' Retirement System—A mandatory retirement program for eligible custodial, food service, maintenance, and transportation employees, and less-than-full-time educational, administrative, and support employees. You must work at least 50 percent of the regular schedule to participate in FCERS.

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

FSA—Flexible Spending Account—An account that allows you to set aside pre-tax dollars directly from your paycheck to help you save taxes on certain costs, like health care and dependent day care.

FMLA—Family and Medical Leave Act—A federal law enacted in 1993 that requires employers with more than 50 employees to provide eligible workers with up to 12 weeks of paid or unpaid leave for employees who have 12-months of service and 1,250 working hours for a serious health condition, birth or adoption or active military service member caregiving.

Generic Drugs—Generic Equivalent—Drugs equivalent in therapeutic power to brand-name originals because they contain identical active ingredients at the same dosage.

Health Care Flexible Spending Account—A flexible spending account for health care expenses incurred by you or your dependents. This account allows you to reimburse yourself with pre-tax dollars for eligible health care expenses. You do not have to be enrolled in an FCPS health plan to enroll in this program.

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.

IDM—Integrated Disability Management—A program that consists of Short-Term Disability (STD), Long-Term Disability (LTD), and Workers' Compensation plans and the coordination of benefits through all applicable programs.

Leave of Absence—An unpaid absence or unpaid leave granted by FCPS for any cause for a period specified under FCPS regulations, including an absence due to service in the United States Armed Forces.

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.

LTD—Long-Term Disability—An insurance plan that is part of the IDM program designed to help replace part of your salary while you are unable to work due to a personal illness or injury for an extended period of time that exceeds the FCPS STD period.

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

Monthly Paid Employees—Educational, administrative, and support employees who work full time.

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

Open Enrollment—A period of time in the fall when you can enroll or change your medical, dental, and/or FSA plans 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 of coinsurance amounts you pay for health care. Copayments and deductiblesare 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 percentage of the premium.

Pre-Tax Premiums—Certain FCPS plans are known as Section 125 or "cafeteria plans," which means you pay your premiums for these plans with pre-tax dollars. This decreases the amount of your pay that is taxable, but requires the plans to adhere to strict rules for enrolling, changing, or canceling coverage.

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 off-label use of expensive and potentially dangerous drugs.

Program Administrator—An outside contractor, for example, Liberty Mutual, who administers the IDM program.

Spouse—A person to whom you are legally married.

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 dependent turning age 26, or a spouse's or dependent's change in employment status or their employer's open enrollment.

STD—Short-Term Disability—A plan that is part of the IDM program that continues to pay your salary and provide benefits when you are away from work due to a serious personal illness or injury for a period not to exceed 5 work months.

Specialty Medications—A home or office delivery service for participants who use specialty oral or injectable medications. After an initial 30-day supply of a specialty medication is filled at a network pharmacy, the medication is covered through the Specialty Care Pharmacy managed by CVS Caremark.

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

TDA—Tax-Deferred Account—An optional retirement savings program, also known as a 403(b) plan, which allows you to save pre-tax dollars for retirement.

VRS—Virginia Retirement System—A mandatory retirement program for full-time educational, administrative, and support employees (monthly paid). You are a member of VRS Plan 1 if you were hired before July 1, 2010. You are generally a member of VRS Plan 2 if you were hired on or after July 1, 2010.

Workers' Compensation—A plan that is part of the IDM program designed to pay medical expenses, and, if necessary, replace lost wages if you sustain an injury or contract an illness determined to be compensable under the Worker's Compensation Act.

Fairfax County Public Schools
Karen Garza, Superintendent

Office of the Superintendent
Susan Quinn, Chief Operating Officer

Department of Human Resources
Chace Ramey, Assistant Superintendent

Office of Benefit Services
De Hawley Brown, Director

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

Revised October 2016