FAIRFAX COUNTY PUBLIC SCHOOLS

Employee Benefits HANDBOOK

About This Handbook

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

"Welcome to the FCPS benefits program! As an FCPS employee, we offer you an extensive benefits package: You may choose the medical and dental plans that best meet your needs. We also offer first-rate retirement programs to provide you with financial security at the end of your career.

We put a great deal of time and financial resources into developing and administering this comprehensive benefits program and hope you find it a source of support to you and your family throughout your tenure with Fairfax County Public Schools."

Kevin North
Assistant Superintendent of Human Resources

Your Benefits Contacts

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

Health Care Plans

Aetna Dental (DPPO and DMO)
www.aetna.com
877-238-6200
8 am–6:30 pm M–F

CareFirst BluePreferred (PPO)
www.bluecard.com
800-296-0724
7 am–10 pm M–F

CareFirst BlueChoice (POS)
www.carefirst.com
800-296-0724
7 am–10 pm M–F

Kaiser Permanente
www.kaiserpermanente.org
800-777-7902
7:30 am–5:30 pm M–F

Express Scripts
(Prescription drug plan for CareFirst members)
www.express-scripts.com
866-815-0003
24 hours/7 days/wk

UnitedHealthcare Vision
www.myuhcvision.com
800-638-3120
8 am–11 pm M–F

Flexible Spending Accounts

Fringe Benefits Management Company (FBMC)
www.myFBMC.com
800-342-8017
24-hour Automated Service
800-865-3262 (FBMC)
24 hours/7 days/wk

Retirement

Educational Employees' Supplementary Retirement System of Fairfax County (ERFC)
www.fcps.edu/ERFC
703-426-3900
800-426-4208
8 am–4:30 pm M–F

Virginia Retirement System (VRS)
www.varetire.org
888-827-3847 (VA-RETIR)
8:30 am–5 pm M–F

Fairfax County Employees' Retirement System (FCERS)
www.fairfaxcounty.gov/retirement
703-279-8200
800-333-1633
8:30 am–4:30 pm M–F

Retirement Savings Plans

Great-West Retirement Services—457(b) Plan
www.GWRS.com/fcps
877-449-FCPS (3277)
9 am–8 pm M–F

Tax-Deferred Account–403(b)
See vendor list at www.fcps.edu/DHR/employees/benefits

Life Insurance

ERFC Members – Minnesota Life
www.varetire.org
FCERS Members – Minnesota Life
www.fcps.edu/DHR/employees/benefits

Long-Term Care Insurance

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

Leave Programs

Liberty Mutual—Short-Term and Long-Term Disability and Workers' Compensation Claims
1-800-524-0740
24 hours/7 days/wk

Virginia Workers' Compensation Commission (VWCC)
1000 DMV Drive
Richmond, VA 23220
877-664-2566
804-367-9740 (Fax)
8 am–5 pm M–F

FCPS Resources

Office of Benefit Services
www.fcps.edu/DHR/employees/benefits
571-423-3200
8 am–4:30 pm M–F

Benefit Processing & Administration
HRBenefitQuestions@fcps.edu

Disability & Leaves
Family Medical Leave Act (FMLA) and Leaves of Absence (LOA)
disabilityandleaves@fcps.edu

Workers' Compensation
workerscompensation@fcps.edu

Human Resources (HR) Client Services
HRQuestions@fcps.edu
571-423-3000
800-831-4331, extension 3000
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.

FCPS Benefits-at-a-Glance

This chart outlines your benefits, provides brief descriptions and deadlines, and is a quick reference to the pages where you can find more information about each program. Detailed information is also available at **www.fcps.edu/DHR/employees/benefits**.

Keeping Healthy with— Health, Dental & Vision Plans

Benefit	Description	Deadline	More Information
CareFirst BluePreferred PPO	This preferred provider organization (PPO) plan allows you to see in-network providers anywhere in the country without a referral. You may also use out-of-network providers, but incur additional costs. With this plan, you will have prescription drug coverage through Express Scripts, Inc. and vision plan benefits through UnitedHealthcare Vision (UHC Vision).	If you want to participate in this benefit, you must enroll within 30 days of your hire date or during Open Enrollment. Certain life events may allow you to enroll for coverage mid-year. You must notify Benefit Services within 30 days of a qualifying life event if you wish to enroll or change your coverage.	Page 13
CareFirst BlueChoice POS	This point-of-service (POS) plan allows you to see in-network providers within the CareFirst service area (primarily Northern Virginia, Maryland, and the District of Columbia). You and your dependents must choose a primary care physician (PCP) who coordinates your care and refers you to specialists as needed. You also may use out-of-network providers, but incur additional costs. With this plan, you will have prescription drug coverage through Express Scripts, Inc. and vision plan benefits through UHC Vision.		Page 14
Kaiser Permanente Signature HMO	This health maintenance organization (HMO) plan provides care at Kaiser facilities located throughout Northern Virginia, Maryland, and the District of Columbia. Except for emergencies, care received outside of this area is not covered. This plan includes prescription coverage through Kaiser and vision plan benefits through UHC Vision and Kaiser.		Page 14
Express Scripts	This is the prescription drug plan for CareFirst participants.	You are automatically enrolled if you elect a CareFirst medical plan.	Page 16
UnitedHealthcare Vision	This plan includes an annual comprehensive routine eye exam from any in-network provider and a pair of standard eyeglasses (frames and lenses) or contact lenses in lieu of eyeglasses. There are limited benefits for out-of-network providers.	You are automatically enrolled if you elect a CareFirst or Kaiser medical plan.	Page 21

Health, Dental & Vision Plans *continued*

Benefit	Description	Deadline	More Information
Aetna Dental Preferred Provider Organization (DPPO)	Under this dental preferred provider organization (DPPO) plan, your benefits are greater if you see a dentist in the Aetna network. You may see any dentist on an out-of-network basis, but you pay more if you see an out-of-network dentist. .	If you want to participate in this benefit, you must enroll within 30 days of your hire date or during Open Enrollment. Certain life events may allow you to enroll for coverage mid-year. You must notify Benefit Services within 30 days of a qualifying life event if you wish to enroll or change your coverage.	Page 23
Aetna Dental Maintenance Organization (DMO)	Under a dental maintenance organization (DMO) plan, you must select a primary care dentist when you enroll. You must receive your dental care from that dentist, unless that dentist refers you to a specialist.		Page 24
Wellness Program	FCPS actively promotes good health through ongoing initiatives and is committed to providing opportunities at work sites for enhancing wellness.	Various initiatives will be available throughout the year. See HR Wellness website for details and deadlines: www.fcps.edu/DHR/employees/benefits.	Page 26

Saving Money with—

Flexible Spending Accounts (FSA)

Benefit	Description	Deadline	More Information
Flexible Spending Accounts (FSA)	Participating in the FSA program turns your health care and dependent day care dollars into tax-free dollars for you. Each calendar year, you set aside pretax dollars through FCPS payroll deductions for eligible health care and dependent care (day care) expenses. When you submit your health care and dependent day care receipts to the FSA administrator, you recoup your FSA dollars as tax-free reimbursements.	If you want to participate in this benefit, you must enroll within 30 days of your hire date or during Open Enrollment. Certain life events may allow you to enroll for coverage mid-year. You must notify Benefit Services within 30 days of a qualifying life event if you wish to enroll or change your coverage.	Page 28 You have 90 days from the end of the calendar year to submit your eligible expenses for reimbursement. Employees who terminate employment or retire have shorter reimbursement periods (see page 32).
Health Care FSA	You receive reimbursements for eligible expenses you and your dependents incur that are not covered by your health plan. You do not have to be enrolled in an FCPS health plan to participate in the Health Care FSA program.	If you want to participate in this benefit, you must enroll within 30 days of your hire date or during Open Enrollment. Certain life events may allow you to enroll for coverage mid-year. You must notify Benefit Services within 30 days of a qualifying life event if you wish to enroll or change your coverage.	Page 29 You have 90 days from the end of the calendar year to submit your eligible expenses for reimbursement. Employees who terminate employment or retire have shorter reimbursement periods (see page 32).

Flexible Spending Accounts (FSA) *continued*

Benefit	Description	Deadline	More Information
Dependent Day Care FSA	You receive reimbursements for day care-type expenses for dependent children under the age of 13, or for any dependent, regardless of age, who must have daily care because of a physical or mental disability. Care must be provided so that you and your spouse (if married) can work or attend school full-time.	If you want to participate in this benefit, you must enroll within 30 days of your hire date or during Open Enrollment. Certain life events may allow you to enroll for coverage mid-year. You must notify Benefit Services within 30 days of a qualifying life event if you wish to enroll or change your coverage.	Page 31 You have 90 days from the end of the calendar year to submit your eligible expenses for reimbursement. Employees who terminate employment or retire have shorter reimbursement periods (see page 32).

Protecting Future Care Needs—

Long-Term Care Insurance

Benefit	Description	Deadline	More Information
Long-Term Care Insurance	This **optional** plan provides for nursing home or assisted living insurance coverage at group rates. You may elect coverage for you, your spouse, parents, parents-in-law, grandparents, and grandparents-in-law. You pay the full cost.	Coverage is guaranteed for you if you enroll within 30 days of your hire date. You may enroll at a later date, but the benefit will not be guaranteed, and you will be subject to medical underwriting.	Page 44

Protecting Your Family—

Life Insurance

Benefit	Description	Deadline	More Information
VRS Member Basic Life Insurance	This basic term life insurance coverage is **mandatory** for VRS and ERFC members. FCPS and you share in the cost of this coverage while you are an active employee.	Enrollment is automatic upon date of hire. **Note:** A premium holiday is in effect for this coverage through June 2012.	Page 47
VRS Member Optional Life Insurance	**You may purchase additional optional life insurance** for yourself, your spouse, and your dependents (subject to maximums).	Your coverage is guaranteed if you enroll within 30 days of hire (subject to certain dollar maximums). You may also apply for optional insurance at any other time, but the enrollment will not be guaranteed. You pay all costs for optional coverage.	Page 47
FCERS Member Basic Life Insurance	This basic term life insurance coverage is **mandatory** for FCERS members. FCPS pays the full cost for basic coverage while you are an active employee.	Enrollment is automatic upon date of hire.	Page 48

Life Insurance *continued*

Benefit	Description	Deadline	More Information
FCERS Member Optional Life Insurance	**You may purchase additional optional life insurance** for yourself, your spouse, and your dependents (subject to plan maximums).	Your coverage is guaranteed if you enroll within 30 days of hire (subject to various dollar and plan maximums). You may also apply for optional insurance at any other time, but the enrollment will not be guaranteed. You pay all costs for optional coverage.	Page 48

Saving for Your Future— FCPS-Sponsored Retirement Plans

Benefit	Description	Deadline	More Information
Virginia Retirement System (VRS)	This is a **mandatory** defined benefit retirement program for full-time educational, administrative, and support employees (paid monthly). FCPS contributes the full cost of this plan. If you were hired prior to July 1, 2010, you are enrolled in *VRS Plan 1*. Employees hired on or after July 1, 2010, are enrolled in *VRS Plan 2*.	Enrollment is automatic upon date of hire.	Page 49
Educational Employees' Supplementary Retirement System of Fairfax County (ERFC)	This is a **mandatory** defined benefit retirement program for full-time educational, administrative, and support employees (paid monthly). ERFC members contribute 4% of their salary, and FCPS contributes the balance. If you were hired before July 1, 2001, you are in the *ERFC Legacy* plan. If you were hired on or after July 1, 2001, you are in the *ERFC 2001* plan.		Page 50
Fairfax County Employees' Retirement System (FCERS)	This is a **mandatory** defined benefit retirement program for full- and part-time custodial, food service, maintenance, and transportation employees and less-than-full-time educational, administrative, and support employees. You have the option of contributing 4% (Plan A) or 5.33% (Plan B) of your salary.	Enrollment in Plan A is automatic upon date of hire. If you choose to enroll in Plan B, you must do so within 30 days of your hire date. Plan B requires higher contributions and, therefore, provides a higher retirement benefit. If you do not choose a plan, you will be enrolled automatically in Plan A. Your choice of enrollment in either Plan A or Plan B is **irrevocable** after your first 30 days of employment.	Page 51

Saving for Your Future—

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

Benefit	Description	Deadline	More Information
Deferred Compensation 457(b) and **Tax-Deferred Account (TDA) 403(b)**	These **optional** programs give you the opportunity to save more for retirement by making pre-tax contributions to the 457(b) plan and/or the 403(b) plan through payroll deductions.	You may enroll at any time.	Page 52 Page 53

Maintaining Your Pay & Benefits—

Integrated Disability Management (IDM)

Benefit	Description	Deadline	More Information
Short-Term Disability (STD)	Under the STD plan, FCPS continues to pay your salary and provides benefits when you are away from work due to a serious personal illness or injury. Employees must satisfy a 20-consecutive workday elimination period before becoming eligible for benefits. Once the elimination period has been satisfied, benefits may continue for a maximum of 5 work months. There is no cost to you to participate in the STD plan. Employees hired on or after 7/1/2010 must satisfy a 12-month eligibility period before becoming covered by the plan. Participation is **mandatory after 12 calendar months of service.**	You should notify your supervisor immediately that you will be away from work and call the IDM program administrator before the fifth consecutive day of absence in a month; or on your fifth absence from work in a month for the same medical condition; or when you are diagnosed with a serious illness or injury that could lead to an extended leave.	Page 56
Long-Term Disability (LTD)	The LTD plan provides partial income replacement if you are unable to work due to an illness or injury that lasts for six or more calendar months. Premiums are paid after taxes; therefore, the benefit is tax free when received. Participation is **mandatory.**	If you have exhausted the 5 work months under the STD plan, your claim will be transferred automatically to the LTD plan, where the program administrator will review it to determine if you are eligible for LTD benefits. If you were not eligible for STD benefits, you must notify Libety Mutual prior to the end of the six-month period.	Page 58

Integrated Disability Management *continued*

Benefit	Description	Deadline	More Information
Workers' Compensation	Workers' compensation pays medical expenses and, when necessary, replaces lost wages (after a 7-day waiting period) if you sustain an injury or contract an occupational illness determined to be compensable by the Virginia Workers' Compensation Act. Participation is **mandatory.** There is no cost to you to participate in this plan.	You should notify your supervisor immediately of your on-the-job injury or illness and call the IDM program administrator (800-524-0740) within 24 hours of your injury or illness. If you need immediate medical attention, go to the nearest emergency room for treatment. If your injury or illness is not life threatening, refer to the *FCPS Workers' Compensation Provider Panel* at www.fcps.edu/DHR/employees/benefits.	Page 59

Taking Time for Your Personal & Professional Needs— Leave Programs

Benefit	Description	Deadline	More Information
Family & Medical Leave Act (FMLA)	This federal program allows those actively employed for 12 months or more to be eligible for 12 weeks of leave during a 12-month period for a serious personal illness; the birth or adoption of a child; the placement of a foster child; or the care of a sick spouse, child, or parent. The **leave period is unpaid** unless you use your accrued sick or annual leave.	You should apply for FMLA at least 30 days in advance of your leave or as soon as you know you need to take leave.	Page 61
Leaves of Absence (LOA)	This program provides two types of leaves—designated and nondesignated—to help you meet your personal and professional needs.	If you are a less-than-12-month employee, you must apply for a LOA by March 31, if you want to take leave for the next fiscal year. Twelve-month employees must apply at least 30 days in advance.	Page 63
Sick Leave	Twelve-month employees accrue sick leave that can be used for personal illness or injury, the care of immediate family members, and bereavement leave. FCPS allows you to carry an unlimited sick leave balance.	Enrollment is automatic upon date of hire.	Page 64

Leave Programs *continued*

Benefit	Description	Deadline	More Information
Personal Leave	If you work fewer than 12 months, you may request up to 3 days of sick leave each fiscal year as personal leave.		Page 64
Annual Leave	Twelve-month employees earn annual leave based on years of service. During your first 10 years of service, you may accumulate up to 30 days of annual leave/year. After 10 years, you may accumulate up to 40 days of annual leave/year.		Page 65
Paid Nonworkdays	FCPS pays bus drivers and transportation attendants for nonworkdays. The number of paid nonworkdays depends on whether you were hired before or after July 1, 2005, or migrated to the fiscal year 2006 pay scale.		Page 65
Holidays	Twelve-month employees have 12 holidays/year (not including Inauguration Day every fourth year). Those who work fewer than 12 months also have winter, spring, and summer vacation breaks.		Page 65

Employee Assistance Program

Benefit	Description	Deadline	More Information
Employee Assistance Program (EAP)	This program provides short-term confidential counseling and referral services if you are experiencing personal problems.		Page 66

How to Enroll & Determine Eligibility

The 30-Day Rule

If you are a new employee, you must enroll for health, dental, optional life and FSA benefits within **30 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 days** from the date of a status change or qualifying event to change your health, dental, life insurance, and FSA benefits.

If You Are a New Employee

All regular or contracted full-time and part-time employees are eligible to participate in the FCPS benefit programs described in this Handbook. Please note the following:

- FCPS offers several retirement plans, and your membership is determined by your job category.
- If your contract or work schedule is less than 50 percent of full time, you pay higher contribution amounts for health and dental benefits, and you are not eligible to participate in the retirement, life insurance, and long-term disability programs.
- If both you and your spouse are regular or contracted full-time and part-time employees, you may be eligible for reduced contribution rates for your health benefits. See the Spousal Rates listed in the *Benefits Cost Comparison,* which is published each year.

FCPS encourages all new employees to participate in its New Employee Orientation program, where you will receive detailed information about your benefit programs. You have 30 days from your date of hire to complete and return your medical, dental, and flexible spending accounts (FSA) enrollment forms. Late enrollment for these programs is not accepted.

Your participation in the health, dental and, life insurance and programs takes effect on the first day of the month following your date of hire, provided you submit your enrollment form within 30 days of your hire date. If you submit your enrollment forms after the payroll deadline for that pay period, you will have a double deduction in a future paycheck.

Your participation in the FSA program takes effect on the first day of the month following your date of hire or the first of the month after you sign the enrollment form, whichever is later.

If You Are a Current Employee

You may enroll, add, or cancel coverage for yourself or your dependents or change your health care benefits and FSA participation during 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. Late enrollments for these programs are not accepted.

At any other time during the year, you may only enroll, add, or cancel coverage for yourself (or your dependents) or change your health care coverage and FSA participation if you experience a status change or qualifying event (see pp. 10–12).

Dependent Eligibility

The following individuals are eligible to be covered under your benefits:

- Your spouse
- Your biological child(ren) or stepchild(ren)
- Your adopted child(ren) or child(ren) placed for adoption
- Child(ren) for whom you have been appointed legal guardian or for whom you have legal custody
- Certain eligible foster children

Dependent children must be under the age of 26, unless certified by the health and/or dental plan for continued coverage due to disability.

When to Change, Add, or Cancel Your Benefits for Life-Changing Events

When you experience certain life-changing events—times in your life like marriage, birth of a child, divorce, or death of a spouse or dependent—you may be able to change your health and life insurance benefits and participation in the Flexible Spending Account (FSA) program. You must notify the Office of Benefit Services to change your benefits enrollment within **30 days*** of your life-changing event. The type of change determines the effective date.

These life events are also called **status changes** or **qualifying events.** They are detailed in the *U.S. Treasury Regulations for Section 125 of the Internal Revenue Code* governing cafeteria plans. The following events are examples of Section 125 status changes or qualifying events:

- Loss of health coverage.
- A move that causes loss of eligibility to participate in your HMO plan.
- A significant cost change, coverage curtailment, or improvement, a new option, or a change in coverage under your, your spouse's, or your dependent's plan.
- Entitlement to or loss of Medicare or Medicaid.
- Marriage or divorce. You may not drop coverage for a spouse if you are legally separated; however, you must drop your spouse's coverage upon your divorce.
- Changing from a full-time to a less than half-time position or a less than half-time to a full-time position.
- Beginning or returning from an unpaid leave of absence.
- Spouse's or other dependent's change in employment status that affects his or her eligibility for medical and/or dental benefits (or his or her employer's open enrollment).
- Death of a spouse or child.
- Birth or placement of a child for adoption. If you notify the Office of Benefit Services within **30 days,** your baby's medical benefits become effective on your baby's date of birth, date of adoption (or date placed for adoption). Note: 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.
- Dependent reaching age 26.

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

Examples:

– 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 March 1.

– 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). Your baby's coverage begins March 17th. If you are converting to MiniFamily or Family coverage, your premiums will change effective March 1.

– A baby is placed with you for adoption on October 24, and you add him or her to your health plan on October 30. His or her coverage takes effect October 24th. If you are converting to MiniFamily or Family coverage, your premiums will change effective October 1.

How to Change Your Coverage—Life Events & the 30-Day Rule

The IRS consistency rule states that the health care election change must be on account of, and correspond to, a change in status that affects eligibility under the health plan. Paperwork must be received by FCPS within **30 days*** of your status change.

It is your responsibility to inform the Office of Benefit Services about a status change by completing a *Documentation for Midyear Benefit Changes* form, which is available under *Forms* at www.fcps.edu/DHR/employees/benefits or by calling Human Resources (HR) Client Services. You must also provide the required documentation for the request for the change in eligibility.

If you fail to notify FCPS within the **30-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-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 contributions.

Adding or Removing a Family Member

- If you marry, you may change your enrollment from Individual to Minifamily, or Family.
- If you divorce, you may change your enrollment to Individual or Minifamily (from Minifamily or Family). Once you are divorced, your former spouse no longer qualifies for FCPS health insurance. Separation is not a legal event in Virginia, and you cannot drop or add your spouse due to a separation.
- If you and your spouse 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.

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

REQUIRED DOCUMENTATION INCLUDES:

- Birth certificate or letter of live birth.
- Adoption papers or legal papers indicating placement for adoption.
- Court order appointing you legal guardian of a child or requiring you to cover a child, or an order requiring someone else to provide coverage for your dependent.
- Marriage certificate stating date of marriage.
- Divorce decree (applicable pages).
- Death certificate.
- Open Enrollment notice from your spouse's or dependent's employer, including enrollment dates and effective date.
- Letter from your spouse's or dependent's Human Resources Department or insurance plan with insurance cancellation date.
- Letter from your spouse's or dependent's Human Resources Department or insurance plan explaining circumstances regarding a significant cost change, a significant coverage curtailment, a significant improvement, a new option, or a change in coverage.
- Copy of your Medicare card or Medicare/Medicaid letter.

- If you have a child participating in the Dependent Day Care Flexible Spending Account (FSA) plan, and you add a new child to the family, you may change your dependent day care account contribution.
- If your son or daughter "ages out"— that is, he or she turns age 26—he or she is no longer eligible for FCPS coverage as a dependent. Coverage ends at the end of the month in which he or she turns age 26.

Employment Changes

- If you are enrolled through a health plan with your spouse's employer and your spouse loses coverage, you and your family may enroll in an FCPS plan.
- If your spouse changes jobs and you join your spouse's employer's plan, your enrollment in that plan will allow you to cancel your FCPS coverage.
- If your spouse's or dependent's employer has a benefits open enrollment period that does not coincide with the FCPS enrollment period, and if you, your spouse, or your dependent joins that plan, you may cancel FCPS coverage.
- If you return to active employment from a leave of absence or retirement and are eligible for benefits, you must enroll within **30 days** of your status change.

In addition to submitting an enrollment and change form, you must also provide documentation of the event as described on the *Documentation for Midyear Benefit Changes* 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 health benefit 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.

Overlapping Coverage

When both spouses work, each person may be covered by his or her employer's health plan, and each may include children and the other spouse as dependents. This can lead to overlapping coverage.

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.

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

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.

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 active employee or are retired. In addition, some types of managed care plans, such as health maintenance organizations (HMOs), cannot coordinate benefits.

Preexisting Conditions

None of the health care plans offered by FCPS will deny you or your qualified dependents coverage because of a preexisting condition.

Keeping Healthy with Health, Dental & Vision Plans

Medical Plans

Fairfax County Public Schools (FCPS) offers three medical plans, all of which include prescription and vision benefits:

- CareFirst BluePreferred, a national preferred provider organization (PPO) plan (with Express Scripts for prescription drugs and UnitedHealthcare Vision for vision).
- CareFirst BlueChoice, a local point-of-service (POS) plan (with Express Scripts for prescription drugs and UnitedHealthcare Vision for vision).
- Kaiser Permanente HMO (with Kaiser Pharmacy for prescription drugs and both Kaiser and UnitedHealthcare Vision for vision).

CareFirst BluePreferred PPO

BluePreferred is a national plan. This plan allows you to see in-network providers **anywhere in the country without a referral** from a primary care physician (PCP). You may access out-of-network providers, but you pay less when you use in-network providers.

Plan Highlights

- You do not have to choose a PCP.
- The plan provides access to network benefits for dependent students away at school and retirees who leave the area after retirement.
- You pay a copayment for most office visits.
- Registered nurses staff a 24/7 medical advice service to answer your health care questions.
- 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.

Details About CareFirst PPO Medical Coverage

- Details about your medical coverage are available in the CareFirst *Summary Plan Document*, available at www.fcps.edu/DHR/employees/benefits.
- Visit www.bluecard.com to search the national network of providers.

- FCPS has contracted with Express Scripts to provide prescription drug benefits for CareFirst members. (See page 16 for details.)
- FCPS has contracted with UnitedHealthcare Vision for routine vision care benefits. (See page 21 for details.)
- *Great Beginnings* is a case management support program for pregnant FCPS employees and dependents.

CareFirst BlueChoice POS

BlueChoice is a local health care plan. This plan allows you to see **in-network providers located in Northern Virginia, Maryland, and the District of Columbia.** You pay less when you use in-network providers.

Plan Highlights

- You may also use out-of-network providers. You pay more when you receive care from out-of-network providers.
- You **must choose a primary care physician (PCP)** who coordinates your care and provides referrals to specialists as needed.
- Routine gynecological care does not require a referral.
- You pay a copayment for most office visits.
- For services not considered office visits, most in-network services are covered at 90 percent of the plan allowance. The remaining 10 percent is the coinsurance amount for which you are responsible.
- FCPS has contracted with Express Scripts to provide prescription drug benefits for CareFirst members. (See page 16 for details.)
- FCPS has contracted with UnitedHealthcare Vision for vision care benefits. (See page 21 for details.)

Additional Services and Programs

- Registered nurses staff a 24/7 medical advice service to answer your health care questions.
- *Great Beginnings* is a case management support program for pregnant FCPS employees and dependents.
- Inpatient and outpatient behavioral health care must be coordinated through Magellan.
- Details about your medical coverage are available in the CareFirst *Summary Plan Document* publication available at www.fcps.edu/DHR/employees/benefits.
- Visit www.carefirst.com for network providers.

Kaiser Permanente Signature HMO

Kaiser's Signature HMO plan provides a wide range of integrated preventive care and health assessments, including outpatient services, laboratory, radiology, pharmacy, and health education, to members who reside in Kaiser's service area.

Plan Highlights

- You **must have a referral** from your primary care physician to see a specialist.
- You may receive care at all Kaiser medical facilities located throughout the local area. Some Kaiser facilities are urgent care centers for non-life threatening after-hours emergencies.
- Care and services not directly managed by Kaiser Permanente are not covered, except for emergencies received out of the area.
- Kaiser manages its own retail and mail service pharmacy plan and uses a drug formulary—a list of medications and drugs that its health care professionals use to prescribe. Prescription refills may be requested through the member website, as well as through *EZ Refill,* a 24-hour refill line.
- FCPS has contracted with UnitedHealthcare Vision to provide vision care benefits for Kaiser members. (See page 21 for details.) Or, Kaiser members may continue to use the services of optical centers within Kaiser facilities.

Additional Services and Programs

- Kaiser offers online features that provide secure access to your health information. You can:
  - view lab results
  - e-mail your doctor's office
  - schedule and view future appointments
  - obtain health care reminders
  - view information on ongoing health conditions
  - view immunization records
  - act for a family member (proxy)

To use these online services, you need to complete a simple registration form on www.kaiserpermanente.org:

- Click on *Members.*
- Select *Maryland/Virginia/Washington DC.*
- Click *Sign on* at the top of the page.
- Click *Register now* and follow the instructions.

Other benefits include:

- *Be Well* is a free, health education program, which includes classes on managing high blood pressure, diabetes, back pain, etc.
- Discounts on health club memberships, coverage for acupuncture, chiropractic care, and massage therapy are available for Kaiser members.
- A 24-hour *Medical Advice and Appointment Line,* which is available by calling 703-359-7878 or 800-777-7904.

Details about your coverage are available in the *Kaiser Summary Plan Document,* available at www.fcps.edu/DHR/employees/benefits.

Visit www.kaiserpermanente.org for more information.

Contact Information for Your Benefit Questions

Call the toll-free numbers below 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.*

CareFirst BluePreferred PPO and BlueChoice POS
800-296-0724

Kaiser Permanente
800-777-7902

Express Scripts (CareFirst members)
866-815-0003

UnitedHealthcare Vision
800-638-3120

FCPS Prescription Drug (Rx) Plans

Express Scripts Inc. (ESI) manages the prescription drug plan for CareFirst members. Kaiser Permanente manages its own prescription drug plan for its members. The plan basics are:

Express Scripts

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

Retail Pharmacy

Generic	$ 7	minimum (or cost of drug prior to coinsurance, if less)
	$ 25	maximum
Brand	$ 15	minimum
	$ 25	maximum

Mail/Home Delivery (90-day supply)

Generic	$ 14	minimum (or cost of drug prior to coinsurance, if less)
	$ 50	maximum
Brand	$ 30	minimum
	$ 50	maximum

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

Kaiser Permanente

Copayments only.

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

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

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

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

Mail (90-day supply)

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

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

Express Scripts—Pharmacy Benefit Manager for CareFirst members

Plan Highlights

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

- **You must use 75 percent of your local pharmacy prescription and 60 percent of your home delivery prescription before you can refill your prescription.**
- **Vacation Override**—If you are going on vacation and you need more than a 1-month supply of your medication, you should ask your pharmacist to call the Pharmacy Help Line and request a vacation override. This will allow you to fill your next 1-month prescription early. If you need more than a 1-month supply, you must use the mail order program, which allows you to receive up to a 90-day supply of your medication. You must pay for any additional months of medication(s).
- Details about your coverage are available in the *Summary Plan Document,* available at www.fcps.edu/DHR/employees/benefits. This document is updated regularly and contains additional details about **Specialty Medications, Prior Authorization, Step Therapy,** and **Drug Quantity Limits.**
- Visit www.express-scripts.com for more information.

Additional Services and Programs

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

Express Scripts Prescription Drug Programs

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

The purpose of prior authorization is to prevent misuse and the off-label use of expensive and potentially dangerous drugs. A list of drugs currently on the prior authorization list is available at www.fcps.edu/DHR/employees/benefits. Because of the changing nature of pharmacy products, this document is regularly updated. Prior to issuing a prescription on the Prior Authorization list, your doctor's office should call the ESI Prior Authorization department at 800-417-8164 or fax the form titled *Prior Authorization Medication Request* (available on the FCPS website or by calling ESI Customer Service). The physician must complete, sign, and fax the form to 800-357-9577.

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

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

If you have unsuccessfully tried a first-step drug or your doctor decides one is not appropriate for medical reasons, ask your doctor's office to call the ESI Prior Authorization department at 800-417-8164 or fax the form titled *Prior Authorization Medication Request* (available on the FCPS website or by calling ESI Customer Service, 866-815-0003). The physician must complete, sign, and fax the form to 800-357-9577.

If Express Scripts approves the prior authorization request, the second-step drug will be covered by the plan. You will have a higher copay.

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

A list of step therapy medications is available at www.fcps.edu/DHR/employees/benefits. This list is regularly updated.

Specialty Medications—This is a home or office delivery service for employees who use specialty oral or injectable medications.

After an initial 34-day supply of a specialty medication is filled at a network pharmacy, the plan covers the medication only through the Specialty Care Pharmacy managed by **CuraScript.** You receive a maximum 1 month's supply each time you refill your prescription. It will be sent by overnight mail to you. The telephone number for CuraScript is 866-848-9870.

Generics Preferred Program

Generally, people want to make wise choices when it comes to their medications—they want a quality product that meets their medical needs at an affordable price. The new Express Scripts Generics Preferred Program can help you do that.

How Does the Generics Preferred Program Work?

When you fill a prescription:

1. The pharmacy will determine if a generic drug is available. If a generic is not in stock, you may choose either to wait until the pharmacy has the generic in stock, visit another pharmacy, or pay the brand copay. In this case, you will not pay the ancillary amount for the brand drug (see #3 below). Additionally, you will not pay the ancillary amount if:
   - Your physician documents the medical need for the brand drug in writing, and Express Scripts concurs with the medical necessity for a brand.
   - No generic exists for the brand.
2. If a generic drug is available and you choose the generic, you will pay the copayment for a generic drug. This copayment will be less than the brand drug copayment.

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

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

3. If a generic drug is available and you choose the brand, you will pay the generic copayment plus an ancillary amount in addition to the copayment. This ancillary amount is the price difference between the generic drug and the brand drug.

Examples (The following examples are for illustrative purposes only for a one-month supply. Prescription drug prices are subject to market cost changes):

Brand Drug	Brand Price	What You Pay	Generic Drug	Generic Price	What You Pay
Zocor 20 mg	$ 152.98	$ 147.40	Simvastatin 20 mg	$ 12.58	$7.00
Ambien 5 mg	$ 150.93	$ 140.76	Zolpidem 5 mg	$ 17.17	$7.00
Prozac 20 mg	$ 152.04	$ 147.16	Fluoxetine 20 mg	$ 11.88	$7.00
Example: Simvastatin (Generic)		$ 7.00 copay	(20% of $12.58, minimum $7.00)		
Zocor (Brand)		$ 147.40 copay	($7.00 generic copay + $140.40, the difference between the cost of the Zocor and the cost of Simvastatin)		

Prescription Examples:
(The following are for illustrative purposes only):

Your physician prescribes Zocor and allows you to buy the generic Simvastatin:

SCENARIO # 1
You Choose to Use the Home Delivery Program:

- Complete the Home Delivery form. Allow 2–3 weeks for delivery on a new prescription.
- Choose the generic equivalent Simvastatin.
- Pay $14.00 for a 3-month supply of the generic.

SCENARIO # 2
You Choose to Fill Your Rx at a Local Pharmacy:

- Choose the generic Simvastatin and fill your prescription twice at a local pharmacy. You pay $7.00 for each fill. On your third fill, you choose to continue to use the local pharmacy and begin to pay $17.00 for up to a 34-day supply ($7.00 + $10 additional charge for receiving the third fill of a generic medication at a local pharmacy).
- Pay $31.00 for a 3-month supply of the generic.

SCENARIO # 3
You Choose the Brand and Fill Your Rx at a Local Pharmacy:

- Choose the brand Zocor and fill your prescription twice at a local pharmacy. You pay $147.40 for each fill. On your third fill, you choose to continue to use the local pharmacy and begin to pay $167.40 for up to a 34-day supply ($147.40 + $20 additional charge for receiving the third fill of a brand name medication at a local pharmacy).
- Pay $502.20 for a 3-month supply of the brand-name drug.

Home Delivery Program

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

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

Using home delivery for your maintenance prescription drugs saves you money on your copayments. Basically, you receive a 3-month supply of your prescription drug with the Home Delivery Program for what you would have spent for a 2-month supply at a retail pharmacy.

You should obtain 2 prescriptions from your physician:

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

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

Ordering Refills:

Order refills of your Home Delivery prescriptions by:

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

Under the ESI Pharmacy Program:

- You complete a *Prescription Mail Order* form and begin saving immediately on your maintenance prescriptions.
- You may fill up to a 1-month supply of a maintenance prescription drug 2 times from a local participating pharmacy.
- After that, you have the choice of ordering your prescription drugs from the Express Scripts Home Delivery Program or paying an additional charge ($10/generic and $20/brand), beginning with your third retail fill.

With the Home Delivery Program:

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

To Contact Express Scripts

1. Go to www.express-scripts.com or
2. Call Express Scripts customer service at 800-815-0003

Vision Benefit Plan

FCPS offers an affordable, quality comprehensive vision plan through UnitedHealthcare Vision (UHC Vision). You will automatically be enrolled in UHC Vision for yourself and any dependents covered on your FCPS medical plan, whether the plan is with CareFirst or Kaiser.

Plan Highlights

- UHC Vision offers a national network of more than 30,000 participating private practice and retail chain providers.
- A $15 copayment is required at the time of service when you seek an eye exam from an in-network provider. There is no copay for standard eyeglasses, or covered contact lenses in lieu of eyeglasses.
- If you choose lens options not covered by the program, such as, but not limited to, progressive lenses, high index, tints, UV, and anti-reflective coating, you may be able to purchase these options at a discount.
- When making your appointment with an in-network provider, identify yourself as having UHC Vision coverage. You are not required to show an identification card.
- If you see an **out-of-network** provider to obtain services and/or materials, you must pay the provider the full amount of the bill and request a copy of the bill that shows the amount of the eye examination, lens type, and frame. **You do not need a claim form;** send the itemized bill to UHC Vision, PO Box 30978, Salt Lake City, UT 84130.

The following information must also be included with the documentation:

- Employee's name and address;
- Employee's ID# or Social Security Number;
- Employee's employer name; and
- Patient's name, date of birth, and relationship to employee.

Exclusions

- Post-cataract lenses
- Non-prescription items
- Medical or surgical treatment for eye disease that requires the services of a physician
- Workers' Compensation services or materials
- Services or materials that the patient obtains from any governmental organization or program at no cost
- Services or materials that are not specifically covered by the plan
- Replacement or repair of lenses and/or frames that have been lost or broken
- Cosmetic extras, except for scratch-resistant coating

Laser Eye Surgery

UHC Vision has partnered with The Laser Vision Network of America to provide our members with access to discounted laser eye surgery procedures.

To find a UHC Vision network provider, go to www.myuhcvision.com—or—you may call UHC Vision's Customer Service at 800-638-3120.

Your UnitedHealthcare Vision Plan

	In-Network[1]	Out-of-Network Reimbursement[2]
Eye Exam (once every 12 months)	Covered in full after $15 copay	Up to $40
Eyeglass Lenses (once every 12 months)		
• Standard single vision	Covered in full	Up to $40
• Standard lined bifocal	Covered in full	Up to $60
• Standard lined trifocal	Covered in full	Up to $80
• Standard lenticular	Covered in full	Up to $80
Lens Options	Standard scratch-resistant coating and polycarbonate lenses are covered in full. Lens options not covered by the plan, such as progressive lenses, high index, tints, UV, and anti-reflective coating, may be available at a discount.	No options covered; no discounts apply.
Frames[3] (once every 24 months)	Covered in full	Up to $45
Elective Contact Lenses[4] (once every 12 months)		
• Covered in full contacts	Covered in full (up to 4 boxes of disposable lenses)	Up to $105
• All other elective contacts	Up to $105 allowance	Up to $105
Necessary Contact Lenses[5]	Covered in full	Up to $210

1. **In-Network Benefits**—This plan includes a $15 exam copay and no copay for eyeglasses or contact lenses. The exam copay and costs for any additional patient options not covered by the plan are payable to the network provider by the plan participant.
2. **Out-of-Network Benefits**—The plan participant pays full fee to the provider and UHC Vision reimburses the participant for services rendered up to maximum allowance. There are no copays or deductibles.
3. **Frame Benefit**— Receive a $130 retail frame allowance at participating retail chain or private practice providers.
4. Contact lenses are provided in lieu of eyeglasses (lenses and frame). UHC Vision's contact lens benefit covers in full the fitting/evaluation fees, contact lenses (from UHC Vision's formulary), and up to two follow-up visits *from an in-network provider.* A $105 allowance is applied toward the fitting/evaluation fees and purchase of contacts from an out-of-network provider or toward non-formulary lenses purchased from an in-network provider. Toric, gas permeable, and bifocal contacts are all examples of contacts that are outside of the formulary selection.
5. Necessary contact lenses are determined at the provider's discretion for one or more of the following conditions: following cataract surgery without intraocular lens implant; to correct extreme vision problems that cannot be corrected with spectacle lenses; with certain conditions of anisometropia; with certain conditions of keratoconus. If your provider considers your contacts necessary, ask your provider to contact UHC Vision to confirm reimbursement before you purchase such contacts.

Dental Plans

FCPS offers you a choice of two dental plans through Aetna Dental:

- Aetna Dental Preferred Provider Organization (DPPO)
- Aetna Dental Maintenance Organization (DMO)

Aetna Dental Preferred Provider Organization (DPPO)

Plan Highlights

- You receive care from either an in-network dentist or from any out-of-network dentist. You pay less when you use in-network providers; you pay more when you receive care from out-of-network providers.
- **You do not have to choose a primary care dentist.**
- This plan usually has a wider choice of in-network dentists than a dental maintenance organization (DMO) plan.
- Coverage includes preventive care, basic care, and major services.
- You pay a copayment based on an allowable charge. Network dentists must accept the Aetna negotiated fees and are not allowed to charge more.
- Details about your coverage are available in the *Aetna Dental Summary Plan Document* available at www.fcps.edu/DHR/employees/benefits.
- Visit www.aetna.com for more information.

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.

DPPO Orthodontia Coverage

- The Aetna DPPO Plan covers three specific orthodontic procedures:
  - Comprehensive treatment, also known as full banding. This treatment involves procedures that reduce or eliminate an existing malocclusion.
  - Removable appliance therapy.
  - Fixed or cemented appliance therapy.
- Aetna considers both removable and fixed or cemented appliance therapies to be preventive, as are minor treatments used to control harmful habits, such as thumb sucking or tongue thrusting.
- The FCPS dental plan does not cover **Phase I treatments,** such as limited or partial banding.
- The DPPO plan only covers orthodontia treatments that began prior to a child turning age 19.

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.

To find a network provider, go to www.fcps.edu/DHR/employees/benefits.

Aetna Dental Maintenance Organization (DMO)

Plan Highlights

- The Aetna DMO plan is a lower cost plan that has a limited network of providers. Call your dentist to ensure that he or she is in the network.
- You may only use dentists who are part of the Aetna DMO network; **out-of-network providers are not covered under this plan.**
- Most basic 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.
- You must select a dentist when you enroll and receive all your dental care from that dentist, unless that dentist refers you to a specialist. You may change your primary care dentist at any time.
- If you are moving and want to check for a DMO network in your new area, call Aetna customer service.
- Aetna DMO plan **does not cover pediatric dentists.**
- Details about your coverage are available in the *Aetna Dental Summary Plan Document* at www.fcps.edu/DHR/employees/benefits.
- Visit www.aetna.com for more information.

DMO Orthodontia Coverage

- The Aetna DMO plan covers three specific orthodontic procedures:
  - Comprehensive treatment, also known as full banding. This treatment involves procedures that reduce or eliminate an existing malocclusion.
  - Removable appliance therapy.
  - Fixed or cemented appliance therapy.
- Aetna considers both removable and fixed or cemented appliance therapies to be preventive, as are minor treatments used to control harmful habits, such as thumb sucking or tongue thrusting.
- The Aetna DMO dental plan **does not cover Phase I treatments,** such as limited or partial banding.
- The DMO **covers orthodontia for any age.**

To find a network provider, go to www.fcps.edu/DHR/employees/benefits.

Pretreatment Authorization Under the DPPO or DMO

Aetna Dental suggests that prior to services being rendered, you obtain a pretreatment authorization for any nonemergency treatment plan that exceeds $350 to determine whether the service is covered, as well as reasonable and customary fees.

- Aetna Dental sends an authorization form with Aetna's estimated payment to you and your dentist after 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.
- 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 the 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.

Get Your Teeth Cleaned, Your Eyes Checked & Your Muscles Massaged

Aetna Dental also offers access to discounted fitness and alternative health care services and products.

As an Aetna 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 and nutritional supplements and other health-related products through participating retailers.

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

Dental Plan Comparison

	DPPO In-Network	DPPO Out-of-Network	DMO
Deductible	None	$ 50 individual $ 150 family	None
Orthodontic Deductible	None	$ 50	None
Preventive & Diagnostic	100%	90%*	No Charge
Basic Restorative	80%	70%	No Charge
Major Restorative	50%	40%	Fee Schedule
Orthodontia	50%**	40%**	$ 2,300 copay
Annual Maximum (not including orthodontia)	$ 1,500	$ 1,200	None
Orthodontia Lifetime Maximum	$ 1,500	$ 1,000	One treatment plan

* Deductible does not apply **Dependent children under age 19 only

Wellness at FCPS

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

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

Wellness Initiatives

Wellness Website

Visit the FCPS Wellness website at www.fcps.edu/DHR/employees/benefits/wellness. It includes comprehensive information and resources on topics ranging from planning a pregnancy to lowering stress or starting a worksite walking program. E-mail your wellness questions to HRWellness@fcps.edu.

Flu Clinics

Onsite flu clinics are coordinated every fall to offer FCPS employees an easy and convenient means to obtain a flu immunization. HR Wellness works in conjunction with the site wellness liaisons to coordinate logistics for the flu clinics.

Flu clinics are also offered at the open enrollment open houses to FCPS employees, retirees and family members 18 years and older.

HR Wellness Talks

HR Wellness provides talks, workshops, 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, e-mail HRWellness@fcps.edu.

Health Club Membership Discounts

FCPS employees are eligible for certain health club discounts through the Smooth Transitions program. See *Employee Incentives* page on the Benefits website for further details.

Fitness Challenges

HR Wellness sponsors a 6-week fitness challenge every spring and fall that is open to all FCPS employees. The primary focus of the fitness challenge 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 5 days a week. In turn, participants receive daily motivational e-mails from HR Wellness, which include strategies and interactive sites on fitness, nutrition, and stress management, to challenge and inspire them throughout the challenge.

All fitness challenge participants are eligible to have their names placed in weekly random prize drawings for health-related prizes, such as cookbooks, exercise bands, pedometers, and exercise DVDs. Fitness challenges adhere to HIPAA compliance standards for wellness programming and are open to all employees, irrespective of physical limitations.

Health Fairs/Health Screenings

HR Wellness sponsors health fairs and health events throughout the year and offers free consultations to assist sites in coordinating their own health events to encourage employee wellness.

Fitness Classes

FCPS employees age 18 and older can access the Gatehouse Administrative Center fitness facility for free after signing the participation agreement form found on the fitness center website at http://fcpsnet.fcps.edu/admincenter/fitness.html. 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 sites can also coordinate after-work fitness classes with private fitness instructors, as long as they follow the guidelines in Attachment F of *Community Use Regulation 8420.* If your site would like information on how to coordinate a workplace fitness class, contact HR Wellness HRWellness@fcps.edu.

Saving Money with Flexible Spending Accounts

NOTE: *Effective January 1, 2011, over-the-counter medications will no longer be covered under Health Care Flexible Spending Accounts unless issued by a physician's prescription.*

We all know that budgeting, saving, and investing are basic elements of sound financial planning, but sometimes we overlook things that can have a beneficial effect on our financial situation. FCPS flexible spending accounts is one such benefit, in that it can help you reduce your out-of-pocket expenses for medical, dental, and vision care, as well as for dependent day care expenses, by allowing you to pay for these expenses in pre-tax dollars. FCPS offers two flexible spending accounts: the Health Care FSA and Dependent Day Care FSA.

What is a flexible spending account?

A flexible spending account (also called FSA) is an FCPS-sponsored benefit that allows you to pay for eligible medical, dental, and vision expenses, as well as work-related child and adult day care expenses, on a pre-tax basis. With FSAs, you direct a part of your pay, tax-free, into one or both of these special accounts that you can use throughout the year to reimburse yourself for eligible out-of-pocket expenses.

How does a FSA benefit me?

A FSA saves you money by reducing your income taxes. The contributions you make to a FSA are deducted from your pay before your federal, state, or Social Security taxes are calculated. The end result is that you lower the amount of taxes you pay and increase your spendable income. Typically your participation in a FSA is effective for a calendar year and ends December 31.

You can save hundreds or even thousands of dollars a year. For example, an individual in the 28 percent federal income tax bracket who pays $2,000 in qualified medical expenses out of a FSA would save $560 in taxes!

When will you become eligible?

If you are a new employee, your FSA becomes effective on the first day of the month following the month in which your enrollment form is received, provided you submit your form within 30 days of your date of hire into a benefits-eligible position.

Example:

If your hire date is August 27 and you sign your enrollment form on September 5, your FSA will become effective October 1.

How do flexible spending accounts work?

Each year, you determine how much money you want to contribute for the year into the health care spending account and/or the dependent day care spending account. You may contribute any amount from $120 to $4,000 into the health care spending account and up to $5,000 into the dependent day care spending account. **It is important to remember:** *Money set aside for the health care spending account can only be used to claim health care expenses and not dependent day care expenses. Likewise, a dependent day care spending account can only reimburse expenses related to day care for eligible dependents.*

The amount you designate for the year is taken out of your paycheck in equal installments each pay period and placed in a FSA.

If you do not enroll as a new employee, you may enroll during the annual open enrollment period. Otherwise, you may only enroll if you have a

qualified life event change, such as marriage, birth, divorce, or loss of a spouse's insurance coverage. Qualified family status changes are listed on pp. 10–12.

How do I decide how much to contribute to my flexible spending account?

Your FSA funds are subject to use-or-lose rules. It's important to give some thought to calculating how much money to contribute for the year, because if you put in more money than you need, by law, you lose it.

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. Be conservative so you don't risk forfeiting any money. To help you determine an amount for your Health Care FSA, use the worksheet on page 30. To determine how much to contribute to the Dependent Day Care FSA, consider how much you paid in day care expenses last year and any increases or changes for the upcoming year.

What is a Health Care FSA?

A Health Care Flexible Spending Account (also called Health Care FSA) is like a personal bank account in which you can set aside an amount of money on a pre-tax basis **to cover qualified health care expenses that are not covered by your health plan.**

You may use the Health Care FSA for health care expenses that are not covered elsewhere and could be 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.

What expenses are eligible for health care reimbursement?

Any expense that is considered an eligible medical expense by the Internal Revenue Service and is not reimbursed through your insurance plans can be reimbursed through the Health Care Flexible Spending Account. For a more complete listing of eligible medical expenses, please refer to *IRS Publication 502.* Examples include:

- Copayments on 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, prescription medicines and drugs, and insulin.
- 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.

What expenses are not eligible for Health Care FSA reimbursement?

Examples of ineligible expenses include:

- Effective January 1, 2011, over-the-counter medications are excluded unless issued as a prescription by your physician.
- Your health plan premiums, including COBRA premiums.
- Health club dues and physical treatments unrelated to a specific health problem, such as massage.

Non-eligible reimbursements, *continued on page 31*

Health Care FSA Amounts & Worksheet

You can set aside any amount from $120 to $4,000 a year to pay for eligible medical expenses. Be sure to estimate your expected out-of-pocket expenses carefully, because FSA money not claimed during your period of coverage is forfeited.

The Health Care FSA worksheet below can help you review your estimated expenses for you, your spouse, and any dependents—even if they are not covered under your health plan. Remember, the expenses covered under the health care plan you choose for this year may be different from last year.

Type of Expense	Your Estimate
Deductibles for medical and dental	$ _____
Copayments for medical, dental, and vision services	$ _____
Coinsurance	$ _____
Amounts paid over the usual and customary health plan limits	$ _____
Prescriptions	$ _____
Vision care (eyeglasses, contact lenses, prescription sunglasses, corrective eye surgery, cleaning solutions)	$ _____
Dental and orthodontics	$ _____
Treatments and therapies	$ _____
Fees and services (physicals)	$ _____
Medical equipment (wheelchair, crutches, oxygen, artificial limbs)	$ _____
Psychiatric care (psychotherapists, psychiatrists, and psychologists)	$ _____
Assistance for the disabled	$ _____
Miscellaneous expenses (hearing aids)	$ _____
Add together all the expenses you recorded above	**$** _____

Also compare your estimate to last year's typical expenses, and budget accordingly for the upcoming year.

You pay for your health benefits and participate in the FSA program with pre-tax dollars. Because you are not taxed on the dollars you spend on your health benefits or set aside in your FSA account(s), the IRS has very specific rules governing when you enroll, make changes, or cancel your health care or FSA choices during a plan year. These rules are also contained in *FCPS Regulation 4730.5*.

Non-eligible reimbursements, *continued from page 29*

- Cosmetic surgery.
- Costs for cosmetic dental procedures.
- Prescription drugs for cosmetic purposes.
- Dietary supplements and vitamins.
- Cosmetics.
- Sunblock.
- Toiletries (e.g., toothpaste, lotions).

You cannot receive reimbursement for a health care expense if you also itemize the expense as a deduction on your tax return. Additional eligible and ineligible expenses can be found at www.fcps.edu/DHR/employees/benefits. The administrator for FCPS Flexible Spending Accounts reviews all submitted expenses according to the *Internal Revenue Service Code Section 125* regulations.

What is a Dependent Day Care FSA?

A Dependent Day Care Flexible Spending Account (also called Dependent Day Care FSA) is designed to help you pay for eligible day care expenses for your children and other qualifying family members while you and (if married) your spouse are working. Dependent Day Care FSA funds are set aside from your paycheck before taxes are deducted, allowing you to pay for eligible day care expenses tax-free.

Who is qualified to be covered by a Dependent Day Care FSA?

A qualifying individual includes a **qualifying *child*** if he or she:

- Is a U.S. citizen, national, or a resident of the U.S., Mexico, or Canada,
- Has a specified family-type relationship to you,
- Lives in your household for more than half of the taxable year,
- Is under age 13, and
- Has not provided more than one-half of his or her own support during the taxable year.

A qualifying individual includes your **spouse** if he or she:

- Is physically and/or mentally incapable of self care,
- Lives in your household for more than half of the taxable year, and spends at least 8 hours/day in your home.

A qualifying individual includes your **qualifying *relative*** if he or she:

- Bears a specified relationship to the employee (relationship test),
- Has over half of his or her individual support provided by the employee (support test),
- Is a U.S. citizen, national, or a resident of the U.S., Mexico, or Canada,
- Is physically and/or mentally incapable of self care,
- Is not a qualifying child of anyone else,
- Lives in your household for more than half of the taxable year, and spends at least 8 hours/day in your home, and
- Receives more than half of his or her support from you during the taxable year.

What is considered an eligible expense?

Examples include:

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

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 who could be claimed as a dependent on your tax return.

Who and what are considered eligible day care providers?

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.

Dependent Day Care FSA Amounts

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 separately to pay for eligible dependent day care expenses.

Deciding Between a Dependent Day Care FSA & Federal Tax Credit

If you have eligible dependent day care expenses, you must choose between the Dependent Day Care FSA or 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. FBMC offers a free tax calculator on its website to assist you with determining which credit is best for you. Go to www.myfbmc.com.

Once I enroll, how do I submit a claim for reimbursement from my FSA accounts?

HEALTH CARE SPENDING ACCOUNT: As you incur medical expenses that are not covered or partially covered by your insurance, you submit a copy of the *Explanation of Benefits* or the provider's invoice and proof of payment to the plan administrator, who will then issue you a reimbursement check.

DEPENDENT DAY CARE SPENDING ACCOUNT: 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 your form indicates the individuals for whom services were provided and the dates of service.

Reimbursement forms may be obtained from the FCPS Human Resources website at www.fcps.edu/DHR/employees/benefits or by calling FBMC at 800-831-4331, x3000.

You can also submit your FSA claims online through www.myFBMC.com. This process allows you to submit, via the web, a scanned image of a completed claim form, along with scanned images of supporting documentation. Submitting claims online gets reimbursement requests to FBMC faster than traditional mail, resulting in quicker reimbursements from FBMC.

How long do I have to submit claims?

FOR ACTIVE EMPLOYEES: You have 90 days after the end of the calendar year to submit claims for eligible expenses incurred during the previous calendar year.

FOR TERMINATED EMPLOYEES:

- 10-month employees who completed their contract: You have until November 30 to submit your claims.
- 11-month employees who completed their contract: You have until October 31 to submit your claims.
- 12-month employees or 10/11 month employees who did not complete their contract: You have 90 days from the end of the month in which you terminate your employment with FCPS to submit claims for eligible expenses incurred prior to your coverage termination.

Any money left in your FSA account after the 90-day period will be forfeited and, by law, cannot be returned to you.

The amount that you elect to contribute into a FSA does not carry over from year to year. You must enroll each year to participate.

Health Care Benefits in Retirement

Eligibility

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

- Have been continuously enrolled in a medical and/or dental plan since January 1, 2007;
- Be eligible for normal or early retirement benefits, and elect to commence your pension benefits at the time you terminate employment with FCPS
- Have Medicare Parts A and B, if you and/or your spouse are age 65 or older.

Note: Participants who retire on or after January 1, 2012, must have been enrolled in a FCPS medical or dental plan for sixty (60) consecutive months immediately prior to retirement.

You must indicate your election to continue benefits prior to retirement.

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 at a later date unless you are a DHO participant as described below.

Deferred Health Option

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

By paying a monthly premium, DHO participants retain the right to enroll in FCPS retiree medical and/or dental coverage at a later date, if the DHO participant loses health coverage due to the death of or divorce from a spouse. Additionally, subsequent to the DHO enrollment, if the retiree gains a dependent, that dependent is eligible for coverage under a HIPAA special enrollment right.

If the DHO participant is not permitted to continue his/her late or former spouse's health insurance plan, the DHO participant may enroll in the type of health insurance plan that he/she loses.

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.

Important Information for the Year You Retire

You and your dependents may continue your participation in FCPS medical and dental plans when you retire as long as you had coverage for the required time frame prior to retirement. (See *Eligibilty* for more details.)

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

- Through the end of August, if you have a 10-month contract and retire at the end of the school year.
- Through the end of July, if you have an 11-month contract, and retire at the end of the school year.
- Through the last month of your employment, if you are a 12-month employee, or if you are a 10- or 11-month employee that retires prior to the end of the school year.

If you are age 65 or older when you retire, Medicare becomes your primary coverage and FCPS' medical plan will be secondary. You must elect Medicare parts A & B when you become eligible.

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 a sheet of coupons on an annual basis, showing the monthly premium you must pay each month.

Address Changes

You must keep your address updated with ERFC/FCERS and/or VRS 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(s) will end on the same schedule as health insurance (described on page 33). The last day you may submit claims for your FSA is:

- November 30, if you have a 10-month contract and retire at the end of the school year.
- October 31, if you have an 11-month contract and retire at the end of the school year.
- If you are a 12-month employee (or a 10/11 month employee retiring before the end of your contract) 90 days following the end of the month in which you terminated employment.

Remember that you have 90 days from the end of the month in which you retire to submit FSA claims for reimbursement expenses **incurred before your coverage ends.** Do not wait until the end of the calendar year to submit your expenses for reimbursement.

CareFirst POS Members

When you retire and reach age 65, you can no longer participate in CareFirst POS. You will be required to enroll in either the CareFirst PPO or Kaiser Medicare Plus Plan (if you reside within Kaiser's service area).

Kaiser Permanente Members

Retired members of Kaiser Permanente must live in the local service area to retain coverage with Kaiser Permanente. If you do not live in Kaiser's 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. Go to the Kaiser website at www.kaiserpermanente.org or contact Kaiser directly for more details.

FCPS Subsidies

If you are a retiree age 55 or older (or you retire due to a disability), FCPS provides a subsidy toward the cost of your FCPS medical coverage. The subsidy reduces the cost of your medical coverage.

The subsidy schedules for VRS, ERFC, and FCERS members are available at www.fcps.edu/DHR/retirees/benefits.

As a retiree, you do not pay your health plan contributions on a pre-tax basis as you did as an active employee. Contact your tax advisor for information about the tax status of your contributions.

For further health care plan details, see the *Summary Plan Documents,* which are posted on the FCPS website at www.fcps.edu/DHR/employees/benefits. All plan documents also are available by calling HR Client Services at 571-423-3000.

Legislation Applicable to FCPS Health Plans

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

Social Security (SSN) Reporting Requirement

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

Medicare Rx (Medicare D) Plan

For FCPS Employees & Dependents Eligible for Medicare

The Medicare prescription drug plan became effective January 1, 2006. All FCPS medical plans include prescription drug coverage that is currently more comprehensive than the Medicare prescription drug plan, and your FCPS medical coverage is primary to Medicare. As an active employee, you do not need to enroll in a Medicare Rx (Medicare D) plan.

For more information about Medicare, visit www.cms.hhs.gov or call the Centers for Medicare and Medicaid Services at 1-800-Medicare.

▼ *The following information only applies if you currently have Medicare or will become eligible for Medicare later in the year.*

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

Please read this notice carefully. *This notice 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 you can get help to make decisions about your prescription drug coverage 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.

Important Notice, *continued on page 38*

	CareFirst Blue Preferred PPO In-Network You Pay	Out-of-Network You Pay
Annual Deductible (Individual/Family)	None	$250/$500 (all services subject to deductible unless otherwise noted)
Out-of-Pocket Maximum	$500 Individual/$1,000 Family (excludes copays)	$1,500 Individual/$3,000 Family (excludes copays)
Office Visits—Primary Care & Specialist	$15 copay	30% of plan allowance
Inpatient Physician Services	10% of plan allowance	30% of plan allowance
Routine Exams & Immunizations	$15 copay	Not covered
Lab and X-ray	Outpatient—Covered in full at network radiology or laboratory centers; Inpatient—10% of plan allowance	Outpatient—30% of plan allowance; Inpatient—30% of plan allowance
In-Hospital Emergency Care	$50 copay (waived if admitted), then 10% of plan allowance	$50 copay (waived if admitted), then 10% of plan allowance
Infertility	Artificial Insemination—Covered; In-vitro—Covered up to $100,000 lifetime maximum	Artificial Insemination—Covered; In-vitro—Covered up to $100,000 lifetime maximum
Maternity Care	$15 copay first visit, then covered in full	30% of plan allowance
Well Baby Care	$15 copay/visit	Not covered
Outpatient Surgical and Ambulatory Care	10% of plan allowance	30% of plan allowance
Inpatient Hospital Admission	$100/admission copay, then 10% of plan allowance	$100/admission copay, then 30% of plan allowance
Durable Medical Equipment	10% of plan allowance	30% of plan allowance
Physical Therapy (Outpatient)	$15 copay, 90-day maximum/calendar year	30% of plan allowance, 90-day maximum/calendar year
Chiropractic Care	$15 copay	30% of plan allowance
Mental Health	Outpatient—10% of plan allowance; Inpatient—$100/admission copay, then 10% of plan allowance	Outpatient—30% of plan allowance; Inpatient—$100/admission copay, then 30% of plan allowance
Alcohol and Drug Abuse Rehabilitation	Outpatient—10% of plan allowance; Inpatient—$100/admission copay, then 10% of plan allowance	Outpatient—30% of plan allowance; Inpatient—$100/admission copay, then 30% of plan allowance
Prescription Drugs	Provided by Express Scripts for CareFirst members	
Vision	Provided by UnitedHealthcare Vision for all medical plan participants; comprehensive vision plan, including frames, lenses, and exams	

Note: FCPS plans are considered "grandfathered" under the Patient Protection and Affordable Care Act. As permitted by the Act, grandfath

CareFirst BlueChoice POS In-Network You Pay	Out-of-Network You Pay	Kaiser Permanente
None	$250/$500 (all services subject to deductible unless otherwise noted)	None
$250 Individual/$500 Family (excludes copays)	$1,500 Individual/$3,000 Family (excludes copays)	$3,500/Individual; $9,400/Family
$15 copay	30% of plan allowance	$15 copay
10% of plan allowance	30% of plan allowance	Covered in full
$15 copay	Not covered	Covered in full
Outpatient—Covered in full at network radiology or laboratory centers; Inpatient—10% of plan allowance	Outpatient—30% of plan allowance; Inpatient—30% of plan allowance	Covered in full
$50 copay (waived if admitted), then 10% of plan allowance	$50 copay (waived if admitted), then 10% of plan allowance	Covered in full after $75 copay (waived if admitted)
Artificial Insemination—Covered; In-vitro—Covered up to $100,000 lifetime maximum	Artificial Insemination—Covered; In-vitro—Covered up to $100,000 lifetime maximum	Artificial insemination—Covered at 50% of allowable charges; In-vitro—Not covered
$15 copay first visit, then covered in full	30% of plan allowance	Covered in full after initial diagnosis
$15 copay/visit	Not covered	Covered in full for children under age 5
10% of plan allowance	30% of plan allowance	$15 copay per visit
$100/admission copay, then 10% of plan allowance	$100/admission copay, then 70% of plan allowance	$100/admission copay, then covered in full
10% of plan allowance	30% of plan allowance	Covered in full (includes prostheses and orthotics)
$15 copay, 90-day maximum/calendar year	30% of plan allowance, 90-day maximum/ calendar year	Covered in full, short-term duration; $15 copay/visit
$15 copay	30% of plan allowance	Not covered
Outpatient—10% of plan allowance; Inpatient—$100/admission copay, then 10% of plan allowance	Outpatient—30% of plan allowance; Inpatient—$100/admission copay, then 30% of plan allowance	Outpatient—$15 copay; Inpatient—$100/admission copay, then covered in full
Outpatient—10% of plan allowance; Inpatient—$100/admission copay, then 10% of plan allowance	Outpatient—30% of plan allowance; Inpatient—$100/admission copay, then 30% of plan allowance	Outpatient—$15 copay; Inpatient—$100/admission copay, then covered in full
→		Kaiser Rx
→		

ered health plans can preserve certain basic health coverage that was already in effect when the law was enacted.

Important Notice, *continued from page 35*

You can join a Medicare drug plan when you first become eligible for Medicare and each year from November 15 through December 31. 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 re-enroll 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 FCPS 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 also may 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).

Remember: Keep this Creditable Coverage notice. If you decide to join one of the Medicare drug plans, you may be required to provide a copy of this notice when you join to show whether or not you have maintained Creditable Coverage and whether or not you are required to pay a higher premium (a penalty).

Date:	January 1, 2011
Name of Sender:	Fairfax County Public Schools
Contact:	Office of Benefit Services
Address:	8115 Gatehouse Road Suite 2700 Falls Church, VA 22042
Phone Number:	571-423-3200

COBRA— When You or Your Family Lose Your Health Coverage

COBRA continuation coverage is a continuation of plan coverage when coverage would otherwise end because of a life event known as a "qualifying event." Specific qualifying events are listed below. FCPS must offer COBRA continuation coverage to each person who is a "qualified beneficiary." A qualified beneficiary is someone who will lose coverage under the plan because of a qualifying event. Depending on the type of qualifying event, you, your spouse, and your dependent children may be qualified beneficiaries.

Under the plan, qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage. 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 information generally 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 temporary or substitute.
- Your employment ends for any reason other than gross misconduct.

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

- Your employment status changes to temporary or substitute.
- 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.

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

How long does COBRA coverage last?

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 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, or your death, the plan administrator is automatically notified.

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

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

Examples:

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

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

If you have questions about your COBRA continuation coverage, you should contact the plan administrator or you may contact the nearest regional or district office of the U.S. Department of Labor'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, phone 571-423-3200.

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.

Mental Health Parity & Addiction Equity Act

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

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

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 Health benefits. If military service is expected to last more than 30 days, the service member may

continue health benefits for up to 24 months. He/she is required to pay premium costs of *up to* 102 percent of the full premium for continued coverage.

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.

Health Insurance Portability & Accountability Act (HIPAA)

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

Under HIPAA, a pre-existing period cannot be longer than 12 months (18 months for late enrollment, reduced by previous periods of creditable coverage). An individual receives credit for previous coverage that occurred without a break in coverage of 63 days or more. (A break in coverage of 63 days or more is not credited against a pre-existing condition exclusion period.)

HIPAA requires group health plans to offer special enrollment opportunities without having to wait until the plan's next regular open enrollment period. A special enrollment opportunity occurs if 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. Department of Health and Human Services following a breach of unsecured protected health information.

FCPS Office of Equity & Compliance 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 & Compliance. For more information, visit www.fcps.edu/DHR/employees/oec/hipaa.htm.

Newborns' & Mothers' Health Protection Act

The Newborn and Mother's 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.

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 of the medical plan providers, available on the FCPS website, www.fcps.edu/DHR/employees/benefits or contact your health plan vendor.

Patient Protection & Affordable Care Act

Disclosure of Grandfather Status

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

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

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

Notice of Opportunity to Enroll in Connection with Extension of Dependent Coverage to Age 26

Individuals whose coverage ended, or who were denied coverage (or were not eligible for coverage), because the availability of dependent coverage of children ended before attainment of age 26 are eligible to enroll in FCPS health and dental plans during the fall open enrollment period (September 29–October 29, 2010). Enrollment will be effective January 1, 2011. For more information, contact the Office of Benefit Services at 571-423-3200, option 3.

Patient Protection Disclosure

The CareFirst POS and Kaiser Permanente HMO plans generally require the designation of a primary care provider. You have the right to designate any primary care provider who participates in the plan network and who is available to accept you or your family members. Until you make this designation, the plan may designate one for you. For information on how to select a primary care provider, and for a list of the participating primary care providers,

contact CareFirst BlueCross Blue-Shield at 202-479-8000 or Kaiser Permanente at 301-468-6000.

For children, you may designate a pediatrician as the primary care provider.

You do not need prior authorization from CareFirst or Kaiser Permanente or from any other person (including a primary care provider) in order to obtain access to obstetrical or gynecological care from a health care professional in the plan's network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services following a preapproved treatment plan, or procedures for making referrals. For a list of participating health care professionals who specialize in obstetrics or gynecology, contact CareFirst or Kaiser Permanente at the numbers above.

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

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

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

Medicaid website:
http://www.dmas.virginia.gov/rcp-HIPP.htm
Medicaid Phone: 800-432-5924

CHIP website: http://www.famis.org
CHIP phone: 866-873-2647

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

Once it is determined that you or your dependents are eligible for premium assistance under Medicaid or CHIP, your employer's health plan is required to permit you and your dependents to enroll in the plan—as long as you and your dependents are eligible, but are not already enrolled in the employer's plan. This is called a "special enrollment" opportunity, and **you must request coverage within 60 days of being determined eligible for premium assistance.**

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

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

866-444-EBSA (3272)

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

877-267-2323, x 61565

Protecting Future Care Needs—

Long-Term Care Insurance

The Long-Term Care offers a variety of options to help pay for care in the event you are unable to care for yourself.

Unlike Long-Term Disability, which replaces a portion of your income to cover your normal living expenses, Long-Term Care helps you pay for the care you need if you ever suffer from a chronic illness or disability that makes you unable to care for yourself for an extended period of time.

Eligibility

You are eligible to elect Long-Term Care if you are a benefits-eligible employee.

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

Employees who have elected Long-Term Care may continue coverage on a direct pay basis upon retirement or termination of employment.

Plan Highlights

Daily Community-Based Care Benefit—Pays the actual cost of services you receive, up to the amount elected, for care in the following settings:

- Your own home
- Adult day care facility

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

Daily Facility Care Benefit—Pays the actual cost of services you receive, up to the amount elected, for care in the following facilities:

- Nursing homes
- Assisted living facilities
- Hospice facilities

Lifetime Maximum Benefit—Your Lifetime Maximum Benefit is the total amount of insurance you purchase. It is the total available pool of money you can use to pay for long-term care services.

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

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

Optional Feature

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

Qualifying for Benefits

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

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

OR

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

Enrollment

How do I enroll for coverage?

If you are a new employee, you may enroll for coverage within 30 days of your date of hire. You are not required to submit evidence of insurability unless you are selecting the 100 percent community-based care benefit.

How do I enroll my family members?

All family members must submit evidence of eligibility and be approved by CNA before coverage will begin.

- Your spouse may submit a short-form application.
- Parents, parent-in-laws, grandparents, grandparent-in-laws, retirees and their spouses require a long-form application.

To enroll in Long-Term Care coverage, visit CNA online for enrollment information at www.ltcbenefits.com. The password is "FCPS".

When does coverage start?

Your coverage starts on the first day of the month after your application has been approved.

When can I change my coverage?

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

Do my dependents and I have to reenroll every year?

No. Long-Term Care coverage carries over from one year to the next, so you don't have to enroll each year.

Exclusions

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

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

Additional Features of the Long-Term Care Benefit

Alternate Plan of Care—Allows coverage for long-term care services, special devices, or other needs not otherwise covered by the contract. It applies to care received in non-standard facilities or settings, or care or non-standard services received at home. Benefit payments for the Alternate Plan of Care feature depend on the specific plan of care developed, but cannot exceed the Daily Facility Care Maximum.

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

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

Caregiver Training—Pays up to 3 times your Daily Home-Based Care Benefit to train an informal caregiver or an independent provider to care for you in your residence. It also pays for training required to license or certify an independent provider, if required. You do not need to satisfy the waiting period to receive this benefit.

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

Home Medical Technology—Pays up to $1,000 each year for assistive devices, medical monitoring or communications technology, medication compliance equipment, and emergency response systems used in your residence. It also covers home modifications necessary to accommodate this kind of equipment or as needed to allow you to remain at home. The Alternate Plan of Care feature may supplement this benefit.

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

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

Respite Care—Covers the temporary use of paid long-term care services to relieve family members and other "informal" caregivers of their duties so they can take needed time off. The Respite Care Benefit pays either the Daily Facility Care Benefit or Daily Home-Based Care Benefit up to 14 days per year, depending on where benefits are used. You do not need to satisfy the waiting period to receive this benefit.

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

Waiting Period—You will need to satisfy a 90-calendar-day waiting period before benefits can be paid. You must only satisfy this waiting period once in your lifetime. You do not need to incur any paid services during this time.

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

Protecting Your Family—
Life Insurance

Life Insurance for VRS Members

As an active member of the Virginia Retirement System (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 in the cost for basic life insurance. **Note:** A premium holiday is in effect for basic life through June 2012.

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 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 benefits according to the loss experienced in the accident (e.g., loss of an arm, a leg, or your sight).

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 $700,000.
- Insure your spouse for half of the amount of your coverage, up to a maximum of $350,000.
- 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 only once a year on July 1. Rate tables are available at www.fcps.edu/DHR/employees/benefits and on the VRS website at www.varetire.org. You pay all costs for optional life insurance, which are deducted in equal installments from your paycheck each pay period.

When can I enroll?

Optional life insurance for the employee is a guaranteed benefit (subject to maximums) if you enroll within 31 days of your hire date. You may apply for optional coverage after 31 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.

When does coverage end?

You may continue your optional life insurance if you retire or terminate service but defer retirement. You must have 60 months of optional life before leaving service and elect continuation of coverage within 31 days of leaving service.

Life Insurance for FCERS Members

Active participants of the Fairfax County Employees' Retirement System (FCERS) receive life insurance as well as accidental death and dismemberment benefits. FCPS sponsors this plan and insures this plan through Minnesota Life Insurance Company. Employees who work less than 50 percent of a normal scheduled work week (15 hours per week for food service) are not eligible for life insurance.

Basic Group Life Insurance

- You automatically are covered for 1 time 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:
  – Spouse $5,000; Child(ren) $2,000.
  – Spouse $10,000; Child(ren) $5,000.

You pay all costs for optional and dependent life insurance, which FCPS deducts in equal installments from your pay each pay period. Rate tables are available in the Group Life Plan brochure at www.fcps.edu/DHR/employees/benefits.

A Note About Optional Life Insurance

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

Accidental Death & Dismemberment Benefits

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 benefits according to the loss experienced in the accident (e.g., the loss of an arm, a leg, or your sight).

See www.fcps.edu/DHR/employees/benefits for more details.

Saving For Your Future—

Your FCPS-Sponsored Retirement Plans

FCPS provides retirement plans that will help you enjoy the years after you leave FCPS. When to retire and which payment options to choose are very personal decisions, and they will require you to take time to become familiar with your retirement plan(s). You are encouraged to make these decisions with the advice of a professional financial planner or tax advisor, who can help you weigh your FCPS retirement benefits with other savings.

Eligibility & Enrollment

Your employment status and category determine the retirement plan(s) to which you may belong, and enrollment in the appropriate retirement plan is automatic.

Retirement plans for full-time educational, administrative, and support employees (monthly paid):

- Virginia Retirement System (VRS) Plan 1 for employees hired before July 1, 2010, or VRS Plan 2 for employees hired on or after July 1, 2010; and
- Educational Employees' Supplementary Retirement System of Fairfax County *(ERFC Legacy* or *ERFC 2001*)

Retirement plan for full- and part-time custodial, food service, maintenance, and transportation employees (biweekly paid) and less-than-full-time educational, administrative, and support employees:

- Fairfax County Employees' Retirement System (FCERS)

All employees, including hourly paid employees and substitute teachers, participate in Social Security and Medicare.

Virginia Retirement System (VRS)

Full-time educational, administrative, and support employees (monthly paid)

The Virginia Retirement System (VRS) is a mandatory defined benefit retirement program sponsored by the Commonwealth of Virginia.

FCPS pays for your VRS retirement benefits.

You become fully vested in VRS after 5 years of eligible service. Once vested, VRS Plan 1 members are eligible to receive:

- Unreduced retirement benefits beginning at age 50 with 30 or more years of service, or at age 65 with 5 or more years of service.
- Early retirement benefits beginning at age 55 with 5 or more years of service, or as early as age 50 with 10 or more years of service.

Once vested, VRS Plan 2 members are eligible to receive:

- Unreduced retirement benefits beginning at Normal Social Security retirement age with at least 5 years of service, or when age and years of service equal 90.
- Early retirement benefits beginning at age 60 with 5 or more years of service.

Both VRS plans include disability and death benefits and annual cost-of-living adjustments. VRS also provides life insurance coverage upon service retirement or disability retirement at no cost to participants.

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

Full-time educational, administrative, and support employees (monthly paid)

The ERFC is a defined benefit retirement plan designed to **supplement VRS** benefits and Social Security benefits to provide you with more income throughout your retirement. Under ERFC, you contribute 4 percent of your salary in equal installments from your paycheck each pay period. FCPS also contributes to your ERFC retirement.

Your date of hire determines the ERFC plan in which you are enrolled.

ERFC Legacy Plan

If you were hired on or before June 30, 2001, you are covered under the *ERFC Legacy* plan. Under this plan you:

- Become vested after 5 years of service.
- Are eligible for unreduced retirement beginning at age 55 with 25 or more years of service, or at age 65 with 5 or more years of service.
- Have the option to take early retirement benefits beginning at age 45 with 25 or more years of service, or at age 55 with 5 or more years of service.
- Are eligible for annual cost-of-living adjustments.
- Are eligible for disability and death benefits.

Under the *ERFC Legacy* plan, your retirement is based on your age, years of service, and final average compensation, and is calculated in conjunction with your VRS and Social Security retirement benefits. The ERFC basic benefit has two separate parts: You receive a lifetime benefit from the time you retire until you die, and you receive an additional temporary benefit until the age at which you become eligible for full Social Security benefits. Under current law, this will occur between the ages of 65 and 67 years.

At retirement, the *ERFC Legacy* plan converts unused sick leave to additional retirement service credit to increase the amount of benefits payable, but you cannot use your sick leave to determine your eligibility to retire.

ERFC 2001 Plan

If you were hired on or after July 1, 2001, you are covered under the *ERFC 2001* plan. Under this plan you:

- Become vested after 5 years of service.
- Earn unreduced retirement benefits beginning at age 60 with 5 or more years of service, or at any age with 30 or more years of service.
- Are eligible for annual cost-of-living adjustments.
- Are eligible for a death benefit.

ERFC 2001 bases your retirement benefit on your age, years of service, and final average compensation.

As a general rule, ERFC retirement benefits will cease when you die. If you die after retirement, your survivor or your estate will receive a refund of your accumulated contributions, minus any benefits already paid to you. If you want to provide a continuing benefit to your survivor after your death, you may elect one of three survivor options that provide a reduced benefit to you during your lifetime to accommodate an ongoing benefit for an eligible beneficiary after your death.

Fairfax County Employees' Retirement System (FCERS)

Full- and part-time custodial, food service, maintenance, and transportation employees (biweekly paid) and less-than-full-time educational, administrative, and support employees

The FCERS is a defined benefit plan that provides retirement income for eligible members. Members may receive normal, early service, or vested retirement benefits. In circumstances where illness or injury occurs, FCERS may provide ordinary or service-connected disability retirement benefits, death benefits and optional survivor benefits, and annual cost-of-living adjustments (COLAs).

FCERS is a mandatory retirement system for school employees (defined above) who are less than 59½ years when hired by FCPS. Employees who are being reported by FCPS as a member of VRS are not covered, nor are substitute or temporary employees. If your scheduled hours are less than 50 percent of the normal scheduled work week (less than 15 hours per week for food service employees), you are not eligible for membership in FCERS.

Under FCERS, you must elect membership in Plan A or Plan B within 30 days of your hire date. This election is irrevocable. If you do not elect a plan within the first 30 days of employment, FCPS automatically enrolls you in Plan A.

- If you elect Plan A, you contribute 4 percent of your salary up to the maximum Social Security taxable wage base and 5.33 percent of your salary in excess of the Social Security taxable wage base.
- If you elect Plan B, you contribute 5.33 percent of your salary. Plan B requires higher contributions because it provides a higher retirement benefit.

In addition to your contributions, FCPS contributes to FCERS to help fund all future FCERS retirement benefits.

Note: *You can always see what plan you are in by looking at your pay stub.*

You become vested in FCERS after 5 years of service. Once you are vested, you are eligible to receive:

- Normal retirement benefits at or after age 50 when your age and years of service (including sick leave) total 80, or at age 65 with 5 or more years of service.
- Early retirement benefits at or after age 50 when your age and years of service (including sick leave) total 75 or more.
- Deferred vested retirement benefits at age 65—If you terminate employment prior to retirement eligibility and leave your contributions in the system, you can apply for deferred vested benefits at age 65.

Refund of Contributions

If you terminate employment without retiring, you may leave your contributions and interest with FCERS or withdraw your contributions and interest by requesting a refund or rollover to an IRA or other qualified plan.

DROP—A Retirement Option for FCERS Members

If you are eligible for normal service retirement, you are eligible for the Deferred Retirement Option Program (DROP).

This program allows you to retire under the FCERS plan and continue to work and receive your monthly FCPS paycheck. However, instead of receiving your retirement benefit, FCERS places it in a separate account that earns an annual rate of 5 percent interest, compounded monthly. You may remain in DROP for up to 3 years. At the end of your DROP period, you must terminate your FCPS employment. You may take the money in your account either as a lump sum, a monthly annuity, or as a rollover into another qualified retirement plan. A DROP estimator is available on the FCERS website. You also may contact FCERS to schedule an appointment with a retirement counselor to discuss your DROP options.

For more information, call FCERS at 703-279-8200.

Saving for Your Future—

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

You can enhance your financial future by participating in the optional retirement savings plans sponsored by FCPS. Financial experts suggest that you plan for retirement income that includes your pension, Social Security, and your own personal savings. 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. These plans can help you meet your retirement savings goals. Putting money aside for the future is one of the most important decisions you can make.

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.

Benefits-eligible, full- and part-time employees may invest in either a 403(b), a 457(b) plan, or in both plans. All employees, including temporary, hourly staff, are eligible to contribute to the 403(b) plan. Tax laws allow eligible employees to contribute 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- and part-time salaried employees may enroll in the 457(b) plan. The plan is not available to temporary, hourly employees. Each year, the IRS sets limits on the amount you may contribute to a 457(b) plan. The Office of Benefit Services will post these limits online when available at www.fcps.edu/DHR/employees/benefits/457b.htm.

A Note About Retirement Savings Plans

As with any investment decision, you should take the time to read any material you receive and make sure you have done your homework before you invest.

A 457(b) plan also:

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

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 Great-West Retirement Services at 877-449-FCPS (3277). Check the FCPS Benefits website at www.fcps.edu/DHR/employees/benefits/457b.htm for more detailed information.

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.

Here's how the TDA program works:

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 providers offer an easy online enrollment and salary reduction process. 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 posted and updated on the website at www.fcps.edu/DHR/employees/benefits/403b.htm.

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.

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.

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

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
- Ability to change investment strategy at a later time
- Track record of investments you are considering

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

FCPS has granted permission to 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.

Each year, the IRS sets limits on the amount you may contribute to a 403(b) plan. The Office of Benefit Services will post these limits online when available at www.fcps.edu/DHR/employees/benefits/403b.htm.

FCPS 403(b) Universal Availability Notice

What is a 403(b) plan?

A 403(b) plan is a tax-deferred retirement plan available to employees of public educational institutions and certain tax-exempt organizations. A 403(b) plan allows you to make pre-tax contributions by convenient payroll reduction 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 59½, leave your job, or upon death or disability. However, distributions can also be available in the event of financial hardship. Bear in mind that distributions before age 59½ 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 59½.

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% and you contribute a $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 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 are eligible to participate.

What is the maximum amount that I can contribute?

The IRS limits the annual contributions you can make to a 403(b) plan. For 2010, you can contribute the lesser of 100% of your taxable income or:

- Under Age 50 $16,500
- Age 50 and older $22,000

Limits are adjusted each year. Limits for 2011 will be issued in the fall of 2010. See *IRS Publication 571* for more information.

403(b) Universal Availability Notice, *continued*

When do I enroll?

You can enroll in the plan immediately upon your date of hire and anytime thereafter, as long as you are an employee of Fairfax County Public Schools. For investment provider contacts, please visit www.fcps.edu/DHR/employees/benefits/403b.htm.

When are my elective deferral contributions effective?

After completing the enrollment requirements, your elective deferral contributions will begin the first day of the following month, or as soon as administratively possible. Completed enrollment requests must be received by the 20th 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. Salary reduction agreements for new enrollments, changes, or stops received by the 20th of any given month will become effective on the 1st 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
800-892-5558, x 88860
www.valic.com/fcps

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

Great-West Retirement Services
877-449-FCPS (3277)
www.gwrs.com/fcps

Maintaining Your Pay & Benefits—

Integrated Disability Management (IDM)

Program Summary

FCPS offers an Integrated Disability Management (IDM) program to FCPS employees. This 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 and Long-Term Disability plans and, if the condition is work-related, Workers' Compensation. No cost is associated with your participation in the Short-Term Disability (STD) plan and Workers' Compensation (WC); a minimal cost is associated with the Long-Term Disability (LTD) plan.

For complete IDM program details and eligibility rules, refer to the IDM handbook at www.fcps.edu/DHR/employees/benefits/pdfs/idmhandbook.pdf.

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 your progress and when you expect to return to work. 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. 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 received.

Short-Term Disability (STD)

The STD plan provides 100 percent salary replacement after you are disabled for more than 20 consecutive workdays. This 20-workday elimination period can be paid or unpaid, depending on your accrued leave balance.

If you have no accrued leave, you will be in a leave-without-pay status during all or part of the elimination period. When calculating the elimination period, Liberty Mutual may count absences that are nonconsecutive if they are related to the same health condition and can be confirmed by your health care provider. After that time, you are automatically transferred to the STD plan if you have been working with Liberty Mutual and your absence is medically necessary and supported.

STD replaces lost wages and only applies to actual workdays. You do not receive STD benefits for holidays or during the spring, summer, and winter breaks, nor do these nonworkdays count toward eligibility for the elimination period.

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 for eligibility for your elimination period, nor are benefits paid during these nonworked periods.

Liberty Mutual mails a medical release form to you for your signature. You must complete this form and return it to Liberty Mutual as soon as possible. In the meantime, Liberty Mutual contacts your doctor to begin gathering medical information in order to make a claims decision within your 20-workday elimination period. If you fail to cooperate with Liberty Mutual, your claim may be significantly delayed and/or denied.

Note: Employees hired on or after July 1, 2010, must satisfy a 12-month eligibility period before becoming eligible to apply for benefits under the plan.

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 benefits.

If You Become Seriously Ill or Injured or Have Been Diagnosed with a Serious Illness…

You **must** notify your supervisor immediately that you will be away from work. You **must** also 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 you file more than 5 workdays after the beginning of the disability if you do not provide this notice, but you may appeal the denial.

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

The STD Appeal Process

You may appeal a decision made by Liberty Mutual to an Appeals Committee, which is composed of five FCPS employees. The disability and leaves coordinator from the Office of Benefit Services chairs the committee as a nonvoting member.

For information about filing an appeal, contact the Office of Benefit Services, Disability and Leaves Section. Your appeal must:

- be in writing,
- include any additional medical evidence not previously provided,
- state the reasons why you believe Liberty Mutual's decision is incorrect, and
- include the IDM plan provision that you think was not followed.

The committee notifies you in writing no later than 30 days following the hearing on whether it decided to uphold Liberty Mutual's decision or approve your claim. If your appeal is denied, the committee's notice will include a specific reference to the plan provision upon which the denial is based. The committee's decision shall be binding for all parties.

SHORT-TERM & LONG-TERM DISABILITY

First Step	Elimination Period	Short-Term Disability	Long-Term Disability
Call Liberty Mutual's 24-hr number: 1-800-524-0740 – Call immediately upon diagnosed disability, or work-related injury or illness; or by the fifth consecutive missed day of absence; or upon the fifth absence for the same medical condition from work. – If you are eligible, the elimination period begins on the first workday of absence. (Note: STD benefits are for employees only.) – Liberty Mutual will then mail you a medical release form. Please complete, sign, and return this form immediately to avoid pay delays during your absence.	FAMILY MEDICAL LEAVE ACT (UP TO 12 WEEKS) 20 consecutive workdays* (Sick Leave, Annual Leave, or Leave Without Pay**) – Liberty Mutual verifies your claim and may request additional information. – First, your accumulated sick leave is used, then your annual leave is used to supplement your pay. If this leave is not available, you will be placed on leave without pay. (Note: Employees on leave without pay will be responsible for their employee contributions for their insurance.)	100% of salary (up to 5 months) If approved for STD benefits: – Disability refers to your inability to perform all assigned duties of your occupation with FCPS. – Your disability begins on the 21st workday up to 5 months.* Upon receiving STD benefits: – You do not accrue any leave. – Any forms of employment must be approved by Liberty Mutual. – Liberty Mutual will periodically evaluate your claim up to 5 months for continued STD benefits.	66⅔ % of salary If approved for LTD benefits: – Payments will begin on the 181st day, or after all your accrued leave has been used, if elected. Upon receiving LTD payments: – Your status changes to Inactive Employee. This means that you will be responsible for paying full cost to FCPS for health and dental insurance. – You do not pay your LTD premium unless you return to work. – You do not accrue any leave, and by not being paid by FCPS, your retirement plans no longer receive contributions. – Your rights to a position with FCPS are maintained for a maximum of 24 months while approved for LTD benefits.

* *Excludes spring, summer, or winter breaks and holidays for 10-, 11-, or 12-month employees. Employees hired on or after July 1, 2010, must satisfy a 12-month eligibility period before becoming eligible for benefits.*

** *Liberty Mutual may count absences for nonconsecutive workdays if related to same health condition.*

Long-Term Disability

LTD benefits may begin after 180 days of disability. If you are receiving benefits from the STD plan and your claim is approaching the end of the 5-month STD period, Liberty Mutual automatically reviews your disability claim to determine if you are eligible to collect Long-Term Disability (LTD) benefits when your STD benefit period ends.

If you were not eligible to receive STD benefits because you were in your eligibility period, you should notify Liberty Mutual prior to the end of the 180-day period.

Participation in the LTD plan is mandatory. FCPS deducts your cost—$0.282 per $100 of salary—from your pay each pay period. Since you pay the entire cost for the LTD plan on an after-tax basis, payments from the plan are not taxable if you receive LTD payments.

If eligible for benefits, the plan pays 66⅔ percent of your pre-disability pay. While you are receiving LTD benefits, you are not required to pay your LTD premium deduction. Your LTD premium deduction automatically begins again once you return to work.

FCPS automatically enrolls all new employees into the LTD plan. Any employee who declined coverage during the initial enrollment period in 1999 and who wants to enroll in the future may enroll during Open Enrollment each fall, but he or she will be subject to a preexisting condition investigation if a claim is filed within 1 year of enrolling.

Your Benefits During LTD

While you are receiving LTD payments, you are in an Inactive Employee status. That means that you may continue to participate in the health insurance, dental insurance, and other optional benefit programs if the plans allow such participation, but you must pay the full cost for these benefits by remitting payment to FCPS. You cannot contribute to the retirement plans if you are not paid by FCPS, nor can you accrue sick and/or annual leave.

WORKERS' COMPENSATION

First Step	Waiting Period	Workers' Comp	Workers' Comp & STD	Workers' Comp & LTD
	FAMILY MEDICAL LEAVE ACT (UP TO 12 WEEKS)			
Call Liberty Mutual's 24-hr number: 1-800-524-0740 – Call immediately for any work-related injury or illness on an FCPS facility. – Notify your supervisor of injury or illness immediately. – Waiting period begins on the first calendar day of absence. – Liberty Mutual will then mail you forms to complete in order to finish processing your claim. Once received, please return within 5 workdays.	**7 calendar days (Sick Leave, Annual Leave, or Leave Without Pay)** – Liberty Mutual begins to verify your claim and may request additional information. – First your accumulated sick leave is used, then your annual leave to supplement your pay. If this leave is not available, you will be placed on leave without pay. (Note: Employees on leave without pay will be responsible for their employee contributions for their insurance.) – Leave will not be reinstated during this time.	**66 2/3 % of AWW† 8-20 workdays (Sick Leave, Annual Leave, or Leave Without Pay)** If approved for Workers' Compensation: – Disability refers to your inability to perform all assigned duties of your occupation with FCPS. Upon receiving Workers' Comp benefits: – Any forms of employment must be approved by Liberty Mutual. – You will receive 66 2/3% of AWW † if all your leave has been used, up to a statutory maximum.	**66 2/3 % of AWW† 33 1/3 % STD (21 workdays up to 5 months)** If approved for Workers' Comp and STD benefits: – Your disability begins on the 21st day up to 5 months.* – You do not accrue any leave. – Liberty Mutual will periodically evaluate your claim. * *Excludes spring, summer, or winter breaks and holidays for 10-, 11-, or 12-month employees. Employees hired on or after July 1, 2010, must satisfy a 12-month eligibility period before becoming eligible for benefits.*	**66 2/3 % of AWW† 33 1/3 % of LTD** If approved for Workers' Comp and LTD benefits: – Your disability begins at the end of your STD benefit period. Upon receiving LTD benefits: – Your status changes to an inactive employee. This means that you will be responsible for paying full cost to FCPS for health and dental insurance. – You do not pay LTD deduction unless you return to work. – You do not accrue any leave, and by not being paid by FCPS, your retirement plans no longer receive contributions.

† AWW = Average Weekly Wage of earnings for preceding 52 weeks divided by 52.

Workers' Compensation

If you are injured on the job or believe that you may have sustained an occupational illness and/or injury, you may be eligible to receive Workers' Compensation benefits. Benefits available through Workers' Compensation include payment for medical expenses incurred as a result of the accident, and partial replacement of pay if the injury prevents you from working. FCPS continues to pay the employer portion of the medical and dental plan contributions if you are losing time and have been approved for Workers' Compensation benefits.

While You Are Collecting Benefits from the IDM Program

You do not accrue sick leave or annual leave when you are collecting STD, LTD, or Workers' Compensation, because they are not considered paid statuses for the purpose of accruing leave.

If you are approved for STD, LTD, or Workers' Compensation, you should not attend school or worksite functions as an employee, such as field trips or job interviews, or be on school or worksite premises without the consent of your doctor and with the approval of Liberty Mutual.

If you are injured while at work, you should:

- Call Liberty Mutual immediately at 800-524-0740 to report your injury. Liberty Mutual is available to take your call and provide assistance 24 hours per day, 7 days per week. If there is an emergency and you are unable to call, someone may call on your behalf.
- Be sure to notify your supervisor.
- As soon as possible, select a physician from the *Workers' Compensation Provider Panel* for ongoing medical care. Provide Liberty Mutual with the physician's name and appointment date. The Provider Panel is updated regularly on the FCPS website at www.fcps.edu/DHR/employees/benefits. Following all emergency treatment, you should call Liberty Mutual to inform them of your progress toward recovery.

- Complete and return the *Physician Selection* form, *Secondary Employment Data Sheet,* and medical release form (Liberty Mutual provides these to you) so that Liberty Mutual can process your claim. For your protection, FCPS requires that you return these forms to Liberty Mutual within 5 business days. Should you encounter any problems while completing the forms, contact Liberty Mutual as soon as possible.

Your Information Is Confidential

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

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

For more information about the IDM program, refer to the FCPS Integrated Disability Management Program handbook online. You can reach Workers' Compensation at workerscompensation@fcps.edu or 571-423-3200, option 2, and Short-Term and Long-Term Disability at disabilityandleaves@fcps.edu or 571-423-3200, option 1.

Taking Time for Your Personal & Professional Needs—

Leave Programs

Family & Medical Leave Act (FMLA)

If you have been actively employed with FCPS for the previous 12 months, 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 an 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.

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 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, 6 weeks' recovery is recommended for a regular delivery, and 8 weeks' recovery is recommended 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.

Liberty Mutual will contact you after your baby's birth to discuss your return to work and will notify FCPS of your intentions. A representative from the Disability and Leaves Office will contact you to discuss your options if you need or desire more time off, including taking additional leave through your work location (30 days or less), participating in a remaining FMLA, or taking an unpaid leave of absence.

For more information about maternity leave, go to www.fcps.edu/DHR/employees/benefits and click on *Publications*; the IDM handbook contains more information.

Important note: Your baby is not automatically enrolled for health insurance. Regardless of whether you will be covering your baby under an FCPS health 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 days** of the date of birth; contact the Office of Benefit Services to obtain the appropriate enrollment form or go to: www.fcps.edu/DHR/employees/benefits/forms.htm.

MATERNITY LEAVE

First Step	Elimination Period	Short-Term Disability	FMLA‡
Call Liberty Mutual's 24-hr number: 1-800-524-0740 – 30 calendar days prior to your due date. – Immediately if your doctor orders bed rest. – Notify your supervisor as soon as possible of your expected absence dates. – Elimination period begins on the first workday of absence. (Note: STD benefits are for employees only.)	FAMILY MEDICAL LEAVE ACT‡ → 20 consecutive workdays* (Sick Leave, Annual Leave, or Leave Without Pay**) Regular Birth (6 weeks postpartum) → (4 weeks) + (up to 2 weeks) Cesarean Birth (8 weeks postpartum) → (4 weeks) + (up to 4 weeks) – Liberty Mutual verifies your claim and may request additional information. – First your accumulated sick leave, then your annual leave is used to supplement your pay. If this leave is not available, you will be placed on leave without pay. (Note: Employees on leave without pay will be responsible for employee contributions of their insurance.)	100% of salary If approved for STD benefits: – Disability refers to your inability to perform all assigned duties of your occupation with FCPS. – Your disability begins on the 21st workday up to 5 months.* Upon receiving STD benefits: – You do not accrue any leave. – Any forms of employment must be approved by Liberty Mutual. – Liberty Mutual will periodically evaluate your claim up to 5 months for continued STD benefits.	+ up to 6 weeks FMLA ‡ = 12 wks. + up to 4 weeks FMLA ‡ = 12 wks. – All sick leave must be used first before using any annual leave. – FCPS continues to pay employer portion of your insurance. (Note: Employees on leave without pay will be responsible for employee contributions of their insurance via direct bill.) – Notify FCPS of your intended return to work date. – If more time away from work is needed, a FCPS representative from the Disability & Leaves Office will discuss your options with you.

* *Excludes spring, summer, or winter breaks and holidays for 10-, 11-, or 12-month employees. Employees hired on or after July 1, 2010, must satisfy a 12-month eligibility period before becoming eligible for benefits.*

** *Liberty Mutual may count absences for nonconsecutive workdays if related to same health condition.*

‡ *If eligible and approved for FMLA* (see Regulation 4835).

During the 20-Consecutive-Workday Elimination Period

- You must use your paid leave if you have a balance; you must use your sick leave prior to using your annual leave.
- If you have no paid leave, you will be in a leave-without-pay status.
- Sick and annual leave will continue to accrue.

During STD…

- You will continue to participate in mandatory benefit plans, including basic life insurance, retirement, and LTD, and optional benefit plans, including medical coverage, dental coverage, Long-Term Care (LTC), flexible spending accounts, and optional life insurance.
- You do not accrue sick leave or annual leave while on STD.
- You do not receive STD benefits for nonworked periods, such as spring, winter, and summer breaks. STD only applies to your actual workdays.

Remember, you have 30 days from the day you deliver to modify any of your optional benefits, such as adding your new baby to your medical plan coverage.

During FMLA…

- You must use paid leave if you have a balance; sick leave must be used prior to using your annual leave.
- FCPS continues to pay the employer portion of your health care premiums for this period of time.

- If you do not have a balance of paid leave or sick leave to use up during the time you are on FMLA (that is, you are taking an unpaid leave of absence), you will need to pay your portion of your health premiums and other benefits during this time. A *Benefit Billing Election* form will be included with your approval letter.

Leaves of Absence (LOA)

FCPS provides two types of long-term 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 31** preceding the school year you wish to take leave.

A **designated** LOA is provided for specific purposes, and FCPS requires documentation supporting your LOA. You need not have worked for FCPS for a specified time period prior to requesting this type of leave. 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 leave.

A LOA typically does not extend past 24 months, although FCPS allows extensions under certain circumstances, such as military and child care. Before you take a 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, e-mail the Disability and Leaves Section at disabilityandleaves@fcps.edu.

Your Benefits & LOA

During a LOA, FCPS automatically cancels your health, life, and optional life insurance, and flexible spending accounts on the last day of the month for which you have paid a premium or made a contribution through payroll deductions. 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 Your LOA

You must pay the full premium (the employee and employer portions) if you want to maintain your benefits while you are on a LOA. FCPS must receive a *Benefit Billing Election* form and payment no later than 30 days after the date that you have paid for your benefits via regular payroll deductions. The Office of Payroll Management, Insurance Accounting 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.

Medical and dental, flexible spending accounts, optional life insurance, long-term care insurance, and deferred compensation plans—require reenrollment. These benefits are reinstated if you submit your enrollment forms within 30 days of your return to work. If you do not submit your enrollment forms within 30 days of your return to work, you are not able to enroll

for optional benefits, including health, until the next open enrollment period. Call HR Client Services for enrollment forms or go to www.fcps.edu/DHR/employees/benefits.

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 as defined in *Regulation 4819*.
- 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. 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. Leave is not available for use until the pay period after it is accrued.

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.

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 3 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

Employees who work a 12-month schedule accrue annual leave beginning with 13 days per year in the first year of service. FCPS adds 1 additional day of leave for each year of service between the 1st and the 13th 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 11th 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 a leave-eligible position to one that does not accrue 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 nonworkdays 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

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.

Employee Assistance Program

The Employee Assistance Program (EAP) is available to all FCPS employees to help when you are experiencing personal problems that may or may not affect your job performance. You may self-refer, or your supervisor may refer you to the program.

EAP provides short-term confidential counseling and referral services to help with mental health, substance abuse, job stress, relationship issues, and other personal problems, and makes referrals to outside providers, community resources, and support groups.

For more information about EAP, call the Office of Equity & Compliance at 571-423-3050.

Glossary & Acronyms

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

Biweekly Paid Employee—Full- 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 FCPS County 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.

Compensable Claim—A Workers' Compensation claim for benefits that is covered under the Virginia Workers' Compensation Act.

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.

DMO—Dental Maintenance Organization—A dental group practice plan that generally has no deductibles and has low copayments for many services.

DPPO—Dental Preferred Provider Organization—A type of managed care dental plan that contracts with primary and specialty care dentists to provide comprehensive dental services. Dental providers exchange discounted services for an increased volume of patients and prompt payment. 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 provided by FCPS that offers assessment and referral for personal issues such as stress, family, relationship problems, substance abuse, grief, and life change adjustment.

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 full- and part-time 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 Kaiser physicians to prescribe for patients for particular medical conditions.

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 unpaid leave each year for births, adoptions, foster care placements, and illnesses of employees and their families.

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. Although coverage varies by individual HMOs, they generally have low copayments and no deductibles or lifetime maximums.

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 an illness or injury for an extended period of time that exceeds the FCPS STD period.

Minifamily—You and one dependent.

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 enroll in the FSA plans and health plans for the next calendar year.

Out-of-Network—Care 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 the deductible and the coinsurance amounts that you pay for health care. Copayments are not included in your out-of-pocket expenses.

POS—Point-of-Service—A type of managed care plan that contracts with employers, insurance companies, or other administrators to provide comprehensive medical service. Medical providers exchange discounted services for an increased volume of patients and prompt payment. A POS plan requires that a primary care physician (PCP) coordinates your medical care and provides referrals for specialty care.

PPO—Preferred Provider Organization—A type of managed care plan that contracts with employers, insurance companies, or other administrators to provide comprehensive medical service. Medical and dental providers exchange discounted services for an increased volume of patients and prompt payment. A PPO does not require a referral prior to receiving medical care or seeing a specialist.

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 provides 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.

Qualifying Event—Status Change—An event that changes your eligibility status or that of your dependents. These events include the birth or adoption of a child, marriage, divorce, death of a spouse or child, a change in the marital status of a dependent under the age of 26, a dependent turning age 26, or a spouse's or dependent's change in employment 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 34-day supply of a specialty medication is filled at a network pharmacy, the medication is covered through the Specialty Care Pharmacy managed by CuraScript.

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

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 a member of VRS Plan 2 if you were hired on or after July 1, 2010.

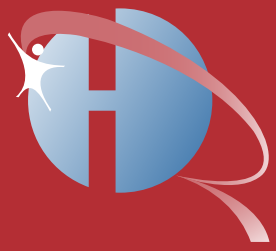
Workers' Compensation—A plan that is part of the IDM program designed to pay medical expenses, and, if necessary, replace lost wages if you sustain an injury or contract an illness determined to be compensable under the Worker's Compensation Act.

Notes

Fairfax County Public Schools
Jack D. Dale, Superintendent

Department of Human Resources
Kevin North, Assistant Superintendent

Office of Benefit Services
De Hawley Brown, Director



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