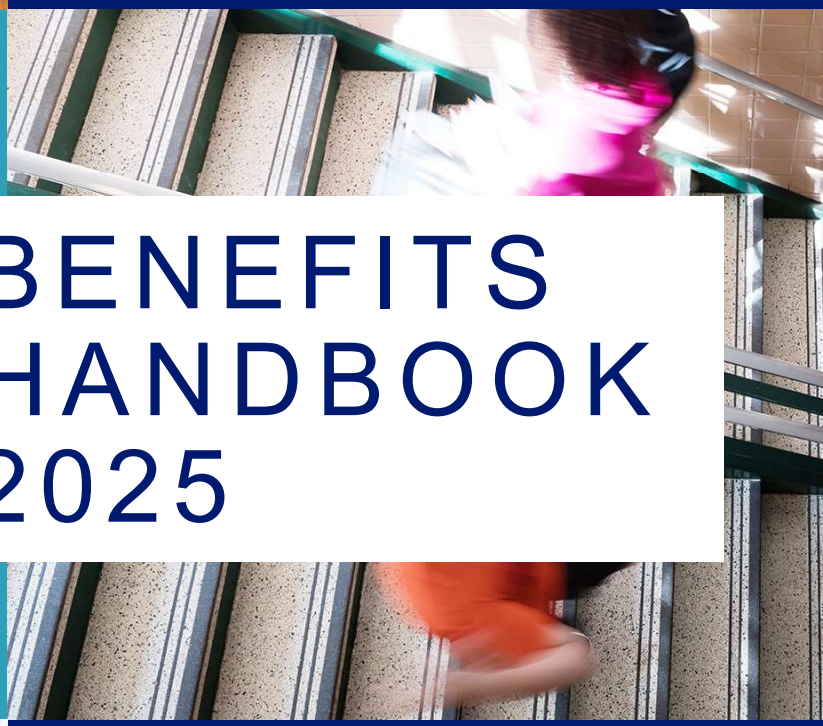

Employee BENEFITS HANDBOOK 2025

Fairfax County PUBLIC SCHOOLS
ENGAGE • INSPIRE • THRIVE

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HEALTH PLANS			
Aetna Dental (DPPO and DNO)	www.ih-aetna.com/fcps	**877-238-6200**	**8 am–6 pm (M-F)**
Cigna Open Access Plus (OAP)	www.cigna.com/fcps	**877-501-7992**	**Available 24/7**
Kaiser Permanente HMO	https://my.kp.org/fcps	**800-777-7902**	**7:30 am–9 pm (M-F)**
CVS Caremark (Prescription drug plan for Cigna OAP members)	www.info.caremark.com/fcps	**888-217-4161**	**Available 24/7**
EMPLOYEE ASSISTANCE PROGRAM			
Guidance Resources by ComPsych	www.guidanceresources.com	**855-355-9097**	**Available 24/7**
FLEXIBLE SPENDING ACCOUNTS			
Optum Bank	www.optumbank.com/FCPS	**844-875-5714**	**Available 24/7**
RETIREMENT PLANS			
Virginia Retirement System (VRS)	www.varetire.org	**888-827-3847 (VA-RETIR)**	**8:30 am–4 pm (M-F)**
Educational Employees' Supplementary Retirement System of Fairfax County (ERFC)	www.erfcpension.org	**703-426-3900 844-758-3793**	**8 am–4:30 pm (M-F)**
VOYA (Third-party administrator for the VRS Hybrid Defined Contribution Component)	https://www.fcps.edu/about-fcps/employees/benefits-payroll-salary/benefits/supplemental-retirement-savings-plans/vrs	**1-877-327-5261 1-VRS-DC-PLAN1**	**8:30 am–5 pm (M-F)**
Fairfax County Employees' Retirement System (FCERS)	www.fairfaxcounty.gov/retirement/schools	**703-279-8200 800-333-1633**	**8 am–4:30 pm (M-F)**
457(b) & 403(b) RETIREMENT SAVINGS PLANS			
EMPOWER Retirement (457b/403b Plan)	www.fcps.empower-retirement.com	**877-449-FCPS (3277)**	**9 am–8 pm (M-F)**
Corebridge Financial (403b Plan)	www.corebridgefinancial.com/rs/fcps	**800-445-7862**	**9 a.m. – 8 p.m. (M-F)**
LIFE INSURANCE			
VRS Members – Securian Financial	www.varetire.org	**1-800-441-2258**	**8:30 am–4 pm (M-F)**
FCERS Members – MetLife	www.fcps.edu, search "Life Insurance"	**866-492-6983**	**8 am–11 pm (M-F)**
LEAVE PROGRAMS			
Sedgwick—Short-Term Disability and Workers' Compensation	www.sedgwick.com/FCPS	**855-937-1387**	**8 am–8 pm (M-F)**
MetLife—Long-Term Disability	www.metlife.com/mybenefits	**888-444-1406**	**8 am–11 pm (M-F)**
Virginia Workers' Compensation Commission (VWCC)	**1000 DMV Drive Richmond, VA 23220**	**877-664-2566 804-367-9740 (Fax)**	**8:30 am–4:45 pm (M-F)**
FCPS RESOURCES			
Human Resources (HR) Client Services	FCPS StaffConnect	**571-423-3000 800-831-4331**	**8 am–4:30 pm (M-F)**
Office of Benefit Services:	FCPS StaffConnect	**571-423-3200, then**	**8 am–4:30 pm (M-F)**
• **Employee Insurance and Financial Programs**		• **option 3**	
• **Disability & Leaves**		• **option 1**	
• **Workers' Compensation**		• **option 2**	
Employee Assistance Program	EAPQuestions@fcps.edu	**N/A**	**8 am–4:30 pm (M-F)**
Employee Wellness	EmployeeWellness@fcps.edu	**N/A**	**8 am–4:30 pm (M-F)**

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

Request for Accommodations: If you require an accommodation based on a qualified disability, please contact the Office of Equity & Employee Relations at least seven business days in advance of the event. Equity & Employee Relations is at 571-423-3070. Cancellation of sign language interpreters must be made at least three (3) days prior to the event.

Eligibility and Enrollment

The 30-Day* Rule

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

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

The requested change must be consistent with the event.

If You Are a New Employee

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

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

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

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

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

If You Are a Current Employee

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

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

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

**Temporary/hourly employees who meet the Affordable Care Act (ACA) definition of full-time employee (30+ hours per week) are also eligible for health benefits.

Dependent Eligibility Definitions & Required Documentation for FCPS Health Plan Coverage

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

Dependents	Eligibility Definition	Documentation Required
Spouse	A person to whom you are legally married	Photocopy of the first page of the employee and spouse's IRS Form-1040 for the most recent tax year that includes both the employee and spouse's information, which must be "Married filing jointly" or "Married filing separately" (you may remove all financial information). A photocopy of IRS Form-4868 can be submitted in lieu of the Form-1040 if both employee and spouse are listed. *Note: Not required if married in same year as being added to plan **-AND-** Photocopy of government issued marriage certificate
Adopted Child*	An adopted son or daughter of the employee or a child placed for adoption	Photocopy of a Final Adoption Decree or an Interlocutory Decree of Adoption with the presiding judge's signature and seal; **-OR-** Photocopy of the child's birth certificate showing the employee as the adopting parent.
Biological Child/ Stepchild*	A biological son or daughter of the employee	Photocopy of birth certificate showing the employee or spouse's name as mother or father; If adding a stepchild, must also provide a photocopy of the employee and spouse's marriagecertificate and a copy of your most recent federal tax return documenting marital status.
Child under Legal Guardianship*	A child for whom the employee has been appointed legal guardian	Photocopy of the final court order, with the presiding judge's signature and seal, affirming the employee as the child's legal guardian.
Child under Legal Custody*	A child for whom the employee has been granted legal custody	Photocopy of the court order of custody with the presiding judge's signature and date, affirming the child's placement in legal custody of the named employee.
Foster Child*	Certain eligible foster children	Photocopy of the certified foster care documents with the name of the child and the name of the employee.
Disabled Child	Age 26 or older, who is wholly dependent on the employee for support and maintenance due to a disability that occurred prior to age 26 and who has been certified as disabled by the health/ dental plan. No disability certification is required for a child under age 26.	Photocopy of birth certificate showing employee's name as mother or father **-AND-** You must also complete the health/dental plan's disability certification form, available from the FCPS website. Search on keywords "benefits forms".

*Children must be under age 26, unless disabled.

Examples of ineligible individuals include: former spouse; former spouse's child not biologically related to you (exceptions may apply with applicable court orders); child age 26 or older unless they are disabled and dependent on you for support as defined above. **If the source document is not in English, you must have the document translated prior to supplying it to the Office of Benefits Services.** Document copies can typically be obtained in the locality where the birth or marriage occurred, or via these websites. Fees will likely apply. www.vitalchek.com or www.vitalrec.com; www.irs.gov/taxtopics/tc156.html (for copy of tax return).

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

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

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

- Marriage: Within 30 calendar days of the date of marriage, you must:
  - request to add your spouse to your coverage, or
  - request to cancel your coverage (in order to be added by your new spouse to their coverage)
- Divorce: Within 60 calendar days of the date of divorce, you must:
  - file the necessary forms to remove your former spouse from your coverage
- You may not drop coverage for a spouse if you are legally separated; however, you must drop your former spouse and any ineligible stepchildren upon your divorce.
- Birth or adoption: If you notify the Office of Benefit Services within **30 calendar days,** your child's medical benefits become effective on the date of birth, date of adoption (or date placed for adoption). As an adoptive parent, you do not have to wait until the adoption is final to add your child to your health plan.
- Becoming the legal guardian of a child.
- A court order requiring you to cover a child or an order requiring someone else to cover your dependent.
- Death of a spouse or child.
- Spouse's or other dependent's change in employment status that affects their eligibility for medical and/or dental benefits (or their employer's open enrollment).
- Beginning or returning from an unpaid leave of absence.
- Loss of health coverage.
- Significant increase or reduction in hours.
- Dependent reaching age 26.
- A significant cost change, coverage curtailment, improvement, new option, or a change in coverage under your spouse's or dependent's plan.
- A move that causes loss of eligibility to participate in your HMO plan.
- Entitlement to or loss of Medicare or Medicaid.

Required documentation may include:

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

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

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

How to Change Your Coverage

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

It is your responsibility to inform the Office of Benefit Services about a status change by completing an enrollment and change form, which is available under the Benefit Forms section of the FCPS website or by calling Human Resources (HR) Client Services. You must also provide the required documentation to request the change in coverage. If you fail to notify the Office of Benefit Services within the **30 calendar day*** period, you may not enroll, cancel, or change coverage until the next Open Enrollment. Changes made to your coverage during Open Enrollment become effective January 1 of the following calendar year.

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

Adding or Removing a Family Member/30-day deadline

- If you marry, you may change your enrollment from Individual to Employee + 1 or Family. You may also cancel coverage if you are being added to your new spouse's coverage.
- If you divorce, you must remove your former spouse from your coverage. Once you are divorced, your former spouse no longer qualifies for FCPS health insurance, unless qualifies for, and elects COBRA continuation coverage.

  You may also enroll in coverage if you are losing coverage under your ex-spouse. Please note that separation is not a legal event in Virginia, and you cannot drop or add your spouse due to a separation.
- If you have a baby, adopt a baby, or gain legal guardianship of a child, you can add the new dependent and change your level of coverage.
- If you have a baby, you may enroll in the Dependent Day Care Flexible Spending Account (FSA) plan.
- If your child turns age 26, they are no longer eligible for FCPS coverage as a dependent. Coverage ends at the end of the month in which they turn age 26, unless certified as disabled by your health/dental plan.

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

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

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

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

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

Qualifying Event Examples:

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

2. You have a baby on March 17 (the life event), and you add your baby to your health plan on April 1 (within 30 days). Because this is a HIPAA special enrollment event, you are also eligible to add your spouse and/or other eligible dependent children within 30 days of the date of birth (the qualifying event).
   - Coverage for your newborn takes effect on the date of birth (March 17).
   - Coverage for your spouse/other eligible dependents takes effect on the 1st day of the month following the qualifying event (April 1).

3. If adding the baby to your plan results in a change in tier (i.e., you are converting Individual to Employee + 1, or Employee + 1 to Family coverage), your premiums will change effective March 1. If you are also adding a spouse and/or other dependent children to your health plan due to the birth of a child, their coverage, and any change in premiums will take effect on April 1 if your enrollment shifts from from Employee + 1 to Family.

4. A baby is placed with you for adoption on October 24, and you add your baby to your health plan on October 30. Your baby's coverage takes effect October 24. If you are converting to Employee + 1 or Family coverage, your premiums will change effective October 1.

Employment Changes - 30 calendar-day deadline

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

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

Requesting an Appeal

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

Coordination of Benefits

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

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

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

If you are married, and both you and your spouse cover your dependent children, the plan that covers the parent whose birthday falls first in the calendar year is usually primary for any dependent children. Other factors that can change which plan pays first include eligibility for Medicare, court decrees or custody arrangements, the length of time you are covered, and whether you are an employee or retiree. See your plan's Summary Plan Document for more details.

Preexisting Conditions

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

Public Law 110-173 requires FCPS' health plans to report participant's Social Security Numbers (SSNs) in order to coordinate benefits with Medicare or other insurance benefits. All participants (employees and dependents) age 45 or older must provide SSNs in order for FCPS health plans to meet the requirements of this law. All participants who are receiving kidney dialysis or have received a kidney transplant, as well as all participants under age 45 who have Medicare, are also required to report SSNs.

Medical Plans

FCPS offers employees a choice between two medical plans, which include prescription and vision benefits: Cigna Open Access Plus (OAP) & Kaiser Permanente.

Cigna Open Access Plus (OAP)

The Cigna Open Access Plus plan provides an extensive national network of physicians, hospitals, and ancillary health care providers.

Plan Highlights

- You do not have to choose a Primary Care Provider (PCP).
- You are not required to obtain referrals to specialists.
- In-network preventive care is covered at 100% for checkups, screenings, vaccines, prenatal care, and more.
- Employees covering one or more dependents, all eligible expenses from any covered family member contribute to the Family Deductible of $800.
- Employees enrolled with individual coverage, all eligible expenses will contribute to the Individual deductible of $400.
- You pay a copayment or coinsurance for in-network covered office visits..
- Most in-network services are covered at 90% of the plan allowance. The remaining 10% is the coinsurance amount you pay.
- Most out-of network services are covered at 70% of the plan's allowed charges, except for mental health and emergency services.
- Family-building benefits provided through WINFertility.
- Vision benefits are provided through Cigna Vision, using the EyeMed vision network.

To find network providers and review both the Summary of Benefits and Coverage and the Summary Plan Booklet, visit the Cigna website.

CVS Caremark provides prescription drug benefits for Cigna Open Access Plus members (See page 9 for details.)

Kaiser Permanente

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

Plan Highlights

- This plan provides a wide range of integrated preventive care and health assessments, including outpatient services, laboratory, radiology, pharmacy, and health education, to its members.
- All services must be provided by Kaiser Permanente physicians, unless referred by Kaiser to an external provider.
- You pay a copayment for most in-network office visits.
- You **must have a referral** from your primary care physician to see a specialist.
- Preventive care is covered at 100% for checkups, screenings, vaccines, prenatal care and more when provided in-network.
- You may receive care at any Kaiser medical facility in the local area. Some Kaiser facilities include urgent care centers for non-life-threatening after-hours emergencies.
- Care and services not directly managed by Kaiser Permanente are not covered, except for out-of-area emergencies.
- Prescription drugs may be obtained at a Kaiser Permanente medical center.
- Participants are eligible for a 25% discount on frames and lenses, and a 15% discount on contact lenses when obtained at a Kaiser Permanente optical facility. This discount is in addition to the annual $150 vision benefit allowance.

To review the Summary of Benefits and Coverage and the Evidence of Coverage visit the Kaiser Permanente website.

Pharmacy Benefits Program for Cigna Members

Your prescription drug plan, administered by CVS Caremark, provides access to a network of more than 68,000 retail pharmacies and home delivery.

Your Coinsurance or Copayments 1, 2

The amount you pay for your covered medications depends on the type of medication (generic, brand, or specialty) and where you fill your prescription.

	Where your Prescription is Filled:	
Acute and Maintenance Medications	**CVS Retail Pharmacy (or Affiliated Pharmacy) Location or Mail Order through CVS Caremark**	**Participating Non-CVS Retail Pharmacy Location**
Up to a 30-day supply	Generic: $10 Brand Name 20% of cost of drug (maximum $75)	
31 to 60-day supply	Generic: $14 Brand Name: 20% of cost of drug; (maximum $150)	
61 to 83-day supply	Generic: $21 Brand Name: 20% of cost of drug (maximum $225)	
84 to 90-day supply	Generic: $14 Brand Name: 20% of cost of drug (max. $150)	Generic: $21 Brand Name: 20% of cost of drug (max. $225)
Specialty Medications	**CVS Specialty Pharmacy**	
Up to a 30-day supply	Generic: $7 Brand Name: 20% of cost of drug (maximum $75) *Note: Specialty medicines must be filled through CVS Specialty Pharmacy after the initial fill at a participating retail pharmacy.*	

[1] *Effective January 1, 2021, the maximum copay per 30-day supply of insulin is $50. $0 copay applies to diabetic test strips and lancets*
[2] *If the cost of the medicine is less than the minimum copayment, you will pay the lower amount.*

Coverage details can be found in Your Pharmacy Benefits Handbook available on the CVS

Pharmacy Benefits Program for Kaiser Permanente Members

You can obtain prescription medications at a Kaiser Permanente medical center, a participating community network pharmacy, or through mail order.

Your Copayments [1, 2]

The amount you pay for your covered medications depends on the type of medication (generic, brand, or specialty) and where you fill your prescription.

Where your Prescription is Filled:	Your Copay:	
Mail Order	**Up to a 90-day Supply**	
	Generic: $10 copay Brand formulary: $20 copay Brand non-formulary: $35 copay	
Kaiser Permanente Medical Center Pharmacy	**Up to a 60-day Supply**	**Up to a 90-day Supply**
	Generic: $10 copay Brand formulary: $20 copay Brand non-formulary: $35 copay	Generic: $15 copay Brand formulary: $30 copay Brand non-formulary: $52.50 copay
Participating Community Network Pharmacy	**Up to a 60-day Supply**	**Up to a 90-day Supply**
	Generic: $30 copay Brand formulary: $50 copay Brand non-formulary: $75 copay	Generic: $45 copay Brand formulary: $75 copay Brand non-formulary: $112.50 copay

[1] *Effective January 1, 2021, the maximum copay per 30-day supply of insulin is $50.*
[2] *If the cost of the medicine is less than the minimum copayment, you will pay the lower amount.*

Details about your coverage can be found on the Kaiser Permanente website or by calling Kaiser Permanente toll-free at 1-800-777-7902.

Dental Plans

FCPS offers you a choice of two Aetna dental plans:

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

You can elect dental benefits separately from medical benefits.

Aetna Dental Preferred Provider Organization (DPPO)

Plan Highlights

- Coverage includes preventive care, basic care, and major services. **You do not have to choose a primary care dentist.**
- This plan has a wide choice of in-network dentists.
- You can receive care from either an in-network or out-of-network dentist. You pay more when you receive care from out-of-network providers.
- You pay coinsurance based on an allowable charge. Network dentists must accept the Aetna negotiated fees and are not allowed to charge more.
- Certain orthodontic procedures are covered for treatment that begins prior to a child turning age 20.
- The plan pays 50 percent of the cost of orthodontia if you are obtaining treatment from an in-network dentist and 40 percent of the cost if you are using an out-of-network dentist up to a lifetime maximum.

Questions?

Call Aetna Dental Customer Service at 877-238-6200 to get your basic dental questions answered!

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

Aetna Dental Network Only (DNO)

Plan Highlights

- When you enroll you must select a primary care dentist who will perform all your dental care, unless that dentist refers you to a specialist. You may change your primary care dentist at any time and must call by the 15th of the month for the change to be effective the 1st of the following month.
- The Aetna DNO plan is a lower cost plan that has a more limited network of providers. Before enrolling, call your dentist to ensure that they are in the network.
- You may only use dentists who are part of the Aetna DNO network; **out-of-network providers are not covered under this plan.**
- Most preventive dental services are covered at 100 percent. Other dental services will require you to pay a copayment per service.
- There are no deductibles and no dollar annual maximums, although limitations may apply to certain procedures.
- If you are moving and want to check for a DNO network in your new area, call Aetna customer service.
- Orthodontia is covered regardless of age. Services must be provided by a DNO-covered provider.

Find a network provider for the Aetna DPPO and DNO plans on the Aetna Dental website. Details about your coverage can be found in the Aetna Dental Summary Plan Document, which is also posted on the Aetna website.

Pretreatment Authorization Under the DPPO or DNO

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

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

Discounts on Other Services

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

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

Simply show your Aetna Dental ID card to participating professionals and retailers. Additional information about discounts and participating vendors can be found on the Aetna Dental website.

Dental Plan Comparison Chart

	DPPO: In-Network	**DPPO:** Out-of-Network***	**DNO:** In-Network
Deductible	None	$ 50 individual $ 150 family	None
Orthodontic Deductible	None	$ 50	None
Preventive and Diagnostic	Covered in full	10%	Covered in full (preventive); Varies by service (diagnostic)
Basic Restorative	20%	30%	Varies by service (see benefit summary)
Major Restorative	50%	60%	Varies by service (see benefit summary)
Orthodontia	50%**	60%**	$ 2,300†
Annual Maximum‡ (not including orthodontia)	$ 2,000	$ 1,500	None
Orthodontia Lifetime‡ Maximum*	$ 1,500	$ 1,000	n/a

*Orthodontic benefits limited to one treatment plan. Patient responsible for amounts above orthodontia lifetime maximum.
**Dependent children under age 20 only.
***In addition to coinsurance, you pay any amount in excess of usual, customary, and reasonable fees.
†Amount includes orthodontia treatment, screening exam, diagnostic records and retainer
‡Limits are combined across in- and out-of-network for DPPO only.

Employee Wellness

The Employee Wellness Program inspires, educates, empowers, and energizes FCPS employees to lead healthier lifestyles, fostering work/life balance and productivity. In addition to partnerships with healthcare vendors, FCPS staff have unlimited access to wellness programs and initiatives that promote emotional, social, and physical health, as well as work-life balance.

Visit the Employee Wellness webpage for information and resources on wellness topics and current wellness programming.

Wellness Initiatives

Flu Clinics

In partnership with INOVA Well, FCPS offers the Flu Clinic Program from late August through early to mid-November each year. It provides FREE flu immunizations to all FCPS employees, including full-time, part-time, hourly, and substitutes. Flu clinics are held at worksites across FCPS. Visit us on the Hub to stay updated about wellness programming and upcoming events.

Health Screenings

In partnership with Kaiser Permanente (KP), FCPS offers Biometric Health Screenings. These screenings are held at worksites across FCPS throughout the school year. Health screenings are FREE to all FCPS staff, including full-time, part-time, hourly, and substitutes. Visit us on the Hub to stay updated about wellness programming and upcoming events.

Virtual Wellness Challenges

Employee Wellness offers online challenges twice a year for all FCPS employees, designed to reduce health risks and encourage a healthy lifestyle. Employees can participate individually or form teams within their site. During the challenge, participants set wellness goals and track their healthy habits. Weekly random prize drawings provide opportunities to win health-related prizes.

Employee Wellness Incentives

Employees enrolled in an FCPS health plan (the primary cardholder) may earn up to a $100 gift card reward by completing their annual physical andlaboratory screenings. The program runs through December 31.

- Cigna Members: http://cigna.com/fcps
- Kaiser Members: http://my.kp.org/fcps

Employee Wellness Support

Employee Wellness provides a variety of presentations, workshops, and webinars designed for both small and large groups upon request. Sites can select from a broad range of wellness and health topics, including work-life balance, stress management, fitness, nutrition, and more. In addition, we offer Wellness Connection Tables, where employees can interact directly with wellness resources and experts.

Gatehouse Fitness Center

FCPS employees age 18 and older can access the Gatehouse Administration Center fitness facility for free. Employees must complete the participation agreement form found on the Gatehouse Administration Center webpage under "Building Amenities".

Participants of our health insurance vendors can also take advantage of gym and fitness discounts through their health insurance plan's wellness programs. Visit your health provider's microsite for more details:

- Cigna Open Access Plus
- Kaiser Permanente Signature HMO

Wellbeats

Wellbeats is your on-demand fitness and well-being benefit, FREE to benefit-eligible employees. It offers over 1,400 classes led by certified instructors, covering workouts, nutrition, cooking, and mindfulness classes for all ages and skill levels. Highlighted features include *Kids in the Classroom, Launch My Health Programs*, and the ability to invite up to five Friends and Family to join. Wellbeats was designed to inspire you to stay healthy and feel your best!

How to Access Wellbeats:

If you are new to Wellbeats or have forgotten your login information, follow these simple steps:

- Visit Wellbeats Portal at
- Log in using your FCPS email address.
- Click "Next," then select "Forgot My Password."
- Wellbeats will email you a code to reset your password.

For any account issues, please email support@wellbeats.com.

Lactation Support Program

In conjunction with Section 4207 of the Patient Protection and Affordable Care Act (also known as the Health Care Reform), Fairfax County Public Schools (FCPS) provides a supportive environment to enable lactating employees "reasonable break times" and private, non-restroom locations to express their milk during the workday for the first year of the child's life. FCPS also subscribes to the Code of Virginia 22.1-79.6, which applies to any mother who is employed by the local school board or enrolled as a student.

Employees must submit a Lactation Request Form to their program manager at least 30 days in advance of their return to work from maternity leave for approval. For more information, visit the Hub and search the keyword "lactation".

Disease Management

Disease management programs help employees with chronic conditions manage their health and reduce complications by coordinating high-quality care. These programs do not replace your doctor's advice. Since chronic conditions are a major driver of healthcare costs for FCPS, participating can also help save money for both you and the plan.

Here are some examples of chronic conditions that may be identified to participate in a disease management program:

- Cardiovascular disease
- Diabetes
- Osteoporosis
- Arthritis
- Multiple sclerosis
- Lupus
- Asthma
- Crohn's disease

You may be identified to participate through a physician referral, medical claims, or your annual health assessment. If eligible, a registered nurse or healthcare professional will contact you to offer personalized support by phone or through online health coaching. You can decide how often you want to engage with the program, and there is no cost to you.

Participation is confidential and managed solely by your insurance plan. FCPS does not receive any identifiable health information, in compliance with privacy laws. We encourage you to take advantage of these resources for your health.

Employee Assistance Program

The Employee Assistance Program (EAP), in partnership with Guidance Resources, is a free benefit available to all FCPS employees and their household members. Designed to support a healthy work-life balance, the EAP provides 24/7 access to resources, information, and support for navigating life's challenges. EAP Services include:

- **Confidential Counseling:** (up to 6 sessions per school year)
- Work and lifestyle support.
- Legal and financial guidance
- Digital support and self-care tools via the KOA Care 360 platform
- Free online will preparation

To get started, call the FCPS dedicated line at 855-355-9097 or register for a login account at www.guidanceresources.com (Enter Web ID: FCPS).

For more information, visit the Hub, and search keywords "EAP".

Contact Your EAP

There are three ways to access your GuidanceResources benefits:

- Call 1-855-355-9097 to speak with a Guidance Consultant who will assist you in identifying the right resource to meet your needs.
- Visit Guidance Resources Online (GRO), register with organization ID: FCPS, create your own personal username and password and explore all GRO has to offer.
- Download the *GuidanceNow* app on your smartphone or tablet from your preferred app store and enjoy the convenience of Guidance Resources on the go.

Flexible Spending Accounts

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

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

1. You determine how much you want to contribute into one or both accounts ($250-$3,300 for the Health Care FSA and $250-$5,000 for the Dependent Day Care FSA).
2. The amount you designate is taken out of your paycheck pre-tax and placed in the FSA account(s).
    - For monthly-paid employees, deductions are taken 10 months of the year (Jan. - June and Sept.- Dec.).
    - For biweekly-paid employees, deductions are taken over 20 pay periods. No deductions are taken in July and August.
3. You use that money to reimburse yourself for eligible out-of-pocket expenses.

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

Eligibility and Enrollment

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

Accessing Your FSA Funds

Optum Bank, the FSA plan administrator for FCPS, will send participants two Optum Bank debit Mastercards® once your enrollment is processed. You can also submit your claim by mailing a paper claim, submitting a claim through your account via the Optum Bank website or the mobile app.

Health Care FSA participants will have immediate access to their annual election amount to pay for eligible expenses. Dependent Day Care FSA participants may only access funds if the money has already been deducted and put into their FSA account.

Using Your Debit Card

The Optum Bank debit Mastercard® is a convenient way to pay for eligible expenses. You can use it at the pharmacy, pay for copays at the doctor's office, or write your card number on your provider bill. (The provider or merchant must accept Mastercard® payments.) When you use your debit card to pay for eligible health care expenses, the amount of the payment is deducted from your FSA account balance.

Dependent Daycare FSA participants can also use their debit card for eligible daycare expenses. You may pay for eligible daycare expenses if the money has already been deducted from your pay. Your provider must accept MasterCard®. In order for the debit card transaction to be approved when your provider swipes your card or runs it through the payment processing system, your provider must have a Merchant Category (MCC) code. Many of the larger day care providers have an MCC code, but smaller day care providers and in-home providers will not have a code. If your provider does not have an MCC code, you will need to pay the provider first and then file a claim for reimbursement.

Be sure to keep your receipts as you may need to substantiate a debit card transaction or provide proof of eligible expenses for the IRS.

Health Care FSA

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

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

Eligible expenses include:

- Sunscreen if over SPF 15 and labeled "Broad Spectrum"
- Copayments for covered expenses
- Prescription drugs or prescription drug copays
- Deductibles
- Contact lenses and eyeglasses
- Braces
- Out-of-pocket expenses paid to doctors, dentists, surgeons, chiropractors, osteopaths, psychiatrists, psychologists, and Christian Science practitioners
- Out-of-pocket expenses for hospital services, nursing services, laboratory fees, and radiology services
- Acupuncture treatments
- Inpatient treatment at a center for alcohol or drug addiction
- Smoking-cessation programs and prescribed drugs to help nicotine withdrawal
- Dentures, hearing aids, crutches, wheelchairs, and guide dogs for the blind or deaf
- Some over the counter medications such as cold medicines, band-aids, as well as feminine hygiene products
- Fees in excess of reasonable and customary amounts allowed by your insurance

Ineligible expenses include:

- Health plan premiums, including COBRA premiums
- Long-term care premiums
- Health club dues
- Physical treatments unrelated to a specific health problem and prescribed by your physician, such as massage
- Cosmetic surgery or cosmetic dental procedures
- Prescription drugs for cosmetic purposes
- Dietary supplements and vitamins
- Cosmetics
- Sunblock under 15 SPF
- Toiletries (e.g., toothpaste, lotions)

A comprehensive list can be found on the Optum website www.optumbank.com/fcps. For a more complete listing of eligible medical expenses, please refer to *IRS Publication 502*.

Contribution Amounts

To determine how much to contribute, make a list of the expected out-of-pocket medical expenses for you and your dependents for the upcoming calendar year. For example, if you always exceed your deductible, include the deductible amount in your calculation. You can set aside between $250 and $3,300 each year.

Dependent Day Care FSA

This FSA is designed to help you pay for eligible day care expenses for your child(ren) and other qualifying family members while you and your spouse (if married) are working. It is not designed to reimburse for the health care expenses of your dependent.

Qualifying Dependents

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

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

See *IRS Publication 503* for more information on qualifying dependents.

Examples of eligible expenses include:

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

Eligible day care providers include:

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

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

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

Contribution Amounts

To determine how much to contribute, consider how much you paid in day care expenses last year and any increases or changes for the upcoming year. The minimum annual election amount is $250. Each year, you can set aside up to:

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

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

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

$660 Annual Carryover

Participants in the Health Care FSA are able to carryover $660 in unused funds from 2025 to 2026. The carryover provision applies to participants even if they do not elect to participate in the FSA program the following year. The carryover funds are not available to the participant until after the claims filing deadline of March 31 each year. Per federal guidelines, this carryover provision option is not available for the Dependent Daycare FSA.

> Example:
> Employee elects $1,200 for the Health Care FSA for the 2025 plan year but only uses $400. Employee will carryover $660 from the 2025 plan year to 2026. Participant will forfeit $140 for the 2025 plan year.

Claims Submission Deadlines

Your FSA funds are subject to use-or-lose rules. Be conservative when calculating how much money to contribute for the year because any money left over in your FSA account, over the $640 carryover provision for the Health Care FSA, will be forfeited and, by law, cannot be returned to you. For all employees and former employees: The filing deadline for FSA claims incurred in the current plan year will be March 31 following the plan year.

> Example:
> The claims filing deadline for the 2024 plan year is March 31, 2025.

Questions About FSAs?

For enrollment/claims questions:

Optum Bank
11000 Optum Circle,
Eden Prairie, MN 55344
844-875-5714, available 24/7
Fax: 1-855-244-5016
www.optumbank.com/FCPS

Preparing for Retirement

Health Care Benefits

At the end of your career, FCPS provides eligible retirees a valuable benefit in the ability to retain health coverage at retirement. Your ability to retain coverage can vary based on your date of employment or retirement.

Following your last day of employment, your health coverage will continue:

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

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

Eligibility to Retain Health Benefits

In order to retain FCPS health coverage as a retiree, you must meet all the following eligibility requirements:

- **Retired from FCPS employment:** In order to retain benefits, you must meet the definition of "retiree". Generally, this means upon transition from active status, you immediately began drawing a pension check from one of the FCPS sponsored pension plans.
- **Covered at Time of Retirement:** You must be enrolled in the line(s) of coverage (i.e., medical and/or dental) you wish to continue into retirement.

  For example, if you are retiring on July 1, 2025, and wish to maintain both medical and dental benefits into retirement, you must be covered under both the FCPS medical and dental plan on June 30, 2025.

  If you are covered only under the medical plan, you are not eligible to retain dental coverage.
- **Meet Enrollment or Tenure Requirement:** Your enrollment or tenure requirement is based on your date of hire or date of retirement as shown below.

Date of Hire/ Retirement	Enrollment or Tenure Requirement
Actively employed as of 12/31/18	Covered under the FCPS medical and/or dental plans for 60 or more continuous months at the time of retirement **-or-** Employed with FCPS for 15 or more years in a benefits-eligible position at the time of retirement
Hired on or after 1/1/19	Employed with FCPS for 15 or more years in a benefits-eligible position at the time of retirement

- **Elect Medicare Parts A and B when first eligible.** For most retirees, eligibility occurs at age 65, but may occur earlier due to disability. This requirement applies to all individuals who will be covered under the FCPS medical plans. Medicare eligibility must be maintained to remain covered under the FCPS plans. View the Becoming Eligible for Medicare webpage for more information.

If you would like more information regarding retiree health eligibility, review the Health Care Benefits in Retirement webpage.

Preparing for Retirement

Cancelling or Re-entering the FCPS Plan During Retirement

Employees who are eligible to retain coverage as a retiree may choose to drop coverage and re-enter the plan at a later date, provided all of the following criteria are met. **Retirees have only one re-entry right to the plan.**

In order to re-enter the FCPS plan, you must:

- **Meet the *Eligibility to Retain Health Benefits*** requirements are described on page 19, and
- **Be eligible and enrolled with Medicare.** If you will be covering dependents, all dependents must also be eligible and enrolled with Medicare.
- **Provide proof of comparable coverage** for the preceding 12 consecutive months.
  - If you are newly eligible for Medicare, you must have been enrolled in a plan that provides hospitalization, major medical, and pharmacy benefits.
  - If you are eligible for Medicare, you must have been enrolled in Medicare Parts A, B, and D.
- **Apply for coverage timely.** You must apply for coverage within 30 calendar days of a qualifying event or during Open Enrollment.

Still have questions?

For more information about maintaining your benefits in retirement, please refer to the Retiree Benefits Handbook (www.fcps.edu, search keywords "Retiree publications").

Life Insurance

Life Insurance for VRS Members

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

Basic Group Life Insurance

- You are automatically enrolled for coverage of 2 times your annual salary (rounded to the next highest thousand).
- You and FCPS share the cost for basic life insurance. You pay approximately $0.36 per thousand dollars of coverage for basic life insurance.

Optional Group Life Insurance

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

- Yourself of up to 8 times your salary (rounded to the next higher $1,000), up to a maximum of $800,000*
- Spousal coverage for half of the amount of your coverage, up to a maximum of $400,000*
- Coverage for 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 covered individual's age and the amount of coverage. Age-related premium rate changes occur once a year on July 1.

Evidence of insurability is required if applying for optional coverage in excess of $400,000*, or spousal coverage above option 1.

You pay all costs for optional life insurance.

Enrollment

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

Coverage Period

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

Accidental Death & Dismemberment (AD&D) Benefits

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

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

How to Apply

To apply for optional life insurance as a VRS member, you can apply online through your myVRS account. For benefit and coverage questions, contact Securian's Richmond branch office at 1-800-441-2258 or send an email to RBO@securian.com.

Life Insurance for FCERS Members

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

Basic Group Life Insurance

- You automatically are covered for 1 times your annual salary, rounded to the next higher $1,000.*
- FCPS pays the full cost for this coverage as long as you are actively at work.
- You may continue coverage while you are on leave-without-pay or long-term disability, but you will be responsible for the full premium.
- Maximum coverage: $250,000
- Age reductions apply.

*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 15 days until the last day of the month in which the child reaches age 21, or age 25 if a full-time student in an accredited educational institution). 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:
  - Option 1: Spouse $5,000; Child(ren) $2,000*.
  - Option 2: Spouse $10,000; Child(ren) $5,000*.

*If your spouse or child is eligible for employee coverage, they cannot be covered as a dependent. A child may be covered by one parent.

Maximum coverage: $250,000

- Age reductions apply: beginning at age 65, coverage reduces to a percentage of the amount in effect prior to age 65; to 65% at age 65; and to 50% at age 70.

You pay all costs for optional and dependent life insurance.

How to Apply

To apply for optional and/or spouse/dependent life, you can apply online through your MetLife account. Under employer name, search for "Fairfax County Public Schools", then log in to your account. If you are a new user, you will need to click "Register" to create your account. If you have any questions, contact MetLIfe at 1-866-492-6983 (Mon. – Fri., 8am-11pm).

Accidental Death & Dismemberment Benefits (AD&D)

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

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

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

Elections made outside this period and elections exceeding these amounts require Evidence of Insurability (EOI). Applicants previously declined coverage must also provide EOI.

Your FCPS-Sponsored Retirement Plans

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

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

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

Full-time educational, administrative, and certain operational employees

Virginia Retirement System (VRS)

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

- **Employees hired before July 1, 2010 and vested as of January 1, 2013, are covered under VRS Plan 1.** Plan 1 members are eligible for normal (unreduced) retirement benefits at age 50 with 30 years of service, or at age 65 with 5 years of service. For more details about Plan 1, visit the VRS website.
- **Employees hired on or after July 1, 2010 (or your VRS membership date is before July 1, 2010, and you were not vested as of January 1, 2013) are covered under VRS Plan 2.** Plan 2 members are eligible for normal (unreduced) retirement benefits at normal Social Security retirement age with at least five years of creditable service, or when the combination of the employee's age and years of creditable service total 90 or more. For more details about Plan 2, visit the VRS website.
- **Employees hired on or after January 1, 2014, with no previous VRS service credit, are covered under the VRS Hybrid Retirement Plan.** A hybrid retirement plan combines the features of a defined *benefit* plan and a defined *contribution* plan. While the defined benefit portion of the plan provides for a *traditional* pension benefit, the defined contribution portion of the plan provides benefits based on your contributions, employer matching contributions and investment earnings. You contribute a mandatory 1% of creditable compensation each month, and FCPS contributes a mandatory 1% match.

  You have the additional opportunity to contribute to the Hybrid 457 Deferred Compensation Plan - even if you are already saving under the FCPS 403(b) Plan or the FCPS 457(b) Plan. Increasing your voluntary contributions not only provides you with additional financial security at retirement, it also allows you to receive partial matching contributions from FCPS to the defined contribution component of your account.

  The first 1% of voluntary contributions will be matched with a 1% contribution by FCPS. Each additional 0.5% increase by the member (up to a maximum of 4%) will be matched by FCPS with a 0.25% contribution (up to a maximum of 2.5%). You may select from a variety of available investment options and can change (increase, decrease, or stop) your voluntary contributions each month.

Below is the schedule of matching contributions:

Voluntary Contribution Matching Schedule	Your Voluntary Contribution	FCPS Match
	0.00%	0.00%
	0.50%	0.50%
	1.00%	1.00%
	1.50%	1.25%
	2.00%	1.50%
	2.50%	1.75%
	3.00%	2.00%
	3.50%	2.25%
	4.00%	2.50%

Effective January 1, 2025, Voya is the Hybrid 457 third-party administrator for VRS. For questions about the defined contribution component of your account you can contact Voya at 1-VRS-DC-Plan1 (1-877-327-5261) and ask to speak with an Investor Services Representative.

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

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

Vested Contributions

Members are always 100% vested in their own contributions.

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

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

For More Information

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

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

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

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

Starting July 1, 2024, if you are an ERFC Legacy member who is eligible for an unreduced retirement, the Deferred Retirement Option Program (DROP) allows the option to retire for purposes of the ERFC pension plan while continuing to work full time for FCPS and receive a salary for a maximum of five years. Find more information about DROP on the ERFC website.

If you were hired July 1, 2001 to June 30, 2017, you are covered under the *ERFC 2001 Tier 1 Plan*. If you were hired on or after July 1, 2017, you are covered under the *ERFC 2001 Tier 2 Plan.*

After your first full paycheck, new enrollees in the ERFC system will receive an email confirmation of your enrollment in the ERFC Retirement system. Members establish their own online ERFC*Direct* account for secure access to their personal retirement information. ERFC*Direct* allows members to designate beneficiaries for ERFC benefits. *Your ERFC beneficiary designation is separate from your VRS beneficiary designation.*

Go to erfcpension.org for more information and plan booklets

Fairfax County Employees' Retirement System (FCERS)

For full-time and part-time custodial, food service, maintenance, and transportation employees; and part-time educational, administrative, and operational employees.

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

Employees hired before January 1, 2013, are in FCERS Plan A or B. Employees hired between January 1, 2013, and June 30, 2019, are members in Plan C or D. Employees hired on or after July 1, 2019, are members in Plan E.

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

Plan A and B members are eligible to receive normal retirement benefits as early as age 50 with 30 years of service, i.e. when age and years of service (including sick leave) total 80. Plan C, D, and E members are eligible to receive normal retirement benefits as early as age 55 with 30 years of service, i.e. when age and years of service (including sick leave) total 85. Alternatively, all members are eligible to receive normal retirement benefits at age 65 with 5 or more years of service.

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

FCPS encourages you to start planning early by reviewing your available options and seeking the advice of a professional financial planner or tax advisor who can help you align your FCPS retirement benefits with your other savings plans and retirement goals.

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

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

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

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

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

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

Deferred Compensation—457(b)

All benefits-eligible full-time and part-time employees may enroll in the 457(b) plan. The plan is not available to temporary, hourly employees. The 457(b) plan offers best-in-class mutual funds and investment options.

A 457(b) plan:

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

It's easy to enroll either online via the EMPOWER website or by calling 877-449-FCPS (3277).

You can also refer to Regulation 4750 for established policies on the 457(b) plan.

Deferred Compensation—403(b)

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 investment options.

To enroll in the 403(b) plan and to establish an account with one of the authorized providers, visit any of the providers' websites. These sites offer easy online enrollment and salary reduction processes. You may only contribute to one vendor at a time, but you may have 403(b) balances with more than one provider. The most current list of authorized providers, including contact information, is available on the 403(b)/457(b) Approved Providers page on the FCPS website. Investing in a 403(b) plan may seem complex. When you meet with a 403(b) provider, you should ask about:

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

To improve service to you and comply with IRS 403(b) regulations, FCPS has partnered with TSA Consulting Group (TSACG) to work with you and your FCPS-authorized 403(b) vendor to simplify transactions on your account, such as loans, hardship withdrawals, rollovers, transfers, exchanges, and distributions.

Refer to the vendor websites on the 403(b)/457(b) Approved Providers page for instructions on increasing or decreasing your contributions. You can also refer to Regulation 4750 for established policies on the 403(b) plan.

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

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

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

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

FCPS 403(b) Universal Availability Notice

What is a 403(b) plan?

A 403(b) plan is a tax-deferred retirement savings plan available to employees of public educational institutions and certain tax-exempt organizations. A 403(b) plan allows you to make 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 may 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 percent 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 be aware that defaulted loan amounts will be taxed as ordinary income and might be subject to a 10 percent 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 percent and you contribute $100 a month to a 403(b) plan, you've reduced your federal income taxes by roughly $25. In effect, your $100 contribution costs you only $75. The tax savings increases with the size of your 403(b) contribution.
- **Tax-deferred growth and compounding interest–**In a 403(b) plan, your interest and earnings accrue tax deferred. That means interest on your interest also grows tax deferred. The compounding interest can allow your account to grow more quickly than saving in a taxable account, where interest and earnings are generally taxed each year.
- **You take the initiative–**Contributing to a 403(b) retirement savings plan can help you take control of your future. Other sources of retirement income, including state pension plans and, if applicable, Social Security, rarely replace a person's final salary upon retirement. That's why it's up to you to make sure you'll have enough money for retirement.

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

Am I eligible to participate?

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

What is the maximum amount I can contribute?

The IRS limits the annual contributions you can make to a 403(b) plan. Limits may be adjusted each year. The limits for 2025 will be:

- Under Age 50: $23,500*
- Age 50-59, 64+: $31,000*
- Age 60-63: $34,750*

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

*If you are a >50% owner of another business with a defined benefit contribution retirement plan, please notify FCPS.

When can I enroll?

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

When are my elective deferral contributions effective?

After completing the online enrollment requirements, your elected deferral percentage will begin the first day of the following month or as soon as administratively possible. Completed online enrollments must be entered by the twentieth of the month to be effective on the first day of the following month.

Can I change or stop my elective deferral contributions?

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

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

- **Corebridge Financial**
  800-445-7862
  www.corebridgefinancial.com/rs/fcps

- **EMPOWER**
  877-449-FCPS (3277)
  https://fcps.empower-retirement.com/

Integrated Disability Management

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

Short-Term Disability (STD)

FCPS will provide salary replacement through the STD program, if the employee has been certified disabled for a personal illness or injury for more than 10 continuous workdays and the employee has opened a claim with Sedgwick (855-937-1387), the FCPS program administrator. After an elimination period of 10 consecutive workdays, this plan replaces your income for up to five months if you are disabled, and your claim is approved. For organ donors, the 10 workday elimination period is waived.

Eligibility

Employees are enrolled on the first of the month after 12 calendar months of service from date of employment or re-employment.

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

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. Advanced leave balances will be adjusted and prorated for the time of the extended absence after you return to work.

Short-Term Disability Benefits

As a result of your STD benefits claim approval, you will receive **90% of your current salary without using any of your leave balances.** This option maintains your accrued leave balances after use of your leave for the 10 workday elimination period.

Sedgwick will review required medical information to confirm that the absence is medically necessary and approval for STD benefits.

Non-contracted days (e.g. summer, spring, winter and holiday breaks) do not count for eligibility nor are benefits paid.

Long-Term Disability (LTD)

If you are receiving payment from the STD program and the claim is approaching the end of the five-month STD period, MetLife will automatically review your case to determine eligibility for the LTD program.

Premium Cost

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

Long-Term Disability Benefits

The program pays 66 2/3% of pay if you continue to be disabled after 180 days (6 months), which coincides with the end of STD payments. While employees are receiving LTD benefits, they are not required to pay the cost for LTD. The deduction automatically begins again once you return to work. You may continue to participate in the medical, dental, and life insurance programs. Other optional benefit programs may continue, if the plans allow such participation. Employees must pay the premium cost for these benefits through personal check or money order made payable to FCPS.

Workers' Compensation

If an employee is injured on the job or has sustained an occupational illness, the employee may be eligible to receive workers' compensation benefits. Benefits available through workers' compensation include payment for medical expenses and wage loss benefits if the employee is disabled for more than 5 workdays as a result of the compensable occupational illness/injury. The statutory compensation rate is 66 2/3% your pre-injury average weekly wage.

Eligibility

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

If a workplace injury/illness occurs:

1. And is life-threatening or limb-threatening injury, seek immediate medical attention!
2. Call Sedgwick immediately (or as soon as possible) at 855-937-1387 to report the injury and/or illness. Sedgwick is available to take the call and provide assistance 24/7. If there is an emergency and you are unable to call, someone else may call for you. Sedgwick can also provide you with panel providers to choose from when you call.
3. For non-life/limb-threatening medical services, refer to the Workers' Compensation Provider Panel list on the FCPS website to schedule an appointment with the panel provider.
4. Medical expenses and prescription costs related to your approved workers' compensation claim will be paid by Sedgwick. You are not responsible for paying co-payments, consultation fees, or fees for visits to an approved workers' compensation provider panel physician or facility. If the physician or facility requires you to pay for the office visit, you should refer them to Sedgwick.
5. If your medical condition requires specialty care, your workers' compensation provider panel physician will make the referral. If your panel provider refers you to see a specialist, please Sedgwick is aware of the referral. Sedgwick may offer you a panel of three (3) specialists to choose from.
6. If you choose to use a physician who is not approved by Sedgwick, treatment may not be covered by your workers' compenation benefit. You may be responsible for payment of the services from the non-approved provider.

Your Information Is Confidential
All medical and personal information you or your physician supplies is confidential and protected from unauthorized use or disclosure by Sedgwick/Metlife. Certain claims may require the use of a separate, written authorization form. When Sedgwick/Metlife sends you forms, sign and return them as quickly as possible so there is no delay in processing your claim. To ensure payments reach you in a timely manner, notify Sedgwick/Metlife and FCPS of any address or phone number changes.

Leave Programs

Family & Medical Leave Act

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

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

Paid Parental Leave (PPL)

Eligible employees can receive 8 weeks of paid leave for childbirth, adoption, or foster placement. Paid Parental Leave (PPL) will provide employees with paid time off, making this transitional time a little easier for families.

PPL will start at different times based on whether you are a birthing-parent or non-birthing, adoptive, or foster parent:

Birthing parents will start their PPL on the first workday after their STD benefits (if approved) end. For less-than-12 month employees who give birth over the summer break and may not be approved for STD, PPL will begin on the first contracted workday of the new school year.

Non-birthing, adoptive, or foster parents can choose which day to start their PPL as long as it's within six (6) months from the date of the child's birth/date of adoption or placement into foster care.

You may contact a Disability and Leaves team member at 571-423-3200 to discuss your options if you need or desire more time off, including taking an additional absence without pay through your work location (30 days or less), participating in a remaining FMLA period, or taking an unpaid leave of absence greater than 30 days.

For more information about birth/adoption/ childcare-related leave, we encourage you to attend an Expectant Parents Workshop or view the "Preparing for Your Absence" packet.

Your baby is not automatically enrolled for medical insurance.

You need to add your baby to your FCPS benefits and you must do so within 30 days of the birth or adoption even if you currently have family coverage.

You will need to complete an enrollment and change form which is available under the Benefit Forms section.

Leaves of Absence

FCPS provides two types of long-term (30 days or more), unpaid leaves of absence (LOA) to help you meet your personal and professional needs—**designated** and **non-designated.**

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

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

A **non-designated** LOA is available to you after 5 consecutive years of working for FCPS 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 non-designated LOA.

For school-based employees, a request **must** be submitted by **March 1** preceding the school year you wish to take an LOA. An LOA does not extend past 24 months, although FCPS can allow extensions under certain circumstances, such as military and child care. Before you take an LOA, you should find out how it may affect your retirement and benefits. If you need additional information or assistance on the types of leaves available, eligibility, and the application process, please contact the Disability and Leaves section in the Office of Benefit Services via FCPS StaffConnect.

Your Benefits & LOA

While on an approved LOA, you have the option to make changes to your current benefits, to include dropping coverage and/or dependent(s) within **30 calendar days** of the first day of approved leave. During an LOA, you will be required to pay for your elected benefits by personal check or money order. If you participate in the Flexible Spending Account for health care, you will not be covered during your LOA unless you have elected to continue these benefits on a direct pay basis. If you participate in the Flexible Spending Account for dependent care, your benefit must be discontinued while on LOA. You must take action upon your return to work if you want this benefit.

Action Required To Maintain Your Benefits During LOA

You must elect to continue optional benefits during an LOA. In most cases, you pay the full premium (the employee and employer portions) of your benefits while you are on an LOA. FCPS must receive an initial payment no later than 30 calendar days after the date that you were approved for your LOA. The Office of Payroll Management will then send you 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.

If you did not continue your FCPS benefits while on LOA, you must re-enroll in optional benefits—medical and dental, flexible spending accounts, optional life insurance, and deferred compensation plans, upon your return to work.

These benefits are reinstated if you submit your enrollment forms within 30 calendar days of your return to work. If you do not

submit your enrollment forms within 30 calendar days of your return to work, you are not able to enroll for optional benefits, including medical and dental insurance, until the next open enrollment period or when you experience a qualifying life event. Call HR Client Services at 571-423-3000 for enrollment forms or visit the Benefit Forms webpage.

Sick Leave

All employees assigned a specific number of contract days or workdays are eligible for sick leave. Fourteen (14) days of sick leave is credited when you report to the first scheduled contract day at the beginning of each contract year. Employees on STD, LTD, WC, LOA, will have their prorated sick leave granted when they return to work. Sick leave will be prorated and adjusted for extended absences (STD,LTD, WC, LOA). There is no limit on the accumulation of sick leave from one year to the next.

You may use sick leave for:

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

To use sick leave, enter your request in MyTime and submit it to your principal or program manager, who approves your sick leave use.

For more information concerning the modifications to the requirements of sick leave, visit the Time Away from Work webpage.

Sick Leave & Retirement

ERFC & FCERS Members

FCPS converts sick leave accrued by *vested* **ERFC** 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.

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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.

Please Note: ERFC members who are retiring from FCPS and re-employing with another Virginia school district should contact ERFC prior to transferring leave, as the transfer could negatively impact your ERFC pension benefit.

Personal Leave

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

Annual Leave

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

To use your annual leave, enter your request in MyTime and submit it to your principal

or program manager, who approves your annual leave use.

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

If you move from a less-than-12-month position to a 12-month position, you will begin earning annual leave based on the total years of service you have with FCPS

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

at the time of your transfer. If you terminate employment or move from an annual leave-eligible position to one that does not accrue annual leave, you are paid for your accumulated annual leave.

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

Reciprocity of Annual Leave

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

Paid Non-workdays

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

Holidays

Regulation 1344 and Regulation 4421 list which of days are paid and unpaid for various employee categories.

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.

To view the current list of holidays, please view the current school calendars are available on the Holidays webpage.

Legislation Applicable to FCPS Health Plans

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

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

Patient Protection and Affordable Care Act

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

Medicare, Medicaid, and SCHIP Extension Act of 2007

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

COBRA—Maintaining Health Coverage for You or Your Family

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

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

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

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

- Your employment status changes to a non-benefits eligible position
- You lose eligibility due to reduction in hours during the preceding measurement period (12-month period during which an employee's average weekly hours worked will be measured to determine eligibility for coverage)
- Your employment ends for any reason other than gross misconduct
- Your eligible dependent(s) (spouse and/or dependent children) become qualified beneficiaries when they lose coverage under the plan if any of the following qualifying events occurs:
- Your employment status changes to a non-benefits eligible position
- You lose eligibility due to reduction in hours during the preceding measurement period (12-month period during which an employee's average weekly hours worked will be measured to determine eligibility for coverage).
- Your employment ends for any reason other than your gross misconduct
- You and your spouse divorce
- Your child loses eligibility for coverage under the plan as a "dependent child"
- You die

How long does COBRA coverage last?

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

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

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

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

Examples:

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

You must send written notice to the FCPS Office of Benefit Services. In addition, you must provide documentation supporting the event.Once the plan administrator receives notice that a qualifying event has occurred, FCPS will offer COBRA continuation coverage to each of the qualified beneficiaries. For each qualified beneficiary who elects COBRA, coverage will begin on the date that plan coverage would otherwise have been lost.

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

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

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

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

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

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

1. Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.
2. FCPS has determined that the prescription drug coverage offered by the FCPS plan is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and, therefore, is considered Creditable Coverage.

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

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

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

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

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

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

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

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

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

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

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

For more information about Medicare prescription drug coverage:

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

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

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

Newborns' & Mothers' Health Protection `Act

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

Break Time for Nursing Mothers

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

For more information about the Lactation Policy, please visit the Hub. Please email lactationquestions@fcps.edu with questions regarding this program.

Women's Health & Cancer Rights Act

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

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

These benefits are provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under the plan. Benefits provided in connection with a mastectomy are subject to the plans' regular deductibles and copayments. For more information, refer to the *Summary Plan Documents* for each medical plan provider, available on the FCPS Benefits website.

Mental Health Parity & Addiction Equity Act

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

The law also requires that health plans not impose any limits on the frequency of treatment, the number of visits, the days of coverage, or other similar limits for mental

health/substance abuse benefits that are more restrictive than those imposed on medical/surgical benefits. If a health plan offers out-of-network medical/surgical benefits, it also must offer out-of-network mental health/substance abuse benefits.

Genetic Information Nondiscrimination Act (GINA)

GINA prohibits employers from requiring or purchasing genetic information about you or your family members. The law also prohibits group and individual health insurers from using your genetic information in determining eligibility or premiums.

Health Insurance Portability & Accountability Act

The Health Insurance Portability & Accountability Act (HIPAA) requires group health plans to offer special enrollment opportunities without having to wait until the plan's next regular open enrollment period. A special enrollment opportunity occurs if an individual with other health insurance loses that coverage, or if a person becomes a new dependent through marriage, birth, adoption, or placement of adoption. Employees or dependents must request enrollment within 30 days of the loss of coverage or life event triggering the special enrollment.

Loss of eligibility for Medicaid or State Children's Health Insurance Programs (CHIP) also results in a special enrollment opportunity; enrollment must be requested within 60 days of the event in this instance.

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

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

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

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

Uniformed Services Employment & Readjustment Rights Act (USERRA)

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

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

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

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

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

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

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

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

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

U.S. Department of Labor
Employee Benefits Security Administration
www.dol.gov/ebsa
1-866-444-EBSA (3272)

U.S. Department of Health & Human Services
Centers for Medicare & Medicaid Services
www.cms.hhs.gov
1-877-267-2323, option 4, ext. 61565

Health Insurance Marketplace Coverage Options and Your Health Coverage

Form Approved
OMB No. 1210-0149
(expires 12-31-2026)

PART A: General Information

Even if you are offered health coverage through your employment, you may have other coverage options through the Health Insurance Marketplace ("Marketplace"). To assist you as you evaluate options for you and your family, this notice provides some basic information about the Health Insurance Marketplace and health coverage offered through your employment.

What is the Health Insurance Marketplace?

The Marketplace is designed to help you find health insurance that meets your needs and fits your budget. The Marketplace offers "one-stop shopping" to find and compare private health insurance options in your geographic area.

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

You may qualify to save money and lower your monthly premium and other out-of-pocket costs, but only if your employer does not offer coverage, or offers coverage that is not considered affordable for you and doesn't meet certain minimum value standards (discussed below). The savings that you're eligible for depends on your household income. You may also be eligible for a tax credit that lowers your costs.

Does Employment-Based Health Coverage Affect Eligibility for Premium Savings through the Marketplace?

Yes. If you have an offer of health coverage from your employer that is considered affordable for you and meets certain minimum value standards, you will not be eligible for a tax credit, or advance payment of the tax credit, for your Marketplace coverage and may wish to enroll in your employment-based health plan. However, you may be eligible for a tax credit, and advance payments of the credit that lowers your monthly premium, or a reduction in certain cost-sharing, if your employer does not offer coverage to you at all or does not offer coverage that is considered affordable for you or meet minimum value standards. If your share of the premium cost of all plans offered to you through your employment is more than 9.12%[a] of your annual household income, or if the coverage through your employment does not meet the "minimum value" standard set by the Affordable Care Act, you may be eligible for a tax credit, and advance payment of the credit, if you do not enroll in the employment-based health coverage. For family members of the employee, coverage is considered affordable if the employee's cost of premiums for the lowest-cost plan that would cover all family members does not exceed 9.12% of the employee's household income.[a][b]

Note: If you purchase a health plan through the Marketplace instead of accepting health coverage offered through your employment, then you may lose access to whatever the employer contributes to the employment-based coverage. Also, this employer contribution -as well as your employee contribution to employment-based coverage- is generally excluded from income for federal and state income tax purposes. Your payments for coverage through the Marketplace are made on an after-tax basis. In addition, note that if the health coverage offered through your employment does not meet the affordability or minimum value standards, but you accept that coverage anyway, you will not be eligible for a tax credit. You should consider all of these factors in determining whether to purchase a health plan through the Marketplace.

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[a] Indexed annually; see https://www.irs.gov/pub/irs-drop/rp-22-24.pdf for 2023.

[b] An employer-sponsored or other employment-based health plan meets the "minimum value standard" if the plan's share of the total allowed benefit costs covered by the plan is no less than 60 percent of such costs. For purposes of eligibility for the premium tax credit, to meet the "minimum value standard," the health plan must also provide substantial coverage of both inpatient hospital services and physician services.

When Can I Enroll in Health Insurance Coverage through the Marketplace?

You can enroll in a Marketplace health insurance plan during the annual Marketplace Open Enrollment Period. Open enrollment varies by state but generally starts November 1 and continues through at least December 15.

Outside the annual Open Enrollment Period, you can sign up for health insurance if you qualify for a Special Enrollment Period. In general, you qualify for a Special Enrollment Period if you've had certain qualifying life events, such as getting married, having a baby, adopting a child, or losing eligibility for other health coverage. Depending on your Special Enrollment Period type, you may have 60 days before or 60 days following the qualifying life event to enroll in a Marketplace plan.

There is also a Marketplace Special Enrollment Period for individuals and their families who lose eligibility for Medicaid or Children's Health Insurance Program (CHIP) coverage on or after March 31, 2023, through July 31, 2024. Since the onset of the nationwide COVID-19 public health emergency, state Medicaid and CHIP agencies generally have not terminated the enrollment of any Medicaid or CHIP beneficiary who was enrolled on or after March 18, 2020, through March 31, 2023. As state Medicaid and CHIP agencies resume regular eligibility and enrollment practices, many individuals may no longer be eligible for Medicaid or CHIP coverage starting as early as March 31, 2023. The U.S. Department of Health and Human Services is offering a temporary Marketplace Special Enrollment period to allow these individuals to enroll in Marketplace coverage.

Marketplace-eligible individuals who live in states served by HealthCare.gov and either- submit a new application or update an existing application on HealthCare.gov between March 31, 2023 and July 31, 2024, and attest to a termination date of Medicaid or CHIP coverage within the same time period, are eligible for a 60-day Special Enrollment Period. That means that if you lose Medicaid or CHIP coverage between March 31, 2023, and July 31, 2024, you may be able to enroll in Marketplace coverage within 60 days of when you lost Medicaid or CHIP coverage. In addition, if you or your family members are enrolled in Medicaid or CHIP coverage, it is important to make sure that your contact information is up to date to make sure you get any information about changes to your eligibility. To learn more, visit HealthCare.gov or call the Marketplace Call Center at 1-800-318-2596. TTY users can call 1-855-889-4325.

What about Alternatives to Marketplace Health Insurance Coverage?

If you or your family are eligible for coverage in an employment-based health plan (such as an employer-sponsored health plan), you or your family may also be eligible for a Special Enrollment Period to enroll in that health plan in certain circumstances, including if you or your dependents were enrolled in Medicaid or CHIP coverage and lost that coverage. Generally, you have 60 days after the loss of Medicaid or CHIP coverage to enroll in an employment-based health plan, but if you and your family lost eligibility for Medicaid or CHIP coverage between March 31, 2023 and July 10, 2023, you can request this special enrollment in the employment-based health plan through September 8, 2023. Confirm the deadline with your employer or your employment-based health plan.

Alternatively, you can enroll in Medicaid or CHIP coverage at any time by filling out an application through the Marketplace or applying directly through your state Medicaid agency. Visit https://www.healthcare.gov/medicaid-chip/getting-medicaid-chip/ for more details.

How Can I Get More Information?

For more information about your coverage offered through your employment, please check your health plan's summary plan description or contact

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

PART B: Information About Health Coverage Offered by Your Employer

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

3. Employer name Fairfax County Public Schools		4. Employer Identification Number (EIN) 54-0805373
5. Employer address 8115 Gatehouse Road, Suite 2700		6. Employer phone number 571-423-3000
7. City Falls Church	8. State VA	9. ZIP code 22042
10. Who can we contact about employee health coverage at this job? Department of Financial Services, Office of Benefit Services		
11. Phone number (if different from above)	12. Email address FCPS StaffConnect portal	

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

- **As your employer, we offer a health plan to:**

  ☐ **All employees. Eligible employees are:**

  ☑ **Some employees. Eligible employees are:**

  All full-time and part-time employees in authorized positions who are eligible to participate in FCPS benefit programs and those working the minimum required hours.

- **With respect to dependents:**

  ☑ **We do offer coverage. Eligible dependents are:**

  The eligible employee's spouse and child(ren) as defined in the Fairfax County Public Schools Employee Benefits Handbook.

  ☐ **We do not offer coverage.**

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

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

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

Glossary & Acronyms

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

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

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

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

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

Deductible—The amount of covered expenses that a Plan participant must pay each calendar ear before the Plan begins paying benefits.

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

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

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

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

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

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

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

Employee + 1—You and one dependent (either spouse or eligible child).

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

Family—You and two or more dependents.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Open Enrollment—A period of time in the fall when you can enroll or change your medical, dental, and/or FSA plans for the next calendar year.

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

Out-of-Pocket—The amount of money you pay in addition to your premium payments each calendar year.

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

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

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

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

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

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

Spouse—A person to whom you are legally married.

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

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

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

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

TDA—Tax-Deferred Account—An optional retirement savings program which allows you to save pre-tax dollars for retirement.

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

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

Fairfax County Public Schools
Dr. Michelle Reid, Superintendent

Office of the Superintendent
Leigh Burden, Chief Financial Officer

Office of Benefit Services
Lisa Edmonds, Director

Department of Financial Services
Office of Benefit Services
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