



**FY
20
27**

Early Retiree BENEFITS GUIDE

(FOR PARTICIPANTS UNDER AGE 65)

Table of Contents

| | |
|----|---|
| 4 | Enrolling In Your Benefits |
| 5 | Benefits Open House Sessions |
| 6 | Medical and Pharmacy Plan Overview |
| 7 | Consumer Directed Health Plan (CDHP) |
| 8 | Medical and Pharmacy Coverage |
| 12 | *NEW* UnitedHealthcare/Optum Rx FAQs |
| 14 | Health Savings Account |
| 15 | Dental Plan |
| 17 | Vision Plan |
| 19 | Information for Retirees Who Will Become 65 During This Plan Year |
| 20 | Benefit Terms Overview |
| 21 | Contact Information |





Letter From the Office of the City Manager

The FY 2027 Open Enrollment period will run from Monday, May 4, 2026 to Friday, May 29, 2026. Open Enrollment is your opportunity to select the benefits that best meet the needs of you and your family.

This Guide provides an overview of the benefits available and what's new for FY 2027. Please review this information carefully. We also invite you to attend one of our benefits open houses and the annual Health Fair to learn more and get answers to any questions you have. Details on those events can be found in the Guide.

Benefit elections you make during Open Enrollment will take effect on July 1, 2026. Be sure to act by May 29 if you wish to enroll or make changes to your existing benefits.

James F. Parajon

City Manager

Alyssa Williamson

Chief Human Resources Officer

Enrolling in Your Benefits

The Open Enrollment period is from May 4 through May 29. During this period, retirees may make the following types of changes:

- Enroll in or cancel participation in any benefit plan.
- Change health plans (Kaiser or United Healthcare [UHC]).
- Enroll in dental and/or vision coverage.
- Change family members to be covered and the coverage level (children are eligible until age 26).
Note: New dependent enrollments during this period require documentation of eligibility.
- Terminate Voluntary Retiree Life coverage

Retirees in the City of Alexandria Medical Insurance Reimbursement Plan

Complete the enclosed Medical Insurance Reimbursement Plan form to satisfy the Annual Documentation Requirements for continued participation in the plan (may be submitted later if your plan year starts after July and you have not yet received the information).

Making Changes to Your Coverage

If you are considering making a change to your coverage, read the information in this guide carefully. If you have questions or need additional information, consider attending one of the Benefits Open House Sessions listed on the next page.

If you decide to make a change, you must complete the Early Retiree Plan Change Form included in this package and return it via mail (preferable) to the address below (or drop it off at the Human Resources Department) so that it is postmarked by May 29.

How to Contact Us

You may reach the Department of Human Resources Benefits Team.

By email: DHR.Benefits@alexandriava.gov

By mail: 2331 Mill Road, Room 301, Alexandria, VA 22314

By phone: 703.746.3777

By visiting us online at:

www.alexandriava.gov/human-resources/retirees-corner

For assistance in making changes, contact a member of the Benefits Team.

IMPORTANT REMINDERS

- If you participate in a Kaiser or UnitedHealthcare plan and do not want to make any changes, you do not need to do anything. You do not need to return any information.



Benefits Open House Sessions

Fiscal Year 2027's Benefits Open Enrollment will run from May 4, 2026 (Monday) through May 29, 2026 (Friday).

| DATE | TIME | LOCATION |
|---|--------------------------------|---|
| May 5 (Tuesday) | 10:00 a.m. to 1:00 p.m. | Old Town 421 King St., Suite 200 |
| May 6 (Wednesday) | 10:00 a.m. to 1:00 p.m. | DCHS 4850 Mark Center Drive, Rm 9208 |
| May 7 (Thursday) | 7:00 a.m. to 9:00 a.m. | T&ES 2900 Business Center Drive, Door 2900-B |
| May 12 (Tuesday) | 10:00 a.m. to 1:00 p.m. | DHR 2331 Mill Road, 3rd Floor |
| May 13 (Wednesday) | 1:00 p.m. to 3:00 p.m. | Sheriff's Office 2003 Mill Road, 1st Floor |
| May 14 (Thursday) HEALTH FAIR | 10:00 a.m. to 2:00 p.m. | First Baptist Church of Alexandria 2932 King Street |
| May 19 (Tuesday) | 1:00 p.m. to 3:00 p.m. | Police 3600 Wheeler Road, HQ |
| May 20 (Wednesday) | 10:00 a.m. to 1:00 p.m. | Fire 5255 Eisenhower Avenue, Classroom 3/4 |

Medical and Pharmacy Plan Overview

The City offers a choice of five medical plans with coverage for prescription drugs. You can choose from three plans administered by UnitedHealthcare (UHC) and two plans from Kaiser Permanente. To select the plan that best suits your family, consider the key differences between the plans, the cost of coverage and how the plan covers services throughout the year.

HOW YOUR PLAN WORKS

Your deductible

- You pay out-of-pocket for most medical and pharmacy expenses, except for preventive services, until you reach the deductible. If you are enrolled in a Consumer Driven Health Plan (CDHP), you can pay for these expenses from your Health Savings Account (HSA).

Your coverage

- Once your deductible is met, you and the plan share the cost of covered medical and pharmacy expenses. The plan will pay a percentage of each eligible expense, and you will pay the rest.

Your out-of-pocket maximum

- When you reach your out-of-pocket maximum, the plan pays 100% of covered medical and pharmacy expenses for the rest of the plan year. Your deductible and coinsurance apply toward the out-of-pocket maximum.

MAKING THE MOST OF YOUR PLAN

Getting the most out of your plan also depends on how well you understand it. Keep these important tips in mind when you use your plan.

- **In-network providers and pharmacies:** You will always pay less if you see a provider within the medical and pharmacy network. Some plans only cover in-network services.
- **Preventive care:** In-network preventive care is covered at 100% (no cost to you). Preventive care is often received during an annual physical exam and includes immunizations, lab tests, screenings and other services intended to prevent illness or detect problems before you notice any symptoms.

UNDERSTANDING YOUR PHARMACY COVERAGE

- **Prescription categories:** Medications are categorized by cost, safety and effectiveness. These tiers also affect your coverage.
 - **Generic** – A drug that’s equivalent to brand-name drugs in use, dose, strength, quality and performance, but is not trademarked.
 - **Preferred brand** – A drug with a patent and trademark name that is considered “preferred” because it’s safe and effective and usually less expensive than other brand-name options.
 - **Non-Preferred brand** – A drug with a patent and trademark name that is “not preferred” because it’s usually more expensive than other generic and brand preferred options.
- **Mail order pharmacy:** If you take a maintenance medication on an ongoing basis for a condition like high cholesterol or high blood pressure, you can use the Mail Order Pharmacy to save on a 90-day supply.
- **Members enrolled in UHC plans:** If you have a **Specialty Medication** that requires a prior authorization you may be eligible to enroll in the Variable Copay program with UHC/OptumRx to cut costs. Optum Specialty is our specialty medication pharmacy, your practitioner may reach out to Optum Specialty to authorize specialty medications.

Consumer Driven Health Plan (CDHP)

Reminder to Consider the CDHP

The City offers a CDHP to employees and retirees because of the significant opportunity to save on premiums and taxes. The UnitedHealthcare CDHP and the Kaiser CDHP can help you take control of both your money and your health. CDHPs combine medical coverage with a Health Savings Account that you can use to save money to pay your health care expenses with tax-free dollars.

IMPORTANT NOTE

If you have Medicare coverage, you CANNOT contribute to a Health Savings Account.

ADVANTAGES OF THIS PLAN

- Pay lower premiums.
- Triple tax savings: The money you contribute, growth, and withdrawal when you use the money for eligible health care expenses are all tax-free.
- You can spend the money as expenses occur or you can save it for the future.

NOTE: There is no City contribution to the HSA for retirees.

IMPORTANT WAYS THIS PLAN IS DIFFERENT

- If you cover any family members, you must meet the family deductible before coverage begins for anyone.
- The deductible is significantly higher. You pay the full cost of medical care (except preventive care) and prescription drugs until you meet your deductible.



Medical and Pharmacy Coverage

UNITEDHEALTHCARE (UHC) MEDICAL PLANS

| Medical Plan Provisions | CDHP | | CHOICE AND CHOICE PLUS | CHOICE PLUS |
|---|-----------------------------------|-------------------|---------------------------------|---|
| | In-Network | Out-of-Network | In-Network | Out-of-Network |
| Plan Year Deductible <i>(Individual/Family)</i> | \$1,700/\$3,400 | | \$400/\$800 | \$800/\$1,600 |
| Plan Year Out-of-Pocket Maximum <i>(Individual/Family)</i> | \$6,450/\$12,900 | \$12,900/\$25,800 | \$3,175/\$6,350 | \$3,175/\$9,525 |
| Preventive Care | Covered at 100% | 30%* | Covered at 100% | 20%* |
| Primary Care Office Visits for Illness/Injury | 10%* | 30%* | \$15 Copay* | 20%* |
| Specialist Visits/Urgent Care Center | 10%* | 30%* | \$25 Copay* | 20%* |
| Inpatient Hospitalization | 10%* | 30%* | \$500 Copay* (per admission) | 20%* + \$500 Copay (per admission) |
| Emergency Room <i>(waived if admitted)</i> | 10%* | 30%* | \$150 Copay* | \$150 Copay* |
| X-ray, Lab, and Diagnostics | 10%* | 30%* | 0% | 20%* |
| CT, PET, MRI, MRA, and Nuclear Medicine | 10%* | 30%* | \$100 Copay* | 20%* |
| Outpatient Mental Health and Substance Abuse Services | 10%* | 30%* | \$15 Copay* | \$15 Copay after in-network deductible* |
| Transgender Benefits | Subject to applicable coinsurance | | Subject to standard copays | Subject to applicable coinsurance |
| Pregnancy Services | 10%* | 30%* | 0% | 20%* |
| Prenatal Visits | Covered 100% | 30%* | Covered 100% | 20%* |
| Pharmacy Provisions <i>(Provided by UHC/Optum)</i> | | | | |
| Annual Deductible <i>(Individual/Family)</i> | Combined with Medical | | None | None |
| Out-of-Pocket Maximum <i>(Individual/Family)</i> | Combined with Medical | | \$1,000/\$3,000 | Not applicable |
| Retail Pharmacy <i>(up to a 30-day supply)</i> | | | | |
| Generic | 10%* | Not applicable | \$15 Copay | Not applicable |
| Preferred Brand | 20%* | Not applicable | \$30 Copay | Not applicable |
| Non-Preferred Brand | 30%* | Not applicable | \$50 Copay | Not applicable |
| Retail or Mail Order <i>(up to a 90-day supply)</i> | | | | |
| Generic | 10%* | Not applicable | \$37.50 Copay | Not applicable |
| Preferred Brand | 20%* | Not applicable | \$75 Copay | Not applicable |
| Non-Preferred Brand | 30%* | Not applicable | \$125 Copay | Not applicable |

*After Deductible

Medical and Pharmacy Coverage *(Continued)*

KAISER PERMANENTE MEDICAL PLANS

| Medical Plan Provisions | CDHP | DHMO | HMO** |
|---|--|---------------------------------|--------------------------------|
| | In-Network | In-Network | In-Network |
| Calendar Year Deductible <i>(Individual/Family)</i> | \$1,700/\$3,400 | \$400/\$800 | None |
| Out-of-Pocket Maximum <i>(Individual/Family)</i> | \$3,500/\$7,000 | \$2,200/\$6,400 | \$3,500/\$9,400 |
| Preventive Care | Covered at 100% | Covered at 100% | Covered at 100% |
| Primary Care Office Visits for Illness/Injury | 10%* | \$15 Copay | \$15 Copay |
| Specialist Visits/Urgent Care Center | 10%* | \$25 Copay | \$25 Copay |
| Inpatient Hospitalization | 10%* | \$500 Copay* (per admission) | \$500 Copay (per admission) |
| Emergency Room <i>(waived if admitted)</i> | 10%* | \$150 copay | \$150 copay |
| X-ray, Lab, and Diagnostics | 10%* | Covered at 100% | Covered at 100% |
| CT, PET, MRI, MRA, and Nuclear Medicine | 10%* | \$75 Copay* | \$75 Copay |
| Outpatient Mental Health and Substance Abuse Services <i>(Individual/Group)</i> | 10%*/10%* | \$15 Copay/\$7 Copay | \$15 Copay/\$7 Copay |
| Outpatient Surgery | 90%* | \$50 Copay | \$50 Copay |
| Transgender Benefits | Subject to applicable deductible and coinsurance | Subject to standard copays | Subject to standard copays |
| Pregnancy Services | 10%* | \$500 Copay* (per admission) | \$500 Copay (per admission) |
| Prenatal Visits | Covered at 100% | Covered at 100% | Covered at 100% |
| Pharmacy Provisions <i>(Provided by Kaiser Permanente)</i> | | | |
| Annual Deductible | Combined with Medical | None | None |
| Out-of-Pocket Maximum <i>(Individual/Family)</i> | Combined with Medical | Combined with Medical | Combined with Medical |
| Retail Pharmacy <i>(up to a 30-day supply)</i> | | | |
| Generic <i>(Medical Center/Pharmacy***)</i> | \$20 Copay*/\$30 Copay* | \$15 Copay/\$25 Copay | \$15 Copay/\$25 Copay |
| Preferred Brand <i>(Medical Center/Pharmacy***)</i> | \$30 Copay*/\$50 Copay* | \$30 Copay/\$40 Copay | \$30 Copay/\$40 Copay |
| Non-Preferred Brand <i>(Medical Center/Pharmacy***)</i> | \$45 Copay*/\$65 Copay* | \$50 Copay/\$55 Copay | \$50 Copay/\$55 Copay |
| Retail and Mail Order Pharmacy <i>(up to a 90-day supply)</i> | | | |
| Retail, 90-day supply | 3x Copay | 3x Copay | 3x Copay |
| Mail Order, 90-day supply | 2.5x KPMC Copay | 2.5x KPMC Copay | 2.5x KPMC Copay |

*After Deductible

**The HMO plan cannot be actively enrolled into unless you already have coverage on this plan.

*** Medical Center = Kaiser Permanente Medical Center; Pharmacy = Other Network Pharmacies

Medical and Pharmacy Coverage *(Continued)*

KAISER PERMANENTE MEDICAL PLAN DHMO DEDUCTIBLES

The DHMO was changed from all services being subject to the deductible, to only certain services applying to the deductible. These services are generally received from non-Kaiser providers with a referral. See below for a list of services that apply to the deductible and others where only a copay or no cost sharing is collected.

| DEDUCTIBLE APPLIES | | NO DEDUCTIBLE | |
|--|--|---|--|
| <ul style="list-style-type: none"> ▪ Inpatient Care ▪ Skilled Nursing Facilities ▪ Specialty Imaging (MRIs, CT, etc.) ▪ Home Health Care | <ul style="list-style-type: none"> ▪ Hospice Services ▪ Durable Medical Equipment ▪ Orthotics | <ul style="list-style-type: none"> ▪ Preventive Care (no copay) ▪ Primary Care Visit ▪ Specialist Visit ▪ Urgent Care ▪ Emergency Room | <ul style="list-style-type: none"> ▪ X-rays, Labs, and Diagnostics (no copay) ▪ Pregnancy Services ▪ Prescription Drugs |

Monthly Medical Premiums

| | UNITEDHEALTHCARE MEDICAL PLANS | | |
|----------------------|--------------------------------|----------------|---------------|
| | Retiree* | City Subsidy** | Total Premium |
| CDHP | | | |
| Retiree Only | \$747.11 | \$260.00 | \$1,007.11 |
| Retiree + Spouse | \$1,787.31 | \$260.00 | \$2,047.31 |
| Retiree + Child(ren) | \$1,452.13 | \$260.00 | \$1,712.13 |
| Family | \$2,465.34 | \$260.00 | \$2,725.34 |
| Choice | | | |
| Retiree Only | \$865.52 | \$260.00 | \$1,125.52 |
| Retiree + Spouse | \$1,963.50 | \$260.00 | \$2,223.50 |
| Retiree + Child(ren) | \$1,653.38 | \$260.00 | \$1,913.38 |
| Family | \$3,120.40 | \$260.00 | \$3,380.40 |
| Choice Plus | | | |
| Retiree Only | \$1,084.31 | \$260.00 | \$1,344.31 |
| Retiree + Spouse | \$2,393.50 | \$260.00 | \$2,653.50 |
| Retiree + Child(ren) | \$2,025.34 | \$260.00 | \$2,285.34 |
| Family | \$3,772.97 | \$260.00 | \$4,032.97 |

*For retirees who are eligible for the \$260 monthly City contribution, your monthly cost is the amount in the Retiree Column for your Coverage Level and Plan in the table above.

**If you have under 25 years of service with the City and were hired after July 1, 2008, please see the Retiree Insurance Program Handbook for information about your City Subsidy (available online at www.alexandriava.gov/human-resources/retirees-corner).

Monthly Medical Premiums *(Continued)*

| | KAISER PERMANENTE MEDICAL PLANS | | |
|----------------------|---------------------------------|----------------|---------------|
| | Retiree* | City Subsidy** | Total Premium |
| CDHP | | | |
| Retiree Only | \$481.60 | \$260.00 | \$741.60 |
| Retiree + Spouse | \$1,178.70 | \$260.00 | \$1,438.70 |
| Retiree + Child(ren) | \$1,000.72 | \$260.00 | \$1,260.72 |
| Family | \$1,964.80 | \$260.00 | \$2,224.80 |
| DHMO | | | |
| Retiree Only | \$649.42 | \$260.00 | \$909.42 |
| Retiree + Spouse | \$1,504.27 | \$260.00 | \$1,764.27 |
| Retiree + Child(ren) | \$1,286.01 | \$260.00 | \$1,546.01 |
| Family | \$2,468.36 | \$260.00 | \$2,728.36 |
| HMO | | | |
| Retiree Only | \$771.05 | \$260.00 | \$1,031.05 |
| Retiree + Spouse | \$1,740.24 | \$260.00 | \$2,000.24 |
| Retiree + Child(ren) | \$1,492.79 | \$260.00 | \$1,752.79 |
| Family | \$2,833.15 | \$260.00 | \$3,093.15 |

*For retirees who are eligible for the \$260 monthly City contribution, your monthly cost is the amount in the Retiree Column for your Coverage Level and Plan in the table above.

**If you have under 25 years of service with the City and were hired after July 1, 2008, please see the Retiree Insurance Program Handbook for information about your City Subsidy (available online at www.alexandriava.gov/human-resources/retirees-corner).





UnitedHealthcare/Optum Rx FAQs

(Applies to participants on any of the UHC Medical Plans)

The City has partnered with UHC and Optum RX to provide top-tier pharmacy benefits while reducing out-of-pocket costs, ensuring safety, and quickly addressing any questions or issues.

How do I access my prescription coverage?

Present your UHC ID card and prescription at any in-network pharmacy. The pharmacist will verify coverage and inform you of your copay or coinsurance.

Your Prescription Benefit Coverage (PBC) provides a snapshot of your plan's drug coverage, copays, benefits, and key services in easy-to-understand terms.

Where can I get my prescriptions filled in-person?

You can fill prescriptions at thousands of participating pharmacies nationwide. For the best value, use a network pharmacy. Visit your providers website at myuhc.com.

If you have a Specialty Medication that requires a prior authorization, Optum Rx is our specialty medication pharmacy. Your practitioner may reach out to Optum Rx to authorize specialty medications.

What is a drug list or formulary?

A formulary (or drug list) is a list of FDA-approved brand-name and generic medications covered by your plan.

If your provider prescribes a medication not on the formulary, you'll pay the full cost. Talk to your provider about choosing an alternative on the formulary.

Call Member Services on the back of your ID card to check if a medication is covered. You can also refer to your Summary of Benefits for coverage details.

What is the difference between generic & brand medications? How does it affect my benefits?

Brand-name drugs are made by one manufacturer and may have patent protection. Generic drugs contain the same active ingredients but are available after the patent expires, often saving you money.

Are generic medications as safe and effective as brand-name drugs?

Yes, generic medications are FDA-regulated and must be therapeutically equivalent to brand-name drugs, with the same active ingredients, dosage, and strength.

UnitedHealthcare/OptumRx FAQs *(Continued)*

How can I request a generic medication?

Your healthcare provider and pharmacist are the best sources of information about generic medications. Simply ask one of them if your prescription can be filled with an equivalent generic medication.

Can my prescription be switched to a drug with a lower copay?

You can view lower cost options from your myuhc.com portal. Once you find an alternative, discuss with your healthcare provider and they can send in a new prescription to the pharmacy.

What is a prior authorization?

A prior authorization is required for certain medications to ensure they're a good fit for you and your coverage. Your provider must submit documentation for review. Call Member Services for assistance in processing the authorization.

How do I order medications using home delivery?

Home delivery is a convenient option for members to get a 3 month supply on maintenance medications for chronic conditions. It ensures you never miss a dose and can be more cost-effective. Check your plan for details on copay differences between home delivery and retail pharmacies.

I am going to be out of town for an extended period, how do I get an extra supply of drugs to cover me for that time?

If you need extra medication while out of town, call Member Services on the back of your ID card to request a vacation override. Provide your travel dates, and UHC will update the system for pharmacy pickup.

Who do I contact with questions about my specific plan and/or medications?

Your UHC Member Services Team is available to answer any questions you may have. You can reach them Monday through Friday, from 7:00 a.m. to 8:00 p.m. ET by calling **833-760-7892**.



Health Savings Account

A Health Savings Account (HSA) is a tax-free savings account linked to the UnitedHealthcare and Kaiser CDHP, allowing you to pay for current and future medical expenses for you and your dependents.

Eligibility details

- You must be enrolled in the UHC CDHP or Kaiser CDHP medical plan.
- You cannot contribute to an HSA if you are enrolled in any other health coverage or Medicare, or claimed as a dependent on someone else's tax return.



START IT

- Contributions to an HSA are tax-free for you. (Note: There is no City contribution to the HSA for retirees.)
- You can open an HSA account with Optum Bank. Visit [Optumbank.com](https://www.optumbank.com) and make contributions directly to your account.
- The CDHP costs less than other plans so the money you save on premiums can be put into your HSA. This helps you save money on taxes and gives you more flexibility and control over your health care dollars.

BUILD IT

- All of the money in your HSA is yours even if you are no longer enrolled in one of the City's plans.
- In Calendar Year 2026, the total of your contributions can be up to \$4,400 for individual coverage and \$8,750 for family coverage. If you are age 55 or older, you can contribute an additional \$1,000 per year.

USE IT

- You can withdraw your money tax-free at any time, as long as you use it for qualified expenses (a list can be found on [irs.gov](https://www.irs.gov)).
- You can also save this money and hold onto it for future eligible health care expenses.

GROW IT

- Unused money in your HSA will roll over, earn interest and grow tax-free over time.
- You decide how to use the HSA money, including whether to save it or spend it for eligible expenses. When your balance is large enough, you can invest it – tax-free.

Aetna's Dental Plans

It's important to have regular dental exams and cleanings so problems are detected before they become painful and expensive. Keeping your teeth and gums clean and healthy will help prevent most tooth decay and is an important part of maintaining your overall health.

The City offers two dental options to non-Medicare-eligible retirees through Aetna: the Dental Maintenance Organization (DMO) Plan and the Preferred Provider Organization (PPO) Plan. Both plans provide coverage for most dental care and pay 100% of the cost of preventive care, such as routine checkups and cleanings.

DMO PLAN

To be eligible for benefits under this plan, you must live in a DMO service area, and dental services must be provided by a primary care dentist selected from the network of participating DMO dentists. In addition, your primary care dentist must refer you for specialist care.

The DMO Plan also offers the following advantages:

- No deductible
- Lower premium costs
- No plan maximum each year

PPO PLAN

Under this plan, you can receive care from any dentist without a referral, but savings are possible if you choose a dentist who participates in the Aetna Network because they have agreed to provide care for covered services at negotiated rates. Benefits received from a non-participating dentist are subject to charge limits.

FIND A DENTAL PROVIDER

Log onto [aetna.com](https://www.aetna.com) or call **877-238-6200**, Monday through Friday, from 8 a.m. to 6 p.m., and an Aetna Dental customer service representative can help you find a dentist.



Aetna's Dental Plan Provisions

| Dental Plan Provisions | DMO | PPO |
|---|-----------------|---|
| Annual Deductible <i>(Amount you pay before the Plan kicks in)</i> | None | \$50 Individual/\$150 Family |
| Calendar Year Maximum <i>(Amount the Plan will pay each year)</i> | No maximum | \$1,000 (per individual) |
| Diagnostic and Preventive Services** <i>(e.g., Exams, Cleanings, and Bitewing X-rays)</i> | Covered at 100% | Covered at 100% (no deductible) |
| Basic Care <i>(e.g., Fillings and Simple Extractions)</i> | Copay | 25%* |
| Major Care <i>(e.g., Root Canals, Dentures, Crowns and Oral Surgery)</i> | Copay | 50%* |
| Orthodontia | \$2,400 copay | Children Only: 50% to lifetime maximum of \$1,500 |
| Do you need to choose a Primary Care Dentist? | Yes | No |
| Do you need a referral from your Primary Care Dentist to see a Specialist? | Yes | No |
| Do you need to go to a dentist that participates in the Aetna network? | Yes | No (you can go in or out of network) |

*After deductible

MONTHLY DENTAL PREMIUMS

| Coverage Level | DMO | PPO |
|---------------------|---------|----------|
| Retiree | \$16.00 | \$40.26 |
| Retiree + Spouse | \$27.53 | \$83.29 |
| Retiree +Child(ren) | \$23.20 | \$70.16 |
| Family | \$36.23 | \$109.56 |

**Diagnostic and preventive benefits are available two times per year.



Aetna's Vision Plan

The City offers the option to elect the Aetna Vision Preferred Plan. This plan provides coverage for routine eye exams and pays for most of the cost of glasses or contact lenses once each year. You can choose any licensed eye care provider; however, you always save money and generally pay less out-of-pocket if you see providers within the Aetna Vision Network. Network providers will also submit the claim for you.

FIND A VISION PROVIDER

Choose from more than 55,000+ vision offices and retailers, including popular chains like:

- LensCrafters
- Target Optical
- Pearle Vision
- CVS Optical

FIND AN EYE DOCTOR OR VISION CARE RETAILER NEAR YOU

You can look up independent vision care providers and retailers that participate by visiting aetnavision.com and clicking on Find a Provider.

You can also use Online Vision Partners:

- glasses.com
- targetoptical.com
- lenscrafters.com
- ray-ban.com
- contactsdirect.com

MORE INFORMATION

Contact Aetna's Customer Care Services at **877-973-3238**, Monday through Friday from 8 a.m. to 6 p.m.



Aetna's Vision Plan Provisions

| Vision Plan Provisions | PPO | |
|---|--|--|
| | Aetna Vision Network | Out-of-Network |
| Eye Exams | You pay \$0 | Plan reimburses \$30 |
| Lenses <i>Single vision</i> <i>Bifocal</i> <i>Trifocal</i> | You pay \$15 for all standard lenses (with standard scratch coating included) | Plan reimburses \$25 Plan reimburses \$40 Plan reimburses \$55 |
| Eyeglass Frames* | \$150 allowance, then 20% discount | Plan reimburses \$75 |
| Contact Lenses | You pay \$40 for standard fitting; \$150 allowance, then 15% discount over allowance | Plan reimburses \$120 |
| Discounts <i>Additional pairs of glasses</i> <i>Non-covered Items (e.g., cleaning cloths and contact lens solution)</i> <i>U.S. Laser Network</i> <i>Retinal imaging</i> | Up to 40% discount 20% discount Vision correction discount Up to \$39 | No discount |
| Frequency <i>Eye exams</i> <i>Lenses</i> <i>Eyeglass frames</i> <i>Contact lenses</i> | Once every 12 months One pair of glasses once every 12 months One pair of glasses once every 12 months One order of contacts once every 12 months | |

*Upgraded lens options, such as progressive bifocals, are available for an additional cost. Certain lens options, such as tints, anti-reflective, and UV coating, are covered for an additional fixed fee.
You can receive 1 pair of eyeglasses OR 1 order of contact lenses every 12 months.

MONTHLY VISION PREMIUMS

| Coverage Level | PPO |
|---------------------|---------|
| Retiree | \$8.54 |
| Retiree + Spouse | \$20.43 |
| Retiree +Child(ren) | \$14.47 |
| Family | \$23.83 |



Information for Retirees Who Will Become 65 During This Plan Year

WHAT IF I WILL BE MEDICARE-ELIGIBLE THIS YEAR?

All Medicare-eligible City retirees and their spouses (those 65 and older) are no longer permitted to remain in a City “Employee Plan” and MUST enroll in one of the following:

- Kaiser Medicare Advantage Plan
- UnitedHealthcare Medicare Advantage (PPO)
- City of Alexandria Insurance Reimbursement Plan. (If you choose coverage under any other health plan, eligible expenses will be reimbursed by the City for up to \$260 per month.) If you were hired after July 1, 2008, the subsidy will be prorated.

Also, Aetna Dental and Vision coverage ends but can be continued under COBRA for 18 months. Aetna offers Vital Savings (a discount program for dental care, vision, hearing aids, gym memberships, and more) to Medicare-eligible retirees and their spouses.

WHAT DO I HAVE TO DO?

Three months before your 65th birthday, apply for Medicare Parts A and B.

- When you receive your Medicare A&B card, contact the Benefits Office (dhb.benefits@alexandriava.gov), and they will provide you with the appropriate enrollment form.
- You will then need to complete the enrollment form and return it to the Benefits Office, along with a copy of your Medicare A&B card.
- The Benefits Office will submit your enrollment package to the appropriate carrier, who will enroll you in their Plan.

If you are covered under an employer-sponsored health insurance plan (through your own job or your spouse’s), you can postpone applying for Medicare Part B.

WHAT IF MY SPOUSE IS NOT MEDICARE-ELIGIBLE? ARE THEY ELIGIBLE TO REMAIN ON THE “EMPLOYEE PLAN?”

Yes. The under 65-year-old spouse of a retiree currently insured in a City-sponsored plan may continue to receive coverage on the City-sponsored “Employee Plan” until he/she is Medicare-eligible.

WHAT IF MY SPOUSE IS MEDICARE-ELIGIBLE AND I AM NOT?

You would continue in the “Employee Plan,” and your spouse can enroll in one of the City’s Medicare Advantage plans.

The City pays for (or reimburses) up to \$260 for either you or your spouse (the older of the two of you), but not both. If you and/or your spouse enroll in Kaiser or UnitedHealthcare Medicare Advantage plans, the City pays the monthly premium directly to the carrier for the oldest, eligible enrollee only. For example, if your spouse elects the UnitedHealthcare Medicare Advantage Plan, the City will debit your account for \$339.37 per month to cover the difference between the \$599.37 premium and the \$260 maximum City reimbursement.

All premiums for the younger individual (whether Kaiser, UnitedHealthcare, or another plan of your choice) are the responsibility of the retiree. If both you and your spouse elect a plan other than the City-sponsored plans, your costs of up to \$260, based on your years of service, will be reimbursed monthly.

WHY AM I RECEIVING A W-2 FOR SUPPLEMENTAL LIFE INSURANCE?

IRS rules on paying taxes over \$50,000:

Group-term life insurance over \$50,000 is provided to an employee after their termination, and the employee share of Social Security and Medicare taxes on that period of coverage is paid by the former employee with their tax return and isn’t collected by the employer.

Benefit Terms Overview

Calendar Year Deductible and Out-of-Pocket Maximums – Plan deductibles and out-of-pocket maximums reset January 1 (applies to Kaiser Permanente plans)

Coinsurance – The sharing of cost between you and the plan. For example, 80% coinsurance means the plan covers 80% of the allowed cost of service after a deductible is met. You will be responsible for the remaining 20% of the allowed cost assuming you remain in network. You could be subject to Balance Billing if you go out-of-network.

Consumer Driven Health Plan (CDHP) – A type of health plan that gives you more control of your health care expenses. A CDHP most often pairs with a Health Savings Account (HSA) or some other tax-advantaged account.

Copay – A fixed amount (for example \$15) you pay for a covered health care service, usually when you receive the service. The amount can vary by the type of service.

Deductible – The amount you have to pay for covered services each year before your health plan begins to pay.

Fiscal year maximum – The maximum benefit amount paid each fiscal year for each family member enrolled in the dental plan.

Generic drugs – A drug that's equivalent to brand-name drugs in use, dose, strength, quality and performance, but is not trademarked.

Health Savings Account (HSA) – An HSA is a personal savings account for those enrolled in a Consumer Driven Health Plan (CDHP). You may use your HSA to pay for qualified medical expenses such as doctor's office visits, hospital care, prescription drugs, dental care and vision care. You can use the money in your HSA to pay for qualified medical, dental, and vision expenses now, or in the future, for yourself and your dependents, even if they are not covered by the CDHP.

In-network – A designated list of health care providers (doctors, dentists, etc.) with whom the insurance provider has negotiated special rates. Using in-network providers lowers the cost of services for you and the company.

Inpatient – Services provided to an individual during an overnight hospital stay.

Mail order pharmacy – Mail order pharmacies generally provide a 90-day supply of a prescription medication for a lesser copay amount. Plus, mail order pharmacies offer the convenience of shipping directly to your door.

Non-preferred brand drugs – A drug with a patent and trademark name that is "not preferred" because it's usually more expensive than other generic and brand preferred options.

Out-of-network – Providers that are not in the plan's network and who have not negotiated discounted rates. The cost of services provided by out-of-network providers is much higher for you and the City. Higher deductibles and coinsurance will apply.

Out-of-pocket maximum – The maximum amount you and your family must pay for eligible expenses each plan year. Once your expenses reach the out-of-pocket maximum, the plan pays benefits at 100% of eligible expenses for the remainder of the year. Your annual deductible is included in your out-of-pocket maximum.

Outpatient – Services provided to an individual at a hospital facility without an overnight hospital stay.

PBM – Pharmacy Benefit Manager

Plan Year Deductible and Out-of-Pocket Maximum – Deductibles and Out-of-Pocket maximums reset every July 1 (applies to UHC plans).

Preferred brand drugs – A drug with a patent and trademark name that is considered "preferred" because it's safe and effective and usually less expensive than other brand-name options.

Primary Care Provider (PCP) – A doctor (generally a family or internal medicine practitioner or pediatrician) who provides ongoing medical care. A primary care physician treats a wide variety of health-related conditions.

Reasonable & Customary Charges (R&C) – Prevailing market rates for services provided by health care professionals within a certain area for certain procedures. Reasonable and Customary rates may apply to out-of-network charges.

Specialist – A provider who has specialized training in a particular branch of medicine (e.g., a surgeon, cardiologist or neurologist).



Contact Information

| Coverage | CARRIER | PHONE | WEBSITE/EMAIL |
|------------------------|---------------------------------------|--------------|--|
| Medical and Pharmacy | UnitedHealthcare (Group #: 714332) | 866-844-4864 | myuhc.com |
| Medical and Pharmacy | Kaiser Permanente (Group #: 4073) | 855-249-5018 | kp.org |
| Health Savings Account | Optum Bank | 866-234-8913 | optumbank.com/support/customer-support/contact-us.html |
| Dental | Aetna (Group #: 737479) | 877-238-6200 | aetna.com |
| Vision | Aetna (Group #737479) | 877-973-3238 | aetnavision.com |
| Human Resources | Benefits Team | 703-746-3777 | alexandriava.gov/human-resources/retirees-corner DHR.Benefits@alexandriava.gov |

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This document is an outline of the coverage provided under your employer's benefit plans based on information provided by your company. It does not include all the terms, coverage, exclusions, limitations, and conditions contained in the official Plan Document, applicable insurance policies and contracts (collectively, the "plan documents"). The plan documents themselves must be read for those details. The intent of this document is to provide you with general information about your employer's benefit plans. It does not necessarily address all the specific issues which may be applicable to you. It should not be construed as, nor is it intended to provide, legal advice. To the extent that any of the information contained in this document is inconsistent with the plan documents, the provisions set forth in the plan documents will govern in all cases. If you wish to review the plan documents or you have questions regarding specific issues or plan provisions, you should contact your Human Resources/Benefits Department.