Serving Learners, Families, and the Community

CECIL COUNTY PUBLIC SCHOOLS
OFFICE OF THE SUPERINTENDENT
GEORGE WASHINGTON CARVER EDUCATION LEADERSHIP CENTER
201 BOOTH STREET • ELKTON, MD 21921

phone: 410.996.5499 • fax: 410.996.5471 • www.ccps.org

Jeffrey A. Lawson, Ed.D.
Superintendent of Schools

Diana B. Hawley
President, Board of Education

Notice Concerning Your Spouse's Eligibility

CCPS will provide primary medical coverage to any spouse whose employer does not offer medical coverage, or an individual medical plan that costs the spouse more than $239 per month.

In order to determine your spouse's eligibility for medical insurance, information is required to be uploaded to your Benelogic File cabinet as described below:

- *If your spouse is employed:* **Form 1** must be completed and signed by you; and **Form 2** must be completed and signed by you, your spouse, and your spouse's employer. Copy of Summary of Benefits for all plans offered along with the employer's rate shate.

- *If your spouse is self-employed, unemployed or retired:* **Form 1** must be completed and signed by you.

- *If your spouse is employed and you are carrying them as secondary coverage:* **Form 1** must be completed and signed by you and copy of the insurance card.

If for any reason a CCPS Employee fails to furnish the required documentation within 31 days of the Open Enrollment end date or their qualified life event change effective date, CCPS medical coverage, including prescription drug, will be reduced to 20%.

Please Note: If your spouse is eligible for and enrolled in a non-HSA health care plan provided by their own employer, your spouse's insurance will be considered primary and the CCPS will provide secondary coverage. CCPS will pay claims under the CCPS plan only after the other insurance company issues its benefit payment. Combined payment from both plans will not exceed 100% of the claim. Additionally, if your spouse is enrolled in a HSA through their employer, CCPS cannot provide secondary coverage per IRS Ruling 2005-25.

It is critical for you to promptly communicate your spouse's change in work status to CCPS, as their insurance eligibility may be directly affected. In order to determine your spouse's eligibility for other health insurance coverage, additional information will be required periodically from all active employees who have a spouse on their CCPS health insurance

For more information, please contact the Benefits office at:

BENEFITSINFO@CCPS.ORG
(410) 996-5415

Enclosures

Cecil County Public Schools
Benefits Department

Spousal Coordination of Benefits Form
Form 1

Instructions: Complete and upload the document to your Benelogic file cabinet. Please be aware that returning incomplete forms, including missing signatures, will delay the determination process.

PLEASE PRINT ALL INFORMATION REQUESTED			Check Medical Carrier: ☐ Blue Cross ☐ Aetna
Full Name (Last, First, Middle Initial):			Home Phone Number (Include area code):
CCPS Employee ID Number:			Is your spouse a benefit eligible CCPS employee? ☐ Yes ☐ No
Spouse's Full Name (Last, First, Middle Initial):	Spouse's Last Four of Social Security Number:	Spouse: ☐ Male ☐ Female	Spouse's Date of Birth:

Spouse Information

My spouse is: ☐ Not Employed ☐ Employed Full-time ☐ Employed Part-time ☐ Self-employed ☐ Retired

Name and Address of Spouse's Employer:	Spouse's Employer Human Resource/Benefits Office Contact Information: HR/Benefits Contact Name: HR/Benefits Contact Phone Number:

1. Does your spouse's employer offer medical insurance to its employees? ☐ Yes ☐ No

2. Does the medical plan(s) offered by your spouse's employer cover prescription drugs? ☐ Yes ☐ No ☐ Unsure ☐ N/A

3. Is your spouse enrolled in medical insurance made available through their employer? ☐ Yes ☐ No ☐ N/A

4. Does your spouse's employer offer a wellness incentive that is tied into the cost of their medical insurance? ☐ Yes ☐ No ☐ Unsure ☐ N/A

5. Does your spouse's employer charge a fee in addition to the regular cost of medical insurance for reasons such as tobacco use, weight, spousal coverage, etc.? ☐ Yes ☐ No ☐ Unsure ☐ N/A
   If so, what is the amount of the surcharge? _____

6. If your spouse is offered benefits through their employer, what is the monthly employee cost for the lowest **employee only** medical plan, including any incentive discounts offered by the employer? Please be sure to include flexible benefit and health savings account credits made by your spouse's employer. _____

7. If your spouse is electing secondary medical insurance through CCPS, please provide the primary insurance carrier's information: Insurance Carrier Name: _____
   Policy Number: _____
   Member ID: _____
   Insurance Effective Date: _____

8. What is the annual plan renewal dates for your spouse's employer medical coverage? _____ through _____

9. If you are completing this form as a result of your spouse's loss of coverage, please indicate the date their coverage will end/ended. _____

10. Additional Comments? _____

_____

Continued on back

Employee Authorization and Acknowledgement

I understand that the following applies to spouses eligible for medical coverage through their own employer:

- This information will be shared with the Cecil County Public Schools' plan administrator(s).
- If a spouse elects secondary medical coverage through CCPS, their employer's plan will be primary and will pay towards their covered expenses before the CCPS plan will pay towards additional covered expenses, if any, up to the maximum allowed under the CCPS plan. At no time will payment exceed 100% of the allowable benefits.
- If my spouse enrolls in or is enrolled by their employer in a Health Savings Account, I cannot provide secondary medical coverage through CCPS, per IRS RULING 2005-25.

I understand this form must be completed in order to enroll my spouse on my CCPS medical insurance plan. This form will be used to determine my spouse's eligibility to receive primary CCPS medical benefits. The following spouses are eligible for primary CCPS coverage:

- Spouses whose employer does not offer medical coverage, or
- Spouses whose employer's require an employee contribution of more than $239 per month for the lowest priced individual medical benefit plan.

I understand that if any of this information changes, I must complete a new form within 31 days of the change effective date.

Notice to all parties completing this form: To ensure benefits are coordinated properly between employers, CCPS will verify the accuracy of information by conducting audits, contacting you, and/or contacting your spouse's employer. Providing false information may result in disciplinary action, up to and including termination of employment. **Please return completed form to the Benefits Office.**

I certify that to the best of my knowledge all statements made in the Spouse Information section are correct.

_____ _____

CCPS Employee Signature *Date*

Cecil County Public Schools
Benefits Department

Spousal Coordination of Benefits Form 2

Instructions: Complete the Employee & Spouse section and have your spouse's employer complete the Employer Statement section. Upload both forms 1 and 2 along with all support documentation to your Benelogic file cabinet within 31 days of the Open Enrollment end date or the qualifying life change event effective date. Please be aware that incomplete forms, including missing signatures, will delay the determination process.

EMPLOYEE & SPOUSE

CCPS Employee Name: _____

CCPS Employee ID: _____

Spouse's Name: _____

Spouse's Last Four of Social Security Number: _____

I understand this form must be completed in order to add my spouse to my CCPS medical insurance plan. This form will be used to determine a spouse's eligibility to receive primary CCPS health benefits.

I understand if any of this information on this form changes, or my spouse or I experience a qualifying life event, must complete a new form within 31 days of the change effective date.

X _____ _____

CCPS Employee Signature *Date*

Spouse's Authorization to Release Information

I hereby authorize my employer to release information requested below in the course of my benefit verification. I also understand that if there is any change in this information I must notify Cecil County Public Schools within 31 days of the qualifying life event effective date.

X _____ _____

Signature of Spouse of CCPS Employee *Date*

EMPLOYER STATEMENT

Employer name and address: _____

_____

1. Does your organization offer a medical plan to its employees? YES____ NO____

If you selected "No", stop here and sign on the back of the form. Please return the completed form to your employee.

2. Please list all of the medical plans offered to the spouse by your organization and the monthly employee cost for ***individual only*** coverage. If your company offers a wellness related incentive on medical premiums, please indicate the cost of the medical plan as if the spouse participated. **Attach a copy of your organization's rate sheet and Benefits Summary for all plans offered.**

Plan Name				
Type of Plan (HMO, PPO, POS, HDHP, HSA, etc.)				
The Employee's monthly cost for Individual Coverage				
Is a health and welfare fringe benefit offered. If yes, what is the amount?				
Does the plan have an associated Health Savings Account (HSA)?				
Dollar amount the employer contributes to the HSA on behalf of the employee.				

Continued on back

Employer Statement Continued

3. Is the above referenced spouse eligible for medical benefits through your organization? YES____ NO____

If no, please indicate why spouse is not eligible:

_____

4. If the above referenced spouse is not currently eligible for medical benefits through your organization, will they be eligible to enroll in a medical plan in the future?

YES____ NO_____ If so when? _____

5. Is the above referenced spouse currently enrolled in your organization's medical benefit program?

YES____ NO____

If Yes: Name of insurance plan _____

Group # of insurance plan _____

Effective Date of coverage_____

A member of the Cecil County Public Schools' Benefits Office may be in contact if there are any questions regarding the information provided on this form.

Thank you for completing this form. If you need further clarification on any questions we have asked, please call (410) 996-5415.

_____ _____

Name (Please Print) *Phone number*

_____ _____

Job Title *email address*

X _____ _____

Signature *Date*