Cecil County Public Schools

Benefits Reference Guide

September 1, 2025 - August 31, 2026

Open Enrollment

May 5, 2025 - May 19, 2025

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Introduction

Cecil County Public Schools is proud to offer a variety of benefit options. You can choose from a number of plans including medical, dental, vision, life insurance and voluntary supplemental programs. Whether you are a new employee enrolling in benefits for the first time or considering your benefit options during open enrollment, this guide is designed to help you through the process. Please take the time to review this information and ask questions so you can make the best decisions for you and your family.

Open enrollment will begin May 5, 2025 and will end May 19, 2025, for the benefit plan year beginning September 1, 2025. If you do not make a new election during the open enrollment period, the prior year's elections will remain in place. **This does not apply to your enrollment in a flexible spending account. If you currently contribute to a flexible spending account and/or wish to contribute for the new plan year, you will need to re-enroll during open enrollment.**

If you have any questions regarding any of the information in this reference guide or require additional information about the CCPS benefits and retirement programs, please visit the website at www.ccps.org or contact the Benefits Office by phone at 410-996-5415 or email at benefitsinfo@ccps.org.

2025 - 2026 Plan Highlights

Plan Design Changes:

Medical:
Aetna HDHP has mandatory changes due to IRS regulations required to keep plan compliant for HSA contributions. No other plan design change to CareFirst (PPO) or Aetna (HMO).

Dental:
No plan design changes to dental plan administered through United Concordia (UCCI).

Vision:
No plan design changes to the 2 existing visions plans offered through EyeMed.

Basic Life & Voluntary Life:
No plan design changes to plan administered through The Hartford.

Rates:
Due to continued rising health care costs, premiums for all of our medical plans, including dental, will be increasing. For more information on those rates, please visit pages14-17.

Payroll Deductions:
The first deduction for your 2025 - 2026 benefits will be on your August 29, 2025, paycheck. Please do not forget to review your deductions to make sure they match your enrollment confirmation statement, which can be printed after completing your enrollment in Benelogic.

Open Enrollment Process

1. **Review your current benefits.** You may access this information by logging into Benelogic (www.ccps.benelogic.com) and clicking on "View Current Benefits". Directions to access your user portal can be found on page 32 of this reference guide. This information reflects your current 2024 - 2025 benefit and dependent information.
2. **Gather documentation for enrollment.** Employees who are adding dependents may be required to upload documentation to the Benelogic File Cabinet to verify dependent eligibility.
3. **Select your benefits.** Access your online enrollment portal at www.ccps.benelogic.com.
4. Verify your benefits on Benelogic. Verify the benefit selections you made are correct. **Print your confirmation statement containing your benefit selections for you and your family.**

Resource Directory

Employer

Cecil County Public Schools (CCPS)
Employee Benefits Department
Monday - Friday, 8:00 a.m. - 4:30 p.m.
(410) 996-5415
benefitsinfo@ccps.org

Directors of Human Resources

Ms. Summer Hodgson
slhodgson@ccps.org

Ms. Joanna Zimmerman
jkzimmerman@ccps.org

Assistants in Human Resources

Ms. Margaret Brown
margaretbrown@ccps.org

Ms. Briane Crouse
bmcrouse@ccps.org

Ms. Melissa Stevens
mestevens@ccps.org

Ms. Cathy Thomas
cthomas@ccps.org

HR Generalists

Ms. Andrea Malone
amalone@ccps.org

Ms. Rosemary Morgan
rmmorgan@ccps.org

Ms. Madison Onifer
maonifer@ccps.org

Administrative Secretaries

Ms. Melisa Nichols
msnichols@ccps.org

Ms. Susan Thompson
slthompson@ccps.org

Provider Companies

Health & Wellness Benefits

Aetna Health Insurance Company
Medical
151 Farmington Ave
Hartford, CT 06156
1-800-370-4526
www.aetna.com

CareFirst BlueCross BlueShield
Medical
PO Box 14115
Lexington, KY 40512-4115
Customer Service: (877) 691-5856
Behavioral Health Certification:
(800) 245-7013
Pre-Authorization: (866) 773-2884
www.carefirst.com

Express Scripts Prescription
1 Express Way
St. Louis, MO 63121
Phone: (800) 282-2881
www.express-scripts.com

Home Delivery Program:
Express Scripts
Home Delivery Service
P.O. Box 6656
St. Louis, MO 63166-6566
Fax: (800) 837-0959
Accredo Specialty Pharmacy
Phone: (877) 222-7336
https://accredo.com/contactus

United Concordia - Dental
1(866) 851-7568
www.unitedconcordia.com/ccps

EyeMed - Vision
PO Box 8504
Mason, OH 45040-7111
(800) 521-3605
www.eyemedvisioncare.com

Business Health Services
Employee Assistance Program
24-Hour Line: (800) 765-3277
https://portal.bhsonline.com/

US Wellness
CCPS Wellness Program
(844) 542-9700
https://cecil-county-public-schools.uswellness.com/

Teladoc
Telemedicine Consultations
(855) 835-2362
teladoc.com/ccps

Tax Favored Accounts

Flexible Benefit Administrators
Flexible Spending Account
PO Box 8188
Virginia Beach, VA 23450
(800) 437-3539
https://fba.wealthcareportal.com/
flexdivision@flex-admin.com

Inspira Financial
Health Savings Account
10802 Farnam Drive, Suite 100
Omaha, NE 68154
(888) 678-8242
www.inspirafinancial.com

Life Insurance

The Hartford
(866) 294-7987
Fax: (866) 427-8329
www.thehartford.com
690 Asylum Avenue
Hartford, CT 06155

Disability/Income Protection

Trustmark Disability Income Insurance
(800) 918-8877
www.trustmarksolutions.com/individual

Retirement Planning

Lincoln Financial Group
Retirement
(800) 234-3500
www.lfg.com

State Retirement Agency
120 East Baltimore Street
Baltimore, MD 21202-6700
(800) 492-5909
www.sra.state.md.us

Summary of Benefits & Coverage

As an employee, the medical benefits available to you represent a significant component of your compensation package. They also provide important protection for you and your family in the case of illness or injury.

Choosing a medical plan is an important decision. To help you make an informed choice, this benefit guide provides you with a Summary of Benefits and Coverage (SBC), which summarizes important information about each medical coverage option in a standard format, to help you compare across options.

A Summary of Benefits and Coverage is provided of the three medical plans offered by Cecil County Public Schools (CCPS):

⇒ Aetna High Deductible Health Plan (HDHP)
⇒ Aetna Select Open Access HMO Plan
⇒ CareFirst BlueCross BlueShield CORE PPO Plan

Each SBC is also available on the CCPS website, www.ccps.org under the Benefits section.

A paper copy of each SBC is available upon request, free of charge, by calling the Benefits Office at (410) 996-5415.

Summary of Benefits and Coverage: What this Plan Covers & What You Pay for Covered Services

Coverage Period: 09/01/2025-08/31/2026

aetna CECIL COUNTY PUBLIC SCHOOLS Open Choice® - HDHP

Coverage for: EE Only; EE+ Family | Plan Type: PPO

The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately. This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, www.HealthReformPlanSBC.com or by calling 1-800-370-4526. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms, see the Glossary. You can view the Glossary at https://www.healthcare.gov/sbc-glossary/ or call 1-800-370-4526 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	For each Plan Year, In-Network: EE Only $1,650; EE+ Family $3,300; Out-of-Network: EE Only $3,300 EE+ Family $6,600.	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the policy, the overall family deductible must be met before the plan begins to pay.
Are there services covered before you meet your deductible?	Yes. In-network preventive care is covered before you meet your deductible.	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost sharing and before you meet your deductible. See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/
Are there other deductibles for specific services?	No.	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	In-Network: EE Only $3,300; EE+ Family $6,600. Out-of-Network: EE Only $6,600; EE+ Family $13,200.	The out–of–pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, the overall family out–of–pocket limit must be met.
What is not included in the out-of-pocket limit?	Premiums, balance-billing charges & health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the out–of–pocket limit.
Will you pay less if you use a network provider?	Yes. See www.aetna.com/docfind or call 1-800-370-4526 for a list of in-network providers.	This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware, your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist?	No.	You can see the specialist you choose without a referral.

All **copayment** and **coinsurance** costs shown in this chart are after your **deductible** has been met, if a **deductible** applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	10% coinsurance	30% coinsurance	None
	Specialist visit	10% coinsurance	30% coinsurance	None
	Preventive care /screening /immunization	No charge	30% coinsurance	You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	10% coinsurance	30% coinsurance	None
	Imaging (CT/PET scans, MRIs)	10% coinsurance	30% coinsurance	None
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.expressscripts.com	Generic drugs	10% coinsurance after deductible	Not covered	Not covered.
	Preferred brand drugs	10% coinsurance after deductible	Not covered	Not covered.
	Non-preferred brand drugs	10% coinsurance after deductible	Not covered	Not covered.
	Specialty drugs	10% coinsurance after deductible	Not covered	Not covered
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	10% coinsurance	30% coinsurance	None
	Physician/surgeon fees	10% coinsurance	30% coinsurance	None
If you need immediate medical attention	Emergency room care	10% coinsurance	10% coinsurance	Copay waived if admitted
	Emergency medical transportation	10% coinsurance	10% coinsurance	Non-emergency transport: not covered, except 30% coinsurance if pre-authorized.
	Urgent care	10% coinsurance	30% coinsurance	None
If you have a hospital stay	Facility fee (e.g., hospital room)	10% coinsurance	30% coinsurance	Pre certification is required
	Physician/surgeon fees	10% coinsurance	30% coinsurance	None

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Office & other outpatient services: 10% coinsurance	Office & other outpatient services: 30% coinsurance	None
	Inpatient services	10% coinsurance	30% coinsurance	Pre certification is required.
If you are pregnant	Office visits	No charge	30% coinsurance	Cost sharing does not apply for preventive services. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound.) Pre-authorization for out-of-network care may apply.
	Childbirth/delivery professional services	10% coinsurance	30% coinsurance	
	Childbirth/delivery facility services	10% coinsurance	30% coinsurance	
If you need help recovering or have other special health needs - Includes treatment of Autism & habilitation services	Home health care	10% coinsurance	30% coinsurance	Pre-authorization required for out-of-network care.
	Rehabilitation services	10% coinsurance	30% coinsurance	60 visits/plan year for Physical, Occupational, and Speech Therapy & Chiropractic care combined.
	Habilitation services	10% coinsurance	30% coinsurance	
	Skilled nursing care	10% coinsurance	30% coinsurance	100 days/plan year. Pre-authorization required for out-of-network care.
	Durable medical equipment	10% coinsurance	30% coinsurance	Limited to 1 durable medical equipment for same/similar purpose. Excludes repairs for misuse/abuse.
	Hospice services	10% coinsurance	30% coinsurance	Pre-authorization required for out-of-network care.
If your child needs dental or eye care	Children's eye exam	Not covered	Not covered	Not covered.
	Children's glasses	Not covered	Not covered	Not covered.
	Children's dental check-up	Not covered	Not covered	Not covered.

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)

• Acupuncture • Cosmetic surgery • Dental care (Adult & Child) • Glasses (Child)	• Long-term care • Non-emergency care when traveling outside the U.S. • Private-duty nursing	• Routine eye care (Adult & Child) • Routine foot care • Weight loss programs - Except for required preventive services.

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)		
• Bariatric surgery • Chiropractic care - 60 visits/plan year combined with rehabilitation services.	• Hearing aids - 1 hearing aid to $1,400 maximum per ear/36 months for children up to age 19.	• Infertility treatment - *For more information & exceptions, see policy document provided by your employer or call the number on your ID card.*

Your Rights to Continue Coverage:

There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is:

- For more information on your rights to continue coverage, contact the plan at 1-800-370-4526.
- If your group health coverage is subject to ERISA, you may also contact the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or http://www.dol/gov/ebsa/healthreform
- For non-federal governmental group health plans, you may also contact the Department of Health and Human Services, Center for Consumer Information and Insurance Oversight, at 1-877-267-2323 x61565 or www.cciio.cms.gov.
- If your coverage is a church plan, church plans are not covered by the Federal COBRA continuation coverage rules. If the coverage is insured, individuals should contact their State insurance regulator regarding their possible rights to continuation coverage under State law.

Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit www.HealthCare.gov or call 1-800-318-2596.

Your Grievance and Appeals Rights:

There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information on how to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact:

- Aetna directly by calling the toll free number on your Medical ID Card, or by calling our general toll free number at 1-800-370-4526.
- If your group health coverage is subject to ERISA, you may also contact the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or http://www.dol/gov/ebsa/healthreform
- For non-federal governmental group health plans, you may also contact the Department of Health and Human Services, Center for Consumer Information and Insurance Oversight, at 1-877-267-2323 x61565 or www.cciio.cms.gov.
- Additionally, a consumer assistance program can help you file your appeal. Contact information is at: http://www.aetna.com/individuals-families-health-insurance/rights-resources/complaints-grievances-appeals/index.html.

Does this plan provide Minimum Essential Coverage? Yes.

Minimum Essential Coverage - Generally includes plans, health insurance available through the Marketplace or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of Minimum Essential Coverage, you may not be eligible for the premium tax credit.

Does this plan meet Minimum Value Standards? No.

If your plan doesn't meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

To see examples of how this plan might cover costs for a sample medical situation, see the next section.

About these Coverage Examples:

This is not a cost estimator. Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost-sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

Peg is Having a Baby
(9 months of in-network pre-natal care and a hospital delivery)

The plan's overall deductible	**$1,600**
Specialist coinsurance	**10%**
Hospital (facility) coinsurance	**10%**
Other coinsurance	**10%**

This EXAMPLE event includes services like:
Specialist office visits *(prenatal care)*
Childbirth/Delivery Professional Services
Childbirth/Delivery Facility Services
Diagnostic tests *(ultrasounds and blood work)*
Specialist visit *(anesthesia)*

Total Example Cost	**$12,700**
In this example, Peg would pay:	
Cost Sharing	
Deductibles	$1,600
Copayments	$0
Coinsurance	$1,000
What isn't covered	
Limits or exclusions	$70
The total Peg would pay is	**$2,670**

Managing Joe's Type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

The plan's overall deductible	**$1,600**
Specialist coinsurance	**10%**
Hospital (facility) coinsurance	**10%**
Other coinsurance	**10%**

This EXAMPLE event includes services like:
Primary care physician office visits *(including disease education)*
Diagnostic tests *(blood work)*
Prescription drugs
Durable medical equipment *(glucose meter)*

Total Example Cost	**$5,600**
In this example, Joe would pay:	
Cost Sharing	
Deductibles	$1,600
Copayments	$0
Coinsurance	$0
What isn't covered	
Limits or exclusions	$4,300
The total Joe would pay is	**$5,900**

Mia's Simple Fracture
(in-network emergency room visit and follow up care)

The plan's overall deductible	**$1,600**
Specialist coinsurance	**10%**
Hospital (facility) coinsurance	**10%**
Other coinsurance	**10%**

This EXAMPLE event includes services like:
Emergency room care *(including medical supplies)*
Diagnostic test *(x-ray)*
Durable medical equipment *(crutches)*
Rehabilitation services *(physical therapy)*

Total Example Cost	**$2,800**
In this example, Mia would pay:	
Cost Sharing	
Deductibles	$1,600
Copayments	$0
Coinsurance	$100
What isn't covered	
Limits or exclusions	$10
The total Mia would pay is	**$1,710**

The plan would be responsible for the other costs of these EXAMPLE covered services.

Summary of Benefits and Coverage: What this Plan Covers & What You Pay for Covered Services

aetna™ CECIL COUNTY PUBLIC SCHOOLS: Aetna Open Access® Aetna SelectSM

Coverage Period: 09/01/2025-08/31/2026

Coverage for: Individual + Family | Plan Type: EPO

The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately. This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, www.HealthReformPlanSBC.com or by calling 410-996-5415. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms, see the Glossary. You can view the Glossary at https://www.healthcare.gov/sbc-glossary/ or call 1-800-318-2596 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	For each Plan Year, In-Network: Individual $200 / Family $400.	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible.
Are there services covered before you meet your deductible?	Yes. In-network preventive care is covered before you meet your deductible.	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost sharing and before you meet your deductible. See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/
Are there other deductibles for specific services?	No.	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	**In-Network: Individual $1,500 / Family $4,500.** **Prescription: $3,600 Individual / $7,200 Family**	The out–of–pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out–of–pocket limits until the overall family out–of–pocket limit has been met.
What is not included in the out-of-pocket limit?	Premiums, balance-billing charges & health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the out–of–pocket limit.
Will you pay less if you use a network provider?	Yes. See www.aetna.com/docfind or call 1-800-370-4526 for a list of in-network providers.	This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware, your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist?	No.	You can see the specialist you choose without a referral.

All **copayment** and **coinsurance** costs shown in this chart are after your **deductible** has been met, if a **deductible** applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$20 copay/visit	Not covered	None
	Specialist visit	$25 copay/visit	Not covered	None
	Preventive care /screening /immunization	No charge	Not covered	You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	$15 copay/visit	Not covered	None
	Imaging (CT/PET scans, MRIs)	$50 copay/visit	Not covered	None
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.express-scripts.com	Generic drugs	$5 copay retail/$10 copay for 90 day maintenance drug mail order	Not covered	Not covered.
	Preferred brand drugs	$25 copay retail/$50 copay for 90 day maintenance drug mail order	Not covered	Not covered.
	Non-preferred brand drugs	$50 copay retail/$100 copay for 90 ay maintenance drug mail order	Not covered	Not covered.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
	Specialty drugs	$5 copay retail for generic; $25 copay retail for preferred brand; $50 copay retail for non-preferred brand/$10 copay mail order for generic; $50 copay mail order for preferred brand; $100 copay mail order for non-preferred brand	Not covered	Not covered.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	$75 copay/visit	Not covered	None
	Physician/surgeon fees	0% coinsurance	Not covered	None
If you need immediate medical attention	Emergency room care	$75 copay/visit	$75 copay/visit	Copay waived if admitted
	Emergency medical transportation	0% coinsurance	0% coinsurance	Non-emergency transport: not covered, except if pre-authorized.
	Urgent care	$35 copay/visit	Not covered	None
If you have a hospital stay	Facility fee (e.g., hospital room)	0% coinsurance	Not covered	Pre certification is required
	Physician/surgeon fees	0% coinsurance	Not covered	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Office & other outpatient services: $25 copay/visit	Not covered	None
	Inpatient services	0% coinsurance	Not covered	None
If you are pregnant	Office visits	No charge	Not covered	Cost sharing does not apply for preventive services. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound.)
	Childbirth/delivery professional services	0% coinsurance	Not covered	
	Childbirth/delivery facility services	0% coinsurance	Not covered	
If you need help recovering or have	Home health care	0% coinsurance	Not covered	None
	Rehabilitation services	$25 copay/visit	Not covered	

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
other special health needs (Includes treatment of Autism & habilitation services)	Habilitation services	$25 copay/visit	Not covered	60 visits/plan year for Physical, Occupational, and Speech Therapy & Chiropractic care combined.
	Skilled nursing care	0% coinsurance	Not covered	100 days/plan year.
	Durable medical equipment	0% coinsurance	Not covered	Limited to 1 durable medical equipment for same/similar purpose. Excludes repairs for misuse/abuse.
	Hospice services	0% coinsurance	Not covered	None
If your child needs dental or eye care	Children's eye exam	Not covered	Not covered	Not covered.
	Children's glasses	Not covered	Not covered	Not covered.
	Children's dental check-up	Not covered	Not covered	Not covered.

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)

- Acupuncture
- Cosmetic surgery
- Dental care (Adult & Child)
- Glasses (Child)
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing
- Routine eye care (Adult & Child)
- Routine foot care
- Weight loss programs - Except for required preventive services.

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)

- Bariatric surgery
- Chiropractic care - 60 visits/plan year combined with rehabilitation services.
- Hearing aids - 1 hearing aid to $1,400 maximum per ear/36 months for children up to age 19.
- Infertility treatment - *For more information & exceptions, see policy document provided by your employer or call the number on your ID card.*

Your Rights to Continue Coverage:

There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is:

- For more information on your rights to continue coverage, contact the plan at 1-800-370-4526.

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- If your group health coverage is subject to ERISA, you may also contact the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or http://www.dol/gov/ebsa/healthreform
- For non-federal governmental group health plans, you may also contact the Department of Health and Human Services, Center for Consumer Information and Insurance Oversight, at 1-877-267-2323 x61565 or www.cciio.cms.gov.
- If your coverage is a church plan, church plans are not covered by the Federal COBRA continuation coverage rules. If the coverage is insured, individuals should contact their State insurance regulator regarding their possible rights to continuation coverage under State law.

Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about The Marketplace, visit www.HealthCare.gov or call 1-800-318-2596.

Your Grievance and Appeals Rights:

There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information on how to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact:

- Aetna directly by calling the toll free number on your Medical ID Card, or by calling our general toll free number at 1-800-370-4526.
- If your group health coverage is subject to ERISA, you may also contact the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or http://www.dol/gov/ebsa/healthreform
- For non-federal governmental group health plans, you may also contact the Department of Health and Human Services, Center for Consumer Information and Insurance Oversight, at 1-877-267-2323 x61565 or www.cciio.cms.gov.
- Additionally, a consumer assistance program can help you file your appeal. Contact information is at: http://www.aetna.com/individuals-families-health-insurance/rights-resources/complaints-grievances-appeals/index.html.

Does this plan provide Minimum Essential Coverage? **Yes.**

Minimum Essential Coverage - Generally includes plans, health insurance available through the Marketplace or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of Minimum Essential Coverage, you may not be eligible for the premium tax credit

.Does this plan meet Minimum Value Standards? **No.**

If your plan doesn't meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

To see examples of how this plan might cover costs for a sample medical situation, see the next section.

About these Coverage Examples:

This is not a cost estimator. Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost-sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

Peg is Having a Baby
(9 months of in-network pre-natal care and a hospital delivery)

The plan's overall deductible	$200
Specialist copayment	$25
Hospital (facility) coinsurance	0%
Other coinsurance	0%

This EXAMPLE event includes services like:
Specialist office visits *(prenatal care)*
Childbirth/Delivery Professional Services
Childbirth/Delivery Facility Services
Diagnostic tests *(ultrasounds and blood work)*
Specialist visit *(anesthesia)*

Total Example Cost	$12,700
In this example, Peg would pay:	
Cost Sharing	
Deductibles	$200
Copayments	$90
Coinsurance	$0
What isn't covered	
Limits or exclusions	$70
The total Peg would pay is	**$360**

Managing Joe's Type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

The plan's overall deductible	$200
Specialist copayment	$25
Hospital (facility) coinsurance	0%
Other coinsurance	0%

This EXAMPLE event includes services like:
Primary care physician office visits *(including disease education)*
Diagnostic tests *(blood work)*
Prescription drugs
Durable medical equipment *(glucose meter)*

Total Example Cost	$5,600
In this example, Joe would pay:	
Cost Sharing	
Deductibles	$200
Copayments	$200
Coinsurance	$0
What isn't covered	
Limits or exclusions	$4,300
The total Joe would pay is	**$4,700**

Mia's Simple Fracture
(in-network emergency room visit and follow up care)

The plan's overall deductible	$200
Specialist copayment	$25
Hospital (facility) coinsurance	0%
Other coinsurance	0%

This EXAMPLE event includes services like:
Emergency room care *(including medical supplies)*
Diagnostic test *(x-ray)*
Durable medical equipment *(crutches)*
Rehabilitation services *(physical therapy)*

Total Example Cost	$2,800
In this example, Mia would pay:	
Cost Sharing	
Deductibles	$200
Copayments	$200
Coinsurance	$0
What isn't covered	
Limits or exclusions	$10
The total Mia would pay is	**$410**

Note: These numbers assume the patient does not participate in the plan's wellness program. If you participate in the plan's wellness program, you may be able to reduce your costs. For more information about the wellness program, please contact: 1-800-370-4526.

The plan would be responsible for the other costs of these EXAMPLE covered services.

Summary of Benefits and Coverage: What this Plan Covers & What You Pay For Covered Services

Cecil County Public Schools

PPO Core

Coverage Period: 09/01/2025-08/31/2026

Coverage for: Individual, Parent & Child, Individual & Spouse, Parent & Children, and Family| Plan Type: PPO

The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately.

This is only a summary. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms see the Glossary. You can see the Glossary at www.carefirst.com/sbcg or call 1-877-691-5856 to request a copy. For more information about your coverage, or to get a copy of the complete terms of coverage, please visit www.carefirst.com.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	In-network providers $500 Individual / $1,500 Family. Out-of-network providers $1,000 Individual / $3,000 Family.	You must pay all the costs up to the deductible amount before this plan begins to pay for covered services you use. The deductible starts over January 1. See the chart starting on page 2 for how much you pay for covered services after you meet the deductible. Coinsurance and copayments do not count toward deductible. Does not apply to preventative care. Does not apply to prescription drug.
Are there services covered before you meet your deductible?	Yes, all In-Network preventive care is covered before you meet your deductible.	This plan covers certain preventative care services without cost-sharing and before you meet your deductible. See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/.
Are there other deductibles for specific services?	There are no other specific deductibles.	You do not have to meet deductibles for specific services, but see the chart starting on page 2 for other costs for services this plan covers
What is the out-of-pocket limit for this plan?	Medical: In-Network providers $2,500 Individual/$5,000 Family. Out-of-Network providers $2,500 Individual/$$5,000 Family. Prescription: $3,600 Individual / $7,200 Family	The out-of-pocket limit is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses.
What is not included in the out-of-pocket limit?	Premiums, balance-billing charges, health care this plan doesn't cover, copayments for certain services, and penalties for failure to obtain pre-authorization for services.	Even though you pay these expenses, they don't count toward the out-of-pocket limit
Will you pay less if you use a network provider?	Yes. See www.carefirst.com or call 877-691-5856 for a list of Network providers.	This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most of you use an out-of-network provider, and you might receive a bill from a provider for the cost of your visit if you receive services from an out-of-network provider (a balance bill). Be aware, your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.

Do you need a referral to see a specialist?	No.	You can see the specialist you choose without a referral.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$20 copay/visit after deductible	30% coinsurance after deductible	If a service is rendered at a Hospital Facility, the additional Facility charge may apply
	Specialist visit	$20 copay/visit after deductible	30% coinsurance after deductible	If a service is rendered at a Hospital Facility, the additional Facility charge may apply
	Retail health clinic	Deductible, then $35 copay per visit	Deductible, then 30% of Allowed Benefit	None
	Preventive care/screening/ immunization	No Charge for covered services	Deductible, then 30% of Allowed Benefit	You may have to pay for services that aren't preventive. Ask your provider if the services you need are preventive. Then check what your plan will pay for. Maximum tests per year may apply.
If you have a test	Diagnostic test (x-ray, blood work)	$15 copay/visit after deductible	30% coinsurance after deductible	----------None----------
	Imaging (CT/PET scans, MRIs)	$75 copay/visit after deductible	30% coinsurance after deductible	----------None----------
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at Express Scripts www.expressscripts.com	Generic drugs	$5 copay retail / $10 copay for 90 day maintenance drug mail order	Not Covered	None
	Preferred brand drugs	$25 copay retail / $50 copay for 90 day maintenance drug mail order	Not Covered	
	Non-preferred brand drugs	$50 copay retail / $100 copay for 90 day maintenance drug mail order	Not Covered	
	Preferred Specialty drugs	$5 copay retail for generic; $25 copay retail for preferred brand	Not Covered	
	Non-preferred Specialty drugs	$50 copay Non-preferred brand retail $100 copay Non-preferred brand mail order	Not Covered	

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	$35 copay/visit after deductible	30% coinsurance after deductible	----------None----------
	Physician/surgeon fees	$20 copay/visit for PCP and specialist after deductible $25 copay/visit for practitioner at hospital after deductible	30% coinsurance after deductible	----------None----------
If you need immediate medical attention	Emergency room care	$100 copay/visit after deductible	$100 copay/visit after deductible	Copay waived if admitted.
	Emergency medical transportation	$0 copay after deductible	$0 copay after deductible	----------None----------
	Urgent care	$35 copay after deductible	$35 copay after deductible	----------None----------
If you have a hospital stay	Facility fee (e.g., hospital room)	10% coinsurance after deductible	30% coinsurance after deductible	Prior authorization is required
	Physician/surgeon fees	$20 copay PCP and Specialist after deductible; $25 copay Practitioner at hospital after deductible	30% coinsurance after deductible	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Office Visit: Deductible, then $20 copay per visit Hospital Facility: Deductible, then $25 copay per visit	Office Visit & Hospital Facility: Deductible, then 30% of Allowed Benefit	For treatment at an Outpatient Hospital Facility, additional charges may apply
	Inpatient services	Deductible, then 10% of Allowed Benefit	Deductible, then 30% of Allowed Benefit	Prior authorization is required; Additional professional charges may apply
If you are pregnant	Office Visits	No charge for covered services	30% coinsurance after deductible	Cost sharing does not apply for preventive services. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound) that may be subject to the deductible, coinsurance, and/or copay.
	Childbirth/delivery professional services	10% coinsurance after deductible	30% coinsurance after deductible	None
	Childbirth/delivery facility services	10% coinsurance after deductible	30% coinsurance after deductible	Additional professional charges may apply

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need help recovering or have other special health needs	Home health care	$35 copay facility; $25 copay practitioner at facility after deductible; $20 practitioner in office after deductible	30% coinsurance after deductible	Physical Therapy is limited to 100 visits per plan year.
	Rehabilitation services	$35 copay facility; $25 copay practitioner at facility after deductible; $20 practitioner in office after deductible	30% coinsurance after deductible	Preauthorization required after initial visit.
	Habilitation services	10% coinsurance after deductible	30% coinsurance after deductible	----------None----------
	Skilled nursing care	10% coinsurance after deductible	30% coinsurance after deductible	----------None----------
	Durable medical equipment	10% coinsurance after deductible	30% coinsurance after deductible	Treatment plan required.
	Hospice services	$35 copay facility; $25 copay practitioner at facility after deductible; $20 practitioner in office after deductible	30% coinsurance after deductible	Physical Therapy is limited to 100 visits per plan year.
If your child needs dental or eye care	Children's eye exam	Not covered	Not covered	None
	Children's glasses	Not covered	Not covered	None
	Children's dental check-up	Not covered	Not covered	None

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)

- Cosmetic surgery
- Dental care (Adult)
- Long-term care
- Routine eye care
- Routine foot care
- Weight loss programs

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)

- Abortion
- Acupuncture
- Bariatric surgery
- Chiropractic care
- Coverage provided outside the US. See www.carefirst.com
- Hearing aids
- Infertility treatment
- Non-emergency care when travelling outside the US
- Private-duty nursing

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: Department of Labor Employee Benefits Security Administration, http://www.dol.gov/ebsa/healthreform, or call 1-866-444-EBSA (3272); or Department of Health and Human Services, Center for Consumer Information and Insurance Oversight, http://www.cciio.cms.gov, or call 1-877-267-2323 x61565. Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit www.HealthCare.gov or call 1-800-318-2596.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact: Department of Labor Employee Benefits Security Administration, http://www.dol.gov/ebsa/healthreform, or call 1-866-444-EBSA (3272); or Department of Health and Human Services, Center for Consumer Information and Insurance Oversight, http://www.cciio.cms.gov, or call 1-877-267-2323 x61565.

Does this plan provide Minimum Essential Coverage? **Yes**
If you don't have Minimum Essential Coverage for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

Does this plan meet the Minimum Value Standards? **Yes**
If your plan doesn't meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

Language Access Services:
[Spanish (Español): Para obtener asistencia en Español, llame al 1-855-258-6518.]
[Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-855-258-6518.]
[Chinese (中文): 如果需要中文的帮助，请拨打这个号码 1-855-258-6518.]
[Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-855-258-6518.]

To see examples of how this plan might cover costs for a sample medical situation, see the next section.

About these Coverage Examples:

This is not a cost estimator. Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

Peg is Having a Baby
(9 months of in-network pre-natal care and a hospital delivery)

- The plan's overall deductible $500
- Specialist *copayment* $20
- Hospital (facility) *coinsurance* 10%
- Other *coinsurance* 10%

This EXAMPLE event includes services like:
Specialist office visits (*prenatal care*)
Childbirth/Delivery Professional Services
Childbirth/Delivery Facility Services
Diagnostic tests (*ultrasounds and blood work*)
Specialist visit (*anesthesia*)

Total Example Cost	$7,540

In this example, Peg would pay:

Cost Sharing	
Deductibles	$500
Copayments	$140
Coinsurance	$210
What isn't covered	
Limits or exclusions	$150
The total Peg would pay is	**$1,000**

Managing Joe's type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

- The plan's overall deductible $500
- Specialist *copayment* $20
- Hospital (facility) *coinsurance* 10%
- Other *coinsurance* 10%

This EXAMPLE event includes services like:
Primary care physician office visits (*including disease education*)
Diagnostic tests (*blood work*)
Prescription drugs
Durable medical equipment (*glucose meter*)

Total Example Cost	$4,100

In this example, Joe would pay:

Cost Sharing	
Deductibles	$500
Copayments	$360
Coinsurance	$130
What isn't covered	
Limits or exclusions	$80
The total Joe would pay is	**$1,070**

Mia's Simple Fracture
(in-network emergency room visit and follow up care)

- The plan's overall deductible $500
- Specialist *copayment* $20
- Hospital (facility) *coinsurance* 10%
- Other *coinsurance* 10%

This EXAMPLE event includes services like:
Emergency room care (*including medical supplies*)
Diagnostic test (*x-ray*)
Durable medical equipment (*crutches*)
Rehabilitation services (*physical therapy*)

Total Example Cost	$9,850

In this example, Mia would pay:

Cost Sharing	
Deductibles	$500
Copayments	$200
Coinsurance	$300
What isn't covered	
Limits or exclusions	$50
The total Mia would pay is	**$1,050**

The plan would be responsible for the other costs of these EXAMPLE covered services.

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Cecil County Public Schools

Benefit Eligibility

Employees

All CCPS employees who work at least 17.5 hours per week in a budgeted position will be eligible for benefits. Employees who work at least 30 hours per week in a budgeted position will also be eligible for a Board contribution towards the cost of the benefit premiums.

New Employees

New Employees have 31 days from their date of hire to complete their enrollment in a CCPS benefits program. If you have moved from a non-benefits eligible status to a benefits eligible status, you will have 31 days from the new eligible status effective date to complete your enrollment. All insurance coverage starts the first of the month following eligibility.

Dependents

You may elect to cover any of your legal dependents under the health care plan. Eligible dependents include:

- **Your child(ren):** your natural children; legally adopted children or children placed with you for adoption; foster children; your stepchildren, regardless of place of residence while you are married to the natural parent, any children who live with you; depends on you for support, and for whom you serve as legal guardian, and any children you are responsible for as a result of a court-ordered custody arrangement. Children may be covered by the medical plan without any student verification requirements up to age 26. Children can be covered by the dental and vision plan up to age 19, or 23 if they are a full-time student. A copy of the official birth certificate, adoption paperwork, or signed court document, and a copy of their social security card must be furnished to the Benefits Office **within 31 days from your date of enrollment**. These documents may be uploaded into the Benelogic "File Cabinet" link.
- **Disabled Dependent:** If your child becomes physically or mentally disabled while covered by a CCPS benefit plan, proof of continuing disability may be required by the carrier to continue coverage beyond the age of 26.
- **Your spouse:** a person to whom you are legally married. Such a person remains a spouse until a decree of divorce is issued. If you are adding a spouse, a copy of the marriage certificate, a copy of the most recent Federal 1040 tax return showing filing status, the spouse's social security card, the Spousal Coordination form and, if employed, the Spouse's Employer Verification form must be furnished to the Benefits Office **within 31 days from your date of enrollment**. These documents may be uploaded into the Benelogic "File Cabinet" link.

Spousal Coordination Requirements

CCPS will provide primary coverage for spouses who are not eligible for health care coverage through their employer. In order to certify a spouse's eligibility for CCPS primary or secondary medical coverage, employees must return a completed Spousal Coordination of Benefits Information Form(s) to the Benefits Office within 31 days of the election of coverage.

How are benefit payments for spousal claims affected?

- If the employee's spouse is eligible for and enrolled in a non-HSA health care plan offered by his or her employer, CCPS will pay for benefits provided under any CCPS health care plan after the spouse's health care pays as the primary insurance carrier. Payments from both plans combined will not exceed 100% of the allowable benefit charge.
- If the employee's spouse is not eligible for health care coverage through their employer, CCPS will pay for benefits as provided under the employee's selected health care plan.
- If the employee's spouse is eligible for and does not enroll in the health care plan offered by his or her employer, the CCPS plan will only pay 20% of allowable charges for services under any CCPS health care plan.

When will CCPS provide primary medical coverage to spouses?
Generally, the employee's spouse is not required to be enrolled in the health care plan where he or she works if ONE of the following applies:

- The spouse is not eligible for benefits under the employer's health care plan because the spouse has not satisfied the employer's requirements as to the number of hours worked.
- The spouse's employer requires the employee to pay **$256** or more per month in health care premiums for individual coverage for the lowest cost plan (including employer HSA contributions).
- The spouse's employer does not offer medical coverage.

What happens when there is a waiting period? The spouse's employer plan may have an eligibility waiting period (a time when the spouse is not eligible to enroll for benefits) or a contribution waiting period (a time period when the spouse is responsible for the full cost of the health care plan). In either case, benefits will be provided under the employee's selected health care plan until the waiting period has been satisfied. Once the spouse has satisfied the eligibility and/or contribution waiting period, all benefits will be paid according to the How are Benefit Payments for Spousal Claims Affected section noted above.

What happens when there is not an Open Enrollment period for the spouse? Under some plans, "loss of coverage" may not be considered a "qualifying life event." Therefore, a spouse may be unable to enroll in their employer's health care plan because there will be no Open Enrollment period until after the new benefit period, which begins in September of each year. In such cases, benefits will be provided under the employee's selected CCPS health care plan until the next Open Enrollment period for the spouse's employer plan, provided such Open Enrollment period occurs prior to January 1, 2025.

What happens when the spouse's employer only offers a HMO program? Some employers may only offer a HMO program and the spouse may live outside of the HMO program service area. In such instances, it is not necessary for the spouse to enroll under their employer's plan. However, CCPS will evaluate the spouse's enrollment under the employer's plan on an annual basis during each Open Enrollment period.

Can I still cover my spouse with secondary coverage when they are enrolled in their employer's High Deductible Health Plan and have a Health Savings Account? Per IRS Ruling 2005-25, if your spouse is enrolled in a Health Savings Account (HSA) through their employer, they cannot be covered with secondary coverage through CCPS. Additionally, any dependents your spouse may cover under this plan cannot also be covered through the Cecil County Public Schools' health care program.

Qualifying Life Events & COBRA

Qualifying Life Events

The elections that you make during Open Enrollment or at initial benefits eligibility will remain in effect for the entire plan year (September 1, 2025 - August 31, 2026). If you experience a qualifying life event outside of the open enrollment period, you are permitted to revise your benefits coverage to accommodate your new status. You may make benefit changes by contacting the Benefits Office and providing the proper documentation.

IRS regulations govern under what circumstances you may make changes to your benefits, and **any change in benefits must be completed within 31 days of the qualifying life event.** This includes notification to the Benefits Office and documentation to support the change requested.

Qualifying Life Events List

Marital Status Changes

- Marriage
- Death of spouse
- Divorce or Annulment
- Spouse gains or loses coverage
- Spouse's employer's Open Enrollment

Personal Status Changes

- Hours or employment changes
- Return from a leave of absence
- Your own gain or loss of dependent coverage

Covered Dependent Changes

- Birth or adoption of a child
- Placement for adoption
- Appointment of legal guardianship
- Death of a dependent child
- Judgement, decree, or order which requires you to cover a dependent child
- Dependent becomes ineligible for coverage
- A change in dependent day care fees, or your dependent child reaching age 13

COBRA

In most cases, if your employment ends, benefits will terminate on the last day of the month in which you worked.

Through federal legislation known as the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), you may choose to continue coverage by paying the full COBRA monthly premium.

Each individual who is covered by a Cecil County Public Schools benefit plan immediately preceding the employee's COBRA event has the right to continue his or her medical, dental, and/or vision plan.

The right to continuation of coverage ends at the earliest of the date:

- you, your spouse, or dependents become covered under another group health plan;
- you become entitled to Medicare;
- you fail to pay the cost of coverage; or
- your COBRA Continuation Period expires.

When a life event change occurs, remember to update your Maryland State Retirement Agency (MSRA) beneficiaries. The MSRA form is available in the Benefits section of the CCPS website: www.ccps.org.

Medical Plan Information

Available Plans

- Aetna High Deductible Health Plan (HDHP) with Health Savings Account
- Aetna Select Open Access
- CareFirst Core PPO

Summary

Medical benefits provide you and your family access to quality health care. Cecil County Public Schools offer three medical plans with different coverage levels from which to choose.

To search for an Aetna provider visit the website www.aetna.com. To search for a CareFirst provider visit the website www.carefirst.com. You can log into your personal profile to search for a doctor directly in your plan's network.

Open Enrollment Timeline

May 05	Enrollment for the 2025 - 26 benefit plan year begins. Select your options at www.ccps.beneogic.com
May 19	Open Enrollment for the 2025 - 26 benefit plan year ends at 11:59 pm
June 30	All Spousal Coordination paperwork is due if you are carrying your spouse on the CCPS medical plan. This documentation is required every plan year and are uploaded to the Benelogic file cabinet.
June 30	Full-time employees who waives CCPS medical plan must upload to the Benelogic file cabinet a completed and signed Acknowledgement of Opt-Out form or a copy of their current insurance card by
August 29	Payroll deductions for your enrollment elections will be reflected on your pay. Review your deductions and report any discrepancies to Human Resources immediately.
September 30	Student verification documentation is due for dependents who turn 20 this benefit plan year up to age 23 enrolled in the CCPS dental and vision plans. Upload documentation to the Benelogic file cabinet.

Health Savings Account (HSA)

If you choose to enroll in the HDHP plan, you will be enrolled in a Health Savings Account (HSA) provided by Inspira. An HSA is a tax-advantaged savings and spending account that can be used to pay for qualified health care expenses.

The Board contributes $500 for those who enroll in individual coverage or $1,000 for those who cover themselves and at least one other person. This money will be deposited on August 29, 2025 or on the first pay after the Inspira account has been set up by the employee. Board contributions to member HSAs will be prorated for those who become benefit eligible after September 1, 2025.

There are two components to an HSA-based coverage plan:

1. A qualified health plan is the insurance component that provides medical coverage for you and your family. This health plan includes a deductible of $1,650 for individuals and $3,300 for family coverage.
2. An HSA with Inspira can be funded by pre-tax payroll contributions from you, the Board, or both.

The 2025 annual contribution limits are as follows:

- $4,300 for individual coverage, and
- $8,550 for family coverage.

Members can set aside an additional $1,000 for "catch-up" contributions for those account holders age 55 or older, until they have enrolled in Medicare benefits. Please keep the Board's contribution in mind when making a determination on your contribution amount for the year.

For more information you can visit the website at **www.inspirafinancial.com** or contact them by phone at **888-678-8242**.

The following example shows how each plan might cover medical care in a given situation. Use this example* to see, in general, how much financial protection a sample patient might have if they are covered under different plans available at Cecil County Public Schools. This example is based on individual coverage.

Lucy has been experiencing back pain that requires outpatient surgery and physical therapy.

Prior to her treatment, she has not paid anything towards her annual deductible.

	Aetna HDHP	Aetna Select	CareFirst Core
PCP Office Visit	$90.00	$90.00	$90.00
Outpatient Surgery	$1,000.00	$185.00**	$445.00**
PCP Office Visit	$90.00	$20.00	$20.00
1 X-Ray	$320.00	$15.00	$15.00
15 Physical Therapy Visits	$160.50	$375.00	$525.00
Total Out-of-Pocket Medical Expenses	$1,660.50	$685.00	$1,095.00
Employee's Annual Premium	$1229.62	$1,768.75	$1,742.27
Total Employee Spend	$2,890.12	$2,453.75	$2,837.27
CCPS Board Contribution to HSA	**$500.00**	N/A	N/A
Total Annual Employee Pay	**$2,930.12**	**$2,453.75**	**$2,837.27**

*The information on this page should be used as an estimate and it is not a price guarantee. Coverage examples are not cost estimators. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your providers charge, and the reimbursement your health plan allows. Before seeking treatment we recommend that you call the provider to verify they are currently in your network and confirm their in-network price for health care services you need.
**This amount is the remaining balance of the annual deductible plus the copay for outpatient surgery per the plan document.

Opt-Out Documentation

To remain compliant with the Patient Protection and Affordable Care Act (ACA), we will require full-time employees who elect to opt-out of the CCPS medical plan to provide documentation of other coverage. This documentation is to show that you are enrolled in a medical plan that provides minimal essential coverage, as defined by the ACA. For the Open Enrollment period, all documentation must be submitted to the Benefits Office by June 30, 2025, *and is only requested for those who have not previously provided documentation.* Individuals hired throughout the year will have 31 days from their hire date to complete and return the Acknowledgement of Opt-Out Election form.

Failure to submit this Form and coordinating documentation by the deadline will result in your default enrollment in the Aetna High Deductible Health Plan for the 2025 – 2026 benefit plan year.

This only applies to those employees who are not enrolled in a CCPS sponsored medical plan. Individuals who are covered through their spouse's CCPS medical plan will not need to provide additional enrollment documentation.

Medical Plan Options

The outline of benefits below is provided for comparative purposes only and is not intended as a contract of benefits. All final benefit determinations will be in accordance with the medical plan contract. Have a question about the medical plan? Contact the Benefits Office at 410-996-5415.

	Aetna HDHP		Aetna Select	CareFirst Core	
	In Network	Out-of-Network	In Network	In Network	Out-of-Network
Deductibles					
Individual	$1,650	$3,300	$200	$500	$1,000
Family	$3,300**	$6,600**	$400	$1,500	$3,000
Co-insurance	10%	30%	N/A	10%	30%
Out-of-Pocket Max					
Individual	$3,300***	$6,600	$1,500	$2,500	$2,500
Family	$6,600***	$13,200	$4,500	$5,000	$5,000
Preventative Care Visit (including pre-natal)	Covered in full	Deductible, then 30%*	Covered in full	Covered in full	Deductible, then 30%
Office Visit	Deductible, then 10%	Deductible, then 30%*	Deductible, then $20	Deductible, then $20	Deductible, then 30%*
Specialist Visit	Deductible, then 10%	Deductible, then 30%*	Deductible, then $25	Deductible, then $20	Deductible, then 30%*
Practitioner Hospital	Deductible, then 10%	Deductible, then 30%*	Deductible, then $20	Deductible, then $20	Deductible, then 30%*
Hospital Facility	Deductible, then 10%	Deductible, then 30%*	Deductible, then $0	Deductible, then $35	Deductible, then 30%*
Inpatient Hospital Stay	Deductible, then 10%	Deductible, then 30%*	Deductible, then $0	Deductible, then 10%	Deductible, then 30%*
Inpatient Surgery	Deductible, then 10%	Deductible, then 30%*	Deductible, then $0	Deductible, then 10%	Deductible, then 30%*
Outpatient Surgery	Deductible, then 10%	Deductible, then 30%*	Deductible, then $75	Deductible, then $35	Deductible, then 30%*
Telehealth Consultations	Deductible, then 10%	N/A	Deductible, then $20	Deductible, then $20	N/A
Urgent Care	Deductible, then 10%	Deductible, then 30%*	Deductible, then $35	Deductible, then $35	Deductible, then $35
Emergency Room	Deductible, then 10%	Deductible, then 10%*	Deductible, then $75	Deductible, then $100	Deductible, then $100
X-Ray & Lab	Deductible, then 10%	Deductible, then 30%*	Deductible, then $15	Deductible, then $15	Deductible, then 30%*
CT Scan & MRI	Deductible, then 10%	Deductible, then 30%*	Deductible, then $50	Deductible, then $75	Deductible, then 30%*

*You may be billed up to the total charges for visits with out of network providers.
**If you have Family coverage under the HDHP, the Family Deductible must be satisfied before the Plan will pay any benefits.
***Your maximum out-of-pocket limit for prescription is $3,450 (individual) and $6,900 (family)

	Aetna HDHP		Aetna Select	CareFirst Core	
	In Network	Out-of-Network	In Network	In Network	Out-of-Network
Physical, Occ, & Speech Therapy	Deductible, then 10%	Deductible, then 30%*	Deductible, then $25	Up to $35 after deductible	Deductible, then 30%*
Chiropractic Care	Deductible, then 10%	Deductible, then 30%*	Deductible, then $25	Deductible, then $20	Deductible, then 30%*
Chemotherapy & Radiation	Deductible, then 10%	Deductible, then 30%*	Deductible, then $25	Deductible, then $35	Deductible, then 30%*
Durable Medical Equipment	Deductible, then 10%	Deductible, then 30%*	Deductible, then $0	Deductible, then 10%	Deductible, then 30%*
Home Health Care	Deductible, then 10%	Deductible, then 30%*	Deductible, then $0	Deductible, then 10%	Deductible, then 30%*
Hospice Care	Deductible, then 10%	Deductible, then 30%*	Deductible, then $0	Deductible, then 10%	Deductible, then 30%*
Organ Transplant	Deductible, then 10%	Deductible, then 30%*	Deductible, then 30%	Deductible, then 10%	Deductible, then 30%*
Skilled Nursing Facility	Deductible, then 10%	Deductible, then 30%*	Deductible, then $0	Deductible, then 10%	Deductible, then 30%*
Delivery /Maternity Care	Deductible, then 10%	Deductible, then 30%*	Deductible, then $0	Deductible, then 10%	Deductible, then 30%*
Infertility Services with Prior Auth.	Deductible, then 10% - 3 lifetime attempt max	Deductible, then 30%* - 3 lifetime attempt max	Deductible, then 50% -$100,000 lifetime max	Deductible, then 10% - 2 lifetime attempt max	Deductible, then 30% *- 2 lifetime attempt max
Mental Health/ Substance Abuse Inpatient Therapy	Deductible, then 10% , with pre-certification	Deductible, then 30% *, with pre-certification	Deductible, then $0, with pre-certification	Deductible, then 10% , with pre-certification	Deductible, then 30% *, with pre-certification
Mental Health/ Substance Abuse Outpatient Therapy	Deductible, then 10% ,	Deductible, then 30%*	Deductible, then $25	Deductible, then $35	Deductible, then 30% *

Glossary of Terms

Deductible: The amount you are required to pay before the plan begins to cover any of the costs. The deductible does not apply to in-network routine preventative wellness care.

Co-pay: The fixed dollar amount you pay towards the cost of covered medical services. This payment will vary by the type of service for each health plan option.

Co-insurance: The percentage you pay towards covered medical services. The remaining balance of the bill is paid by the health care plan. You are responsible for paying this percentage until you have reached the plan's out-of-pocket maximum.

Out-of-Pocket Maximum: The most you will have to pay towards covered expenses during the benefit plan year. Once you meet the out-of-pocket maximum, the plan will pay for any additional covered expenses at 100% for the remainder of the benefit plan year with in-network providers.

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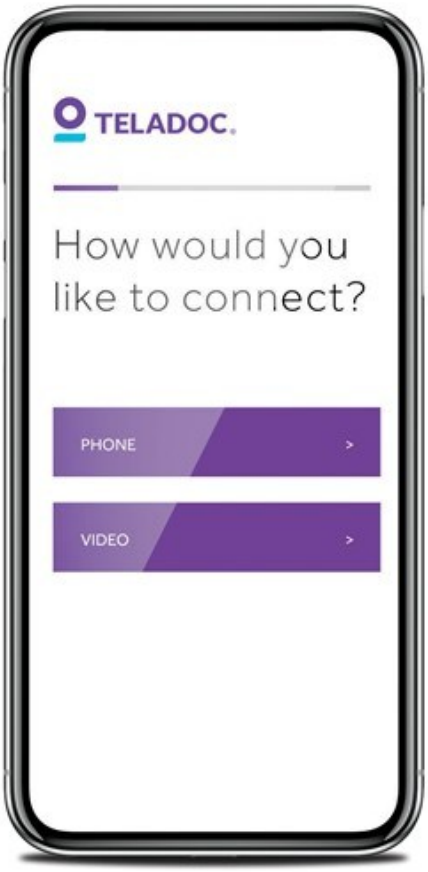
The right care when you need it most

From common care needs to complex conditions, we've got you covered



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CloseKnit™

The care you need when you need it

Primary Care (ages 18+)

- Preventive care to help you achieve your long-term health goals
- Chronic care and disease management
- A dedicated Health Guide to help you navigate the healthcare system
- Answers to your billing and benefits questions

Urgent Care (ages 2+)

- 24/7 access to licensed providers
- Open on weekends and holidays
- Treatment for common illnesses and minor injuries
- Average wait times under 30 minutes

Behavioral Health (ages 2+)

- Behavioral health counseling with licensed therapists
- Psychiatry services including medication management
- Guided and personalized programs tailored to you
- Private 1-on-1 support over phone or video

Nutrition Services (ages 5+)

- Insurance-covered services with a Registered Dietitian
- Personalized, evidence-based nutrition plans
- Continuous nutrition guidance available
- One-time Q&A sessions available

New Parent Support

- Connect with expert lactation consultants
- Help with issues such as feeding, pumping, latching, and more
- Breastfeeding tips and resources for new moms and dads

Am I eligible?

There are only two requirements for registration:

1. Adults 18+ can sign up (dependents ages 2-17 can be added to your account)
2. Must have a CareFirst BlueCross BlueShield health plan, including CareFirst Medicare Advantage and CareFirst Community Health Plan Maryland (some exclusions apply)

SCAN TO GET STARTED

CloseKnit is a registered Trademark owned by, and is the trade name of, Atlas Health, LLC. Atlas Health, LLC d/b/a CloseKnit does not provide Blue Cross Blue Shield products or services and is providing in-person and telehealth services to CareFirst members. Atlas Health, LLC is a corporate affiliate within the CareFirst, Inc. corporate umbrella of companies.

Prescription Drug Coverage

Cecil County Public Schools will continue to partner with Express Scripts to provide your prescription benefits. Express Scripts is offered with all three of the medical plan options available through CCPS. You will receive a separate prescription drug card from Express Scripts, which you can use at any pharmacy in the Express Scripts network, when you enroll in a medical plan for the first time.

Certain Diabetic Medications and Supplies are Covered at 100%

Through Express Scripts, you can continue to receive certain diabetic medications at no cost to you. Some of the products* that are available at a $0 cost are OneTouch glucose meters and test strips, Humulin insulin, Humalog rapid-acting insulin, and Lantus basal insulin. For a full listing of what medications are covered, please visit www.express-scripts.com or contact the Benefits Office at 410-996-5415.

CHECKING IF YOUR MEDICATION IS COVERED

If you are prescribed a new medication you can verify that it is covered by the plan by visiting the Express Scripts website, at www.express-scripts.com, or using the Express Scripts app. The website will advise whether the medication is covered, at what tier it is covered, and if a prior authorization is needed prior to having the medication filled.

PRIOR AUTHORIZATIONS

Certain medications may require a prior authorization before they can be filled by the pharmacy. If this is the case, your doctor will need to complete and submit documentation to Express Scripts for review. To find out if your medication requires a prior authorization visit www.express-scripts.com.

Prior Authorization forms may be found on the CCPS Benefits site: https://www.ccps.org/administration/employment-opportunities/forms

To Contact Express Scripts Member Services:

Express Scripts Headquarters
1 Express Way
St. Louis, MO 63121

Member Services:
Phone: 1-800-282-2881
Fax: 1-800-837-0959
Available 24 hours a day, 7 days a week

www.express-scripts.com

Switch and Save — If you are taking a brand-name medication that has a generic alternative, ask your doctor about switching.

Switch — Switch a maintenance medication prescription from a brand to a generic and you can...

Save — Save every time your prescription is filled because the copay for generics is less than the copay for brands.

*These medications are subject to change as the formulary changes. Formulary changes twice a year; each January and July 1st.

IN NETWORK RETAIL 30-DAY SUPPLY:

	Aetna HDHP	Aetna Select	CareFirst Core
Generic	Deductible, then 10%	$5.00 Copay	$5.00 Copay
Preferred Brand	Deductible, then 10%	$25.00 Copay	$25.00 Copay
Non-Preferred Brand	Deductible, then 10%	$50.00 Copay	$50.00 Copay

How to Order: Present your Express Scripts card to the Pharmacist when filling your prescription.

MAIL ORDER 90-DAY SUPPLY:

	Aetna HDHP	Aetna Select	CareFirst Core
Generic	Deductible, then 10%	$10.00 Copay	$10.00 Copay
Preferred Brand	Deductible, then 10%	$50.00 Copay	$50.00 Copay
Non-Preferred Brand	Deductible, then 10%	$100.00 Copay	$100.00 Copay

How to Order: You can request to have your prescriptions filled by:

1) Mail: Express Scripts, Home Delivery Service, P.O. Box 6656, St. Louis, MO 63166-6566
2) Online: www.StartHomeDelivery.com
3) Fax: 1-800-837-0959

SPECIALTY MEDICATIONS 30-DAY SUPPLY:

	Aetna HDHP	Aetna Select	CareFirst Core
Generic	Deductible, then 10%	$5.00 Copay	$5.00 Copay
Preferred Brand	Deductible, then 10%	$25.00 Copay	$25.00 Copay
Non-Preferred Brand	Deductible, then 10%	$50.00 Copay	$50.00 Copay

How to Order: Your physician will be notified by Accredo Specialty Pharmacy when prior authorization is necessary. You or your physician may request a prior authorization by calling Accredo at 1-877-222-7336. For more information, you can visit their website at https://www.accredo.com/contact-us.

Dental Information

Dental coverage is available through United Concordia Dental. You have the freedom to select the dentist of your choice; however when you visit a participating in-network dentist, you can stretch your benefit dollars to receive more covered services before reaching your annual maximum. Additionally, there is no balance billing, and claims will be submitted by your dentist on your behalf. The program allows you the freedom to visit any licensed dentist. For more information, please refer to your enrollment materials and the United Concordia website.

Keep Your Smile Connected

Visit www.unitedconcordia.com for plan and oral health care information online. Create a free Online Services account to:

- Get your virtual ID cards,
- Find a dentist,
- Review claim information and,
- Research your dental care and conditions.

Plan Features	In-Network Services	Out-of-Network Services
Annual Deductible/Single (plan year)	$25	$25
Annual Deductible/Family (plan year)	$75	$75
Annual Benefit Maximum	$1,500 per person each plan year (does not include orthodontia)	
Class 1—Preventive and Diagnostic **(Examples include Exams/Bitewing X-rays/All Other X-rays/Cleaning & Fluoride Treatments/Space Maintainers)**	Covered 100%	Covered 100%
Class 2—Basic Services (Examples include Basic Restorative (Fillings) Simple Extractions/Endodontics/ Nonsurgical Periodontics/Complex Oral Surgery)	Covered at 80% after the deductible	Covered at 80% after the deductible*
Class 3—Major Services (Examples include Surgical Periodontics/ Inlays, Onlays, Crowns,/Prosthetics (Bridges, Dentures))	Covered at 50% after the deductible	Covered at 50% after the deductible*
Orthodontic Services (up to age 20)	Covered at 50% after the deductible, up to a lifetime max of $1,200	Covered at 50% after the deductible, up to a lifetime max of $1,200*

*Reimbursement is based on UCCI schedule of maximum allowable charges (MAC's). Network dentists agree to accept their allowances as payment in full for covered services. Non-network dentists may bill the member for any difference between the UCCI allowance and their fee (also known as balance billing). Exclusions and limitations apply.

Vision Information

Your vision program is administered by EyeMed. This plan allows you to improve your health through a routine eye exam, as well as save money on all your eye care needs. The plan is available through thousands of provider locations participating in the EyeMed INSIGHT network. With EyeMed Vision Care, you'll get more than a standard vision benefit.

Need to locate a participating provider? Visit www.eyemedvisioncare.com. The EyeMed Vision Care **INSIGHT** network includes more than 30,000 independent and retail providers nationwide. For additional information, call 1-800-521-3605.

Plan Features	Standard Plan		Custom Plan	
	In Network	Out-of-Network Reimbursement	In Network	Out-of-Network Reimbursement
Benefit Period	24 months		12 months	
Eye Exam Co-pay	$0	Up to $48	$0	Up to $48
Eye Glass Frames	Up to $130 allowance; 20% discount above $130	Up to $65	Up to $130 allowance; 20% discount above $130	Up to $65
Contact Lenses **- Conventional** **- Disposable**	Up to $130 allowance; 15% discount above $130	Up to $104	Up to $130 allowance; 15% discount above $130	Up to $104
Standard Plastic Lenses				
Single	$20	Up to $42	Covered in full	Up to $42
Bifocal	$20	Up to $67	Covered in full	Up to $67
Trifocal	$20	Up to $90	Covered in full	Up to $90
Lenticular	$20	Up to $157	Covered in full	Up to $157
Std. Progressive	$85	Up to $67	$65	Up to $67
Prem. Progressive	Tier 1: $105 Tier 2: $115 Tier 3: $130	Up to $67	Tier 1: $85 Tier 2: $95 Tier 3: $110	Up to $67
Lens Options				
UV Coating, Tint, Std. Scratch Resistance	$15	N/A	$15	N/A
Std. Polycarbonate	$40	N/A	$40	N/A
Std. Anti-Reflective	$45	N/A	$45	N/A
Prem. Anti-Reflective	Tier 1:$57 Tier 2: $68	N/A	Tier 1:$57 Tier 2: $68	N/A
Other Add-Ons	20% discount	N/A	20% discount	N/A

Medical Plans

Description	Employee Per Pay Contribution	Employee Annual Contribution	Board Annual Contribution	Total Annual Plan Cost
Opt-Out	($68.18)	($1,500.00)	$1,500.00	$1,500.00
Aetna High Deductible Health Plan & Health Savings Account Medical Only ($500 Individual or $1,000 Family Board Contribution to the Health Savings Account)				
Individual	$65.69	$1,445.20	$8,189.48	$9,634.68
Parent/Child	$124.81	$2,745.92	$15,560.20	$18,306.12
Employee/Spouse	$141.24	$3,107.23	$17,607.65	$20,714.88
Parent/Children	$164.23	$3,613.05	$20,473.95	$24,087.00
Family	$187.55	$4,126.09	$23,381.15	$27,507.24
Aetna Select Open Access Medical Only				
Individual	$86.12	$1,894.61	$10,736.11	$12,630.72
Parent/Child	$163.63	$3,599.80	$20,398.88	$23,998.68
Employee/Spouse	$185.15	$4,073.38	$23,082.50	$27,155.88
Parent/Children	$215.30	$4,736.50	$26,840.18	$31,576.68
Family	$245.87	$5,409.13	$30,651.71	$36,060.84
BlueCross BlueShield CORE Medical Only				
Individual	$83.69	$1,841.15	$10,433.17	$12,274.32
Parent/Child	$159.01	$3,498.19	$19,823.09	$23,321.28
Employee/Spouse	$179.93	$3,958.43	$22,431.13	$26,389.56
Parent/Children	$209.22	$4,602.85	$26,082.83	$30,685.68
Family	$238.93	$5,256.47	$29,786.65	$35,043.12

Dental Plan with Medical

Description	Employee Per Pay Contribution	Employee Annual Contribution	Board Annual Contribution	Total Annual Plan Cost
Individual	$2.85	$62.64	$354.96	$417.60
Parent/Child	$5.41	$119.00	$674.32	$793.32
Employee/Spouse	$5.69	$125.24	$709.72	$834.96
Parent/Children	$7.12	$156.56	$887.20	$1,043.76
Family	$8.54	$187.88	$1,064.68	$1,252.56

Vision Plans with Medical

Description	Employee Per Pay Contribution	Employee Annual Contribution	Board Annual Contribution	Total Annual Plan Cost
Standard EyeMed Vision				
Individual	$0.28	$6.08	$34.48	$40.56
Parent/Child	$0.47	$10.30	$58.34	$68.64
Employee/Spouse	$0.52	$11.50	$65.18	$76.68
Parent/Children	$0.69	$15.14	$85.78	$100.92
Family	$0.77	$16.94	$95.98	$112.92
Custom EyeMed Vision				
Individual	$1.86	$40.88	$34.48	$75.36
Parent/Child	$3.17	$69.82	$58.34	$128.16
Employee/Spouse	$3.56	$78.22	$65.18	$143.40
Parent/Children	$4.67	$102.74	$85.78	$188.52
Family	$5.23	$115.10	$95.98	$211.08

Part-Time Employee Contributions

Employees who work more than 17.5 hours per week and less than 30 hours per week in a budgeted position and want to enroll in benefits can do so at the full premium rate.

Medical Plans

Description	Employee Per Pay Contribution	Employee Monthly Premium	Employee Annual Premium
Aetna PPO High Deductible Health Plan & Health Savings Account Medical Only			
Individual	$437.94	$802.89	$9,634.68
Parent/Child	$832.10	$1,525.51	$18,306.12
Employee/Spouse	$941.59	$1,726.24	$20,714.88
Parent/Children	$1,094.86	$2,007.25	$24,087.00
Family	$1,250.33	$2,292.27	$27,507.24
Aetna Select Open Access HMO Medical Only			
Individual	$574.12	$1,052.56	$12,630.72
Parent/Child	$1,090.85	$1,999.89	$23,998.68
Employee/Spouse	$1,234.36	$2,262.99	$27,155.88
Parent/Children	$1,435.30	$2,631.39	$31,576.68
Family	$1,639.13	$3,005.07	$36,060.84
BlueCross BlueShield CORE PPO Medical Only			
Individual	$557.92	$1,022.86	$12,274.32
Parent/Child	$1,060.06	$1,943.44	$23,321.28
Employee/Spouse	$1,199.53	$2,199.13	$26,389.56
Parent/Children	$1,394.80	$2,557.14	$30,685.68
Family	$1,592.87	$2,920.26	$35,043.12

Employees who waive medical coverage through CCPS, but choose to enroll in dental and vision are responsible for the full premium rates.

Dental Plan

Description	Employee Per Pay Contribution	Employee Monthly Premium	Employee Annual Premium
Individual	$18.98	$34.80	$417.60
Parent/Child	$36.06	$66.11	$793.32
Employee/Spouse	$37.95	$69.58	$834.96
Parent/Children	$47.44	$86.98	$1,043.76
Family	$56.93	$104.38	$1,252.56

Vision Plans

Description	Employee Per Pay Contribution	Employee Monthly Premium	Employee Annual Premium
Standard EyeMed Vision			
Individual	$1.84	$3.38	$40.56
Parent/Child	$3.12	$5.72	$68.64
Employee/Spouse	$3.49	$6.39	$76.68
Parent/Children	$4.59	$8.41	$100.92
Family	$5.13	$9.41	$112.92
Custom EyeMed Vision			
Individual	$3.43	$6.28	$75.36
Parent/Child	$5.83	$10.68	$128.16
Employee/Spouse	$6.52	$11.95	$143.40
Parent/Children	$8.57	$15.71	$188.52
Family	$9.59	$17.59	$211.08

Flexible Spending Accounts

A Flexible Spending Account (FSA) allows you to reduce your taxable income by setting aside pre-tax dollars from each paycheck to pay for eligible out-of-pocket health care and dependent care expenses for you and your family. There are two types of FSAs; Health Care FSA and Dependent Care FSA. You can elect to participate in one or both of these accounts. The FSAs are administered by **Flexible Benefit Administrators.**

In order to participate in either or both FSAs, **you must enroll each year**.

NOTE: If you are enrolled in the Aetna HDHP, you are only eligible to enroll in a limited healthcare flexible spending account. See page 23 for more details.

Using Your FSA

Flexible Benefit Administrators makes it quick and easy for you to use the money in your FSA.

- **Use your Benefits Card.** This is the simplest way to access your funds! Present your card at a qualified merchant or provider and they will swipe your card like any other credit or debit card to pay for your purchase.
- **Pay with Personal Funds and Request a Reimbursement.** Pay using your own personal credit card, cash, or check and keep your itemized receipt as documentation. Log in to your account to request a reimbursement and upload the documentation.

Health Care FSA

Health Care FSAs help you stretch your budget for health care expenses for you and your dependents by allowing you to pay for these expenses using tax-free dollars. You may set aside up to **$3,300** annually, which is deducted from your pay. Funds can be used to pay for qualified health expenses such as deductibles, medical and prescription copays, dental, and vision expenses. You can use the FSA for expenses for yourself, your spouse, and your dependent children even if they are not covered under your medical, dental, or vision plan!

When you submit a claim, you can be reimbursed up to your full annual election (less any previous reimbursement). Please note that health insurance premiums paid for by your employer's plan or by other health insurance coverage are not eligible for reimbursement.

Use it or Lose It

Both FSAs run on the plan year of July 1 - June 30. You will have until September 15, after the plan year ends, to spend any remaining funds you have in your account. Any remaining funds in your FSA at the end of the plan year will be forfeited. Please visit https://fba.wealthcareportal.com for more information.

Substantiation

From time to time, you may be asked to verify your purchase was an eligible expense. To do so, you must attach a receipt or bill from the service provider, which includes all the pertinent information regarding the expense, to the substantiation request and fax it to FBA for processing.

DEPENDENT CARE FSA

The Dependent Care FSA allows you to pay for eligible dependent care expenses with tax-free dollars. You may set aside up to **$5,000** annually in pre-tax dollars, or $2,500 if you are married and file taxes separately from your spouse.

Contributing to a Dependent Care FSA allows you to pay dependent care expenses so that you and your spouse can work or attend school full-time. It includes daycare (center or individual daycare), before/after school care, summer day camp, and elder care.

Eligible expenses include:

- care for your dependent child, under the age of 13, that you can claim as a dependent for tax purposes;
- care for your dependent child who resides with you and who is physically or mentally incapable of caring for him/herself; and
- care for your spouse or parent who is physically or mentally incapable of caring for him/herself.

When submitting a claim, you can only be reimbursed up to the amount you have contributed to date, less any previous reimbursement. You may only receive reimbursements for services already incurred. An expense is incurred when a service is received, not when a bill is paid. Even though your service provider may require payment at the beginning of the service period, you cannot receive reimbursement until after the service is provided. Your dependent care provider must be an individual that you do not claim as a dependent on your tax return.

Savings Example

Shown below is an example of an FSA participant with a monthly expense of $800 for Dependent Care costs.

	With FSA	Without FSA
Gross Monthly Income	**$2,500.00**	**$2,500.00**
FSA Contribution	-$415.00	$0
Taxable Income	**$2,085.00**	**$2,500.00**
Taxes*	$592.44	$691.25
Take Home Pay after Taxes	**$1,492.56**	**$1,808.75**
Dependent Care Expenses	$800.00	$800.00
Available Income	**$692.56**	**$1,008.75**
Tax-Free Reimbursement from FSA	$415.00	$0.00
Net Monthly Income	**$1,107.56**	**$1,008.75**

**Assumes federal withholding of 15%, state withholding equal to 5.75% and social security withholding of 7.65%. For illustrative purposes only. Actual dollar amounts and savings may vary.*

THAT'S A SAVINGS OF $98.81 PER MONTH, OR $1,185.72 FOR THE YEAR!

Eligibility

Your plan begins on July 1, 2025, and ends June 30, 2026. You are eligible to participate in the plan on the first day of the month following your date of hire, if you work at least 17.5 hours or more per week in a budgeted position. If you are hired on the first day of the month, you are benefit eligible on that day. Those employees having a qualifying life event are eligible to enroll within 31 days of the qualifying event date. You must complete the enrollment online to participate in the Flexible Spending Accounts each year during the enrollment period. If you do not re-enroll during open enrollment, your card will be canceled and you will not be able to join until the next plan year.

Election Changes

Once you have enrolled in an FSA you may NOT make any changes to your election unless you have a change in status such as:

- Marriage or divorce
- Birth or adoption
- Involuntary loss of spouse's medical or dental coverage
- Death of dependent
- Unpaid FMLA or Non-FMLA Leave
- Change in Dependent Care Providers

Reimbursement Schedule

All claims received in the office of Flexible Benefit Administrators, Inc (FBA). will be processed within one week via check or direct deposit. You may also use your Benefits Card to pay for eligible expenses.

Health Care Reimbursement

After you are eligible, you can pay for your out-of-pocket health care expenses for yourself, your spouse, and all of your dependents for health care services that are incurred during the plan year and while an active participant. Eligible expenses are those incurred "for the diagnosis, cure, mitigation, treatment, or prevention of disease, or for the purpose of affecting any structure or function of the body."

Examples of Eligible Health Care Expenses

Co-pays, Co-insurance, Deductibles for: Acupuncture, Prescription Eyeglasses/Reading glasses, Contact lens & supplies, Physician, Ambulance, Psychiatrist, Psychologist, Anesthetist, Hospital, Chiropractor, Laboratory/ Diagnostic, Fertility Treatments, Surgery, Dental, Orthodontic Fees, Obstetrician, X-Rays, Eye Exams, Prescription Drugs, Artificial limbs & teeth, Birth control pills/ patches, Vaccinations & Immunizations, Diabetic supplies, Oxygen, Physical Therapy, and Hearing aids & batteries.

Over-the-Counter Medications

Regulations differ regarding eligible over-the-counter medications. If you have any questions, please feel free to contact Flexible Benefit Administrators, Inc. at (800) 437-FLEX.
To view your account visit:
https://fba.wealthcareportal.com.

Health Care Account is Prefunded

This means that you can submit a claim for medical expenses in excess of your account balance. You will be reimbursed your total eligible expenses up to your annual election. The funds that are pre-funded will be recovered through payroll deductions, deposited into your account throughout the Plan Year.

Benefits Card

You may also use your Benefits Card to pay for eligible expenses at approved service providers and merchants. Using your card allows you instant access to your funds with no out of pocket expense. Please keep all your itemized receipts. FBA may request documentation to substantiate Benefit Card transactions to determine eligibility of an expense. You may also elect to have an additional Benefit Card for your dependent(s). Please contact FBA to order additional cards.

Dependent Care Reimbursement

The Dependent Care FSA allows you to pay for day care expenses for your qualified dependent/ child with pre-tax dollars. Eligible dependent care expenses are those you must pay for the care of an eligible dependent so that you and your spouse can work. Eligible dependents, as revised under Section 125 of the Code by the Working Families Tax Act of 2005, are defined as either dependent children or dependent relatives; this can include stepchildren, grandchildren, adopted, or foster children. Refer to the website for more details. Eligible dependents are further defined as:

- Under age 13, or
- Physically or mentally unable to care for themselves, such as a disabled spouse, disabled child, and/or elderly parent that lives with you.

If you and your spouse are contributing to a Dependent Care FSA and are married filing separately, each of you are only able to contribute up to $2,500 each plan year.

Examples of Eligible Dependent Care Expenses

- Au Pair
- Nannies
- Day Camps
- Babysitters
- Licensed Day Care
- Day care for an Elderly Dependent
- Before & After Care
- Day care for a Disabled Dependent
- Nursery School
- Private Pre-School
- Sick Child Center

Examples of Ineligible Dependent Care Expenses

Overnight camps, babysitting for social events, tuition expenses including kindergarten and food expenses (if separate from dependent care expenses), care provided by anyone under the age of 19 or by anyone you claim as a dependent, days your spouse doesn't work (though you may still have to pay the provider), transportation, books, clothing, food, and entertainment. Registration fees are also ineligible if these expenses are shown separately on your bill.

How to Receive Reimbursement

To obtain reimbursement from your FSA, you must complete a Claim Form. This form is available to you in your Employee Guide or on the FBA website. You must attach a receipt or bill from the service provider, which includes all of the following pertinent information regarding the expense: date of service, patient/ dependent's name, amount charged, provider's name, nature of the expense, and amount covered by insurance (for health care FSA only, if applicable). Canceled checks, bankcard receipts, credit card receipts and credit card statements are NOT acceptable forms of documentation. You are responsible for paying your health care and dependent care provider directly.

How to Enroll in the FSA Plan

Step 1: Carefully estimate your eligible health care and dependent care expenses for the upcoming plan year. Then use FBA's online FSA Educational Tools located at https://fba.wealthcareportal.com/ to help you determine your total expenses for the Plan Year.

Step 2: Complete a benefits enrollment online. This amount will be contributed on a pre-tax basis from your paychecks to your FSA. Remember the amount you elect will be set aside before any federal, social security, & state taxes (in most cases) are calculated.

Claims Submissions

Claims can be submitted by (1) email, (2) fax or (3) mail. To submit by email, print form and sign. Email along with documentation to flexdivision@flex-admin.com. To submit via fax, print form and fax to 757-431-1155. To submit via mail send to: Flexible Benefit Administrators, Inc., PO Box 8188, Virginia Beach, VA 23450

FSA Worksheet

Medical FSA - Use this worksheet to estimate eligible medical expenses that you, your spouse, and your qualified dependents will incur during the plan year.

Sample Medical FSA Expenses	Estimated Annual Amount
Medical Insurance Deductibles	
Office Visit Co-Pays	
Prescription Medications	
Physical Therapy/Chiropractic Care	
Hearing Aids/Batteries/Exams	
Prescribed Over-the-Counter Medications	
Dental Insurance Deductibles	
Exams	
Fillings	
Root Canals	
Crowns	
Bridges	
Dental Implants	
Dentures	
Orthodontics	
Vision Exams	
Eyeglasses	
Contact Lenses/Supplies	
Prescription Sunglasses	
Laser Eye Surgery	
Total - Use this amount as a guideline for your upcoming election	

Dependent Care FSA - Use this worksheet to estimate eligible child and dependent care expenses.

Sample Dependent Care FSA Expenses	Estimated Annual Amount
Dependent Care Center Fees	
Nursery/Pre-School Fees (excluding Kindergarten)	
Before and/or After School Care	
In-Home Dependent Care	
Summer Day Camp	
Caregiver's Wages & Employer Taxes	
Total - Use this amount as a guideline for your upcoming election	

Who should enroll in the limited FSA plan?

If you are participating in the Aetna High Deductible Health Care Plan with the Health Savings Account (HSA), you can only enroll in the Limited Healthcare FSA plan for July 1, 2025, through June 30, 2026.

What expenses can be claimed under a limited FSA?

Under the limited FSA, the Health Care Reimbursement Program will only reimburse you for "medical care" (as defined in the Tax Code) that is ***dental, vision,*** or ***"preventive care."***

Examples of Dental and Vision Expenses

- ⇒ Dental procedures that are not for cosmetic purposes and not covered by your insurance such as checkups, fillings, crowns, etc.
- ⇒ Orthodontia
- ⇒ Routine eye exams, procedures, Lasik eye surgery, etc.
- ⇒ Eyeglasses/prescription sunglasses

What are ineligible expenses under a limited FSA?

- ⇒ Your co-payments, deductibles and co-insurance payments for any expenses not related to preventive care
- ⇒ Cosmetic dental procedures (veneers, teeth whitening services, or products)

Are prescription and over the counter medications eligible for reimbursement under a limited FSA?

Medication costs, including over-the-counter drugs, may be reimbursed if they are considered for dental, vision, or "preventive care" expenses. Medications will fall within the guidelines when they are taken by a person who has developed risk factors for a disease that has not yet manifested itself or has not been clinically apparent (no symptoms yet developed). The drugs could also be taken to prevent the recurrence of a disease from which a person has recovered.

Helpful hints on the administration of a limited FSA

Diagnosis information to determine whether a particular medication (that may also be used to treat an existing condition) is being prescribed for preventive purposes may be requested. Letters of medical necessity for Limited FSAs must specifically state that the medication is being used to prevent illness. For example, a letter could state that "Mary needs to take Lipitor to prevent heart disease due to the fact that she has a family history of heart disease." A letter of medical necessity for prevention of an illness will also be required for any OTC drug.

Examples of preventive care eligible expenses

- ⇒ The treatment of high cholesterol with cholesterol-lowering medications to prevent heart disease or the treatment of recovered heart attack or stroke victims.
- ⇒ Drugs or medications used as part of procedures providing preventive care services such as obesity, weight-loss, and tobacco cessation programs.
- ⇒ Screenings: cancer, heart and vascular diseases, infectious diseases, mental health conditions, substance abuse, metabolic, nutritional, endocrine conditions, musculoskeletal disorders, obstetric and gynecologic conditions, pediatric conditions, and vision and hearing disorders.

Life and Accidental Death and Dismemberment (AD&D) insurance provides financial security to your survivors in the event of your death. CCPS provides eligible employees with Group Term Life and AD&D insurance equaling 1½ times their basic salary at no cost. These benefits are offered through the The Hartford.

Who is eligible for life insurance?

All permanent, full-time employees who regularly work 30 hours or more per week in a budgeted position are eligible for Life Insurance coverage.

Life Insurance Plan Description

The Life Insurance plan is term insurance with the term being the period you are employed with CCPS. Term Insurance pays the face amount of coverage upon the death of the insured, only while actively employed. Coverage may be ported into an individual policy when your employment with CCPS ends. The policy does not earn interest or pay dividends to policy holders. The insurance contract is held by the Board, and active members will not receive individual contracts.

Life Insurance Beneficiary Designation

You are required to designate who will receive your life insurance in the event of your death. It is important to review who you've named - at least annually during open enrollment - especially if a marriage, divorce, birth or adoption of a child, or a death in your family takes place. You may update your beneficiary at any time by logging onto the Benelogic website and making the changes.

What is the cost of life insurance coverage?

CCPS pays the premiums for your basic life insurance. However, only the first $50,000 of group term life insurance is tax-free. Federal tax law requires that you be taxed on the value of your group term life insurance in excess of $50,000 depending on your age and the amount of your coverage. This cost is called *imputed income* and is included in your W-2 earnings.

Accidental Death and Dismemberment (AD&D) Insurance

AD&D insurance provides benefits in addition to your life insurance coverage. Benefits will be paid to your designated beneficiary if you die, suffer the loss of a limb in an accident, or are injured in any accident occurring during business or pleasure. The maximum amount of insurance is equal to the amount of your CCPS sponsored group life term insurance.

If bodily injuries result in death or dismemberment within 90 days of the accident, The Hartford will pay benefits according to plan guidelines. Refer to The Hartford Life booklet available in the Benefits section of the CCPS website for more details.

Supplemental Life Insurance

Supplemental Life Insurance coverage is available to **eligible employees who work at least 17 ½ hours or more per week in a budgeted position** through The Hartford. If you request coverage after the initial offering, you will be required to complete an "Evidence of Insurability" (EOI) form in order to receive approval from The Hartford. You may also make changes to the amount of your coverage if you experience a qualifying life event. This protection can provide additional coverage to your CCPS group term program and any other life insurance coverage you may carry. You may elect to purchase in $10,000 increments from a minimum of $10,000 to a maximum of $300,000.

Your Age	Rate per $10,000 (per pay period)
Under 30	$ 0.17
30 - 34	$ 0.22
35 - 39	$ 0.34
40 - 44	$ 0.55
45 - 49	$ 0.82
50 - 54	$ 1.25
55 - 59	$ 2.19
60 - 64	$ 3.31
65 - 69	$ 5.33
70 +	$ 11.24

Dependent Coverage

In addition to your Supplemental Life enrollment you may also purchase additional coverage for your dependents. Dependent life insurance will provide a maximum of $25,000 coverage for a spouse (not to exceed 100% of your basic and supplemental amount), and $10,000 for each child (from 14 days of age to the age of 26).

If you and your spouse both work for CCPS, you cannot insure each other or cover your child(ren) under both policies.

Dependent Supplemental Life Insurance
$ 2.56 per pay

When You Can Enroll

During Open Enrollment, if you elect new or additional coverage greater than $10,000, you will be required to complete an Evidence of Insurability (EOI) form and must be approved by The Hartford before the coverage will begin.

What is the cost of the supplemental life insurance benefit?

Premiums for Supplemental Life Insurance are based on your age and the dollar amount of coverage. All premiums are deducted on a post-tax basis. If you are currently enrolled in supplemental life, you are not required to take any action during open enrollment, unless you wish to increase or decrease your coverage.

Calculate Your Life Insurance Cost Per Pay
Amount Elected:
$ _____
÷ by $ 10,000
$ _____
× by the applicable rate above
$ _____
Your cost per pay
$ _____

Coverage Continuation After Employment

Your Supplemental Life Insurance is portable if you terminate your employment. You may elect to port your coverage within 31 days after your coverage terminates using the form(s) provided to you by the Benefits Office at the time of your retirement or when your employment with CCPS ends.

Preparing for Retirement

Achieving a financially secure retirement is a goal you can achieve through a combination of benefits from CCPS, Social Security, and your own savings. CCPS benefits can accelerate your success if you plan and invest in your financial future.

Highlights

- ⇒ PENSION - You contribute 7% of your annual salary to the state pension system and can retire with the security of a defined monthly pension benefit.
- ⇒ SOCIAL SECURITY - You and CCPS pay equal amounts in FICA taxes as you earn Social Security benefits during your employment with CCPS.
- ⇒ DEFERRED COMPENSATION PROGRAM - Provides you with an easy way to build your own savings with valuable tax advantages.
- ⇒ HEALTH CARE - With at least 14 years of continuous CCPS service at retirement, you may qualify for a subsidy towards the overall costs of post-retirement health care benefits.

Shared Responsibility: The Three Legged Stool

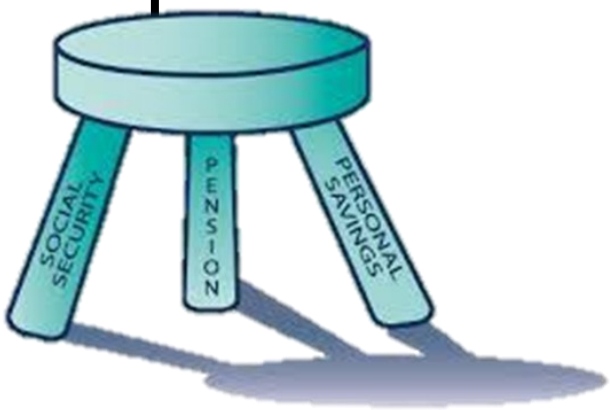
When it comes to achieving a stable retirement, the metaphor of a “three-legged stool” is often used. Each leg represents a component of your resources for income during retirement: employer-sponsored benefits, Social Security and your own savings. If any of the three components are missing or inadequate, it can affect your retirement security.

Pension

As a CCPS employee, you participate in the State Retirement & Pension System (SRPS). You can earn a pension - a defined benefit - providing you with a monthly income throughout retirement, and you do not deal with investment or other risks associated with providing that stream of income.

Social Security

Every pay period, you pay FICA taxes on your covered earnings to participate in Social Security. The program provides a financial “safety net” and is a very important source of the income you expect throughout your retirement.



Deferred Compensation Program

Most people will need more than a pension and Social Security to maintain their standard of living during retirement. Your own savings are essential, and are the element over which you have the most control. The CCPS Deferred Compensation Program allows you to use 403(b) and 457(b) plans to save, invest, and use tax-free dollars to build your own retirement savings.

Example

Samantha was hired in 2020 at the age of 30 and wants to retire by the age of 60. Samantha estimates she will need to replace 80% of her final year's salary to keep the same standard of living while in retirement.

Based on assumptions that Samantha feels are reasonable (such as 4% salary growth, 3% inflation, etc.), she estimates that:

- ⇒ The state pension plan will provide a value equal to about 38% of her final year's pay, and
- ⇒ Social Security will provide a value equal to about 21% of her final year's pay.

However, since Social Security benefits are not payable until at least age 62, with full benefits at age 67, Samantha will have to use more personal savings until her Social Security benefits begin.

Samantha's own personal savings will need to provide a value equal to about 21% of her final year's salary. To get there using the Deferred Compensation Program, Samantha would have to contribute at least 5% of her pay to either 403(b) and/or the 457(b) and she would need to average a rate of 7.75% of return over her working lifetime.

How to Enroll

Lincoln Financial Group manages both the 403(b) and 457(b) plans for Cecil County Public Schools. Members will receive a Welcome Packet with additional information prior to their benefit effective date. The packet will include information on how to setup and access your account online via the following website: www.lfg.com.

If you are more comfortable working with a Certified Financial Planner, you may contact Ms. Elaine Norris at (866) 347-6851 or by email at elaine.norris@lfg.com; or Mr. Dave Weiland at (866) 755-9771 or by email at dave.weiland@lfg.com; or Mr. Josh Scher at Joshua.scher@lfg.com.

An enrollment kit is available that includes an enrollment book, Participation Agreement, and a retirement calculator to help you determine the amount of contributions that you would like to make to the plan. Once you have elected to make contributions, you will be permitted to change or cancel the contribution amount at any time via the Lincoln Financial website.

If you have any further questions, please contact Ms. Christina Tunnell in the Payroll Department at (410) 996-5401 ext. 50112, or by email at ctunnell@ccps.org.

Your Maryland State Retirement and Pension Account

Enrollment in this plan will occur during your new hire orientation. Your contribution to this program is 7% of your annual salary. While employed with CCPS, you will earn service credit toward your retirement benefits. Your service credit and age determine when you are eligible for retirement and the amount of your retirement benefit.

The Pension System provides survivor, disability, & service retirement benefits. For more information on each of these benefits, you can visit the SRPS website at sra.maryland.gov. When you retire, you will be able to choose from multiple payment options. These options range from basic allowance which provides the highest payout, to options that reduce your monthly payment but provide varying degrees of protection to your beneficiary(ies) upon your death.

For more information on your SRPS account and your options at retirement, contact Ms. Briane Crouse, Assistant in Human Resources, at (410) 996-5401 ext. 50303 or the State Retirement & Pension Agency at (800) 492-5909.

Trustmark Disability Insurance

How would you pay household and uncovered medical expenses for you and your family if you were unable to work? Trustmark Disability Income insurance is designed to help provide financial protection under these circumstances.

As an employee who works 30 hours per week or more in a budgeted position, you are eligible to purchase disability income insurance through Trustmark. If elected, coverage may begin the first of the month following your date of employment. However, there are some circumstances in which there may be a waiting period before your benefits become effective.

Disability insurance enrollment period enrollment period is held each fall, after the start of school.

To discuss enrollment:

1. ***Please call 1.443.229.5199***
2. ***Office hours are Monday-Friday, 9 a.m.—8 p.m.***

New hires enrollment window will open the 1st of the month after the date of hire and will be open for 30 days. If enrollment is missed during this time, the next opportunity to enroll will be the fall open enrollment period.

Trustmark Disability provides two benefit options, allowing you the opportunity to choose the benefit that best fits your needs. You can choose from a 0-day accident/7-day sickness elimination period benefit or a 14-day accident/sickness elimination period benefit. When you contact the enrollment call center a representative will ask you a few employment and health related questions. Once answered, they will review the different benefit options available to you.

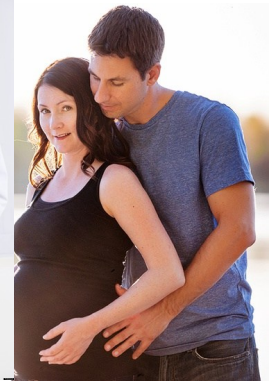
What's covered? Short-term total disability due to non-occupational related sicknesses and/or illness/injury, and maternity leave after 10 months of your effective date, and complications of pregnancy.

The length for which you will receive your disability income is dependent on the period your doctor declares you completely disabled and unable to work. The maximum length of payout for benefits is not to exceed three (3) months.

Premiums for your disability income insurance will be deducted from your bi-weekly pay. When you are ready to draw from your disability insurance, you must contact Trustmark and provide them with any required medical documentation.

Trustmark Disability will run in conjunction with any remaining sick, personal, or annual leave you may be paid while off work.

For more information about the Trustmark Disability program, please refer to the Trustmark brochure and policy manual located in the Benefits sections of the CCPS website.



EMPLOYEE ASSISTANCE PROGRAM

Sometimes life can be challenging. That's why CCPS provides an employee assistance program (EAP) to all eligible employees at no cost. The EAP is designed to provide prompt, confidential* help with a range of personal and family issues that may affect all of us from time to time. You or a member of your household (spouse, dependent children) can receive up to ***six free*** counseling sessions with an EAP Professional per incident, per school year.

EAP counselors will assist you with concerns such as:

- Marital and relationship issues,
- Alcohol and drug abuse,
- Stress management,
- Family/parenting problems,
- Work relationships,
- Legal assistance,
- Wellness information,
- Concierge services,
- Discount shopping programs,
- And much more.

Our EAP provider is Business Health Services (BHS). If you need help or guidance, you may reach out to the EAP at (800) 327-2251, a TTY & Language Line is available. You can also visit them online at https://portal.bhsonline.com. The company log in is **CCPS.**

*Only when the individual calling threatens harm to themselves, family members, co-workers or students will Business Health Services notify your employer. However, only your name and the general nature of your call will be given to your employer. Any specifics discussed during your conversation will not be released.

OTHER VALUABLE BENEFITS

Cecil County Public Schools is pleased to also offer the following valuable benefits to employees:

- Maryland State Retirement and Pension Program
- Sick Leave Bank Membership
- Cecil County Schools Employees' Federal Credit Union
- Retirement Health Care subsidy for employees with 14 or more years of service at the time of retirement
- Wellness Program offered through CCPS & US Wellness

Wellness Program

CCPS Wellness – Wellness Program with Personify Health

Cecil County Public School's wellness program makes it fun and easy to work on your well-being goals every day. Whether you want to sleep better, improve your eating habits, add movement to your day or simply take a few moments to be mindful, we have tools and support to help you develop a healthy, rewarding routine.

Level up and get rewarded!

It's your time to thrive. With over hundreds of activities to track and new rewards available year-round, there are more ways to earn! Complete your program requirements between **April 1, 2025 – March 31, 2026**, to earn your wellness incentive, up to a $250 value!

Program Requirements

- **Complete biometric screening** – make an appointment at an onsite event in the fall, download a physician fax form, or request a lab voucher.
- **Complete 3 preventive care exams** – log each exam completed on your rewards page of the wellness portal
- **Reach level 3** – complete activities to level ip and reach level 3 to qualify for your incentive

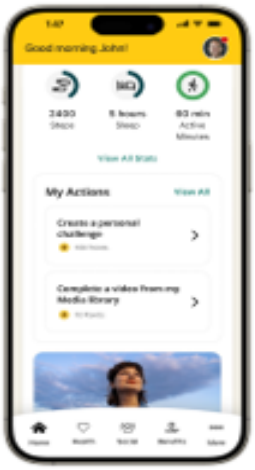
Level 1	Level 2	Level 3	Level 4
10,000 points	30,000 points	45,000 points	70,000 points

Looking to join? Visit ccpswellness.org

Keep on tracking, no matter where you are.

The fun doesn't stop when you leave work. The mobile app has all the same great features as the website – and even more convenience! Visit your Google Play or App Store and search Personify Health or scan the QR code. Log in with your CCPS email address and password you created when you set up your account.

- ✓ **Get healthy tips** – complete your daily cards and explore new ways to eat better.
- ✓ **Compete in challenges** – rally your coworker for the latest company step challenge!
- ✓ **Track your progress** – record steps, healthy habits, and other activities.
- ✓ **Sync your activity** – Connect a wearable device! Be sure to sign into your mobile app at least once every 14 days so your data syncs and counts toward your activity goals.



Rewarding, in every way.

Small steps lead to big changes. We will help you make small, everyday changes to your wellbeing that are focused on the areas you want to improve the most. With daily engagement, you can build healthy habits, challenge coworkers, and experience the lifelong rewards of better health and wellbeing.

Create habits that matter. Earn points along your journey to level up by tracking the activities below. Log in to see the many point-earning opportunities available.

- ☐ Sync your steps and exercise: connect a fitness tracker, your mobile device, or log manually
- ☐ Set your interests for personalized content
- ☐ Track your healthy habits daily
- ☐ Take the Health Check survey to get your health score
- ☐ Participate in Journeys, self-guided courses that help you build healthy habits
- ☐ Compete in company-wide challenges
- ☐ Participate in healthy habit challenges
- ☐ Startup personal steps or habit challenges

FAQs

How do I access the platform?
First time users will need to create your account. Visit join.personifyhealth.com/ccps and follow the on-screen instructions. The email address and password used to create your account is what you will use to sign into the mobile app.

How do I qualify for rewards?
Once you complete 3 preventive care exams, your biometric screening, and reach level 3, you will qualify for the wellness incentive! Track your progress on the wellness platform under the rewards page to make sure your requirements have been completed. A representative from CCPS HR will contact you to redeem your reward.

Can I backlog activities?
Steps and active minutes can be backlogged within a 14-day window. Healthy Habits can be backlogged within a 1-week window. Daily card points can only be earned on the current day and the opportunity to complete cards expire each day. Points for all other activities in the program can be earned and backlogged at any time throughout the program year. If you have an activity tracking device connected, **be sure to sign into your mobile app at least once every 14 days so your data syncs and counts toward your activity goals.**

Who can participate?
All CCPS employees who work **17.5 hours** or more per week are eligible to join the program and work toward earning an incentive.

Is the program mandatory?
No. The wellness program is a completely voluntary program. The program is administered according to federal rules permitting employer-sponsored wellness programs that seek to improve associate health or prevent disease, including the Americans with Disabilities Act of 1990, the Genetic Information Nondiscrimination Act of 2008, and the Health Insurance Portability and Accountability Act, as applicable, among others.

What if I am unable to participate in the wellness program due to a medical condition?
Not sure if you can fully participate in this program because of a disability or medical condition? You may be eligible for alternative ways to participate. For more information, check out our Support page answers or send us an e-mail!

Ongoing member support: Chat support available 2am – 9pm EST, Monday – Friday via "Help" or "Chat" located on the platform when registering and once logged in.

Phone: 888-671-9395 | Email: support@personifyhealth.com
Hours of phone/email support: 8am – 9pm EST, Monday – Friday

personify HEALTH

During Open Enrollment, You Can:

- Change your medical, dental, or vision elections.
- Update or change your dependent information. Remember, if you are adding a child over 19 back onto your dental and vision plans, you will need to complete the student verification paperwork to ensure coverage.
- Elect to participate in a Flexible Spending Account (FSA).
- Elect additional Supplemental Life Insurance. Increases greater than $10k will require an Evidence of Insurability (EOI) form and The Hartford approval.

In order to complete your online enrollment, you will need to access the Benelogic system at **www.ccps.benelogic.com**. If you do not have access to a computer at home, computers are available at your location or in the Human Resources Office. If you need help enrolling, please contact the Benefits Office at (410) 996-5415.

While using the Benelogic Portal to make your selections during the CCPS Open Enrollment period you will be able to compare your new elections to your previous benefit selections.

PLEASE NOTE: If you are a full-time employee you must make a medical plan election to enroll in or opt-out of coverage. Otherwise, your enrollment will default to the Aetna Open Choice PPO High Deductible Health Plan & HSA with Individual only coverage for the 2025—2026 benefit plan year.

When You are Ready to Enroll or Make Changes:

1. Using a computer with Internet, go to **www.ccps.benelogic.com**.
2. Enter your **User ID** which is your last name **and** the last four digits of your Social Security Number (example: smith1234).
3. Enter your **Password.** If this is your first time logging into Benelogic, your password will be the last four digits of your Social Security Number (example: 1234). If you do not remember your Benelogic password, click on the link, “Forgot User ID/Password?”.
4. Accept the Terms of Use and Privacy Policy.
5. Update your Password information, if requested.
6. Click on the **“enroll”** button in the **Open Enrollment Now in Progress** box.
7. Verify information on the screen then click “next” to advance to the next screen.
8. ***IMPORTANT:*** Under Federal Law, if you wish to participate in the Medical and/or Dependent Care Flexible Spending Account (FSA) program, you must make a new election each year during Open Enrollment.
9. Click **Submit** to save your elections.
10. **Print/save** your confirmation statement for your records. This statement confirms your elections and itemizes your payroll deductions for 2025 – 2026.

NOTE: You may log back on at any time during the Open Enrollment period to review or change your elections; however, you must remember to click “submit” to save your changes. The last “submitted” elections will determine your benefits for the plan year beginning September 1, 2025, and ending August 31, 2026.

Flexible Spending Accounts - Health Care and Dependent Care

Health Care FSA Grace Period: The Treasury Department allows more time for you to spend your health care flexible spending account funds. This option allows CCPS to give you a 2 and ½ month grace period after your plan year is over to incur eligible medical expenses (received services) and submit those expenses for reimbursement from the prior year's remaining health care FSA balance. This enhancement provides you the opportunity to utilize health care FSA funds that would otherwise be forfeited. For example, the CCPS plan year ends June 30, 2025, the 2 and ½ month grace period ends on September 15, 2026. You would have until September 15, 2026, to incur expenses which can be reimbursed from your FY2026 annual health care FSA election balance. Your Plan's run-out period (the time after your plan year has ended to submit eligible claims) has also been extended. Participants will have 90 days after the end of the plan year to submit claims. For example, if your plan year ends June 30, 2026, you will have until September 28, 2026, to submit claims for services that were incurred in the prior plan year (7/1/25 through 6/30/26 and the subsequent grace period end date 9/15/2026).

Does the grace period apply to both the Health Care FSA and Dependent Care FSA? Yes. If you have not spent all monies in your Health Care FSA or Dependent Care FSA by the end of the plan year, you may continue to incur claims for expenses during the grace period. The grace period extends 2 and 1/2 months after the end of the plan year, during which time you can continue to incur claims and use up all amounts remaining in your Health Care or Dependent Care FSA.

If I use my debit card during the grace period, which account balance will it reduce? If the debit card is used during the grace period, remaining funds from the previous plan year will first be used until September 15, 2026. Once these funds have been exhausted or the grace period has ended, funds will then be pulled from the current plan year balance. Any claims paid manually will need to be submitted for reimbursement manually.

What happens if I leave CCPS before the end of the Plan Year? The grace period only applies to participants covered on the last day of the applicable plan year. If you terminate coverage prior to the last day of the plan year under the Health Care FSA or Dependent Care FSA, you will have 30 days from your termination date to submit claims for eligible expenses incurred (services received) through your termination date. The grace period will not apply.

How will claim submissions be applied to my account during the grace period and run-out period? Any claims submitted to FBA for eligible medical services incurred during the grace period will automatically be applied to your previous year's health care FSA balance. Once your prior year's health care FSA balance is exhausted, any eligible expenses submitted will be reimbursed from your current plan year election.

What happens if at the end of the grace period, I still have a balance in my prior plan year's Health Care FSA account but no eligible medical expenses to apply to that balance? In this instance, the "use-it-or-lose-it" rule applies and those health care FSA funds are forfeited. The funds can not be carried over to the current plan year, nor can they be received in cash or applied to other expenses.

What happens if I find an old receipt for an eligible medical expense incurred in the prior plan year after I already submitted claims for expenses incurred during the grace period and depleted my prior year's balance to $0? The request will be denied as the prior plan year's health care FSA balance has been exhausted. As noted previously, only eligible medical expenses incurred during the current plan year may be submitted for reimbursement once you have exhausted your prior plan year health care FSA balance (or when the grace period ends).

Can I incur claims in the grace period if I do not re-enroll in a Health Care FSA for the subsequent plan year? Yes. As long as you are an active health care FSA participant on the last day of the prior plan year, you can incur eligible medical expenses during the grace period and submit claims against your remaining Medical Care FSA balance from the prior plan year.

Can I have both, an FSA and HSA? If you are enrolled in the Aetna High Deductible Health Plan, you may use the HSA and a Limited Health Care FSA. The Limited FSA will only reimburse you for care related to qualified dental, vision, or preventative care.

What are the differences between a FSA and HSA?

	Flexible Spending Account	Health Savings Account
Is a healthcare plan required?	No	Yes; the Aetna Open Choice PPO High Deductible Health Plan
Is there a “use-it or lose-it” provision?	Yes	No. Any funds in your account that are not used will roll over from year to year.
Can I take my funds with me if I leave CCPS?	No	Yes, the HSA is portable. You can also use funds towards medical expenses during retirement.
Are my contributions taxed?	No	No
Are withdrawals for qualified expenses taxed?	No	No
Who can contribute?	You	You and CCPS
What is the maximum total contribution for 2025?	$3,300 for Healthcare $5,000 for Dependent Care	$4,300 for individuals $8,550 for two-party or more

Dependent Eligibility

Who is an eligible dependent?

- ⇒ Your spouse.
- ⇒ Your dependent children up to age 26, including a stepchild, adopted child, or foster child (medical plans only).
- ⇒ Your dependent children, until the end of the month they turn 20 (or up to age 23 if a full-time student), including a stepchild, adopted child, or foster child (dental and vision plans).
- ⇒ Your unmarried children of any age who are physically and/or mentally incapable of self-support and cannot earn their own living. (Onset of disability must be prior to age 19 or while covered under the plan.)
- ⇒ Children or grandchildren for whom you have legal guardianship.

⇒ If you and your spouse are both employees of CCPS, you can each enroll as an individual or one of you can elect two-person or family health care coverage. If you elect coverage separately, you can not cover each other as dependents and your eligible child(ren) may only be covered by one of you.

Who is not an eligible dependent?

⇒ Domestic and unmarried partners,
⇒ Parents of employees,
⇒ Dependents over the age of 26, who are not eligible disabled dependents
⇒ Dependents over the age of 20, who are not full-time students (dental/vision plans only),
⇒ Children of domestic or live-in partners,
⇒ Divorced spouses, and
⇒ Stepchildren following divorce from the natural parent.
⇒ Active Military Children

How do I add a new child to my benefits? Log-in to the Benelogic website and click on "Change Request". Your change request will be approved once a copy of the record of birth or adoption papers (if applicable), have been received by the Benefits Office. ***You have 31 days from the child's birth date/adoption date to add the child to your health plans***. Coverage will take effect retroactively to the child's birth/adoption date. If you miss this 31-day period the next opportunity to make an enrollment change is during the annual open enrollment period. You will need to provide a copy of the child's birth certificate and their social security card to verify continued dependent eligibility.

Who is considered a full-time student? Your child who is attending a college, university, or vocational school and enrolled in the equivalent of at least 12 credit hours per academic semester for undergraduate students or 9 credit hours for graduate students. If your child qualifies as a full-time student, dental and vision coverage can be continued until the end of the month of graduation or to the end of the calendar year they turn 23, whichever comes first. Verification of full-time student status will be requested for every Spring and Fall semester.

What do I do when my dependent loses eligibility for coverage? You must notify the Benefits Office as soon as you know that your dependent will no longer meet the eligibility requirements. There are no refunds of bi-weekly premiums as a result of late notification of a dependent's ineligibility. Remember, dependents losing coverage may elect to continue coverage under COBRA for a maximum of 36 months, as long as you have notified the Benefits Office within 60 days of the loss of the dependent's eligibility. *It is fraudulent to include dependents on a CCPS benefit plan who do not meet eligibility requirements. You may be held financially liable for claims paid for ineligible dependents. Providing false dependent information may result in disciplinary action, up to and including termination of employment.*

Continuation of Coverage

Will I be eligible for COBRA if I leave CCPS? Yes. If you were enrolled in health care coverage through CCPS while employed, upon your employment termination, you will receive notification from the Benefits Department on how to continue your health care coverage. This is separate from health care coverage for those individuals who retire from CCPS. For more information on the Retiree Benefit program, please contact the Benefits Department at (410) 996-5415.

Benefit Election Changes

Can I change my elections during the year? IRS regulations only allow you to change your elections outside the annual open enrollment period if you have a qualified life event change. ***Changes must be requested within 31 days of the date of the event.***

What is a qualified life event change? To be considered a qualified life event change, the change must result in the employee or dependent gaining or losing eligibility for benefits. Some examples of life change events include:

- ⇒ Marriage or divorce,
- ⇒ Birth or adoption of a child,
- ⇒ Spouse or child's loss of benefits (i.e. open enrollment), or
- ⇒ Employee's gain or loss of non-CCPS benefits.

This list is not all-inclusive. Call the Benefits Office at 410-996-5415, or email benefitsinfo@ccps.org for answers to specific questions on life changes.

Notice of Special Enrollment Rights. If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance coverage, you may be able to enroll yourself or your dependents in the CCPS plan, provided you request enrollment within 31 days following the loss of coverage. In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents, provided that you request enrollment within 31 days after the qualified life event.

If I am enrolled in a medical plan and my doctor leaves the network, can I change my medical plan election? No, this is not considered a qualified life event change.

Appendix 2: CCPS Notice of HIPAA

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

The effective date of this Notice of Cecil County Public Schools Health Information Privacy Practices (the "Notice") is September 23, 2013.

Cecil County Public Schools Health Plans (the "Plan") provides health benefits to eligible employees of Cecil County Public Schools (the "Company") and their eligible dependents as described in the summary plan description(s) for the Plan. The Plan creates, receives, uses, maintains and discloses health information about participating employees and dependents in the course of providing these health benefits.

For ease of reference, in the remainder of this Notice, the words "you," "your," and "yours" refers to any individual with respect to whom the Plan receives, creates or maintains Protected Health Information, including employees, retirees, and COBRA qualified beneficiaries, if any, and their respective dependents.

The Plan is required by law to take reasonable steps to protect your Protected Health Information from inappropriate use or disclosure.

Your "Protected Health Information" (PHI) is information about your past, present, or future physical or mental health condition, the provision of health care to you, or the past, present, or future payment for health care provided to you, but only if the information identifies you or there is a reasonable basis to believe that the information could be used to identify you. Protected health information includes information of a person living or deceased (for a period of fifty years after the death.)

The Plan is required by law to provide notice to you of the Plan's duties and privacy practices with respect to your PHI, and is doing so through this Notice. This Notice describes the different ways in which the Plan uses and discloses PHI. It is not feasible in this Notice to describe in detail all of the specific uses and disclosures the Plan may make of PHI, so this Notice describes all of the categories of uses and disclosures of PHI that the Plan may make and, for most of those categories, gives examples of those uses and disclosures. The Plan is required to abide by the terms of this Notice until it is replaced. The Plan may change its privacy practices at any time and, if any such change requires a change to the terms of this Notice, the Plan will revise and re-distribute this Notice according to the Plan's distribution process. Accordingly, the Plan can change the terms of this Notice at any time. The Plan has the right to make any such change effective for all of your PHI that the Plan creates, receives or maintains, even if the Plan received or created that PHI before the effective date of the change.

The Plan is distributing this Notice, and will distribute any revisions, only to participating employees, retirees and COBRA qualified beneficiaries, if any. If you have coverage under the Plan as a dependent of an employee, or COBRA qualified beneficiary, you can get a copy of the Notice by requesting it from the contact named at the end of this Notice.

Please note that this Notice applies only to your PHI that the Plan maintains. It does not affect your doctor's or other health care provider's privacy practices with respect to your PHI that they maintain. Receipt of Your PHI by the Company and Business Associates.

The Plan may disclose your PHI to, and allow use and disclosure of your PHI by, the Company and Business Associates without obtaining your authorization.

- ⇒ Plan Sponsor: The Company is the Plan Sponsor and Plan Administrator. The Plan may disclose to the Company, in summary form, claims history and other information so that the Company may solicit premium bids for health benefits, or to modify, amend or terminate the Plan. This summary information omits your name and Social Security Number and certain other identifying information. The Plan may also disclose information about your participation and enrollment status in the Plan to the Company and receive similar information from the Company. If the Company agrees in writing that it will protect the information against inappropriate use or disclosure, the Plan also may disclose to the Company a limited data set that includes your PHI, but omits certain direct identifiers, as described later in this Notice. The Plan may disclose your PHI to the Company for plan administration functions performed by the Company on behalf of the Plan, if the Company certifies to the Plan that it will protect your PHI against inappropriate use and disclosure. Example: The Company reviews and decides appeals of claim denials under the Plan. The Claims Administrator provides PHI regarding an appealed claim to the Company for that review, and the Company uses PHI to make the decision on appeal.
- ⇒ Business Associates: The Plan and the Company hire third parties, such as a third party administrator (the "Claims Administrator"), to help the Plan provide health benefits. These third parties are known as the Plan's "Business Associates." The Plan may disclose your PHI to Business Associates, like the Claims Administrator, who are hired by the Plan or the Company to assist or carry out the terms of the Plan. In addition, these Business Associates may receive PHI from third parties or create PHI about you in the course of carrying out the terms of the Plan. The Plan and the Company must require all Business Associates to agree in writing that they will protect your PHI against inappropriate use or disclosure, and will require their subcontractors and agents to do so, too.

For purposes of this Notice, all actions of the Company and the Business Associates that are taken on behalf of the Plan are considered actions of the Plan. For example, health information maintained in the files of the Claims Administrator is considered maintained by the Plan. So, when this Notice refers to the Plan taking various actions with respect to health information, those actions may be taken by the Company or a Business Associate on behalf of the Plan.

How the Plan May Use or Disclose Your PHI

The Plan may use and disclose your PHI for the following purposes without obtaining your authorization. And, with only limited exceptions, we will send all mail to you, the employee. This includes mail relating to your spouse and other family members who are covered under the Plan.

If a person covered under the Plan has requested Restrictions or Confidential Communications, and if the Plan has agreed to the request, the Plan will send mail as provided by the request for Restrictions or Confidential Communications.

- ⇒ Your Health Care Treatment: The Plan may disclose your PHI for Treatment (as defined in applicable federal rules) activities of a health care provider.
  - ♦ Example: If your doctor requested information from the Plan about previous claims under the Plan to assist in treating you, the Plan could disclose your PHI for that purpose.
  - ♦ Example: The Plan might disclose information about your prior prescriptions to a pharmacist for the pharmacist's reference in determining whether a new prescription may be harmful to you.
- ⇒ Making or Obtaining Payment for Health Care or Coverage: The Plan may use or disclose your PHI for payment (as defined in applicable federal rules) activities, including making payment to or collecting payment from third parties, such as health care providers and other health plans.
  - ♦ Example: The Plan will receive bills from physicians for medical care provided to you that will contain your PHI. The Plan will use this PHI, and create PHI about you, in the course of determining whether to pay, and paying, benefits with respect to such a bill.
  - ♦ Example: The Plan may consider and discuss your medical history with a health care provider to determine whether a particular Treatment for which Plan benefits are or will be claimed is medically necessary as defined in the Plan.

The Plan's use or disclosure of your PHI for payment purposes may include uses and disclosures for the following purposes, among others:

- ⇒ Obtaining payments required for coverage under the Plan.
- ⇒ Determining or fulfilling its responsibility to provide coverage and/or benefits under the Plan, including eligibility determinations and claims adjudication.
- ⇒ Obtaining or providing reimbursement for the provision of health care (including coordination of benefits, subrogation, and determination of cost sharing amounts).
- ⇒ Claims management, collection activities, obtaining payment under a stop-loss insurance policy, and related health care data processing.
- ⇒ Reviewing health care services to determine medical necessity, coverage under the Plan, appropriateness of care, or justification of charges.
- ⇒ Utilization review activities, including precertification and preauthorization of services, concurrent and retrospective review of services.

The Plan also may disclose your PHI for purposes of assisting other health plans (including other health plans sponsored by the Company), health care providers, and health care clearinghouses with their payment activities, including activities like those listed above with respect to the Plan.

Health Care Operations: The Plan may use and disclose your PHI for health care operations (as defined in applicable federal rules) which includes a variety of facilitating activities.

- ⇒ Example: If claims you submit to the Plan indicate that you have diabetes or another chronic condition, the Plan may use and disclose your PHI to refer you to a disease management program.

- ⇒ Example: If claims you submit to the Plan indicate that the stop-loss coverage that the Company has purchased in connection with the Plan may be triggered, the Plan may use or disclose your PHI to inform the stop-loss carrier of the potential claim and to make any claim that ultimately applies.

The Plan's use and disclosure of your PHI for health care operations purposes may include uses and disclosures for the following purposes.

- ⇒ Quality assessment and improvement activities
- ⇒ Disease management, case management and care coordination
- ⇒ Activities designed to improve health or reduce health care costs
- ⇒ Contacting health care providers and patients with information about Treatment alternatives
- ⇒ Accreditation, certification, licensing or credentialing activities
- ⇒ Fraud and abuse detection and compliance programs

The Plan also may use or disclose your PHI for purposes of assisting other health plans (including other plans sponsored by the Company), health care providers and health care clearinghouses with their health care operations activities that are like those listed above, but only to the extent that both the Plan and the recipient of the disclosed information have a relationship with you and the PHI pertains to that relationship.

- ⇒ The Plan's use and disclosure of your PHI for health care operations purposes may include uses and disclosures for the following additional purposes, among others.
- ⇒ Underwriting (with the exception of PHI that is genetic information) premium rating and performing related functions to create, renew or replace insurance related to the Plan
- ⇒ Planning and development, such as cost-management analyses
- ⇒ Conducting or arranging for medical review, legal services, and auditing functions
- ⇒ Business management and general administrative activities, including implementation of, and compliance with, applicable laws, and creating de-identified health information or a limited data set

The Plan also may use or disclose your PHI for purposes of assisting other health plans for which the Company is the plan sponsor, and any insurers and/or HMOs with respect to those plans, with their health care operations activities similar to both categories listed above.

Limited Data Set: The Plan may disclose a limited data set to a recipient who agrees in writing that the recipient will protect the limited data set against inappropriate use or disclosure. A limited data set is health information about you and/or others that omits your name and Social Security Number and certain other identifying information.

Legally Required: The Plan will use or disclose your PHI to the extent required to do so by applicable law. This may include disclosing your PHI in compliance with a court order, or a subpoena or summons. In addition, the Plan must allow the U.S. Department of Health and Human Services to audit Plan records.

Health or Safety: When consistent with applicable law and standards of ethical conduct, the Plan may disclose your PHI if the Plan, in good faith, believes that such disclosure is necessary to prevent or lessen a serious and imminent threat to your health or the health and safety of others.

Law Enforcement: The Plan may disclose your PHI to a law enforcement official if the Plan believes in good faith that your PHI constitutes evidence of criminal conduct that occurred on the premises of the Plan. The Plan also may disclose your PHI for limited law enforcement purposes.

Lawsuits and Disputes: In addition to disclosures required by law in response to court orders, the Plan may disclose your PHI in response to a subpoena, discovery request or other lawful process, but only if certain efforts have been made to notify you of the subpoena, discovery request or other lawful process or to obtain an order protecting the information to be disclosed.

Workers' Compensation: The Plan may use and disclose your PHI when authorized by and to the extent necessary to comply with laws related to workers' compensation or other similar programs.

Emergency Situation: The Plan may disclose your PHI to a family member, friend, or other person, for the purpose of helping you with your health care or payment for your health care, if you are in an emergency medical situation and you cannot give your agreement to the Plan to do this.

Personal Representatives: The Plan will disclose your PHI to your personal representatives appointed by you or designated by applicable law (a parent acting for a minor child, or a guardian appointed for an incapacitated adult, for example) to the same extent that the Plan would disclose that information to you. The Plan may choose not to disclose information to a personal representative if it has reasonable belief that: 1) you have been or may be a victim of domestic abuse by your personal representative; or 2) recognizing such person as your personal representative may result in harm to you; or 3) it is not in your best interest to treat such person as your personal representative.

Public Health: To the extent that other applicable law does not prohibit such disclosures, the Plan may disclose your PHI for purposes of certain public health activities, including, for example, reporting information related to an FDA-regulated product's quality, safety or effectiveness to a person subject to FDA jurisdiction.

Health Oversight Activities: The Plan may disclose your PHI to a public health oversight agency for authorized activities, including audits, civil, administrative or criminal investigations; inspections; licensure or disciplinary actions.

Coroner, Medical Examiner, or Funeral Director: The Plan may disclose your PHI to a coroner or medical examiner for the purposes of identifying a deceased person, determining a cause of death or other duties as authorized by law. Also, the Plan may disclose your PHI to a funeral director, consistent with applicable law, as necessary to carry out the funeral director's duties.

Organ Donation. The Plan may use or disclose your PHI to assist entities engaged in the procurement, banking, or transplantation of cadaver organs, eyes, or tissue.

Specified Government Functions: In specified circumstances, federal regulations may require the Plan to use or disclose your PHI to facilitate specified government functions related to the military and veterans, national security and intelligence activities, protective services for the president and others, and correctional institutions and inmates.

Research: The Plan may disclose your PHI to researchers when your individual identifiers have been removed or when an institutional review board or privacy board has reviewed the research proposal and established a process to ensure the privacy of the requested information and approves the research.

Disclosures to You: When you make a request for your PHI, the Plan is required to disclose to you your medical records, billing records, and any other records used to make decisions regarding your health care benefits. The Plan must also, when requested by you, provide you with an accounting of disclosures of your PHI if such disclosures were for any reason other than Treatment, Payment, or Health Care Operations (and if you did not authorize the disclosure).

Authorization to Use or Disclose Your PHI

Except as stated above, the Plan will not use or disclose your PHI unless it first receives written authorization from you. If you authorize the Plan to use or disclose your PHI, you may revoke that authorization in writing at any time, by sending notice of your revocation to the contact person named at the end of this Notice. To the extent that the Plan has taken action in reliance on your authorization (entered into an agreement to provide your PHI to a third party, for example) you cannot revoke your authorization.

Furthermore, we will not: (1) supply confidential information to another company for its marketing purposes (unless it is for certain limited Health Care Operations); (2) sell your confidential information (unless under strict legal restrictions) (to sell means to receive direct or indirect remuneration); (3) provide your confidential information to a potential employer with whom you are seeking employment without your signed authorization; or (4) use or disclose psychotherapy notes unless required by law.

Additionally, if a state or other law requires disclosure of immunization records to a school, written authorization is no longer required. However, a covered entity still must obtain and document an agreement which may be oral and over the phone.

The Plan May Contact You

The Plan may contact you for various reasons, usually in connection with claims and payments and usually by mail.

Your Rights with Respect to Your PHI

Confidential Communication by Alternative Means: If you feel that disclosure of your PHI could endanger you, the Plan will accommodate a reasonable request to communicate with you by alternative means or at alternative locations. For example, you might request the Plan to communicate with you only at a particular address. If you wish to request confidential communications, you must make your request in writing to the contact person named at the end of this Notice. You do not need to state the specific reason that you feel disclosure of your PHI might endanger you in making the request, but you do need to state whether that is the case. Your request also must specify how or where you wish to be contacted. The Plan will notify you if it agrees to your request for confidential communication. You should not assume that the Plan has accepted your request until the Plan confirms its agreement to that request in writing.

Request Restriction on Certain Uses and Disclosures: You may request the Plan to restrict the

uses and disclosures it makes of your PHI. This request will restrict or limit the PHI that is disclosed for Treatment, Payment, or Health Care Operations, and this restriction may limit the information that the Plan discloses to someone who is involved in your care or the payment for your care.

The Plan is not required to agree to a requested restriction, but if it does agree to your requested restriction, the Plan is bound by that agreement, unless the information is needed in an emergency situation. There are some restrictions, however, that are not permitted even with the Plan's agreement. To request a restriction, please submit your written request to the contact person identified at the end of this Notice. In the request please specify: (1) what information you want to restrict; (2) whether you want to limit the Plan's use of that information, its disclosure of that information, or both; and (3) to whom you want the limits to apply (a particular physician, for example). The Plan will notify you if it agrees to a requested restriction on how your PHI is used or disclosed. You should not assume that the Plan has accepted a requested restriction until the Plan confirms its agreement to that restriction in writing. You may request restrictions on our use and disclosure of your confidential information for the Treatment, pay-ment and health care operations purposes explained in this Notice. Notwithstanding this policy, the plan will comply with any restriction request if (1) except as otherwise required by law, the disclosure is to the health plan for purposes of carrying out payment or health care operations (and it is not for purposes of carrying out Treatment); and (2) the PHI pertains solely to a health care item or service for which the health care provider has been paid out-of-pocket in full.

Right to Be Notified of a Breach: You have the right to be notified in the event that the plan (or a Business Associate) discovers a breach of unsecured protected health information.

Electronic Health Records: You may also request and receive an accounting of disclosures of electronic health records made for Treatment, payment, or health care operations during the prior three years for disclosures made on or after (1) January 1, 2014 for electronic health records acquired before January 1, 2009; or (2) January 1, 2011 for electronic health records acquired on or after January 1, 2009.

The first list you request within a 12-month period will be free. You may be charged for providing any additional lists within a 12-month period.

Paper Copy of This Notice: You have a right to request and receive a paper copy of this Notice at any time, even if you received this Notice previously, or have agreed to receive this Notice electronically. To obtain a paper copy please call or write the contact person named at the end of this Notice.

Right to Access Your PHI: You have a right to access your PHI in the Plan's enrollment, payment, claims adjudication and case management records, or in other records used by the Plan to make decisions about you, in order to inspect it and obtain a copy of it. Your request for access to this PHI should be made in writing to the contact person named at the end of this Notice. The Plan may deny your request for access, for example, if you request information compiled in anticipation of a legal proceeding. If access is denied, you will be provided with a written notice of the denial, a description of how you may exercise any review rights you might have, and a description of how you may complain to Plan or the Secretary of Health and Human Services. If you request a copy of your PHI, the Plan may charge a reasonable fee for copying and, if applicable, postage associated with your request.

Right to Amend: You have the right to request amendments to your PHI in the Plan's records if you believe that it is incomplete or inaccurate. A request for amendment of PHI in the Plan's records should be made in writing to the contact person named at the end of this Notice.

The Plan may deny the request if it does not include a reason to support the amendment. The request also may be denied if, for example, your PHI in the Plan's records was not created by the Plan, if the PHI you are requesting to amend is not part of the Plan's records, or if the Plan determines the records containing your health information are accurate and complete. If the Plan denies your request for an amendment to your PHI, it will notify you of its decision in writing, providing the basis for the denial, information about how you can include information on your requested amendment in the Plan's records, and a description of how you may complain to Plan or the Secretary of Health and Human Services.

Accounting: You have the right to receive an accounting of certain disclosures made of your health information. Most of the disclosures that the Plan makes of your PHI are not subject to this accounting requirement because routine disclosures (those related to payment of your claims, for example) generally are excluded from this requirement. Also, disclosures that you authorize, or that occurred more than six years before the date of your request, are not subject to this requirement. To request an accounting of disclosures of your PHI, you must submit your request in writing to the contact person named at the end of this Notice. Your request must state a time period which may not include dates more than six years before the date of your request. Your request should indicate in what form you want the accounting to be provided (for example on paper or electronically). The first list you request within a 12-month period will be free. If you request more than one accounting within a 12-month period, the Plan will charge a reasonable, cost-based fee for each subsequent accounting.

Personal Representatives: You may exercise your rights through a personal representative. Your personal representative will be required to produce evidence of his/her authority to act on your behalf before the person will be given access to your PHI or allowed to take any action for you. The Plan retains discretion to deny a personal representative access to your PHI to the extent permissible under applicable law.

Complaints

If you believe that your privacy rights have been violated, you have the right to express complaints to the Plan and to the Secretary of the Department of Health and Human Services. Any complaints to the Plan should be made in writing to the contact person named at the end of this Notice. The Plan encourages you to express any concerns you may have regarding the privacy of your information. You will not be retaliated against in any way for filing a complaint.

Contact Information

The Plan has designated the Director of Human Resources as its contact person for all issues regarding the Plan's privacy practices and your privacy rights. You can reach this contact person at:

Cecil County Public Schools
Attn: Joanna Zimmerman, Director of Human Resources
201 Booth Street, Elkton, MD 21921
Phone: (410) 996-5415, email: jkzimmerman@ccps.org

Women's Health and Cancer Rights Act of 1998 (WHCRA)

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 in a manner determined in consultation with the attending physician and the patient, for:

- ⇒ All stages of reconstruction of the breast on which the mastectomy was performed;
- ⇒ Surgery and reconstruction of the other breast to produce a symmetrical appearance;
- ⇒ Prostheses and treatment of physical complications of all stages of a mastectomy, including lymphedemas (swelling associated with the removal of lymph nodes).

Under WHCRA, mastectomy benefits may be subject to annual deductibles and co-insurance applicable to other medical and surgical benefits provided the medical plan which the individual is enrolled. If you would like more information on WHCRA benefits, call the Benefits Office at (410) 996-5415.

Genetic Information Nondiscrimination Act (GINA)

The Genetic Information Nondiscrimination Act (GINA) prohibits the collection of genetic information by both employers and health plans, and defines genetic information very broadly. Asking an individual to provide family medical history is considered a collection of genetic information, even if there is no reward for responding (or a penalty for failure to respond). In addition, a question about an individual's current health status is considered to be a request for genetic information if it is made in a way likely to result in obtaining genetic information (e.g., family medical history). Wellness programs that require completion of health risk assessments or other forms that request health information may violate the collection prohibition unless they fit within an exception to the prohibition for inadvertent acquisition of such information. This exception applies if the request does not violate any laws, does not ask for genetic information, and includes a warning against providing genetic information in any responses. An employer administering a wellness program might include a warning. For additional information on the benefits of including a warning against providing genetic information on wellness program materials, as well as other GINA issues related to health plan wellness programs, see Willis Human Capital Practice *Alert*, December 2010, "EEOC's GINA Regulations".

Newborn's and Mother's Health Protection Act of 1996 (NMHPA)

Group health plans and health insurance issuers generally may not, under federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or to less than 96 hours following a cesarean section. However, federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, Plans and issuers may not, under federal law, require that a provider obtain authorization from the Plan or the issuer for prescribing a length of stay that does not exceed 48 hours (or 96 hours).

Special Enrollment Rights

Federal law allows for special enrollment rights to permit you to elect coverage or add dependents in the case of marriage, birth, adoption, placement for adoption of a child or loss of other coverage as long as you provide written notice to the Benefits department within 31 days of the qualifying life event.

- ⇒ For marriage, coverage will take effect on the first day of the month following the date of the event.
- ⇒ For birth or adoption, coverage will be made retroactive to the date of the event.

Declining health coverage. If you decline enrollment for yourself or your dependents (including your spouse) because of other health insurance coverage, you may be able to enroll yourself or your dependents in this plan, provided you request enrollment within 31 days after your other coverage ends.

New dependents. If you have a new dependent as a result of marriage, birth, adoption or placement for adoption, you may be able to enroll your dependents, provided you request enrollment within 31 days of the qualifying life event.

Special enrollment can be requested only after losing eligibility for another coverage, after employer contributions for coverage stops or after exhausting COBRA coverage that was in effect when you declined coverage. An individual does not have special enrollment rights if the loss of coverage is the result of the failure to pay premiums. If you have any questions regarding special enrollment rights for you and/or your dependents, please email benefitsinfo@ccps.org.

COBRA Continuation Coverage

Introduction

This notice has important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan. **This notice explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect your right to get it.** When you become eligible for COBRA, you may also become eligible for other coverage options that may cost less than COBRA continuation coverage.

The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage can become available to you and other members of your family when group health coverage would otherwise end. For more information about your rights and obligations under the Plan and under federal law, you should review the Plan's Summary Plan Description or contact the Plan Administrator.

You may have other options available to you when you lose group health coverage. For example, you may be eligible to buy an individual plan through the Health Insurance Marketplace. By enrolling in coverage through the Marketplace, you may qualify for lower costs on your monthly premiums and lower out-of-pocket costs. Additionally, you may qualify for a 30-day special enrollment period for another group health plan for which you are eligible (such as a spouse's plan), even if that plan generally doesn't accept late enrollees.

What is COBRA continuation coverage?

COBRA continuation coverage is a continuation of Plan coverage when it would otherwise end because of a life event. This is also called a "qualifying event." Specific qualifying events are listed later in this notice. After a qualifying event, COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." You, your spouse, and your dependent children could become qualified beneficiaries if coverage under the Plan is lost because of the qualifying event. Under the Plan, qualified beneficiaries who elect COBRA continuation coverage [*choose and enter appropriate information:* must pay *or* aren't required to pay] for COBRA continuation coverage.

If you're an employee, you'll become a qualified beneficiary if you lose your coverage under the Plan because of the following qualifying events:

⇒ Your hours of employment are reduced, or

⇒ Your employment ends for any reason other than your gross misconduct.

If you're the spouse of an employee, you'll become a qualified beneficiary if you lose your coverage under the Plan because of the following qualifying events:

Your spouse dies;

⇒ Your spouse's hours of employment are reduced;

⇒ Your spouse's employment ends for any reason other than his or her gross misconduct;

⇒ Your spouse becomes entitled to Medicare benefits (under Part A, Part B, or both); or

⇒ You become divorced or legally separated from your spouse.

Your dependent children will become qualified beneficiaries if they lose coverage under the Plan because of the following qualifying events:

⇒ The parent-employee dies;

⇒ The parent-employee's hours of employment are reduced;

⇒ The parent-employee's employment ends for any reason other than his or her gross misconduct;

⇒ The parent-employee becomes entitled to Medicare benefits (Part A, Part B, or both);

⇒ The parents become divorced or legally separated; or

⇒ The child stops being eligible for coverage under the Plan as a "dependent child."

When is COBRA continuation coverage available?

The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Plan Administrator has been notified that a qualifying event has occurred. The employer must notify the Plan Administrator of the following qualifying events:

The end of employment or reduction of hours of employment;

Death of the employee; or

The employee's becoming entitled to Medicare benefits (under Part A, Part B, or both).

For all other qualifying events (divorce or legal separation of the employee and spouse or a dependent child's losing eligibility for coverage as a dependent child), you must notify the Plan Administrator within 60 days after the qualifying event occurs. You must provide this notice to the Benefits Department.

How is COBRA continuation coverage provided?

Once the Plan Administrator receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. Covered employees may elect COBRA continuation coverage on behalf of their spouses, and parents may elect COBRA continuation coverage on behalf of their children.

COBRA continuation coverage is a temporary continuation of coverage that generally lasts for 18 months due to employment termination or reduction of hours of work. Certain qualifying events, or a second qualifying event during the initial period of coverage, may permit a beneficiary to receive a maximum of 36 months of coverage.

There are also ways in which this 18-month period of COBRA continuation coverage can be extended:

If you or anyone in your family covered under the Plan is determined by Social Security to be disabled and you notify the Plan Administrator in a timely fashion, you and your entire family may be entitled to get up to an additional 11 months of COBRA continuation coverage, for a maximum of 29 months. The disability would have to have started at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period of COBRA continuation coverage. Please contact the CCPS Benefit team within 30 days of the Social Security determination.

If your family experiences another qualifying event during the 18 months of COBRA continuation coverage, the spouse and dependent children in your family can get up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months, if the Plan is properly notified about the second qualifying event. This extension may be available to the spouse and any dependent children getting COBRA continuation coverage if the employee or former employee dies; becomes entitled to Medicare benefits (under Part A, Part B, or both); gets divorced or legally separated; or if the dependent child stops being eligible under the Plan as a dependent child. This extension is only available if the second qualifying event would have caused the spouse or dependent child to lose coverage under the Plan had the first qualifying event not occurred.

Are there other coverage options besides COBRA Continuation Coverage?

Yes. Instead of enrolling in COBRA continuation coverage, there may be other coverage options for you and your family through the Health Insurance Marketplace, Medicare, Medicaid, Children's Health Insurance Program (CHIP), or other group health plan coverage options (such as a spouse's plan) through what is called a "special enrollment period." Some of these options may cost less than COBRA continuation coverage. You can learn more about many of these options at **www.healthcare.gov**.

Can I enroll in Medicare instead of COBRA continuation coverage after my group health plan coverage ends?

In general, if you don't enroll in Medicare Part A or B when you are first eligible because you are still employed, after the Medicare initial enrollment period, you have an 8-month special enrollment period to sign up for Medicare Part A or B, beginning on the earlier of

- The month after your employment ends; or

The month after group health plan coverage based on current employment ends.

If you don't enroll in Medicare and elect COBRA continuation coverage instead, you may have to pay a Part B late enrollment penalty and you may have a gap in coverage if you decide you want Part B later. If you elect COBRA continuation coverage and later enroll in Medicare Part A or B before the COBRA continuation coverage ends, the Plan may terminate your continuation coverage. However, if Medicare Part A or B is effective on or before the date of the COBRA election, COBRA coverage may not be discontinued on account of Medicare entitlement, even if you enroll in the other part of Medicare after the date of the election of COBRA coverage.

If you are enrolled in both COBRA continuation coverage and Medicare, Medicare will generally pay first (primary payer) and COBRA continuation coverage will pay second. Certain plans may pay as if secondary to Medicare, even if you are not enrolled in Medicare.

For more information visit https://www.medicare.gov/medicare-and-you.

If you have questions

Questions concerning your Plan or your COBRA continuation coverage rights should be addressed to the contact or contacts identified below. For more information about your rights under the Employee Retirement Income Security Act (ERISA), including COBRA, the Patient Protection and Affordable Care Act, and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit **www.dol.gov/ebsa**. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.) For more information about the Marketplace, visit **www.HealthCare.gov**.

Keep your Plan informed of address changes

To protect your family's rights, let the Plan Administrator know about any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the Plan Administrator. You may contact the CCPS Benefits Department at (410) 996-5415.

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

If you or your children are eligible for Medicaid or CHIP and you're 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 aren't eligible for Medicaid or CHIP, you won't 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 a State listed below, contact your State Medicaid or CHIP office to find out if premium assistance is available.

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 i*f you aren't 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)****.*

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of January 31, 2024. Contact your State for more information on eligibility:

ALABAMA – Medicaid	COLORADO – Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)
Website: http://myalhipp.com/ Phone: 1-855-692-5447	Health First Colorado Website: https://www.healthfirstcolorado.com/ Health First Colorado Member Contact Center: 1-800-221-3943/ State Relay 711 CHP+: https://www.colorado.gov/pacific/hcpf/child- health-plan-plus CHP+ Customer Service: 1-800-359-1991/ State Relay 711
ALASKA – Medicaid	**FLORIDA – Medicaid**
The AK Health Insurance Premium Payment Program Website: http://myakhipp.com/ Phone: 1-866-251-4861 Email: CustomerService@MyAKHIPP.com Medicaid Eligibility: http://dhss.alaska.gov/dpa/Pages/medicaid/default.aspx	Website: http://flmedicaidtplrecovery.com/hipp/ Phone: 1-877-357-3268
ARKANSAS – Medicaid	**GEORGIA – Medicaid**
Website: http://myarhipp.com/ Phone: 1-855-MyARHIPP (855-692-7447)	Website: https://medicaid.georgia.gov/health-insurance- premium-payment-program-hipp Phone: 678-564-1162 ext 2131
CALIFORNIA – Medicaid	**INDIANA – Medicaid**
Website: https://www.dhcs.ca.gov/services/Pages/TPLRD_CAU_co nt.aspx Phone: 1-800-541-5555	Healthy Indiana Plan for low-income adults 19-64 Website: http://www.in.gov/fssa/hip/ Phone: 1-877-438-4479 All other Medicaid Website: http://www.indianamedicaid.com Phone 1-800-403-0864

To see if any other states have added a premium assistance program since January 31, 2025, or for more information on special enrollment rights, contact:

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

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

About Your Prescription Drug Coverage and Medicare

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with Cecil County Public Schools 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. If you are considering joining, you should compare your current coverage, including which drugs are covered at what cost, with the coverage and costs of the plans offering Medicare prescription drug coverage in your area.

There are two important things you need to know about your current coverage and Medicare's prescription drug coverage:

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. Cecil County Public Schools has determined that the prescription drug coverage offered by the Cecil County Public School's Retiree Healthcare Plans are, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

When Can You Join A Medicare Drug Plan?

You can join a Medicare drug plan when you first become eligible for Medicare and each year from October 15th to December 7th. However, if you lose your current creditable prescription drug coverage, through no fault of your own, you will also be eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare drug plan.

What Happens to Your Current Coverage If You Decide to Join A Medicare Drug Plan?

If you decide to join a Medicare drug plan, your current Cecil County Public School coverage will be affected. Cecil County Public Schools Retiree Healthcare Plan is deemed to be creditable coverage because it:

1. Provides coverage for brand and generic prescriptions;
2. Provides access to retail providers and for mail order coverage;
3. The plan is designed to pay on average at least 60% of participants' prescription drug expenses; and
   a. The prescription drug coverage has no annual benefit maximum or a maximum annual benefit payable by the plan of at least $25,000;
   b. The integrated medical and prescription plan has no prescription deductible, no annual benefit maximum, and has no lifetime combined benefit maximum.

For individuals who elect Part D coverage, coverage under the Cecil County Public School's Retiree Healthcare Plan will end for the individual and all covered dependents.

If you do decide to join a Medicare drug plan and drop your current Cecil County Public Schools coverage, be aware that you and your dependents will not be able to get this coverage back.

When Will You Pay A Higher Premium (Penalty) To Join A Medicare Drug Plan?

You should also know that if you drop or lose your current coverage with Cecil County Public Schools 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% of the Medicare base beneficiary premium per month for every month that you did not have that coverage. For example, if you go nineteen months without creditable coverage, your premium may consistently be at least 19% 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 October to join.

For More Information About This Notice Or Your Current Prescription Drug Coverage

Contact the Benefits Office at Cecil County Public Schools or the Department of Aging at 410-996-8169. NOTE: You will get this notice each year, as well as before the next period you can join a Medicare drug plan, and if coverage through Cecil County Public Schools changes. You also may request a copy of this notice at any time.

For More Information About Your Options Under Medicare Prescription Drug Coverage

More detailed information about Medicare plans that offer prescription drug coverage is in the "Medicare & You" handbook. You'll get a copy of the handbook in the mail every year from Medicare. You also may 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 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

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 1-800-772-1213 (TTY 1-800-325-0778).

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

Date:	September, 2024
Name of Entity/Sender:	Cecil County Public Schools
Contract Office:	Benefits Office
Address:	201 Booth Street, Elkton, MD 21921
Phone Number:	(410) 996-5415

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%[1] 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.[12]

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.

[1] Indexed annually; see https://www.irs.gov/pub/irs-drop/rp-22-34.pdf for 2023.
[2] 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

_____.

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	4. Employer Identification Number (EIN)
Cecil County Public Schools	52-6000923
5. Employer address	6. Employer phone number
201 Booth Street	410-996-5415

7. City	8. State	9. ZIP code
Elkton	MD	21921

10. Who can we contact about employee health coverage at this job?
Benefits Office

11. Phone number (if different from above)	12. Email address
	Benefitsinto.ccps.org

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:

Individuals who worked at least 17.5 hours per week in a budgeted position are eligible to purchase health care at 100% of the premium cost. Individuals who work at least 30 hours per week in a budgeted position are eligible to purchase health care with employer cost share.

- With respect to dependents:

☒ We do offer coverage. Eligible dependents are:

Your child(ren): your natural children; legally adopted children or children placed with you for adoption; foster children; your stepchildren, regardless of place of residence while you are married to the natural parent, any children who live with you; depends on you for support, and for whom you serve as legal guardian, and any children you are responsible for as a result of a court-ordered custody arrangement. Children may be covered by the medical plan without any student verification requirements up to age 26. Children can be covered by the dental and vision plan up to age 19, or 23 if they are a full-time student.

☐ 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.

The information below corresponds to the Marketplace Employer Coverage Tool. Completing this section is optional for employers, but will help ensure employees understand their coverage choices.

13. **Is the employee currently eligible for coverage offered by this employer, or will the employee be eligible in the next 3 months?**

☐ **Yes** (Continue)
13a. If the employee is not eligible today, including as a result of a waiting or probationary period, when is the employee eligible for coverage?_____ (mm/dd/yyyy) (Continue)
☐ **No** (STOP and return this form to employee)

14. Does the employer offer a health plan that meets the minimum value standard*?
☐ Yes (Go to question 15) ☐ No (STOP and return form to employee)

15. For the lowest-cost plan that meets the minimum value standard* **offered only to the employee** (don't include family plans): If the employer has wellness programs, provide the premium that the employee would pay if he/ she received the maximum discount for any tobacco cessation programs, and didn't receive any other discounts based on wellness programs.
a. How much would the employee have to pay in premiums for this plan? $_____
b. How often? ☐ Weekly ☐ Every 2 weeks ☐ Twice a month ☐ Monthly ☐ Quarterly ☐ Yearly

If the plan year will end soon and you know that the health plans offered will change, go to question 16. If you don't know, STOP and return form to employee.

An employer-sponsored health plan meets the "minimum value standard" if the plan's share of the total allowed benefit costs covered by the plan is no less than 60 percent of such costs (Section 36B(c)(2)(C)(ii) of the Internal Revenue Code of 1986

Cecil County Public Schools
Benefit Reference Guide

September 1, 2025—August 31, 2026