



Serving Learners, Families, and the Community

CECIL COUNTY PUBLIC SCHOOLS OFFICE OF HUMAN RESOURCES

GEORGE WASHINGTON CARVER EDUCATION LEADERSHIP CENTER
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Notice Concerning Your Spouse's Eligibility

The Spousal Coordination of Benefits Agreement (SCOBA) applies to **all** spouses enrolled under CCPS medical insurance. It is the employee's responsibility to review the agreement before enrolling a spouse under their health plan.

A spouse's eligibility for primary coverage under the policy is determined on whether a spouse is **offered** healthcare benefits by their employer and the amount they would be required to pay for the lowest individual plan available to them. It is not based on plan design, total plan cost or salary negotiations. CCPS will provide primary medical coverage to any spouse whose employer does not offer medical coverage, or an individual medical plan that costs the spouse **more than \$287 per month**.

A spouse is eligible for enrollment in CCPS medical insurance health plan if they are a legal spouse. Ex-spouses, or civil union partners are **not** eligible to be enrolled.

Please Note: A spouse's enrollment in a CCPS health Insurance plan **does not** automatically guarantee primary coverage under the CCPS Spousal Coordination of Benefits Agreement (SCOBA).

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

- **If your spouse is employed: Form 1** must be completed and signed by you, **Form 2** must be completed and signed by you, your spouse, and your spouse's employer, Copy of Summary of Benefits for all plans offered and the employer's rate sheet.
- **If your spouse is self-employed: Form 1** must be completed and signed by you, and a copy of the most recent tax year 1099 form, S-Corp-Form 2553, or Section C of the 1040 (no financials, just the spouse's name and business name).
- **If your spouse is unemployed or retired: Form 1** must be completed and signed by you.
- **If your spouse is employed and you are carrying them as secondary coverage: Form 1** must be completed and signed by you and copy of the insurance card.
- **If your spouse is a CCPS employee no form is required**, however you must indicate that your spouse is a CCPS employee on the Spouse Employment Designation page of your Benelogic portal.

**FAILURE TO COMPLETE A SCOBA FORM(S) OR PROVIDE DOCUMENTATION WHEN
REQUIRED WILL RESULT IN A REDUCTION OF YOUR SPOUSE'S COVERAGE.**

(Continue on back)

Our Mission: CCPS serves equitably through positive relationships as a safe, collaborative community. We will ensure all learners acquire the knowledge, skills, and qualities to be responsible, caring, and ethical citizens.

Revised: 04/2026

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

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

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

For more information, please contact the Benefits office at:

BENEFITSINFO@CCPS.ORG
(410) 996-5415

Enclosures

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

PLEASE PRINT ALL INFORMATION REQUESTED		Check Medical Carrier: ☐ Blue Cross ☐ Aetna	
Full Name (Last, First, Middle Initial):	Home Phone Number (Include area code):		
CCPS Employee ID Number:	CCPS Employee email:		
Spouse's Full Name (Last, First, Middle Initial):	Spouse's Last 4 of Social Security Number:	Spouse: ☐ Male ☐ Female	Spouse's Date of Birth:

Spouse Employment Information
☐ Not Employed ☐ Employed Full-time ☐ Employed Part-time ☐ Self-employed ☐ Retired

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

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

3. Is your spouse enrolled in medical insurance made available through their employer? ☐ Yes ☐ No
If No, when is your spouse eligible to enroll? _____
If yes, when is the annual renewal dates for your spouse's employer medical coverage? _____

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

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

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

7. Is your spouse enrolled in a Health Saving Account (HSA)? ☐ Yes ☐ No

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

9. Additional Comments or Explanation: _____

Employee Authorization

STOP! Before signing, please read the authorization section on the back of this form. Your signature below verifies that you have read and understand all information included in the authorization section.

I hereby certify that to the above statements are correct and I have read the authorization section:

CCPS Employee Signature

Date

Please read carefully the information below before signing. You are responsible for understanding the requirements of the Spousal Coordination of Benefits Agreement described here, for providing verification as requested, and for the accuracy of the information in this form.

I understand that the following policy applies to spouses who regularly work full-time and are eligible for medical coverage through their own employers and spouses who are retired and are eligible for medical coverage through their former employers:

1. This information will be shared with the Cecil County Public Schools' plan administrator(s).
2. Only legal spouses are eligible to be enrolled. Ex-spouses, or civil union partners are not eligible to be enrolled.
3. If spouses do not enroll in their own employers' medical coverage, CCPS will reduce coverage to 20% of covered services and amounts not paid will be the sole responsibility of the spouse.
4. When spouses enroll in their own employer's medical coverage, those plans pay their benefits first. Then CCPS plans will pay additional covered expenses, if any, up to the maximum allowed under our employee benefit plan, not exceeding a limit of 100% coverage from both plans combined.

I understand that the Coordination of Benefits form must be completed in order to cover my spouse on my CCPS Health Insurance plan. The form is used to determine a spouse's eligibility to receive primary coverage of health insurance. Generally, the following spouses may qualify to receive primary coverage under CCPS health insurance:

- Spouses who are not employed **or**
- Spouses who are self-employed, (verification of eligibility date may be required from the employer); **or**
- Spouses who do not yet qualify for coverage through the employer (verification of eligibility date may be required from the employer); **or**
- Spouses whose employer plan requires a contribution of more than \$287 per month for the lowest employee only plan available (verification from the company will be required), **or**
- Spouses whose employer does not offer medical coverage (verification from the employer will be required).

If any of this information changes, I must complete a new form **within 31 days**.

Notice to all parties completing this form: To ensure benefits are coordinated properly, Cecil County Public Schools will verify the accuracy of information by conducting audits, contacting you, and/or contacting your spouse's employer. It is fraudulent to fill out this form with any information which is false or incorrect or to omit important facts. Providing false or incorrect information may result in disciplinary action and sanctioned payment (reduced to 20%) of claims for your spouse. Any claims that are paid based on false or incorrect information will be reversed and payment will be the responsibility of the spouse.

Instructions: Employment Verification form MUST be completed by a company representative. Incomplete forms will not be reviewed and could result in a disruption of coverage.

EMPLOYEE & SPOUSE

CCPS Employee Name: _____

Spouse's Name: _____

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

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

X _____

CCPS Employee Signature

_____ Date

Spouse's Authorization to Release Information

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

X _____

Signature of Spouse of CCPS Employee

_____ Date

EMPLOYER STATEMENT

Employer Name: _____

Employer's Representative completing this form: _____

Title _____

Email address _____ Telephone number/extension _____

Signature _____ Date _____

1. Does your organization offer a medical plan to its employees? ☐ Yes ☐ No

Is the individual eligible to enroll in your company's health insurance? ☐ Yes ☐ No

If NO, please explain _____

2. Does your company offer any type of credits, contributions or fringe benefits to use toward the cost of medical and prescription drug coverage OR a cash amount in lieu of medical and prescription drug benefits? ☐ Yes ☐ No

3. Is the above employee of your company eligible for medical benefits through your company?

If NO, please give the reason they are not: _____

4. If your employee is not currently eligible for medical benefits, will they be eligible to enroll in a medical plan in the future? ☐ Yes ☐ No If so when? _____
5. Is your employee currently enrolled in your medical benefit program? ☐ Yes ☐ No
- If Yes: Name of insurance plan _____
- Group # of insurance plan _____
- Effective Date of coverage _____

If you answered **"NO"** to ALL the above questions, **STOP**. Form is complete

If you answered **"YES"** to an above question, please continue.

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

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

Healthcare Plans and Rates – Individual only enrollment

Provide information for all plans offered and a copy of the Summary of Benefits

Type of Plan (HMO, PPO, POS, HDHP, HSA, etc.)				
Does the plan include prescription coverage (Y/N)				
Total Premium Cost				
Your company's contribution toward premium				
Employee contribution towards premium				
Frequency of payment: Monthly, bi-weekly, weekly				
Dollar amount the employer contributes to the HSA on behalf of the employee.				

Does your company's health insurance policy recognize loss of coverage as a qualifying event for this individual to enroll in your company's health plan outside of an open enrollment period? ☐ Yes ☐ No

If **"YES"**, please provide the earliest date this employee can enroll in your company's health plan: _____

If **"NO"**, please provide the date of next annual open enrollment, and effective date of your company's health insurance plan.

Open Enrollment Date: _____

Enrollment Effective Date: _____