

Cecil County Public Schools 2027 Retiree Benefits Reference Guide

Benefits Plan Year:
January 1, 2027 - December 31, 2027

Open Enrollment Begins: November 2, 2026

TABLE OF CONTENTS

1	Monthly Benefit Rates
2	CCPS Board Contributions
3	Updating and Electing Coverage
4	Coverage for Non-Medicare Retirees
6	Health Reimbursement Account
8	Coverage for Medicare Retirees
10	Prescription Coverage: Aetna
12	Prescription Coverage: CareFirst through Express Scripts
14	Dental for All Retirees
15	Vision for All Retirees
16	Appendix 1: Notice of Creditable Coverage
18	Appendix 2: Notice of CCPS HIPAA
26	Appendix 3: Legal/Special Notices

Introduction

Cecil County Public Schools is proud to offer a comprehensive benefits package to its retired employees. Whether you are a new retiree going through this process for the first time or considering a change to your benefits options, 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 November 2, 2026, for the benefits plan year beginning January 1, 2027. If you do not make a new election during the open enrollment period the prior year's elections will remain in place, or your coverage will default to the indicated plan if you are enrolled through the Public Exchange.

Non-Medicare Retirees Only:

Non-Medicare eligible retirees will continue to have the option to elect a health care plan through the Public Exchange, spouse's employer's plan, or through a new employer's health care plan. If you re-quire assistance locating a broker to assist you with the enrollment or renewal processes please contact our office at 410-996-5415.

Medicare Retirees Only:

Members who are currently Medicare eligible and enrolled in a supplemental Medicare plan will continue to be offered Medicare supplemental medical and prescription coverage in 2027.
This year's benefits presentation will be held virtually on Thursday, November 5 at 11:00 AM.
The recorded presentation will be made available online by Tuesday, November 10, 2026 for those who are not able to at-tend.
To locate the presentation:

⇒ Visit www.ccps.org
⇒ Toggle over "Administration"
⇒ Select "Human Resources"
⇒ Select "Benefits"
⇒ Select "Retiree Benefits" and the presentation will be posted at the top of the page for your convenience.

If you would like to view the presentation and require assistance, please contact the benefits department and we will be happy to assist you.

Plan Design Changes:

No changes were made to the medical benefit plan designs. All deductibles, co-pays, and co-insurance will remain the same for each plan. Additionally, there are no changes to the dental or vision plan and designs.

Rates:

There will be an increase in premium rates for the Aetna Medicare Advantage plan, CareFirst MediComp plan, and United Concordia Dental for the 2027 benefit plan year. EyeMed vision plan rates will remain the same for the 2027 plan year. For more information on those rates, please visit page 1.

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.

RESOURCE DIRECTORY

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

Ms. Briane Crouse
bmcrouse@ccps.org
Human Resources Administrator

Ms. Joanna Zimmerman
jkzimmerman@ccps.org
Director of Human Resources

Ms. Summer L. Hodgson
slhodgson@ccps.org
Director of Human Resources

Provider Companies

Aetna Medical
P.O. Box 981106
El Paso, TX 79998-1106
(800) 589-2386
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
accredo.com/contact-us

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

EyeMed Vision
PO Box 8504
Mason, OH 45040-7111
(866) 800-5457
www.eyemedvisioncare.com

Flexible Benefit Administrators Flexible Reimbursement Account
PO Box 8188
Virginia Beach, VA 23450
(800) 437-3539
https://fba.wealthcareportal.com/Page/Home

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



MONTHLY BENEFIT RATES

MEDICAL & PRESCRIPTION FOR MEDICARE ELIGIBLE RETIREES		
Coverage Tier	**CareFirst MediComp**	**Aetna Medicare Advantage**
Individual	$1,281.13	$582.82
2 Party	$2,562.27	$1,165.64

Dental Benefits	
Coverage Tier	**United Concordia Dental**
Retiree	$36.94
Retiree/Spouse	$73.87
Retiree/Child	$70.18
Retiree/Children	$92.34
Family	$110.81

Vision Benefits	
Coverage Tier	**EyeMed Standard**
Retiree	$3.38
Retiree/Spouse	$6.39
Retiree/Child	$5.72
Retiree/Children	$8.41
Family	$9.41

Monthly rates for plans offered through the Public Exchange will vary per person/family.

To view the plans available to you, and their cost, please visit http://www.healthcare.gov.

CCPS BOARD CONTRIBUTION

YEARS OF SERVICE	MONTHLY CONTRIBUTION	ANNUAL CONTRIBUTION*
Non-Medicare Eligible Retirees		
14 - 17 Years	$320.17	$3,842.04
18 - 23 Years	$469.08	$5,628.96
24 - 29 Years	$579.17	$6,950.04
30+ Years	$736.08**	$8,832.96**
Medicare Eligible Retirees		
14 - 17 Years	$198.50	$2,382.00
18 - 23 Years	$262.67	$3,152.04
24 - 29 Years	$292.33	$3,507.96
30+ Years	$328.50	$3,942.00

*This dollar amount will be pro-rated for mid-year retirees.

** Or 85% of the retiree's outside healthcare premium. Must provide proof or individual premium.

EXAMPLE TO CALCULATE YOUR MONTHLY COST*

Individual plan(s) and 30+ years of service

Medical (Aetna Individual)	$514.82
Dental	$34.80
Vision	$3.38
Board Contribution	($328.50)
YOUR Cost Share	**$220.50**

*Plan rates used for this example can be found on page 1.

CALCULATE YOUR OWN MONTHLY COST

Enter the cost for each of your selections:

Medical	
Dental	
Vision	
Board Contribution	
YOUR Cost Share	

UPDATING AND ELECTING COVERAGE

During Open Enrollment You Can:

- Change your medical*, dental, or vision elections, and
- Update or change your dependent information. Remember, you are unable to add dependents to your plan (this does not apply to those individuals on the Public Exchange). However, you may remove dependents during the Open Enrollment period.

Non-Medicare Eligible Retirees

Non-Medicare eligible retirees are to submit documentation showing proof of coverage to the Benefits Office by Friday, November 20, 2026. This is to confirm your continued eligibility for the Board's contribution to your Health Reimbursement Account (HRA). If you are enrolled in an outside plan, please be sure to submit the enrollment confirmation reflecting the breakdown of your monthly premium amount for the 2027 plan year. Failure to return the required documentation by the due date will effect the continued reimbursements from your HRA.

Non-Medicare eligible retirees who elect to enroll in their spouse's employer's medical plan, will be eligible to receive contributions into their HRA and return to the Aetna Medicare Advantage supplemental plan when you become Medicare eligible. For more information, please refer to page 6.

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.

Medicare Eligible Retirees

A letter stating your current benefit elections and an enrollment form have been mailed to all Medicare eligible retirees. If you wish to make changes* to your current elections, please complete and return the enrollment form to the Benefits Office by Friday, November 20, 2026. **If you do not want to make changes, you do not need to return the enrollment form.** The completed form can be returned via regular mail or email to the addresses listed below:

1. Mail:
   Cecil County Public Schools
   Attn: Benefits Office; Retiree Enrollment
   201 Booth Street
   Elkton, MD 21921

2. Email:
   benefitsinfo@ccps.org

For those who have elected to only continue dental and/or vision benefit coverage through the CCPS retiree plan, you do not need to do anything at this time. Your coverage will continue as is until we are notified by you, in writing, that you wish to cancel your coverage.

If you are unable to submit documentation prior to the deadlines listed above, please contact the Benefits Office at (410) 996-5415.

*Retirees who became Medicare eligible after January 1, 2017, cannot make an election change to the CareFirst MediComp Medicare Supplemental plan, unless you were Medicare eligible at the time of your retirement. If you are thinking of switching plans, please contact our office to schedule an appointment to talk through your options.

NON-MEDICARE ELIGIBLE RETIREES

Non-Medicare eligible retirees are able to purchase medical coverage outside of Cecil County Public Schools and, in most cases, continue to receive their Board contribution into a Health Reimbursement Account (HRA) through Flexible Benefit Administrators.

Coverage Through The Public Exchange

Non-Medicare eligible retirees may elect a medical plan through the Public Exchange. The plans available to each member varies based on your zip code and age. These plans are in place from January 1, 2027, through December 31, 2027. If you become Medicare eligible during this time, you will need to notify your insurance carrier to cancel your coverage the same date as your Medicare eligibility date.

Initial enrollment or reenrollment in an outside plan is the responsibility of the retiree. ***Legally, we are unable to provide guidance to you as you determine which medical plan option through the Public Exchange best meets your medical and financial needs. However, we can meet with you to review plan content as well as plan comparisons.*** If you require assistance with enrollment in an exchange plan, we encourage you to work with a licensed broker. If you need assistance locating a broker in your area, please contact our office at (410) 996-5415 or via email at benefitsinfo@ccps.org. If you would like to review these plans on your own, you may do so by visiting www.healthcare.gov. Depending on the state you live in, you may be redirected to your state's public exchange. If your state does not have an exchange, you will remain on this site and be directed through the process of selecting a plan.

Coverage Through Your Spouse's Employer Plan

Non-Medicare eligible retirees that have access to a medical plan through their spouse's employer may elect to enroll in their spouse's plan, if eligible, and continue to receive monthly contributions into a HRA. Documentation will need to be provided to the Benefits Office showing confirmation of your enrollment in this plan. Please be aware that if premiums are paid by your spouse using pre-tax dollars, those premiums are not eligible for reimbursement through your HRA per IRS guidelines. You will be able to use your HRA dollars to reimburse yourself for medical and prescription expenses that you and your spouse may incur throughout the year.

Coverage Through Your New Employer

Non-Medicare eligible retirees that have access to a medical plan through their new employer may elect to enroll in their employer's plan. However, those enrolled in an employer plan will not be eligible for contributions in to an HRA for the period they are enrolled in that plan. In the event coverage ends through your new employer, you may then be eligible to receive contributions in to an HRA again.

Paying Your Premium

Payment for your medical premium for a plan purchased through the Public Exchange will need to be made out of pocket directly to the insurance carrier. Once your first payment has been submitted to your insurance provider, you can submit a reimbursement request to CCPS. If you are enrolled in a plan outside of the Public Exchange, through an employer, you will need to follow their guidelines to pay for your medical coverage.

Board Contributions and Subsidies

The Board will provide contributions towards the cost of your medical premium for non medicare eligible retirees. Your Board contribution will be placed into a Health Reimbursement Account (HRA) offered by Flexible Benefit Administrators. The Board will deposit money into this account on a monthly basis (see page 2). You can use this money to reimburse yourself for post-tax medical premiums and other related expenses. Please refer above regarding HRA eligibility.

MEDICAL COVERAGE OPTIONS

Government Subsidies

Retirees have the option to use a government provided subsidy on the Public Exchange to lower the cost of their medical premium. Please be aware that if you choose to use the government subsidy, you will not be eligible for contributions to an HRA. IRS regulation does not allow for individuals to receive both. However, your Board contribution will be used towards the cost of your dental and/or vision plans allowing these benefits to be available to you at no cost. If at any point in time you are no longer eligible for the government subsidy, the Board will contribute funds to your HRA starting the next month.

Receiving Your Reimbursement

Reimbursements from your HRA will be for your monthly medical premium, up to your monthly Board contribution amount. To process your monthly premium reimbursements, you will need to submit confirmation and breakdown of your monthly premium as well as a copy of your first month's invoice. You may set up direct deposit for your HRA reimbursement through your Flex Benefits Admin portal. Enrollment documentation will be required at the time of retirement and for each open enrollment until you reach Medicare eligibility. Reimbursements will occur automatically each month for the remainder of the year.

My Spouse is Medicare Eligible, But I am Not

You each will have your own individual plan. Your eligible spouse will be enrolled in the selected CCPS Medicare supplemental plan and you will need to enroll in coverage through the Public Exchange. The same goes if you are Medicare eligible, but your eligible spouse is not.

Making Mid-Year Changes

You must follow the insurance carrier's rules when making changes mid-year. If you need to cancel or change your coverage at any point throughout the year outside of open enrollment, you will need to notify your insurance carrier for additional information on next steps and what documentation is needed. Those who retire mid-year can obtain a letter from the Benefits Office stating the date coverage will end through CCPS.

Becoming Medicare Eligible

When you become Medicare eligible you will be able to enroll into the CCPS plan. Enrollment should occur effective the same date you become Medicare eligible unless you are currently covered under a plan that allows you to waive Medicare Part B. If you are enrolled in a plan that allows you to waive Part B, you will be required to sign the Temporary Waiver of Medicare Supplemental Enrollment form and return it to our office. Upon signing the form, you are responsible for notifying CCPS when your eligibility changes. Failure to notify CCPS within the designated time frame will forfeit your eligibility to enroll in the group Medicare Supplemental Plan.

Those who become Medicare eligible during the year will be enrolled in the Aetna Medicare Advantage plan starting the same day as their Medicare effective date. You will receive notification from the Benefits Office and a copy of your enrollment form. Contributions to your HRA will cease at Medicare eligibility regardless of enrollment, however, if you have funds remaining in your account, you can continue to use those dollars to pay for your medical and prescription expenses until your account balance is $0.00.

HEALTH REIMBURSEMENT ACCOUNT

CCPS will continue to contribute towards the annual cost of your health care premium. Board contributions into a Health Reimbursement Account (HRA), offered through Flexible Benefit Administrators, will be used to offset the overall cost of your health care. Employees who retire with at least 14 years of service will receive these contributions to an HRA. If you are eligible, you will receive account information at the time you sign up for a medical plan.

A Health Reimbursement Account is an employer sponsored account that reimburses members for medical related premiums and expenses. The Board will deposit money into this account on a monthly basis (see page 2). Each month you may be reimbursed for your medical premium, up to your allotted monthly Board contribution.

In the event you become Medicare eligible mid-year, CCPS will cease contributions towards your HRA the month you become Medicare eligible. This includes those who temporarily waive enrollment. For example, if you become Medicare eligible on July 1, your Board HRA contributions will cease on June 30.

Any additional funds that a member may have in their HRA after reimbursement of your monthly medical premium may be used to pay towards deductibles, coinsurance, and co-pays. Retirees who use these additional funds will have to manually submit for reimbursements through Flexible Benefit Administrators (FBA).

Dental and vision premiums will continue to be deducted from your monthly pension check, if you elected to continue coverage in these plans.

Eligibility

The plan year begins on January 1, 2027, and ends December 31, 2027. You are eligible for funds if you have retired through the Maryland State Retirement Pension System, and have at least 14 years of service with the Board at the time of your retirement. Employees must be enrolled in a health care plan to receive contributions. If the plan you have enrolled in is through your new employer, contributions will go towards your dental and vision benefits, if elected, until you are no longer eligible for coverage through your new employer, or you become Medicare eligible.

Entry Date

Your entry date to the plan is the first of the month following your retirement. However, those who retire with an effective date between July 1, and August 31, will not receive their first HRA deposit until September 1, when your new medical plan becomes effective since all health care remains in effect until August 31.

HRA Deposits by the Board

Deposits will be made on a monthly basis into each eligible retiree's account. The amount that will be deposited into each retiree's account on a monthly basis will vary depending on how many years of service you had with Cecil County Public Schools at the time of your retirement. For your monthly deposit amount, please refer to page 2 of this reference guide.

Online Access

Flexible Benefit Administrators, Inc. provides online account access for all HRA participants. You can visit their website at: www.mywealthcareonline.com/fba.

Your Employee ID is your Social Security Number. The Employer ID, to register for your account, is "CEPS".

Medical Premium Reimbursements

With this account, you can reimburse yourself for medical premiums and out-of-pocket medical and prescription expenses that are incurred during the plan year. Reimbursements will be provided by direct deposit or a mailed paper check to your home address. For quicker receipt of funds, signing up for direct deposit through your FBA portal is encouraged.

Qualified Medical Expenses

With this account, you can reimburse yourself for medical premiums and services incurred. You can request reimbursement online via your account at www.mywealthcareonline.com/fba or by completing a reimbursement form. The form and copies of your receipts should be submitted to FBA for processing. A reimbursement check will be mailed directly to your home, if you have not already set up your direct deposit.

Examples of Eligible Health Care Expenses

- Monthly medical premiums paid for using post-tax dollars.

In the event you will have funds remaining in your account after processing a reimbursement for your medical premium, you may also use these funds to reimburse yourself for expenses paid towards you and your eligible dependent's:

- Deductible,
- Coinsurance, and/or
- Co-pays for medical services and prescriptions.

You will not be able to use remaining funds to pay for your dental and vision premiums, and expenses related to dental and vision care.

Reimbursement for Dependent Medical Expenses

If you file your taxes jointly with your spouse, you may submit a reimbursement request for eligible expenses even if they are not covered by your medical plan. If you claim any dependent children on your taxes, you may also submit a reimbursement request for their eligible expenses.

Submitting a Reimbursement Request for Medical Expenses

To obtain reimbursement from your HRA, you must submit a claim with Flex Benefits Administrators. You can log into the FBA portal to submit a claim directly to FBA. You must attach a receipt or bill from the insurance carrier that includes all pertinent information regarding the expense such as the date of service, patient's name, amount charged, provider's name, nature of the expense, and the amount covered by insurance (if applicable).

Rolling HRA Funds

Any remaining funds in your account following December 31, 2025, will remain in your account and "roll over" from year to year. You will not need to do anything for this to occur. To manage your account balance, you can access your online account at https://fba.wealthcareportal.com/Page/Home

TO CONTACT FLEXIBLE BENEFIT ADMINISTRATORS:

Mailing Address:
2875 Sabre Street, Suite 300
Virginia Beach, VA 23452

Toll Free Telephone Number:
(800) 437-3539

Website Address:
https://fba.wealthcareportal.com/Page/Home

Fax Number:
(757) 431-1155

MEDICARE SUPPLEMENTAL PLANS

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 Medicare Advantage PPO (You Pay)	CareFirst Medi-Comp Plan (You Pay)
How Medicare Works with the Plan	You stay enrolled in Medicare Parts A and B, but Aetna manages your Medicare benefits. Your provider generally sends claims to Aetna, not Medicare first. You pay the copay or coinsurance shown under the Aetna plan.	Medicare processes covered services first, and CareFirst coordinates benefits after Medicare. Your cost may be based on the Medicare Approved Benefit (AB) after the applicable deductible.
Deductibles	$0	Applicable Medicare deductible
Co-Insurance	10%	20% of Medicare AB after deductible
Out of Pocket Max	$1,500 per individual	$1,500 per individual
Lifetime Maximum	Unlimited (Certain benefits such as SNF* have benefit limitations of 120 days per Medicare benefit period)	Unlimited
Preventative Care & Medicare Covered Immunizations	$0 for Medicare-covered preventive services (Guidelines apply)	Covered at 100%, no deductible (Guidelines apply)
Diabetic Supplies	$0 – Includes supplies to monitor your blood glucose from Accu-Chek/Roche and TRUE/Trividia, or from a non-preferred provider when a prior authorization is received. Continuous glucose monitors and supplies: $0 (prior authorization may apply).	Covered under drug program with diagnosis of diabetes - no co-pay for certain supplies and medications (i.e. lancets, syringes, and test strips). Supplies not covered by the drug program may be covered as Durable Medical Equipment.
Doctor's Office Visits (Primary & Specialist)	10%	20% of Medicare AB after deductible
Urgent Care and Emergency Room	Urgent Care: $35 co-pay, worldwide Emergency Room: $50 co-pay, worldwide	$0 of AB, no deductible (initial visit, physician's office, or ER)
Inpatient Hospital Stay	$350 co-pay per stay	20% of Medicare AB after deductible
Assistant Surgeon	Covered in Hospital Room/ Semi-Private Co-pay	20% of Medicare AB after deductible
Anesthesiologist	Covered in Hospital Room/ Semi-Private Co-pay	20% of Medicare AB after deductible
Outpatient Surgery & Dialysis Treatments	10%	20% of Medicare AB after deductible
Diagnostic X-Rays	10%	20% of Medicare AB after deductible

Radiation & Chemotherapy	10%	20% of Medicare AB after deductible
Laboratory Tests	10%	20% of Medicare AB after deductible
Allergy Testing	10%	20% of Medicare AB after deductible
Physical, Occupational, and/or Speech Therapy	10%	20% of Medicare AB after deductible
Chiropractic Care	10% (For spine manipulation to the extent covered by Medicare)	20% of Medicare AB after deductible
Home Health Care & Hospice Services	Home Health: $0 Hospice: Covered by Original Medicare at a Medicare-certified hospice	20% of Medicare AB after deductible
Durable Medical Equipment	10%	20% of Medicare AB after deductible
Skilled Nursing Facility	0% per day, days 1-20; 10% per day, days 21-120	20% of Medicare AB after deductible
Mental Health/ Substance Abuse Inpatient Care	$350 copay per stay	20% of Medicare AB after deductible
Mental Health/ Substance Abuse Outpatient Care	10%	20% of Medicare AB after deductible

Glossary of Terms

(You Pay) means your share of the cost for a covered service.

Aetna Medicare Advantage: You remain enrolled in Medicare Parts A and B, but Aetna manages your Medicare benefits. Providers generally submit covered claims to Aetna, and you pay the copay or coinsurance shown in the Aetna plan.

AB means Medicare Approved Benefit; the amount Medicare approves for a covered service.

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 medical services covered. 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 out-of-pocket maximum.

Out-of-Pocket Maximum: The most you will have to pay towards covered expenses during the benefit 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.

PRESCRIPTION DRUG COVERAGE:
Aetna Medicare Advantage

The Aetna Medicare Advantage Part D prescription plan is bundled with the Aetna Medicare Advantage plan. Members enrolled in this program will have just one ID card for both your medical and prescription insurance.

This program does provide both a 30-day retail option, and a 90-day mail order option. The co-pays are outlined on the next page.

This plan does require the use of generic medications. If a brand name medication is required, your doctor must complete a medical letter of necessity and submit it to Aetna for review. If you choose to purchase a brand name prescription drug when a generic prescription drug is available, you will pay the appropriate co-pay, as well as the difference in cost between the brand name prescription drug and the generic prescription drug.

This plan does not contain a "doughnut hole" as many other Medicare Part D plans do. You will continue paying your applicable co-pay for medications throughout the entire plan year.

Prior Authorizations

Always have your doctor's office verify via Aetna prior to requesting to have the medication filled, whether the medication requires prior authorization. If you are currently on a brand-name medication, your doctor may need to verify the brand is medically necessary over the generic option.

To have a medication pre-certified, your doctor can contact Aetna via the telephone number on your Medical ID card.



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 1.

PRESCRIPTION DRUG COSTS

In-Network Retail 30-Day Supply:

Aetna Medicare Advantage Prescription Plan	
Generic	$10.00 Co-pay
Preferred Brand	$35.00 Co-pay
Non-Preferred Brand	$60.00 Co-pay

How to Order: Present your Aetna Medicare Advantage card to the Pharmacist when filling your prescription.

Mail Order 90-Day Supply:

Aetna Medicare Advantage Prescription Plan	
Generic	$20.00 Co-pay
Preferred Brand	$70.00 Co-pay
Non-Preferred Brand	$120.00 Co-pay

How to Order: You can request to have your prescriptions filled by Aetna Rx Home Delivery:

1) Online: www.aetnaretireeplans.com
2) Phone: 1-888-241-0357
3) Fax: Your doctor can fax your prescription to 1-877-270-3317; They will need to include your Aetna member ID number, your date of birth, and your mailing address on the cover sheet.

You may be able to get extra help to pay for your prescription drug premium and costs. To see if you qualify for extra help, call:

- (800) - MEDICARE (800-633-4227). TTY users should call (877) 486-2048, 24/7.
- The Social Security Office at (800) 772-1213 between 7:00 a.m. and 7:00 p.m., Monday through Friday. TTY users should call (800) 325-0778.
- Your state Medicaid office.

This information is also available in additional languages. Contact Customer Service at (888) 982-3862 (TTY/TDD 711) for additional information. Hours of operation are 8:00 a.m. through 8:00 p.m., seven days a week.

PRESCRIPTION DRUG COVERAGE: CareFirst MediComp

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.

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. Limitations may apply.

Checking if Your Medication is Covered

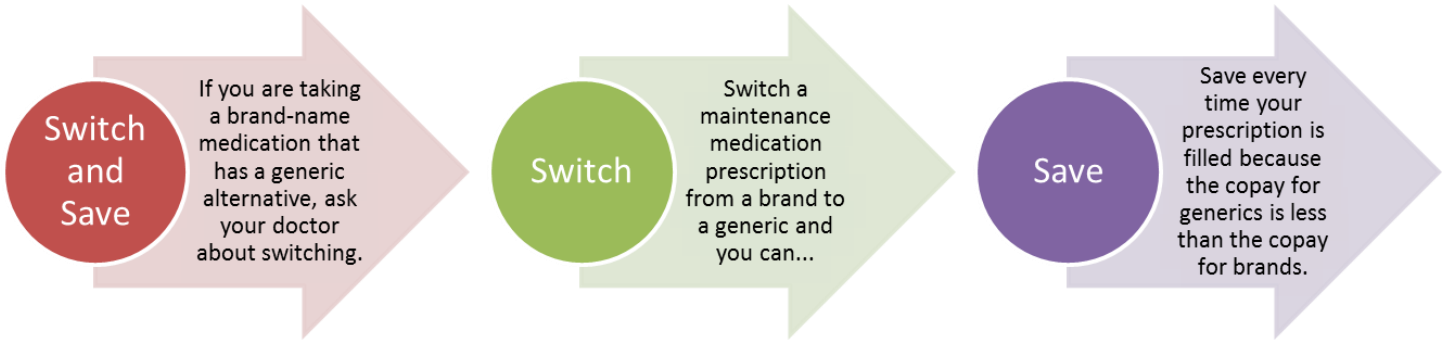
If you are prescribed a new medication you can verify that it is covered by the plan by visiting the Express Scripts website, at www.express-scripts.com, or using the Express Scripts app. The website will advise whether the medication is covered, at what tier it is covered, and if a prior authorization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

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



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

PRESCRIPTION DRUG COSTS

In-Network Retail 30-Day Supply:

CareFirst MediComp Prescription Plan through Express Scripts	
Generic	$5.00 Co-pay
Preferred Brand	$25.00 Co-pay
Non-Preferred Brand	$50.00 Co-pay

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

Mail Order 90-Day Supply:

CareFirst MediComp Prescription Plan through Express Scripts	
Generic	$10.00 Co-pay
Preferred Brand	$50.00 Co-pay
Non-Preferred Brand	$100.00 Co-pay

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:

CareFirst MediComp Prescription Plan through Express Scripts	
Generic	$5.00 Co-pay
Preferred Brand	$25.00 Co-pay
Non-Preferred Brand	$50.00 Co-pay

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 http://accredo.com/contact-us.

DENTAL PLAN

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 PLAN

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 1-866-800-5457.

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

APPENDIX 1: NOTICE OF CREDITABLE COVERAGE

Important Notice From Cecil County Public Schools 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. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice

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 pays 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 15, to December 7. 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 Schools 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:
4. The prescription drug coverage has no annual benefit maximum or a maximum annual benefit payable by the plan of at least $25,000;
5. 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 at 410-996-5415 or the Department of Aging at 410-996-8169. NOTE: You'll get this notice each year. You will also get it before the next period you can join a Medicare drug plan, and if this 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 8, 2026
Name of Entity/Sender:	Cecil County Public Schools
Contract Office:	Benefits Office
Address:	201 Booth Street, Elkton, MD 21921
Phone Number:	(410) 996-5415

APPENDIX 2: NOTICE OF CCPS HEALTH INFORMATION PRIVACY PRACTICES

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.

NOTICE OF CCPS HEALTH INFORMATION PRIVACY PRACTICES CONTINUED

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.

NOTICE OF CCPS HEALTH INFORMATION PRIVACY PRACTICES CONTINUED

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 Benefits Manager 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
(410) 996-5415
jkzimmerman@ccps.org

APPENDIX 3: LEGAL AND SPECIAL NOTICES

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

The Women's Health and Cancer Rights Act requires that group medical plans provide the following services to any person receiving plan benefits in connection with a mastectomy:

- ⇒ Reconstruction of the breast on which the mastectomy has been 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 coinsurance consistent with those established for other benefits under the plan or coverage. The law also contains prohibitions against:

- ⇒ Plans and issuers denying patients eligibility or continued eligibility to enroll or renew coverage under the plan to avoid the requirements of WHCRA.
- ⇒ Plans and issuers providing incentives, or penalizing physicians to induce them to provide care in a manner inconsistent with the WHCRA.

Group health plans, health insurance companies and HMOs covered by the law must notify individuals of the coverage required by WHCRA upon enrollment and annually thereafter.

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.

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.

LEGAL AND SPECIAL NOTICES CONTINUED

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

If you or your children are eligible for Medicaid or CHIP and you'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 if 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 July 31, 2021. Contact your State for more information on eligibility –

ALABAMA – Medicaid	ALASKA – Medicaid
Website: http://myalhipp.com/ Phone: 1-855-692-5447	The AK Health Insurance Premium Payment Program Website: http://myakhipp.com/ Phone: 1-866-251-4861 Email: CustomerService@MyAKHIPP.com Medicaid Eligibility: https://health.alaska.gov/dpa/Pages/default.aspx
ARKANSAS – Medicaid	**CALIFORNIA – Medicaid**
Website: http://myarhipp.com/ Phone: 1-855-MyARHIPP (855-692-7447)	Health Insurance Premium Payment (HIPP) Program Website: http://dhcs.ca.gov/hipp Phone: 916-445-8322 Fax: 916-440-5676 Email: hipp@dhcs.ca.gov
COLORADO – Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)	**FLORIDA – Medicaid**
Health First Colorado Website: https://www.healthfirstcolorado.com/ Health First Colorado Member Contact Center: 1-800-221-3943/State Relay 711 CHP+: https://hcpf.colorado.gov/child-health-plan-plus CHP+ Customer Service: 1-800-359-1991/State Relay 711 Health Insurance Buy-In Program (HIBI): https://www.mycohibi.com/ HIBI Customer Service: 1-855-692-6442	Website: https://www.flmedicaidtplrecovery.com/flmedicaidtplrecovery.com/hipp/index.html Phone: 1-877-357-3268

GEORGIA – Medicaid	INDIANA – Medicaid
GA HIPP Website: https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp Phone: 678-564-1162, Press 1 GA CHIPRA Website: https://medicaid.georgia.gov/programs/third-party-liability/childrens-health-insurance-program-reauthorization-act-2009-chipra Phone: 678-564-1162, Press 2	Health Insurance Premium Payment Program All other Medicaid Website: https://www.in.gov/medicaid/ http://www.in.gov/fssa/dfr/ Family and Social Services Administration Phone: 1-800-403-0864 Member Services Phone: 1-800-457-4584
IOWA – Medicaid and CHIP (Hawki)	**KANSAS – Medicaid**
Medicaid Website: Iowa Medicaid | Health & Human Services Medicaid Phone: 1-800-338-8366 Hawki Website: Hawki - Healthy and Well Kids in Iowa | Health & Human Services Hawki Phone: 1-800-257-8563 HIPP Website: Health Insurance Premium Payment (HIPP) | Health & Human Services (iowa.gov) HIPP Phone: 1-888-346-9562	Website: https://www.kancare.ks.gov/ Phone: 1-800-792-4884 HIPP Phone: 1-800-967-4660
KENTUCKY – Medicaid	**LOUISIANA – Medicaid**
Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP) Website: https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx Phone: 1-855-459-6328 Email: KIHIPP.PROGRAM@ky.gov KCHIP Website: https://kynect.ky.gov Phone: 1-877-524-4718 Kentucky Medicaid Website: https://chfs.ky.gov/agencies/dms	Website: www.medicaid.la.gov or www.ldh.la.gov/lahipp Phone: 1-888-342-6207 (Medicaid hotline) or 1-855-618-5488 (LaHIPP)
MAINE – Medicaid	**MASSACHUSETTS – Medicaid and CHIP**
Enrollment Website: https://www.mymaineconnection.gov/benefits/s/?language=en_US Phone: 1-800-442-6003 TTY: Maine relay 711 Private Health Insurance Premium Webpage: https://www.maine.gov/dhhs/ofi/applications-forms Phone: 1-800-977-6740 TTY: Maine relay 711	Website: https://www.mass.gov/masshealth/pa Phone: 1-800-862-4840 TTY: 711 Email: masspremassistance@accenture.com
MINNESOTA – Medicaid	**MISSOURI – Medicaid**
Website: https://mn.gov/dhs/health-care-coverage/ Phone: 1-800-657-3672	Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005

MONTANA – Medicaid	NEBRASKA – Medicaid
Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084 Email: HHSHIPPProgram@mt.gov	Website: http://www.ACCESSNebraska.ne.gov Phone: 1-855-632-7633 Lincoln: 402-473-7000 Omaha: 402-595-1178
NEVADA – Medicaid	**NEW HAMPSHIRE – Medicaid**
Medicaid Website: http://dhcfp.nv.gov Medicaid Phone: 1-800-992-0900	Website: https://www.dhhs.nh.gov/programs-services/medicaid/health-insurance-premium-program Phone: 603-271-5218 Toll free number for the HIPP program: 1-800-852-3345, ext. 15218 Email: DHHS.ThirdPartyLiabi@dhhs.nh.gov
NEW JERSEY – Medicaid and CHIP	**NEW YORK – Medicaid**
Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/ Phone: 1-800-356-1561 CHIP Premium Assistance Phone: 609-631-2392 CHIP Website: http://www.njfamilycare.org/index.html CHIP Phone: 1-800-701-0710 (TTY: 711)	Website: https://www.health.ny.gov/health_care/medicaid/ Phone: 1-800-541-2831
NORTH CAROLINA – Medicaid	**NORTH DAKOTA – Medicaid**
Website: https://medicaid.ncdhhs.gov/ Phone: 919-855-4100	Website: https://www.hhs.nd.gov/healthcare Phone: 1-844-854-4825
OKLAHOMA – Medicaid and CHIP	**OREGON – Medicaid and CHIP**
Website: http://www.insureoklahoma.org Phone: 1-888-365-3742	Website: http://healthcare.oregon.gov/Pages/index.aspx Phone: 1-800-699-9075
PENNSYLVANIA – Medicaid and CHIP	**RHODE ISLAND – Medicaid and CHIP**
Website: https://www.pa.gov/en/services/dhs/apply-for-medicaid-health-insurance-premium-payment-program-hipp.html Phone: 1-800-692-7462 CHIP Website: Children's Health Insurance Program (CHIP) (pa.gov) CHIP Phone: 1-800-986-KIDS (5437)	Website: http://www.eohhs.ri.gov/ Phone: 1-855-697-4347, or 401-462-0311 (Direct RIte Share Line)
SOUTH CAROLINA – Medicaid	**SOUTH DAKOTA - Medicaid**
Website: https://www.scdhhs.gov Phone: 1-888-549-0820	Website: http://dss.sd.gov Phone: 1-888-828-0059

TEXAS – Medicaid	UTAH – Medicaid and CHIP
Website: Health Insurance Premium Payment (HIPP) Program | Texas Health and Human Services Phone: 1-800-440-0493	Utah's Premium Partnership for Health Insurance (UPP) Website: https://medicaid.utah.gov/upp/ Email: upp@utah.gov Phone: 1-888-222-2542 Adult Expansion Website: https://medicaid.utah.gov/expansion/ Utah Medicaid Buyout Program Website: https://medicaid.utah.gov/buyout-program/ CHIP Website: https://chip.utah.gov/
VERMONT– Medicaid	**VIRGINIA – Medicaid and CHIP**
Website: Health Insurance Premium Payment (HIPP) Program | Department of Vermont Health Access Phone: 1-800-250-8427	Website: https://coverva.dmas.virginia.gov/learn/premium-assistance/famis-select https://coverva.dmas.virginia.gov/learn/premium-assistance/health-insurance-premium-payment-hipp-programs Medicaid/CHIP Phone: 1-800-432-5924
WASHINGTON – Medicaid	**WEST VIRGINIA – Medicaid and CHIP**
Website: https://www.hca.wa.gov/ Phone: 1-800-562-3022	Website: https://dhhr.wv.gov/bms/ http://mywvhipp.com/ Medicaid Phone:+304-558-1700 CHIP Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)
WISCONSIN – Medicaid and CHIP	**WYOMING – Medicaid**
Website: https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm Phone: 1-800-362-3002	Website: https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/ Phone: 1-800-251-1269

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

U.S. Department of Labor
Employee Benefits Security Administration
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

Paperwork Reduction Act Statement

According to the Paperwork Reduction Act of 1995 (Pub. L. 104-13) (PRA), no persons are required to respond to a collection of information unless such collection displays a valid Office of Management and Budget (OMB) control number. The Department notes that a Federal agency cannot conduct or sponsor a collection of information unless it is approved by OMB under the PRA, and displays a currently valid OMB control number, and the public is not required to respond to a collection of information unless it displays a currently valid OMB control number. See 44 U.S.C. 3507. Also, notwithstanding any other provisions of law, no person shall be subject to penalty for failing to comply with a collection of information if the collection of information does not display a currently valid OMB control number. See 44 U.S.C. 3512.

The public reporting burden for this collection of information is estimated to average approximately seven minutes per respondent. Interested parties are encouraged to send comments regarding the burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to the U.S. Department of Labor, Employee Benefits Security Administration, Office of Policy and Research, Attention: PRA Clearance Officer, 200 Constitution Avenue, N.W., Room N-5718, Washington, DC 20210 or email ebsa.opr@dol.gov and reference the OMB Control Number 1210-0137.

OMB Control Number 1210-0137 (expires 1/31/2027)

Cecil County Public Schools
Retiree Benefits Reference Guide
January 1, 2027—December 31, 2027

About This Guide

This benefit summary provides selected highlights of the CCPS employee benefits program. It is not a legal document and shall not be construed as a guarantee of benefits nor of continued employment with CCPS. All benefit plans are governed by master policies, contracts, and plan documents. Any discrepancies between any information provided through this summary and the actual terms of such policies, contracts and plan documents shall be governed by the terms of such policies, contracts and plan documents. CCPS reserves the right to amend, suspend, or terminate any benefit plan, in whole or in part, at any time. The authority to make such changes rests with the Plan Administrator.