

Embracing
Excellence in
Employee
Benefits



 **FOUNDATION**
RISK PARTNERS
PUBLIC ENTITY SERVICES

2026

BENEFITS GUIDE

Table of Contents

Coverage	Page
Welcome	3-4
Eligibility	5
How to Enroll	6
BenefitsVIP	7
Wellness Program	8
Medical Insurance	9-10
Prescription Drug Information	11-12
Know Where To Go	13
Health Savings Account (HSA)	14-15
Excepted Benefit Health Reimbursement Arrangement (EBHRA)	16
Dependent Care Flexible Spending Account (DCFSA)	17
Dental Insurance	18-20
Vision Insurance	21
Basic Life/AD&D Insurance	22
Voluntary Life/AD&D Insurance	23
Short Term & Long Term Disability	24-25
Supplemental Insurance	26-32
Wellbeing Programs	33-34
Glossary	35-36
Contacts	37
Beyond Your Benefits	38
Notice to Employees of Marketplace Coverage	39-41
Medicare Part D Creditable Coverage Notice	42-43
Disclosures	44-48

Welcome to Open Enrollment

Charlotte County Public Schools strives to provide you and your family with a comprehensive and valuable benefits package. We want to make sure you're getting the most out of our benefits—that's why we've put together this Open Enrollment Guide.

Open enrollment is the period each year when you can make changes to your benefits. This guide will outline all of the different benefits CCPS offers, so you can identify which offerings are best for you and your family.

Elections you make during open enrollment will become effective on 1/1/2026. If you have any questions about the benefits outlined in this guide, please feel free to contact the BenefitsVIP Team at 866.549.2585.

WHEN TO ENROLL

Open enrollment begins November 3rd to November 14th.

The benefits you choose during open enrollment will become effective on January 1st, 2026.

Current employees must enroll during the open enrollment period. New employees or newly eligible employees must enroll prior to the fifteenth (15th) day of the month prior to the date of benefits eligibility. Coverage for new hires begins on the first of the month following 43 days of employment.

Medicare Part D Notice

If you (and/or your dependents) have Medicare or will become eligible for Medicare in the next 12 months, a federal law gives you more choices about your prescription drug coverage. Please see the legal notices in the back of this guide for more details.



We're working hard at CCPS to bring you a wide range of benefits that you can take full advantage of. These carefully selected programs are designed to support your well-being and help you become the best version of yourself.

KNOW YOUR BENEFITS!

Making informed decisions about your benefits takes thoughtful planning. By choosing benefits that offer the best care and coverage, you can maximize their value while minimizing their impact on your budget. It's important to approach benefit selection as carefully as you would any major purchase.

All benefits outlined in this guide operate on a calendar year basis. This means your benefits—including deductibles, co-pays, co-insurance, out-of-pocket costs, and carrier payments—reset every January 1st.

The plans you select during Open Enrollment or as a newly eligible employee will remain in effect until December 31st. Changes to your plans can only be made if you experience a qualifying life event.

Pre-Tax Savings - Medical, dental, and vision plans—as well as Dependent Care FSAs—are offered under a Section 125 Cafeteria Plan, allowing you to pay premiums on a pre-tax basis, which reduces your taxable income.

Coordination of Benefits

An employee who has coverage for themselves and under their spouse may fall under the Coordination of Benefits reimbursement. Coordination of benefits determines which group health plan pays first and which plan pays benefits second. The secondary plan may then pay additional benefits. Contact your spouse's benefits representative to inquire about COB.

This document provides a summary of the coverage proposed by the insurance carrier(s), based on the information your company has supplied. It is not intended to include all terms, coverages, exclusions, limitations, or conditions found in the actual policy documents. For complete details, please refer to the official policy contracts. The purpose of this guide is to offer a general overview of your employee benefit plans. It may not address every specific situation that applies to you and should not be considered legal advice. For questions about your individual circumstances, please contact BenefitsVIP. In the event of any discrepancies between this guide and the official carrier contract, the terms of the contract will take precedence.

Eligibility

If you're a full-time employee at CCPS and have satisfied the waiting period, you are eligible to enroll in the benefits outlined in this guide.

Eligible dependents for medical, dental, and vision coverage include:

- Legal Spouse
- Legal Dependent Child(ren)
 - Coverage is allowed until the end of the calendar year in which the dependent turns age 26 for Medical and age 30 for Dental and Vision.
- Disabled Dependents: children who become disabled before age 26, and who rely on you for support, are also eligible for medical, dental, and vision coverages.

Enrollment & Changes

You can enroll for coverage during your new hire waiting period or the annual open enrollment period. New employees or newly eligible employees must enroll prior to the fifteenth (15th) day of the month prior to the date of benefits eligibility. Coverage for new hires begins on the first of the month following 43 days of employment. Outside of these times, you can only change your coverage within 30 days of experiencing a qualifying life event.

Qualifying life events include, but are not limited to:

- Marriage, divorce, or legal separation
- Birth or adoption of a child
- Change in a child's dependent status
- Death of a spouse, child, or other qualified dependent
- Change in employment status or a change in coverage under another employer-sponsored plan

Documents required for a life event: Marriage Certificate, Divorce Decree, Proof of Loss of Coverage, Birth Certificate & Name Change forms

Please Note: The Internal Revenue Service (IRS) does not consider financial hardship a qualifying life event to drop or make changes to coverages mid-year.



How to Access PlanSource

Step One:

Visit the ClassLink website: <https://launchpad.classlink.com/charlotte>

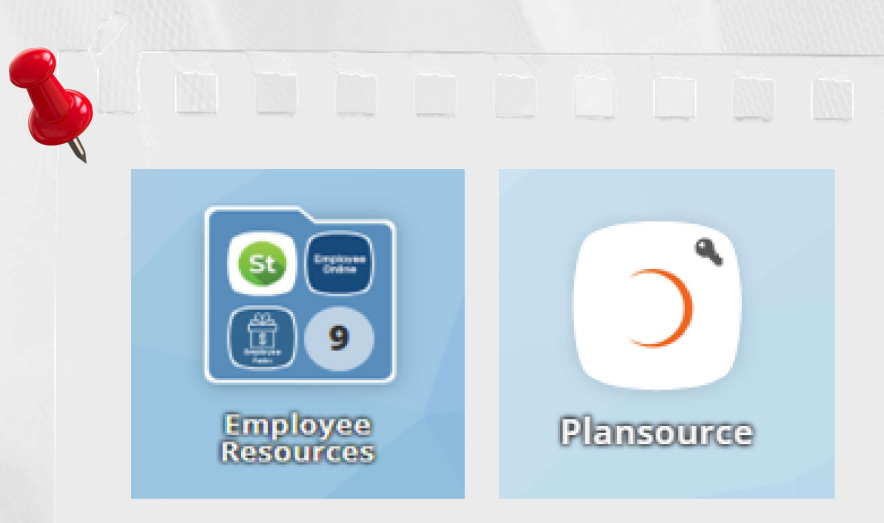
Step Two:

Enter your username and password.



Step Three:

Once you've successfully logged into ClassLink, select PlanSource within the Employee Resources folder to access your benefit information.



BenefitsVIP®

Help starts here.

BenefitsVIP is a powerful, one-stop contact center staffed by seasoned benefits advocates ready to help you and your family resolve benefits issues.

For service that's CONFIDENTIAL and RESPONSIVE, contact:

866.549.2585

Monday-Friday 8:30am-8pm (ET)

Fax: 856.996.2755

FLSchoolBenefits@BenefitsVIP.com



Scan the QR code to email
your BenefitsVIP team now!

- Benefits questions
- ID card requests
- Precertification support
- Claims resolution
- Prescription issues
- Provider network questions
- ...and much more!



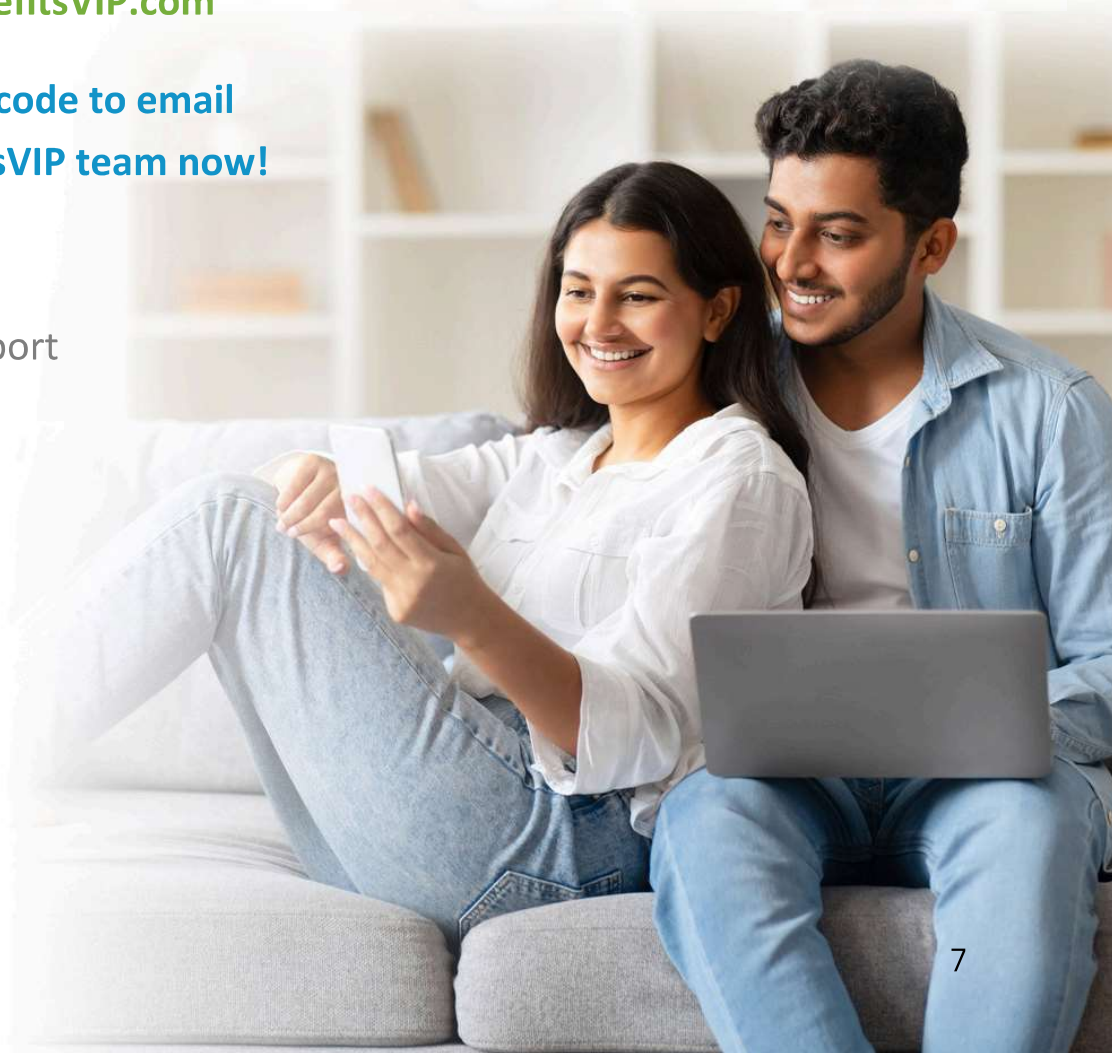
BenefitsVIP.com

Request member assistance and order ID cards with a click.



HealthDiscovery.org

Get vital, useful and fun health insurance and wellness facts.



WELLNESS PROGRAM FOR CHARLOTTE COUNTY HEALTH PLANS



Reduced deductible option

Employees who are enrolled in Charlotte County's healthcare plan have the option of participating in the Wellness program.

Part 1: Make an appointment for initial clinic visit and complete the health risk assessment

- This step must be completed in order to be eligible for part 2
- During this visit an annual tobacco test will be administered. Being tobacco free will earn three points

Part 2: Biometric results from testing can qualify for lower individual medical plan deductible from \$5,750 to \$4,000

- Biometric results that fall within the prescribed range will earn the employee one point each (up to five total)
- Employees who choose to work to get their numbers in range will be able to have these metrics tested again prior to the end of the eligibility window.
- Employee premium contributions for the earned lower deductible of \$4,000 will be the same as for the \$5,750 plan

Tobacco Surcharge

All medically enrolled employees will need to take a tobacco test at the clinic. If a person tests positive, there is a \$50 per pay period tobacco surcharge added to the health insurance premium, if elected. Employees who complete a qualified tobacco cessation program during the plan year will have their health insurance premiums adjusted retroactively to that of a non-tobacco user, effective January 1, 2026 (documentation required). If employees have questions pertaining to cessation program opportunities or this surcharge, please contact Marathon at 941-623-4444. Marathon Health provides health coaching to assist you in reaching your cessation goals. You may also reach out to Tobacco Free Florida at 877-822-6669 to create a free personalized quit plan.

Incentive Program Point Goal: 10 Points		
Incentive Program Activity	Activity Verification	Credit
Biometric Screening Health Outcomes		
Initial clinic visit and completion of HRA	Verified by Health Center Data/Screening Form Submission	2
Blood Pressure $\leq$ 130 mm / 85 hg		1
Fasting Glucose $\leq$ 100 mg / dl or A1c of 5.7 or below		1
HDL (Good Cholesterol) Men $\geq$ 40 mg / dl; Women $\geq$ 50 mg / dl		1
Triglycerides $\leq$ 150 mg / dl		1
Waist Circumference Men $\leq$ 40"; Women $\leq$ 35"		1
Non-tobacco user (annual testing at initial clinic visit)		3

How the program works:

Points achieved 9/1/2025 – 8/31/2026	Eligible plan
7 - 10	\$4,000 deductible plan
0 - 6	\$5,750 deductible plan

Employees should monitor their points progress in the Marathon eHealth Portal

Note: Your health plan is committed to helping you achieve your best health. Rewards for participating in a wellness program are available to all employees who enroll in a CCPS medical plan. If it is unreasonably difficult due to a medical condition for you to achieve the standards for the reward under this program, or if it is medically inadvisable for you to attempt to achieve the standards for the reward under this program, call us at 941-623-4444 and we will work with you to develop another way to qualify for the reward.

UMR (UNITED MEDICAL RESOURCES) MEDICAL PLAN COMPARISON

Plan Name	5750 Plan
In Network	
Individual Deductible	\$5,750
Family Deductible	\$11,500
Coinsurance	100%
Individual Out-of-Pocket Maximum	\$5,750
Family Out-of-Pocket Maximum	\$11,500
Preventive Exams	Covered in Full
Primary Care Physician Office Visit	0% Coinsurance after Deductible
Specialist Office Visit	0% Coinsurance after Deductible
Diagnostic Free Standing Lab (X-Ray / Bloodwork)	0% Coinsurance after Deductible
Major Diagnostic Independent Test Center (MRI, CT, PET)	0% Coinsurance after Deductible
Walk-in Urgent Care	0% Coinsurance after Deductible
Emergency Room	0% Coinsurance after Deductible
Inpatient Hospital	0% Coinsurance after Deductible
Outpatient Surgery	0% Coinsurance after Deductible
Prescription Deductible	Subject to Medical Deductible
Prescription Drugs	0% Coinsurance after Deductible
Out-Of-Network	
Individual / Family Deductible	\$11,500 / \$23,000
Coinsurance	100%
Individual / Family Out-of-Pocket Maximum	\$11,500 / \$23,000

If 7-10 points are earned in wellness program the below deductible will apply:

- In-network deductible and out-of-pocket maximum: \$4,000 individual, \$8,000 family
- Out-of-network deductible and out-of-pocket maximum: \$8,000 individual, \$16,000 family

All benefits are after deductible; Official plan documents are the definitive source of information and take precedence over the benefits described above and available on CCPS website

UMR (UNITED MEDICAL RESOURCES) MEDICAL PLAN RATES

EMPLOYEE'S SEMI-MONTHLY (24) PAYROLL DEDUCTIONS					
	TOTAL COST	HIRED PRIOR TO 6/30/2019		HIRED AFTER 7/1/2019	
		Board Contribution	Employee Cost	Board Contribution	Employee Cost
Employee Only	\$307.50	\$307.50	\$0.00	\$307.50	\$0.00
Employee & Spouse	\$757.50	\$374.90	\$382.60	\$307.50	\$450.00
Employee & Child(ren)	\$482.50	\$376.86	\$105.64	\$307.50	\$175.00
Employee & Family	\$845.00	\$402.46	\$442.54	\$307.50	\$537.50

Dependent Age Limit: Age 26

Spousal Surcharge

If your spouse is eligible for group health insurance through his or her employer, a \$50 per pay period spousal surcharge may apply. The spousal surcharge does not apply if your spouse is not employed or retired. When enrolling in the health insurance plan, if you elect coverage that includes your spouse, you will be required to answer questions to indicate your spouse's eligibility for participation in the CCPS health insurance program. Please note, any willful falsification of information may lead to disciplinary action.

Tobacco Surcharge

All medically enrolled employees will need to take a tobacco test at the clinic. If a person tests positive, there is a \$50 per pay period tobacco surcharge added to the health insurance premium, if elected.

PRESCRIPTION DRUGS - OPTUM RX

5750/4000 Plans			
Plan Type	Supply Duration	Drug Type	In-Network Coinsurance
Retail	Up to 31 day supply	Generic / Preferred Brand / Non-Preferred Brand	0% coinsurance after deductible
Mail Order	Up to 90-day supply	Generic / Preferred Brand / Non-Preferred Brand	0% coinsurance after deductible
Retail 90 Day	Up to 3 month supply, at least 84 days	Generic / Preferred Brand / Non-Preferred Brand	0% coinsurance after deductible

Two Ways to Save on Your Maintenance Prescriptions

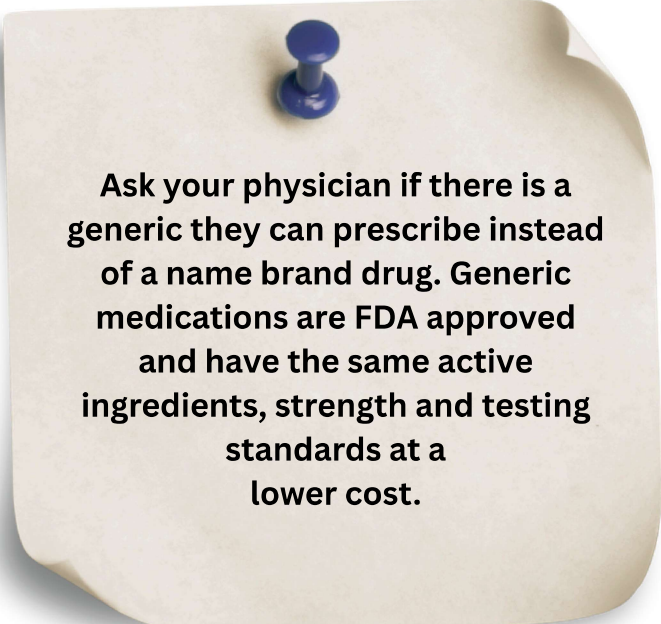
1. For savings and convenience, take advantage of home delivery from Optum Rx. Get a 90-day supply of your medications delivered direct to you, safely and securely, with free standard shipping. Log in at optumrx.com or call 855-524-0381 to learn how to get started with home delivery. Optum Rx can contact your doctor to have a new 90-day prescription sent right to you.
2. You can transfer your maintenance prescriptions to a nearby preferred broad network pharmacy. Your copayment for your 90-day supply will be the same whether you fill your prescriptions through Optum Rx home delivery or at a retail network pharmacy.

Affordable Insulin Program

Members will have more predictable out-of-pocket costs for their insulin and pay no more than \$25 per 30-day insulin Rx.

Eligible Insulins: Humalog, Humalin, Lantus and Toujeo

When a member fills a prescription for a preferred product, they will automatically pay the reduced out-of-pocket amount at the point-of-sale for both home delivery and in-network retail pharmacies. No need to enroll.



Ask your physician if there is a generic they can prescribe instead of a name brand drug. Generic medications are FDA approved and have the same active ingredients, strength and testing standards at a lower cost.



The savings power of Price Edge

To help lower medication costs, your pharmacy plan includes Optum Rx Price Edge.

Here is how Price Edge works for you:



You are already set up.

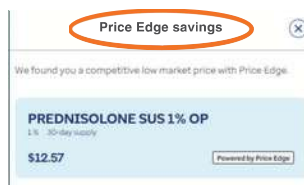
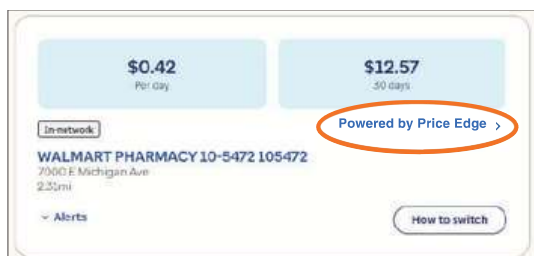


When you fill a prescription for generic medication at a network pharmacy, the Price Edge engine will look for competitive savings — even if the medication is not covered by your plan.



If Price Edge finds savings, you will automatically receive the lower price. It's that easy.

Look for “Powered by Price Edge” to find medication with added savings



To estimate costs before filling your prescription, download the Optum Rx app or sign in at optumrx.com. Then use the drug pricing tool to calculate cost.

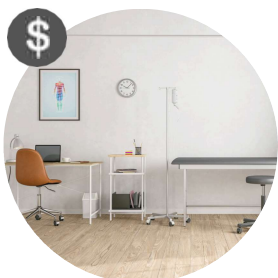
Know Where to Go

When you're not feeling well or when caring for a loved one, you don't want to waste time trying to find what place of care is best. Use this guide to save yourself from the stress.



Telehealth

When you have a minor medical concern and need to see a doctor quickly from anywhere. With telehealth, you can speak to a healthcare professional in just a few clicks with your phone, tablet or computer. Use this for non-emergent concerns such as cold or flu symptoms, allergies or sinus infections.



CCPS Employee Wellness Center

Employees, retirees, covered spouses and dependents aged two and older enrolled in Charlotte County Public Schools health plans are eligible for services at the CCPS Employee Wellness Center. Healthcare Services include Preventive Care, Acute (Sick) Care, Chronic Condition Management, Health Coaching, Medication, and Labs.



Primary Care

When you need your annual check-up, treatment of a chronic condition, or see someone who already knows your history and has access to your records. Primary care physicians typically require appointments and are not available nights and weekends. Your annual check-up is free.



Urgent Care

Visit urgent care when you have a pressing medical concern, but not an emergency. Urgent care is the best fit for sprains, strains, minor broken bones, minor infections, small cuts that need a few stitches, minor burns and x-rays. Urgent care facilities are commonly open on nights and weekends.



Emergency Room

Emergency rooms are designed to treat serious, life-threatening incidents, like a head injury, heart attack, severe burn, choking, breathing problems, deep wound, injury to neck or spine, to name a few examples. If you visit the emergency room when you are not having an emergency, you'll have a long wait and you'll pay the most out-of-pocket.

HEALTH SAVINGS ACCOUNT (HSA)

ADMINISTERED BY: OPTUM

Health savings accounts (HSAs) are a great way to save money and budget for qualified medical expenses. HSAs are tax-advantaged savings accounts that accompany high deductible health plans (HDHPs). HDHPs offer lower monthly premiums in exchange for a higher deductible (the amount you pay before insurance kicks in). **CCPS will contribute \$75 per pay period for employees enrolled in the medical plan.**

WHAT ARE THE BENEFITS OF AN HSA?

There are many benefits of using an HSA, including the following:

- **It saves you money**—HDHPs have lower monthly premiums, meaning less money is being taken out of your paycheck.
- **It is portable**—The money in your HSA is carried over from year to year and is yours to keep, even if you leave the company.
- **It is a tax-saver**—HSA contributions are made with pre-tax dollars. Since your taxable income is decreased by your contributions, you'll pay less in taxes.

The maximum amount that you can contribute to an HSA in 2026 is \$4,400 for individual coverage and \$8,750 for family coverage.

Additionally, if you are age 55 or older, you may make an additional "catch-up" contribution of \$1,000. You may change your contribution amount at any time throughout the year as long as you don't exceed the annual maximum.

For a detailed listing of eligible and ineligible medical expenses, please visit Publication 502 on the IRS website: https://www.irs.gov/publications/p502#en_US_2022_publink1000178851

HSA CASE STUDY

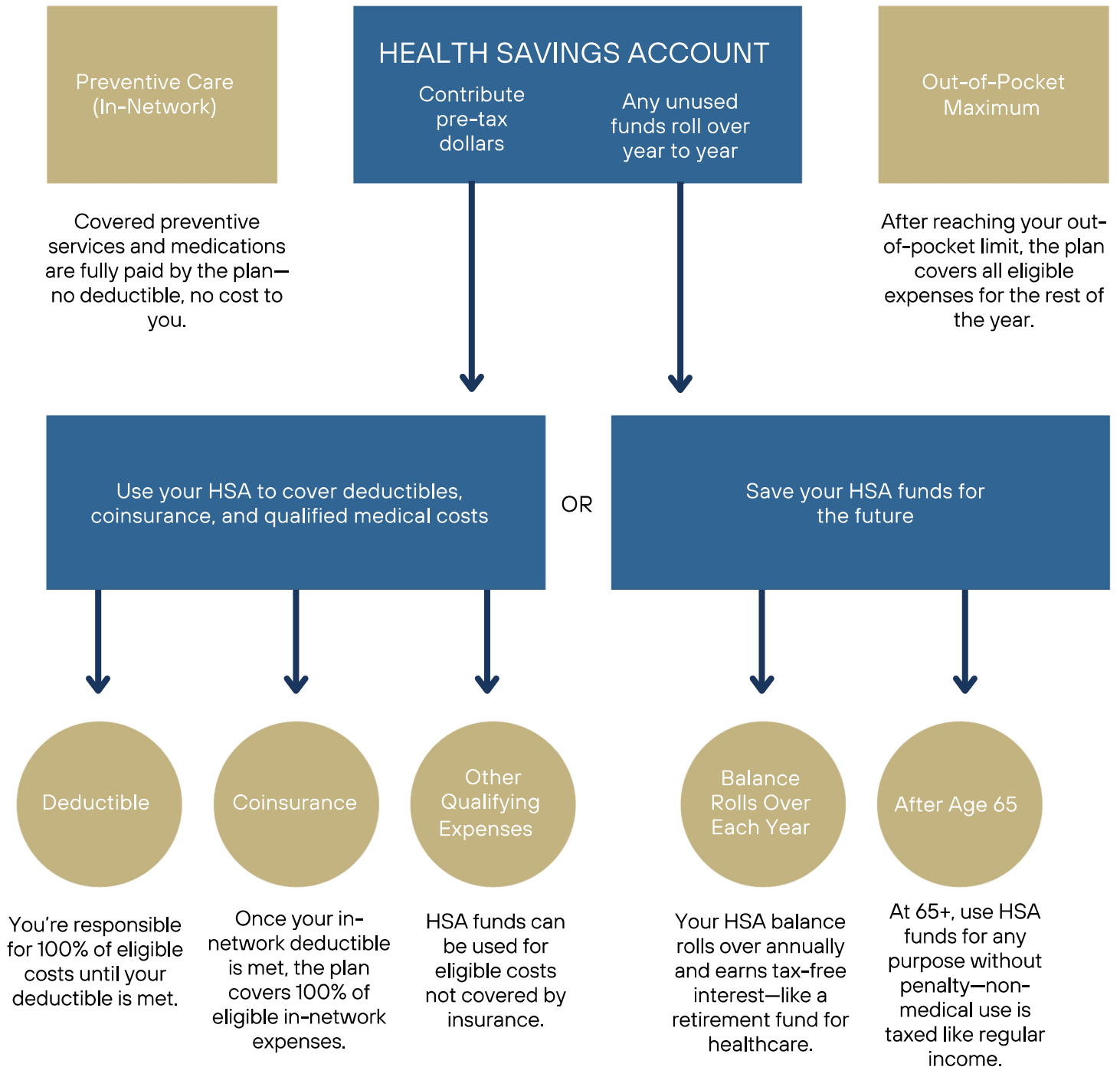
Justin is a healthy 28-year-old single man who contributes \$1,000 each year to his HSA. His plan's annual deductible is \$1,500 for individual coverage. Here is a look at the first two years of Justin's HSA plan, assuming the use of in-network providers. (This example only includes HSA contribution amounts and does not reflect any investment earnings).

Year 1	
HSA - \$1,000 Contribution	\$1,000
Total Expenses:	
Prescription Drugs: \$150	-\$150
HSA Rollover to Year 2	\$850
Since Justin did not spend all his HSA dollars, he did not need to pay any additional amounts out-of-pocket this year.	
Year 2	
HSA Balance: \$850 from Year 1, plus \$1,000 contribution for Year 2	\$1,850
Total Expenses:	
Office Visits: \$100 Prescription Drugs: \$200 Total: \$300	-\$300
HSA Rollover to Year 3	\$1,550
Once again, since Justin did not spend all his HSA dollars, he did not need to pay any additional amounts out-of-pocket this year.	



HEALTH SAVINGS ACCOUNT (HSA)

ADMINISTERED BY: OPTUM



EXCEPTED BENEFIT HEALTH REIMBURSEMENT ARRANGEMENT (EBHRA) ADMINISTERED BY: UMR

An Excepted Benefit Health Reimbursement Arrangement (EBHRA) is provided to you if you decline the medical plan. Excepted Benefit HRAs can reimburse eligible Internal Revenue Service Code Section 213(d) expenses such as medical, dental, vision, Rx and over-the-counter medication and supplies. This plan will also allow for COBRA premiums. Premiums for traditional group or individual health care coverage, or Medicare, are not a covered expense. Final determination of coverage is made at the time a claim is received and processed. If a conflict exists between the information provided to you and the terms of the plan, the terms of the plan will control.

WHAT ARE THE BENEFITS OF AN EBHRA?

- **Company contributions** – Charlotte County Public Schools will make tax-free contributions of \$89.50 per pay period to your EBHRA. You are not eligible to make your own personal contributions.
- **Use your funds** – The money in your account will be automatically added to a debit card to be used for qualified expenses as stated above. Premium claims must be submitted to UMR with a claim form and you must include the premium statement due or check stub showing the premium amount. This account can be used for covered dependents as well. For a list of qualified expenses, register on UMR.com OR visit www.irs.gov.
- **Don't lose your funds** – The money in your EBHRA grows year-over-year. The EBHRA is not portable. If you leave Charlotte County or change plans, you will no longer have access to accumulated funds.

Members will receive two debit cards with the employee's name on them. (Any family member can use the cards). If you already have a card for the Dependent FSA, you will utilize the same card.

If covered under another Health insurance Plan, you will need to submit an Explanation of Benefits (EOB) statement as well as an itemized bill. If documents are not received in a timely manner, your EBHRA account will be suspended until the claim is settled.

If you decline Medical, you will be provided the EBHRA. Should an employee separate from service, the account will be inactivated on the day the employee separates service.

DEPENDENT CARE FLEXIBLE SPENDING ACCOUNT (DCFSA) ADMINISTERED BY: UMR

WHAT IS A DEPENDENT CARE FSA?

Dependent care flexible spending accounts (DCFSA) enable you to set aside some of your pay, on a pre-tax basis, into an account to pay for eligible dependent care expenses. By setting aside money pre-tax, which you would normally be spending post-tax, you save between 25 percent and 40 percent on your everyday expenses.

The dependent care FSA covers child care expense while you are at work for children under age 13 or other dependents who are incapable of self-care.

WHAT ARE THE BENEFITS OF A DEPENDENT CARE FSA?

There are a variety of different benefits of using a DCFSA, including the following:

- **Make contributions** – You set aside pre-tax money through payroll deductions up to IRS limits. For a dependent care FSA, you must contribute no more than \$7,500. Please note, if you are married and file a separate income tax return, the maximum you can contribute is \$3,750. Dependent care FSA funds are available after they've been deducted from your paycheck.
- **Use your funds** – This plan allows you to pay for eligible out-of-pocket dependent care expenses with pre-tax dollars. Eligible expenses may include daycare centers, in-home child care, and before or after school care for your dependent children under age 13. Other individuals may qualify if they are considered your tax dependent and are incapable of self-care.
- **Don't lose your funds** – The money you set aside must be used during the plan year – it will not roll over into your account. Any money left in the account will be forfeited. You have until March to turn in receipts for reimbursement.



DID YOU KNOW?

There is a “use it or lose it” rule that is part of the IRS rules that govern how Flexible Spending Accounts operate.

Good to know:

- Elder care services may be covered under specific criteria. Please contact the Benefits VIP team for further information
- Estimate carefully! Any leftover funds at the end of the plan year will be forfeited per IRS requirements.
- Changes cannot be made to your contribution election during the year without a qualifying life change.

DENTAL - UNITED HEALTHCARE

DMO DENTAL	
Annual Deductible (Individual/Family)	None
Benefit Maximum	None
Orthodontia Lifetime Maximum	None
Diagnostic Services - Most Covered at No Charge	
Description	Copay
EXAM	\$0
BITEWINGS	\$0
PANORAMIC RADIOGRAPHIC IMAGE	\$50
CONE BEAM CAPTURE	\$139-\$189
MAXILLOFACIAL ULTRASOUND IMAGE CAPTURE	\$189
3D DENTAL SURFACE SCAN	\$9
Preventive Services - Most Covered at No Charge	
PROPHYLAXIS (ADULT & CHILD)	\$0
FLUORIDE VARNISH	\$15
SPACE MAINTAINER	\$0
Restorative Services	
AMALGAM	\$0
RESIN COMPOSITE	\$30-\$115
Endodontic Services	
PULP CAP - DIRECT	\$25
PULP CAP - INDIRECT	\$25
TX PULPOTOMY - CORONAL DENTNOCEMENTL JUNC	\$30
BONE GRAFT WITH PERIRADICULAR SURGERY - PER TOOTH	\$47
Periodontic Services	
SURGICAL REVISION PROCEDURE, PER TOOTH	\$0
GINGIVAL IRRIGATION WITH A MEDICINAL AGENT-PER QUAD	\$15
REMOVAL OF NON-RESORBABLE BARRIER	\$20
Prosthodontic Services	
ADJUST COMPLETE & PARTIAL DENTURE	\$15
Implant Services	
RECEMENT OR RE-BOND IMPLANT/ABUTMENT SUPPORTED FIXED PARTIAL DENTURE	\$65
INTERIM IMPLANT CROWN	\$125
REPAIR IMPLANT ABUTMENT, BY REPORT	\$220
RADIOGRAPHIC/SURGICAL IMPLANT INDEX, BY REPORT	\$235
Oral Surgery Services	
EXTRACT ERUPTED TOOTH/EXPOSED ROOT	\$20

DENTAL - UNITED HEALTHCARE

LOW PPO/HIGH PPO DENTAL

	PPO LOW PLAN		PPO HIGH PLAN	
Benefit	In-Network	Out-of-Network*	In-Network	Out-of-Network*
Annual Deductible (Individual/Family)	\$50 / \$150	\$50 / \$150	\$50 / \$150	\$50 / \$150
Benefit Maximum	\$1,000	\$1,000	\$2,000	\$2,000
Orthodontic Lifetime Max: (Adult & Child(ren) Coverage)	Not Covered	Not Covered	\$1,500	\$1,500
Orthodontic Services: (Adult & Child(ren) Coverage)	Not Covered	Not Covered	Plan Pays 50%	Plan Pays 50%
Diagnostic & Preventive Services (Type A) : Periodic Oral Evaluation, Radiographs Lab and Other Diagnostic Tests, Dental Prophylaxis (Cleanings - 2 per 12 month period), Fluoride Treatment, Sealants, Space Maintainers	Plan Pays 80% (Deductible Waived)	Plan Pays 60% of Maximum Allowable Charge* (Deductible Waived)	Plan Pays 100% (Deductible Waived)	Plan Pays 100% of Maximum Allowable Charge* (Deductible Waived)
Basic Services (Type B): Restorations (Amalgams or Composite), Posterior Composites, Emergency Treatment/General Services, Simple Extractions, Oral Surgery (incl. surgical extractions), Periodontics, Endodontics	Plan Pays 80% after Deductible	Plan Pays 60% of Maximum Allowable Charge*	Plan Pays 80% after Deductible	Plan Pays 80% of Maximum Allowable Charge*
Major Services (Type C): Inlays/Onlays/Crowns Dentures and Removable Prosthetics, Fixed Partial Dentures (Bridges)	Plan Pays 50% after Deductible	Plan Pays 40% of Maximum Allowable Charge*	Plan Pays 50% after Deductible	Plan Pays 50% of Maximum Allowable Charge*

*To maximize your dental benefits, consider staying in-network. The percentage of payment to out-of-network dental providers is based on the in-network maximum allowable charge (MAC) per procedure. For example, if the MAC for a routine cleaning (covered at 100% MAC) for an in-network provider is \$40, then UnitedHealthcare will pay the provider \$40. In addition, out-of-network providers can balance bill you for anything above the MAC amount. For example, if the out-of-network dental provider you see for a routine cleaning charges \$100, they can bill you for the additional \$60 because they are not contracted with UnitedHealthcare.

DENTAL RATES

EMPLOYEE'S SEMI-MONTHLY (24) PAYROLL DEDUCTIONS

Employees Enrolled in Medical

Plan Name	DMO	Low Plan	High Plan
Employee Only	\$0	\$7.25	\$12.25
Employee & Spouse	\$5.50	\$21.55	\$31.45
Employee & Child(ren)	\$8.55	\$26.45	\$37.95
Employee & Family	\$12.85	\$40.55	\$56.90

EMPLOYEE'S SEMI-MONTHLY (24) PAYROLL DEDUCTIONS

Employees NOT Enrolled in Medical

Plan Name	DMO	Low Plan	High Plan
Employee Only	\$7.35	\$14.60	\$19.60
Employee & Spouse	\$12.85	\$28.90	\$38.80
Employee & Child(ren)	\$15.90	\$33.80	\$45.30
Employee & Family	\$20.20	\$47.90	\$64.25

DEPENDENT AGE LIMIT: AGE 30



How to Find a Dentist:

The DMO plan is open access so there is no need to designate a general dentist at time of enrollment.

1. To find a provider visit www.myuhcdental.com

PPO Network:

National Options PPO20

DMO Network:

National Exclusive Network

VISION - UNITED HEALTHCARE

VISION - UNITED HEALTHCARE VISION NETWORK

Benefit	In-Network	Out-Of-Network
Eye Exam Copay	\$10	Reimbursed up to \$40
Materials Copay	\$15	Copay Applies
Frames	\$115 Allowance	Reimbursed up to \$45
Single Vision Lenses	Covered in Full after Materials Copay	Reimbursed up to \$40
Bifocal Vision Lenses	Covered in Full after Materials Copay	Reimbursed up to \$60
Trifocal Vision Lenses	Covered in Full after Materials Copay	Reimbursed up to \$80
Elective Contact Lenses (in lieu of eyeglasses)	\$15 copay for formulary; \$105 allowance for non-formulary	Reimbursed up to \$105
Frequency (Exam/Lenses/Frames/Contacts)	12 Months / 12 Months / 24 Months / 12 Months	

EMPLOYEE'S SEMI-MONTHLY (24) PAYROLL DEDUCTIONS

Employees Enrolled in Medical

Plan Name	Vision
Employee Only	\$0
Employee & Spouse	\$2.70
Employee & Child(ren)	\$2.30
Employee & Family	\$9.35

Employees NOT Enrolled in Medical

Plan Name	Vision
Employee Only	\$2.55
Employee & Spouse	\$5.25
Employee & Child(ren)	\$4.85
Employee & Family	\$11.90

DEPENDENT AGE LIMIT: AGE 30

How to Find a Vision Provider:

1. Visit

<https://connect.werally.com/plans/uhc/421>

2. Select "Employer and Individual Plans"

3. Find care by category: people, places, or online providers.

Routine eye exams are important. Your eyes provide a unique look into your health and can reveal other health concerns such as stress, high cholesterol, diabetes, liver problems, and more.

EMPLOYER PAID BASIC LIFE AND AD&D INSURANCE LINCOLN FINANCIAL GROUP

All benefit eligible employees will receive the \$50,000 Basic Life/AD&D benefit amount when enrolling in coverage. This benefit is paid in full by CCPS.

Please be sure to annually check or update your beneficiary information. Your beneficiary is the person you designate to receive your life insurance benefit in the event of your death. ***It is essential that you update or add your beneficiary information during open enrollment. Your beneficiary(ies) are the individuals you designate to receive your life insurance benefit in the event of your death. Please take action to ensure your information is current and accurate.***

LIFE BENEFIT

Life Amount	\$50,000
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ACCIDENTAL DEATH & DISMEMBERMENT (AD&D)

AD&D Amount	\$50,000
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ADDITIONAL BENEFIT FEATURES

Age Reduction	65 - 69: to 67% 70 - 74: to 50% 75 & up: to 35%
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Note: A life insurance benefit of \$50,000 or more is a taxable benefit. You will see the value of the benefit included in your taxable income on your paycheck and W-2

VOLUNTARY LIFE AND AD&D INSURANCE

LINCOLN FINANCIAL GROUP

While CCPS provides basic life insurance, some employees may want to purchase additional coverage. This benefit offers financial protection for employees and their families by providing a payment in the event of a death. Employees can choose coverage amounts based on their individual needs, with options to include spouse and dependent coverage.

VOLUNTARY LIFE & AD&D BENEFIT			
	Employee	Spouse	Children (To Age 26)
Minimum	\$10,000	\$5,000	\$5,000
Maximum	\$200,000	\$100,000 up to 50% of the covered employee amount	\$25,000
Benefit Increments	\$10,000	\$5,000	\$5,000
Guarantee Issue Amount	\$100,000	\$50,000	N/A
Benefit Reduction	65 - 69: to 67% 70 - 74: to 50% 75 & up: to 35%		N/A

VOLUNTARY AD&D MONTHLY (12) RATES	
Age	Premium
Employee	\$0.013 /\$1,000
Spouse	\$0.016 /\$1,000
Child	\$0.016 /\$1,000

VOLUNTARY LIFE INSURANCE EMPLOYEE & SPOUSE MONTHLY (12) RATES (PER \$1,000)		
Age	Employee	Spouse
<25	\$0.063	\$0.070
25-29	\$0.070	\$0.070
30-34	\$0.090	\$0.090
35-39	\$0.100	\$0.110
40-44	\$0.111	\$0.130
45-49	\$0.170	\$0.190
50-54	\$0.303	\$0.360
55-59	\$0.510	\$0.580
60-64	\$0.740	\$1.060
65-69	\$1.400	\$1.820
70-74	\$2.270	\$2.980
75+	\$3.490	N/A

VOLUNTARY LIFE INSURANCE CHILD MONTHLY (12) RATES	
Age	Premium
0-25	\$0.070 /\$1,000

Note: A life insurance benefit of \$50,000 or more is a taxable benefit. You will see the value of the benefit included in your taxable income on your paycheck and W-2

SHORT TERM DISABILITY

THE STANDARD

Short Term Disability insurance covers a portion of your income, so you can pay your bills if you're injured or sick and unable to work. Disability is more common than you might realize, and people can be unable to work for various reasons. In fact, many disabilities are caused by illnesses, including common conditions like heart disease and arthritis. However, most disabilities aren't covered by workers' compensation.

Who is it for?

If you rely on your income to cover everyday expenses, you should consider disability insurance. It ensures that you'll receive partial income if you're injured or too sick to work.

What does it cover?

Most disability insurance pays out a portion or percentage of your income if you're diagnosed with a serious illness or experience an injury that prevents you from doing your job.

Why should I consider it?

Accidents happen, and you can't always anticipate when or if you'll become sick or injured. That's why it's important to have a disability policy that helps you pay your bills if you're unable to collect your normal paycheck.



Replacing Income

Scenario: Mike injures his back in a bicycle accident and can't work for 12 weeks.

- Unpaid time off work: 12 weeks
- Elimination period: 0 Days

After his accident, Mike's Short Term Disability policy kicks in and replaces \$400 of his weekly income for the 12 weeks of his rehabilitation. This provides him with a total of \$4,800 to cover his expenses while he's unable to work.

SHORT-TERM DISABILITY (STD) INSURANCE

Percent of Earnings Covered	60% of Pre-Disability Earnings
Benefit Waiting Period	Accident: 0 Days Illness: 7 Days
Maximum Benefit Period	90 Days / 13 Weeks
Full Time Maximum Weekly Benefit	\$1,500

Please see PlanSource for automated plan cost calculations

LONG TERM DISABILITY

LINCOLN FINANCIAL GROUP

Long Term Disability is more common than you might realize, and people can be unable to work for all sorts of different reasons. In fact many disabilities are caused by illness, including common conditions like heart disease and arthritis. However, most disabilities aren't covered by workers' compensation.

Who is it for?

If you rely on your income to pay for everyday expenses, then you should probably consider disability insurance. It ensures that you'll receive a partial income if you're injured or too sick to work.

What does it cover?

Disability insurance pays out a portion or percentage of your income if you're diagnosed with a serious illness or experience an injury that prevents you from doing your job.

Why should I consider it?

Accidents happen, and you can't always anticipate if or when you'll become sick or injured. That's why it's important to have a disability policy that helps you pay your bills in the event of being unable to collect your normal paycheck.

No cost to you – this benefit is covered 100% by CCPS.



Replacing Income

Scenario: Jim suffers a heart attack that leaves him unable to work for two years.

- Unpaid time off work: 24 months
- Elimination period: 90 days

After a 90 day elimination period, Jim's Long-Term Disability policy kicks in and replaces \$2,000 of his monthly income for the remaining 21 months of his disability or illness. This provides him with a total of \$42,000 to cover his expenses while he's unable to work.

LONG-TERM DISABILITY (LTD) INSURANCE

Percent of Earnings Covered	66.67% of Pre-Disability Earnings
Benefit Waiting Period	90 Days
Maximum Benefit Period	Social Security National Retirement Age (changes based on disability date)*
Full Time Maximum Monthly Benefit	\$8,334

*The age at which the disability begins may affect the duration of the benefits.

CANCER THE STANDARD



Receiving a cancer diagnosis can be one of life's most frightening events. Unfortunately statistics show you probably know someone who has been in this situation.

With Cancer Insurance from The Standard, you can rest a little easier.

Here's How It Works

You choose the coverage that's right for you and your family. Our Cancer insurance pays cash benefits for cancer and 29 specified diseases to help you with the cost of treatments and expenses as they happen. Benefits are paid directly to you unless otherwise assigned. With the cash benefits you can receive from this coverage, you may not need to use funds from your Health Savings Account (HSA) for cancer or specified disease treatments and expenses.

Benefits (subject to maximums)

HOSPITAL CONFINEMENT AND RELATED BENEFITS	Plan 1	Plan 2	MONTHLY PREMIUMS	
Continuous Hospital Confinement (daily)	\$200	\$300		
Extended Benefits (daily)	\$200	\$300		
Private Duty Nursing Services (daily)	\$200	\$300		
Extended Care Facility (daily)	\$200	\$300		
At Home Nursing (daily)	\$300	\$300		
Intensive Care Unit Benefit	N/A	N/A		
RADIATION / CHEMOTHERAPY				
Radiation/Chemotherapy (every 12 months) Blood,	\$5,000	\$10,000		
Plasma and Platelets (every 12 months)	\$5,000	\$10,000		
SURGERY AND RELATED BENEFITS				
Surgery				
1. Inpatient	\$1,500	\$1,500		
2. Outpatient	\$1,725	\$1,725		
Anesthesia (% of surgery benefit)	25%	25%		
Ambulatory Surgical Center (daily)	\$250	\$250		
Second Surgical Opinion	\$200	\$200		
TRANSPORTATION AND LODGING BENEFITS				
Ambulance (per confinement)	\$100	\$100		
Outpatient Lodging (daily, limit \$2,000/12 mo period)	\$50	\$50		

MONTHLY PREMIUMS

	Plan 1	Plan 2
Employee	\$13.69	\$22.25
Family	\$23.04	\$37.50

SPECIFIED DISEASES 29 Specified

Diseases Covered: ALS (Lou Gherig's Disease), Muscular Dystrophy, Multiple Sclerosis, Encephalitis, Rabies, Tetanus, Tuberculosis, Osteomyelitis, Diphtheria, Scarlet Fever, Cerebrospinal Meningitis, Brucellosis, Sickle Cell Anemia, Thalassemia, Rocky Mountain Spotted Fever, Legionnaire's Disease, Addison's Disease, Hansen's Disease, Tularemia, Hepatitis (Chronic B or C), Typhoid Fever, Myasthenia Gravis, Reye's Syndrome, Primary Sclerosing Cholangitis (Walter Payton's Disease), Lyme Disease, Systemic Lupus, Erythematosis, Cystic Fibrosis, and Primary Biliary Cirrhosis.

CRITICAL ILLNESS

AFLAC

Critical Illness Insurance

Chances are you know someone affected by a critical illness—its impact goes beyond physical and emotional challenges, often straining personal finances. While major medical plans cover many costs, they may leave gaps, especially during recovery when out-of-pocket expenses can add stress.

That's where Aflac's Group Critical Illness plan helps. It provides cash benefits for covered conditions like heart attack or stroke, paid directly to you (unless otherwise assigned). This gives you flexibility to cover treatment-related bills or everyday expenses—so you can focus on recovery, not finances.

Key Features:

- Direct cash benefits
- Coverage for you, your spouse, and children
- Portability if you change jobs or retire
- \$100 wellness benefit



Refer to the Schedule of Benefits for a detailed breakdown of covered illnesses and payout amounts.

Covered Critical Illness with Cancer Benefits:	Percentage of Face Amount
Cancer (Internal or Invasive)	100%
Heart Attack	100%
Stroke (Ischemic or Hemorrhagic)	100%
Kidney Failure (End-Stage Renal Failure)	100%
Bone Marrow Transplant (Stem Cell Transplant)	100%
Major Organ Transplant	100%
Coma	100%
Paralysis	100%
Loss of Sight, Hearing or Speech	100%
Coronary Artery Bypass	100%
Non-Invasive Cancer	25%
Metastatic Cancer	25%

ACCIDENT AFLAC

Accident Insurance

Life is unpredictable, and accidents can lead to costly medical bills, lost income, and other expenses. Accident Insurance provides a direct cash payment to help cover these unexpected costs.

With Aflac Accident Insurance, you receive a lump sum benefit based on the type of injury and treatment you receive. Payments are made directly to you, giving you the flexibility to use the funds however you need. Refer to the Schedule of Benefits for a detailed breakdown of covered injuries and payout amounts. You can choose between two plan options designed to suit your needs: Mid and FastTrack.

Aflac Accident Monthly Rates

	Mid	FastTrack
Employee Only	\$6.69	\$7.31
Employee + Spouse	\$11.53	\$12.78
Employee + Children	\$13.81	\$15.79
Employee + Family	\$18.65	\$21.26

KEY BENEFITS

Initial Treatment—Emergency Room

Initial Treatment—Doctor's Office Facility

Hospital Admission

Hospital Confinement (per day)

Intensive Care (per day)

Coma

Lacerations

Fractures

Dislocations

Dismemberment

WELLNESS RIDER

Wellness Benefit (Max number of payments per calendar year, per insured: 1)

PLAN FEATURES

- Available for all family members of participating employees
- Benefits are paid directly to you, unless otherwise assigned.
- Coverage is guarantee-issued (which means you qualify for coverage without having to answer health questions).
- Convenience of payroll-deducted premiums.
- There are no waiting periods.
- Benefits are paid regardless of any other medical insurance.

HOSPITAL INDEMNITY

AFLAC

Help protect yourself from the high costs of hospital care with Aflac. Hospital Indemnity Protection helps cover unexpected expenses and medical bills that can come from even a short stay. All benefits are paid directly to the insured and can be used towards any expense from out-of-pocket medical costs to transportation, meals, childcare and more.

Hospitalization Benefits		
	Amount	
Benefit	Low Plan	High Plan
Hospital Admission (per confinement): Once per covered sickness or accident per calendar year	\$1,000	\$2,000
Hospital Confinement (per day): Maximum confinement period: 31 days per covered sickness or accident	\$150	\$200
Hospital Intensive Care (per day): Maximum confinement period: 10 days per covered sickness or covered accident	Day 1: \$1,000; Day 2-10: \$150	Day 1: \$1,000; Day 2-10: \$200
Dependent Child Neonatal and Pediatric Hospital ICU Rider	Low Plan	High Plan
Dependent Child Neonatal and Pediatric Hospital ICU Benefit (per day): Maximum of 31 days per confinement to a Neonatal or Pediatric Hospital ICU for each covered sickness or accident per dependent child	\$300	\$300



Aflac Hospital Indemnity Monthly Rates		
	Low Plan	High Plan
Employee Only	\$12.88	\$18.54
Employee + Spouse	\$29.06	\$39.40
Employee + Children	\$23.80	\$32.94
Employee + Family	\$39.98	\$53.80

PERMANENT TERM LIFE WITH LONG-TERM CARE AFLAC

What Is It?

Permanent Term Life Insurance provides lifelong coverage with a guaranteed death benefit. When paired with a Long-Term Care (LTC) Rider, it offers additional financial protection if you require extended care due to chronic illness or disability.

Key Features

- Lifetime Coverage: Unlike term life insurance, this policy doesn't terminate until age 120.
- Long-Term Care Rider: Access a portion of your death benefit to cover qualified LTC expenses.
- Premiums are set at the age of issue and will not increase over time.
- Restoration of Benefits

How the LTC Rider Works

If you qualify for long-term care benefits, here's what your plan includes:

- You can accelerate a portion of your death benefit to pay for care. You can choose one of the two options to help cover long-term care expenses:
 - Receive monthly payments equal to 8% of your life insurance benefit for up to 12 months. This may be extended to 24 months, depending on eligibility criteria.
 - Access a one-time payment of 50% of your life insurance benefit to help cover long-term care expenses.
- After using LTC benefits, your life insurance coverage will be restored, ensuring continued protection for your beneficiaries.
- A 90-day waiting period applies before benefits begin.
- Benefits can be used for home care, assisted living, nursing home care, and more.

Why Consider This Coverage?

Dual Protection: Combines life insurance and LTC coverage in one policy.

Cost Efficiency: May be more affordable than purchasing separate LTC insurance.

Peace of Mind: Ensures your family is protected—whether you need care or not.



PET INSURANCE

METLIFE

MetLife Pet Insurance helps cover the costs of unexpected accidents or illnesses, so nothing gets in the way of caring for your pet when they need it most.

Coverage that's a breed apart

With MetLife Pet Insurance, you can count on:



The freedom to visit any U.S. veterinarian. Exam fees are covered for accidents and illnesses.

Flexible plans with no breed exclusions. Find coverage that fits your pet's needs and your budget.

Extra savings with value-driven policies, options and discounts.

- **Multi-pet policy**—5% for the 2nd policy and 10% for each additional policy
- **Family plans option**—One policy and a shared deductible for up to three dogs and cats
- **Discounts of up to 30%**—Enjoy additional savings on pet care, where available

Optional Preventive Care coverage—Save on routine wellness expenses with industry-leading benefits.

How does MetLife Pet Insurance work?



Choose the coverage that's right for you.



Download our mobile app



Visit any U.S.-licensed veterinarian or emergency clinic.



Pay the bill within 90 days and send it to us with your claim documents through our mobile app, online portal, email, fax or mail.



Get a percentage of your money reimbursed⁴ by check or direct deposit if the claim expense is covered under the policy.

Plan cost calculations are based on pet age

You'll have the power of choice to customize your coverage

With our flexible plans, you can select the plan that fits your pet's needs and your finances. Here are just some of the treatments and conditions we cover:

Essential Care coverage

Accidents and illness
Diabetes
Ear infections
Pancreatitis
Cancer
Cruciate ligament

Sophisticated Care coverage

Laser therapy
Holistic care
Acupuncture
Hydrotherapy
IVDD

Optional Preventive Care coverage

Flea and tick
Spay and neuter
Heartworm
Behavioral training
Teeth cleaning

IDENTITY THEFT AND LEGAL COVERAGE



Take Back Control of Your Identity

Your personal data is everywhere—from doctor's offices to mobile apps. Norton LifeLock Benefit Plans prevent fraud, block scams, monitor activity, and strengthen your financial wellbeing.



Protect Your Well-Being from Every Angle

- **Fraud Detection** Monitor identity and finances to detect fraud early
- **Threat Prevention** Block scams and cyberthreats to protect your data and devices
- **Financial Insights** Gain financial insights into your credit, spending and subscriptions

Financial and Digital Wellness

- **Identity Restoration** Get peace of mind with expert help if your identity is compromised
- **Enhanced Privacy** Remove your personal details from data broker sites and enjoy a safer, more private internet experience
- **Scam Detection** Built-in AI assistant helps you navigate suspicious websites and SMS messages, and offers advice if you think you're being scammed



With the LegaEASE Plan, you're covered when you run into life's challenges with paid in full benefits for personal legal matters. LegalEASE has the largest and most highly qualified Attorney Provider Network, with attorneys in all 50 states focusing in over 60 areas of law. We've got you covered no matter the situation or location.

What's Included?



**FAMILY
LAW**



**ESTATE PLANNING
& WILLS**



**AUTO &
TRAFFIC**



**HOME &
RESIDENTIAL**



**FINANCIAL &
CONSUMER**



**GENERAL
COVERAGE**

Plan Details:

\$19.60

monthly paycheck deduction.

Who's Covered:

Employee, Spouse or Domestic Partner, Dependent Children up to age 26.

WELLBEING PROGRAMS

Employee Assistance Program

When you have questions, concerns or emotional issues surrounding your personal or work life, you can count on ComPsych Guidance Resources program (EAP) to offer help. Access to consultant by telephone, resources and tools online, and up to five face-to-face visits with a consultant to help with a short term problem. Our EAP can help you with things like stress, anxiety, depression, chemical dependency, relationship issues, legal issues, parenting questions, financial counseling, and dependent care resources. Best of all, it's free!

Help is available 24/7, 365 days a year!
Telephone: 1(888) 628-4824
Online: www.guidanceresources.com
User Name: LFGsupport
Password: LFGsupport1



EAP services are provided at no cost to the employee

CCPS Employee Wellness Center

CCPS has partnered with Marathon Health, a national leader in workplace health, in an effort to provide more information and care opportunities so that we can help our employees live healthier, more productive lives. They do that in many different ways:

- You will receive personalized and confidential health coaching designed to address your individual healthcare needs. Access to the Marathon eHealth Portal, your online resource for managing and achieving your personal health goals.
- This online resource offers a wide array of health tools and resources! These tools include: secure messaging with your Marathon Health provider, access to your personal health record and online appointment scheduling of virtual and in person appointments! Access to the Marathon eHealth Portal is available at my.marathon-health.com with the username and password you will receive at your home mailing address.





Your mental health matters

Mental health services (ages 12+)

Did you know almost one in five people struggle with mental health issues? It's totally normal to find it tough to talk about, but remember, your brain is just as important as your body. Let's take care of both.

Need someone to talk to? We're here for you. Marathon Health offers mental health counseling exclusively for CCPS's employees and their families at little cost. Whether you are feeling stressed, have anxiety and/or depression, relationship issues, trauma or other mental health concerns, our mental health provider is here to support you. We're here to listen.

Appointments can be in person or virtual and completely confidential.

Meet your mental health Provider



TiaV. Nagel, LMHC, NCC CCTP
Mental Health Provider

CCPS Employee Wellness Center
18150 Murdock Circle
Port Charlotte, FL 33948

CCPS Employee Wellness Center Hours

Monday - Thursday: 6AM - 6PM

Friday: 6AM - 10AM

Saturday: 8AM - 12PM



Schedule an appointment
Call 941-623-4444

Mental health services

- Anxiety, excessive worries
- Depressed mood, sadness
- Grief
- Irritability
- Stress
- Trauma
- Relationship concerns
- Substance or alcohol misuse

Suicide & crisis lifeline:

Call or text 988

Crisis text line:

Text the phrase HOME to 741741



GLOSSARY

of terms

Open enrollment is the time of year reserved for you to make changes to your benefit elections, and unfamiliar terms can make this process confusing. Use these definitions of common open enrollment terms to help you navigate your benefits options.

Coinsurance—The amount or percentage that you pay for certain covered health care services under your health plan. This is typically the amount paid after a deductible is met, and can vary based on the plan design.

Consumer Driven Health Care (CDHC)—Health insurance programs and plans that are intended to give you more control over your health care expenses. Under CDHC plans, you can use health care services more effectively and have more control over your health care dollars. CDHC plans are designed to be more affordable because they offer reduced premium costs in exchange for higher deductibles. Health Reimbursement Arrangements (HRAs) and Health Savings Accounts (HSAs) are common examples of CDHC plans.

Copayment—A flat fee that you pay toward the cost of covered medical services.

Covered Expenses—Health care expenses that are covered under your health plan.

Deductible—A specific dollar amount you pay out of pocket before benefits are available through a health plan. Under some plans, the deductible is waived for certain services.

Dependent—Individuals who meet eligibility requirements under a health plan and are enrolled in the plan as a qualified dependent.

Flexible Spending Account (FSA)—An account that allows you to save tax-free dollars for qualified medical and/or dependent care expenses that are not reimbursed. You determine how much you want to contribute to the FSA at the beginning of the plan year. Most funds must be used by the end of the year, as there is only a limited carryover amount.

Health Management Organization (HMO)—A type of health insurance plan that usually limits coverage to care from doctors who work for or contract within a specified network. Premiums are paid monthly, and a small copay is due for each office visit and hospital stay. HMOs require that you select a primary care physician who is responsible for managing and coordinating all of your health care.

Health Reimbursement Arrangement (HRA)—An employer-owned medical savings account in which the company deposits pre-tax dollars for each of its covered employees. Employees can then use this account as reimbursement for qualified health care expenses.

Health Savings Account (HSA)—An employee-owned medical savings account used to pay for eligible medical expenses. Funds contributed to the account are pre-tax and do not have to be used within a specified time period. HSAs must be coupled with qualified high-deductible health plans (HDHP).

High Deductible Health Plan (HDHP)—A qualified health plan that combines very low monthly premiums in exchange for higher deductibles and out-of-pocket limits. These plans are often coupled with an HSA.

GLOSSARY

of terms

In-network—Health care received from your primary care physician or from a specialist within an outlined list of health care practitioners.

Inpatient—A person who is treated as a registered patient in a hospital or other health care facility.

Medically Necessary (or medical necessity)—Services or supplies provided by a hospital, health care facility or physician that meet the following criteria: (1) are appropriate for the symptoms and diagnosis and/or treatment of the condition, illness, disease or injury; (2) serve to provide diagnosis or direct care and/or treatment of the condition, illness, disease or injury; (3) are in accordance with standards of good medical practice; (4) are not primarily serving as convenience; and (5) are considered the most appropriate care available.

Medicare—An insurance program administered by the federal government to provide health coverage to individuals aged 65 and older, or who have certain disabilities or illnesses.

Member—You and those covered become members when you enroll in a health plan. This includes eligible employees, their dependents, COBRA beneficiaries and surviving spouses.

Out-of-network—Health care you receive without a physician referral, or services received by a non-network service provider. Out-of-network health care and plan payments are subject to deductibles and copayments.

Out-of-pocket Expense—Amount that you must pay toward the cost of health care services. This includes deductibles, copayments and coinsurance.

Out-of-pocket Maximum (OOPM)—The highest out-of-pocket amount paid for covered services during a benefit period.

Preferred Provider Organization (PPO)—A health plan that offers both in-network and out-of-network benefits. Members must choose one of the in-network providers or facilities to receive the highest level of benefits.

Premium—The amount you pay for a health plan in exchange for coverage. Health plans with higher deductibles typically have lower premiums.

Primary Care Physician (PCP)—A doctor that is selected to coordinate treatment under your health plan. This generally includes family practice physicians, general practitioners, internists, pediatricians, etc.

Usual, Customary and Reasonable (UCR) Allowance—The fee paid for covered services that is: (1) a similar amount to the fee charged from a health care provider to the majority of patients for the same procedure; (2) the customary fee paid to providers with similar training and expertise in a similar geographic area; and (3) reasonable in light of any unusual clinical circumstances.

Contacts

Benefit Coverage	Carrier	Phone	Website / Email
Medical	UMR	800-826-9781	www.umar.com
Pharmacy	Optum Rx	Member Services: 855-524-0381 Specialty: 877-656-9604	www.optumrx.com
Dental	United Healthcare	877-816-3596	www.myuhcdental.com
Vision	United Healthcare	800-638-3120	www.myuhcvision.com
HSA	Optum Bank	866-234-8913	www.optumbank.com
Dependent Care FSA	UMR	866-868-0145	www.umar.com
EBHRA	UMR	866-868-0145	www.umar.com
Life/AD&D & Long-Term Disability	Lincoln Financial Group	888-787-2129 800-713-7384	www.mylincolnportal.com
Short Term Disability	The Standard	800-378-2395	https://www.standard.com/businesses-organizations/workplace-solutions/short-term-disability
EAP	ComPsych Guidance Resources	888-628-4824	www.guidanceresources.com
Teladoc	UMR	800-835-2362	www.teladoc.com
Worksite Products	Aflac The Standard	800-433-3036 800-521-3535	https://aflacgroupinsurance.com/customer_service/ https://www.standard.com/ahl
Medicare Assistance	Alliant Medicare Solutions	855-325-4044	www.alliantmedicareolutions.com
Florida State Retiree Benefits Consortium	FSRBC	1-833-686-0983	https://secure.bswift.com/default.aspx?abbrev=myfsrbc
Employee Clinic	Marathon	941-623-4444	my.marathon-health.com
Legal Plan Coverage	LegalEase	800-421-3142	www.legaleaseplan.com
ID Theft	Norton LifeLock	800-543-3562	https://support.norton.com
Pet Insurance	MetLife	1-800-438-6388	https://www.metlifepetinsurance.com/

For assistance with benefit questions, membership card issues, claims & billing inquiries, please contact your Foundation Risk Partners service team.

Benefits VIP

Serves as a powerful, one-stop contact center staffed by seasoned benefits advocates ready to help you and your family resolve benefits issues.

Direct: 866-549-2585

Email: ELSchooBenefits@BenefitsVIP.com

Monday – Friday 8:30am – 8pm (ET)

Elizabeth Penfield

Benefits Sr. Account Manager
Direct Line: 850.424.1867
epenfield@foundationrp.com

Alexa Turner

Benefits Account Manager
Direct Line: 321.257.8273
aturner@foundationrp.com

Beyond Your Benefits

COBRA Q&A

Overview

COBRA is a continuation of Plan coverage when it would otherwise end because of a life event, also called a “qualifying event.” After a qualifying event, COBRA continuation coverage must be offered to each person who is a “qualified beneficiary.” You, your spouse, and your dependent children could become qualified beneficiaries if coverage under the Plan is lost because of the qualifying event. Under the Plan, qualified beneficiaries who elect COBRA continuation coverage must apply for COBRA continuation coverage.

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

- Your hours of employment are reduced, or
- Your employment ends for any reason other than your gross misconduct.

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

- Your spouse dies;
- Your spouse’s hours of employment are reduced;
- Your spouse’s employment ends for any reason other than his or her gross misconduct;
- Your spouse becomes entitled to Medicare benefits (under Part A, Part B, or both); or
- You become divorced or legally separated from your spouse.

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

- The parent-employee dies;
- The parent-employee’s hours of employment are reduced;
- The parent-employee’s employment ends for any reason other than his or her gross misconduct;
- The parent-employee becomes entitled to Medicare benefits (Part A, Part B, or both);
- The parents become divorced or legally separated; or
- The child stops being eligible for coverage under the Plan as a “dependent child.”

When is COBRA available?

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

- The end of employment or reduction of hours of employment;
- Death of the employee; or
- The employee’s becoming entitled to Medicare benefits (under Part A, Part B, or both).

For all other qualifying events (divorce or legal separation of the employee and spouse or a dependent child’s losing eligibility for coverage as a dependent child), you must notify the Plan Administrator within 60 days after

the qualifying event occurs. You must provide this notice to the Charlotte County Public Schools.

Options Besides COBRA

Instead of enrolling in COBRA continuation coverage, there may be other coverage options for you and your family through the Health Insurance Marketplace, Medicaid, or other group health plan coverage options (such as a spouse’s plan) through what is called a “special enrollment period.” Some of these options may cost less than COBRA continuation coverage. You can learn more about many of these options at Healthcare.gov.

More Information

This COBRA Q&A section does not fully describe continuation coverage or other rights under the Plan. More information about continuation coverage and your rights under the Plan is available from your employer.

Keep Address Updated

To protect your family’s rights, let your Plan Administrator know about any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the Plan Administrator.

Taxable Benefits And The IRS

Certain benefits may be taxed if you become disabled, depending on how the premiums were paid during the year of the disabling event. Payments, such as disability, from coverages purchased with pretax premiums and/or nontaxable employer credits, will be subject to federal income and employment (FICA) tax. If premiums were paid with a combination of pretax and after-tax dollars, then any payments received under the plan will be taxed on a prorata basis. If premiums were paid on a post-tax basis, you will not be taxed on the money you receive from the plan. You can elect to have federal income tax withheld by the provider just as it is withheld from your wages.

Consult your personal tax adviser for additional information.

In addition, FICA and Medicare taxes will be withheld from any disability payments paid through six calendar months following the last calendar month in which you worked prior to becoming disabled. Thereafter no FICA or Medicare tax will be withheld.

You will be required by the IRS to pay FICA, Medicare, and federal income taxes on certain other benefit payments, such as those from Hospital Indemnity Insurance, Personal Cancer Expense Insurance and Hospital Intensive Care Insurance, that exceed the actual Healthcare expenses you incur, if these premiums were paid with pretax dollars and/or nontaxable employer credits. If you have questions, consult your personal tax adviser.

Life Insurance Premiums and The IRS

According to IRS regulations, you can pay premiums on a pretax basis for the first \$50,000 of life insurance coverage under a group term life insurance, a group term life insurance plan, covering your life. However, you must pay tax on such coverage exceeding \$50,000.

Social Security

Social Security consists of two tax components: the FICA or OASDI component (the tax for old-age, survivors’ and disability insurance) and the Medicare component. A separate maximum wage to which the tax is assessed applies to both tax components. There is no maximum taxable annual wage for Medicare. The maximum taxable annual wage for FICA is subject to federal regulatory change.

NOTICE TO EMPLOYEES OF COVERAGE OPTIONS

TO: Employees

FROM: Charlotte County Public Schools

DATE: 1/1/2026

RE: Required Notification Regarding the Patient Protection and Affordable Care Act

The attached notification is being provided to you in compliance with the Patient Protection and Affordable Care Act. This notification is strictly informational regarding the Health Insurance Marketplace.

Charlotte County Public Schools is required to notify all employees about the Health Insurance Marketplace. The Marketplace is designed to help you find health insurance that meets your needs and fits your budget. Open Enrollment for health insurance coverage through the Marketplace begins in October, with coverage starting as early as January 1st. Some employees may be able to get lower costs on private insurance in the Marketplace based on their income. However, because Charlotte County Public Schools offers coverage that meets the required standards, you will not be eligible for a tax credit through the Marketplace and may therefore prefer to remain on Charlotte County Public School's group health plan.

If you purchase a health plan through the Marketplace instead of accepting group health coverage offered by Charlotte County Public Schools, then you will lose the employer contribution to the employer-offered coverage. Our employer contribution, as well as your employee contribution to Charlotte County Public School's group health coverage, is excluded from income for federal income tax purposes under current tax regulations. If you choose coverage through the Marketplace, your payments for coverage are made on an after-tax basis.

The Marketplace can help you evaluate your coverage options, including your eligibility for coverage through the Marketplace and its cost. Visit www.HealthCare.gov for more information, including an online application. The attached document will provide you with information that you will need while on the Marketplace website.

Charlotte County Public Schools is not able to address questions regarding the Health Insurance Marketplace. If you have questions regarding the Health Insurance Marketplace, you should visit www.HealthCare.gov.



MARKETPLACE COVERAGE

PART A: General Information

Even if you are offered health coverage through your employment, you may have other coverage options through the Health Insurance Marketplace ("Marketplace"). To assist you as you evaluate options for you and your family, this notice provides some basic information about the Health Insurance Marketplace and health coverage offered through your employment.

What is the Health Insurance Marketplace?

The Marketplace is designed to help you find health insurance that meets your needs and fits your budget. The Marketplace offers "one-stop shopping" to find and compare private health insurance options in your geographic area.

Can I Save Money on my Health Insurance Premiums in the Marketplace?

You may qualify to save money and lower your monthly premium and other out-of-pocket costs, but only if your employer does not offer coverage, or offers coverage that is not considered affordable for you and doesn't meet certain minimum value standards (discussed below). The savings that you're eligible for depends on your household income. You may also be eligible for a tax credit that lowers your costs.

Does Employment-Based Health Coverage Affect Eligibility for Premium Savings through the Marketplace?

Yes. If you have an offer of health coverage from your employer that is considered affordable for you and meets certain minimum value standards, you will not be eligible for a tax credit, or advance payment of the tax credit, for your Marketplace coverage and may wish to enroll in your employment-based health plan. However, you may be eligible for a tax credit, and advance payments of the credit that lowers your monthly premium, or a reduction in certain cost-sharing, if your employer does not offer coverage to you at all or does not offer coverage that is considered affordable for you or meet minimum value standards. If your share of the premium cost of all plans offered to you through your employment is more than 9.12% of your annual household income, or if the coverage through your employment does not meet the "minimum value" standard set by the Affordable Care Act, you may be eligible for a tax credit, and advance payment of the credit, if you do not enroll in the employment-based health coverage. For family members of the employee, coverage is considered affordable if the employee's cost of premiums for the lowest-cost plan that would cover all family members does not exceed 9.12% of the employee's household income.^{1,2}

Note: If you purchase a health plan through the Marketplace instead of accepting health coverage offered through your employment, then you may lose access to whatever the employer contributes to the employment-based coverage. Also, this employer contribution - as well as your employee contribution to employment-based coverage - is generally excluded from income for federal and state income tax purposes. Your payments for coverage through the Marketplace are made on an after-tax basis. In addition, note that if the health coverage offered through your employment does not meet the affordability or minimum value standards, but you accept that coverage anyway, you will not be eligible for a tax credit. You should consider all of these factors in determining whether to purchase a health plan through the Marketplace.

When Can I Enroll in Health Insurance Coverage through the Marketplace?

You can enroll in a Marketplace health insurance plan during the annual Marketplace Open Enrollment Period. Open Enrollment varies by state but generally starts November 1 and continues through at least December 15.

Outside the annual Open Enrollment Period, you can sign up for health insurance if you qualify for a Special Enrollment Period. In general, you qualify for a Special Enrollment Period if you've had certain qualifying life events, such as getting married, having a baby, adopting a child, or losing eligibility for other health coverage. Depending on your Special Enrollment Period type, you may have 60 days before or 60 days following the qualifying life event to enroll in a Marketplace plan.

There is also a Marketplace Special Enrollment Period for individuals and their families who lose eligibility for Medicaid or Children's Health Insurance Program (CHIP) coverage on or after March 31, 2023, through July 31, 2024. Since the onset of the nationwide COVID-19 public health emergency, state Medicaid and CHIP agencies generally have not terminated the enrollment of any Medicaid or CHIP beneficiary who was enrolled on or after March 18, 2020, through March 31, 2023. As state Medicaid and CHIP agencies resume regular eligibility and enrollment practices, many individuals may no longer be eligible for Medicaid or CHIP coverage starting as early as March 31, 2023. The U.S. Department of Health and Human Services is **offering a temporary Marketplace Special Enrollment period to allow these individuals to enroll in Marketplace coverage.**

Marketplace-eligible individuals who live in states served by HealthCare.gov and either- submit a new application or update an existing application on HealthCare.gov between March 31, 2023 and July 31, 2024, and attest to a termination date of Medicaid or CHIP coverage within the same time period, are eligible for a 60-day Special Enrollment Period. That means that if you lose Medicaid or CHIP coverage between March 31, 2023, and July 31, 2024, you may be able to enroll in Marketplace coverage within 60 days of when you lost Medicaid or CHIP coverage. In addition, if you or your family members are enrolled in Medicaid or CHIP coverage, it is important to make sure that your contact information is up to date to make sure you get any information about changes to your eligibility. To learn more, visit [HealthCare.gov](https://www.healthcare.gov) or call the Marketplace Call Center at 1-800-318-2596. TTY users can call 1-855-889-4325.

What about Alternatives to Marketplace Health Insurance Coverage?

If you or your family are eligible for coverage in an employment-based health plan (such as an employer-sponsored health plan), you or your family may also be eligible for a Special Enrollment Period to enroll in that health plan in certain circumstances, including if you or your dependents were enrolled in Medicaid or CHIP coverage and lost that coverage. Generally, you have 60 days after the loss of Medicaid or CHIP coverage to enroll in an employment-based health plan, but if you and your family lost eligibility for Medicaid or CHIP coverage between March 31, 2023 and July 10, 2023, you can request this special enrollment in the employment-based health plan through September 8, 2023. Confirm the deadline with your employer or your employment-based health plan. Alternatively, you can enroll in Medicaid or CHIP coverage at any time by filling out an application through the Marketplace or applying directly through your state Medicaid agency. Visit: <https://www.healthcare.gov/medicaid-chip/getting-medicicaid-chip/> for more details.

MARKETPLACE COVERAGE

How Can I Get More Information?

For more information about your coverage offered through your employment, please check your health plan's summary plan description or contact Dawn Keen.

The Marketplace can help you evaluate your coverage options, including your eligibility for coverage through the Marketplace and its cost. Please visit [HealthCare.gov](https://www.healthcare.gov) for more information, including an online application for health insurance coverage and contact information for a Health Insurance Marketplace in your area.

(1) Indexed annually; see <https://www.irs.gov/pub/irs-drop/rp-22-34.pdf> for 2023.

(2) An employer-sponsored or other employment-based health plan meets the "minimum value standard" if the plan's share of the total allowed benefit costs covered by the plan is no less than 60 percent of such costs. For purposes of eligibility for the premium tax credit, to meet the "minimum value standard," the health plan must also provide substantial coverage of both inpatient hospital services and physician services.

PART B: Information About Health Coverage Offered by Your Employer

This section contains information about any health coverage offered by your employer. If you decide to complete an application for coverage in the Marketplace, you will be asked to provide this information. This information is numbered to correspond to the Marketplace application.

3. Employer name Charlotte County Public Schools		4. Employer Identification Number (EIN) 54-6001201	
5. Employer address 1445 Education Way		6. Employer phone number 941-255-0808	
7. City Port Charlotte	8. State FL	9. ZIP code 33948	
10. Who can we contact about employee health coverage at this job? Dawn Keen			
11. Phone number (if different from above)		12. Email address dawn.keen@yourcharlotteschools.net	

Here is some basic information about health coverage offered by this employer:

As your employer, we offer a health plan to:

All employees. Eligible employees are:

All full-time employees regularly working 20 hours or more per week.

With respect to dependents:

We do offer coverage. Eligible dependents are:

Legal spouse, legal dependent children through the age of 26, and disabled dependents who become disabled prior to the age of 26.

✓ If checked, this coverage meets the minimum value standard, and the cost of this coverage to you is intended to be affordable, based on employee wages.

** Even if your employer intends your coverage to be affordable, you may still be eligible for a premium discount through the Marketplace. The Marketplace will use your household income, along with other factors, to determine whether you may be eligible for a premium discount. If, for example, your wages vary from week to week (perhaps you are an hourly employee or you work on a commission basis), if you are newly employed mid-year, or if you have other income losses, you may still qualify for a premium discount.

If you decide to shop for coverage in the Marketplace, [HealthCare.gov](https://www.healthcare.gov) will guide you through the process. Here's the employer information you'll enter when you visit [HealthCare.gov](https://www.healthcare.gov) to find out if you can get a tax credit to lower your monthly premiums.

MEDICARE PART D NOTICE OF CREDITABLE COVERAGE

Important Notice from Charlotte 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 Charlotte 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. Charlotte County Public Schools has determined that the prescription drug coverage offered by Charlotte County Public Schools is, 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.



MEDICARE PART D NOTICE OF CREDITABLE COVERAGE

When Can You Join A Medicare Drug Plan?

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

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

If you decide to join a Medicare drug plan, your Charlotte County Public Schools coverage will not be affected. See below for more information about what happens to your current coverage if you join a Medicare drug plan. Since the existing prescription drug coverage under OptumRx is creditable (e.g., as good as Medicare coverage), you can retain your existing prescription drug coverage and choose not to enroll in a Part D plan; or you can enroll in a Part D plan as a supplement to, or in lieu of, your existing prescription drug coverage. If you do decide to join a Medicare drug plan and drop your Charlotte County Public Schools prescription drug coverage, be aware that you and your dependents can only get this coverage back at open enrollment or if you experience an event that gives rise to a HIPAA Special Enrollment Right.

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 Charlotte 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 person listed below for further information. 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 Charlotte 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 may also 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 1, 2024

Name of Entity/Sender: Charlotte County Public Schools

Contact--Position/Office: Human Resources

Address: 1445 Education Way | Port Charlotte, FL 33948

Phone Number: 941-255-0808

DISCLOSURES

Wellness Notice – HIPAA

Your health plan is committed to helping you achieve your best health. Rewards for participating in a wellness program are available to all employees. If you think you might be unable to meet a standard for a reward under this wellness program, you might qualify for an opportunity to earn the same reward by different means. Contact us Marathon Health and we will work with you (and, if you wish, with your doctor) to find a wellness program with the same reward that is right for you in light of your health status.

Wellness Notice – ADA

Our wellness program is a voluntary wellness program available to all employees. The program is administered according to federal rules permitting employer-sponsored wellness programs that seek to improve employee health or prevent disease, including the Americans with Disabilities Act of 1990, the Genetic Information Nondiscrimination Act of 2008, and the Health Insurance Portability and Accountability Act, as applicable, among others. If you choose to participate in the wellness program you will be asked to complete a voluntary health risk assessment or "HRA" that asks a series of questions about your health-related activities and behaviors and whether you have or had certain medical conditions (e.g., cancer, diabetes, or heart disease). You will also be asked to complete a biometric screening, which will include a blood test for which would include a blood test for glucose, HDL, LDL, triglycerides and total cholesterol. You are not required to complete the HRA or to participate in the blood test or other medical examinations.

However, employees who choose to participate in the wellness program will qualify for a reduced individual medical plan deductible. To earn these incentives an employee would need to make an appointment for an initial clinic visit, complete the health risk assessment, and submit your biometric testing results.

Although you are not required to complete an HRA or participate in any biometric screenings, only employees who do so will qualify for the lower individual medical plan deductible. If you are unable to participate in any of the health-related activities or achieve any of the health outcomes required to earn an incentive, you may be entitled to a reasonable accommodation or an alternative standard. You may request a reasonable accommodation or an alternative standard by contacting Marathon Health.

The information from your HRA and/or the results from your biometric screening will be used to provide you with information to help you understand your current health and potential risks, and may also be used to offer you services through the wellness program, such as health coaching. You also are encouraged to share your results or concerns with your own doctor.

Insurance and Termination/Resignation of Employment

COBRA BENEFITS

The Consolidated Omnibus Budget Reconciliation Act (COBRA) is a Federal Law that provides employees the opportunity to continue existing group insurance coverage upon separation of service from CCPS. Employee and covered dependents may choose to elect COBRA rights as a CCPS employee if one (1) of the following qualifying events occur.

1. Termination of employment from the District, unless it was due to gross misconduct
2. A reduction of work hours which would result in no longer meeting the eligibility requirements for coverage
3. In the event of death
4. In the event of divorce or legal separation
5. Becoming eligible for Medicare, or
6. A child no longer meets eligibility requirements to be covered as a dependent

Certain coverages may be continued for up to 18 months in the event of a termination or up to 36 months for other qualifying events. Employee and Dependents have up to 60 days to elect COBRA. The election date will be one of the latter: 60 days from the qualifying event, or 60 days the County notified employee of the COBRA rights. If an employee is terminated or voluntarily resigns from CCPS, their medical, dental and vision insurance will be terminated from the group plan on the last day of the month. The insurance companies will be notified of the termination date and will send COBRA information to the employee's current home address. This information will inform you of the option of continuing the coverage on a direct pay basis. Please notify HR if there is a change of address upon termination. If the employee terminates with an EBHRA account, the last day of employment will be the termination date of the account. The employee will have 90 days to submit any claims for the period prior to the termination date for reimbursement. Long Term Disability is terminated the last day of the month of your separation date. Life Insurance is cancelled the last day of the month of employment. You have 30 days from the termination date to contact the Employee Benefits Assistant for information to continue life insurance on a direct pay basis.

RETIREMENT AND INSURANCE

The criteria for continuing coverage after retirement is the employee's age at the retirement date. If the employee is under 65, they may have the option to pay for their medical insurance until age 65. Employees will receive documents at their retirement appointment informing them of their options. If continuing, premium payments will be sent to the CCPS main office. For those electing this option, you will receive notification in the mail that your CCPS insurance will be terminating a month prior to turning 65. If the employee retires at age 65, all insurances are automatically terminated. If the employee has covered their spouse or dependents who are under 65 on their policies, the spouse or dependents may continue coverage under a COBRA policy directly to the insurance vendors. A premium statement will be sent upon notification to the insurance vendors. Spouses and dependents can not continue coverage with the CCPS plan if the retiree is terminated. Long Term Disability and Life Insurance are automatically cancelled. Retirees do have the option to continue Life Insurance on a direct pay basis. The request for information must be made within 30 days of the termination date. For those electing to continue coverage until age 65, you will receive notification in the mail that your CCPS insurance will be terminating. All retirees who continue to carry insurance through CCPS will also participate in the Open Enrollment period. Retirees at age 65 and older may elect the Florida State Retiree Benefits Consortium (FSRBC), which provides Medicare-eligible employees and their dependents with access to Medicare medical, dental, and vision benefits. For more information, please call FSRBC at 1-833-686-0983 or visit their website at: <https://secure.bsswift.com/default.aspx?abbrev=myfsrbc>

DISCLOSURES

NEWBORNS' AND MOTHERS' HEALTH PROTECTION ACT OF 1996 (NEWBORN'S ACT)

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 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 not in excess of 48 hours (or 96 hours).

THE WOMEN'S HEALTH AND CANCER RIGHTS ACT OF 1998 (WHCRA, ALSO KNOWN AS JANET'S LAW)

Under WHCRA, group health plans, insurance companies and health maintenance organizations (HMOs) offering mastectomy coverage must also provide coverage for reconstructive surgery in a manner determined in consultation with the attending physician and the patient. Coverage includes reconstruction of the breast on which the mastectomy was performed, surgery and reconstruction of the other breast to produce a symmetrical appearance, and prostheses and treatment of physical complications at all stages of the mastectomy, including lymph edemas. Call your Plan Administrator for more information.

QUALIFIED MEDICAL CHILD SUPPORT ORDER (QMCISO)

QMCISO is a medical child support order issued under State law that creates or recognizes the existence of an "alternate recipient's" right to receive benefits for which a participant or beneficiary is eligible under a group health plan. An "alternate recipient" is any child of a participant (including a child adopted by or placed for adoption with a participant in a group health plan) who is recognized under a medical child support order as having a right to enrollment under a group health plan with respect to such participant. Upon receipt, the administrator of a group health plan is required to determine, within a reasonable period of time, whether a medical child support order is qualified, and to administer benefits in accordance with the applicable terms of each order that is qualified. In the event you are served with a notice to provide medical coverage for a dependent child as the result of a legal determination, you may obtain information from your employer on the rules for seeking to enact such coverage. These rules are provided at no cost to you and may be requested from your employer at any time.

SPECIAL ENROLLMENT RIGHTS (HIPAA)

If you have previously declined enrollment for yourself or your dependents (including your spouse) because of other health insurance coverage, you may in the future be able to enroll yourself or your dependents in this plan, provided that you request enrollment within 30 days after your other coverage ends. In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents, provided that you request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption.

COVERAGE EXTENSION RIGHTS UNDER THE UNIFORMED SERVICES EMPLOYMENT AND REEMPLOYMENT RIGHTS ACT (USERRA)

If you leave your job to perform military service, you have the right to elect to continue your existing employer-based health plan coverage for you and your dependents (including spouse) for up to 24 months while in the military. Even if you do not elect to continue coverage during your military service, you have the right to be reinstated in your employer's health plan when you are reemployed, generally without any waiting periods or exclusions for pre-existing conditions except for service-connected injuries or illnesses.

MICHELLE'S LAW

Michelle's Law permits seriously ill or injured college students to continue coverage under a group health plan when they must leave school on a full-time basis due to their injury or illness and would otherwise lose coverage.

The continuation of coverage applies to a dependent child's leave of absence from (or other change in enrollment) at a postsecondary educational institution (college or university) because of a serious illness or injury, while covered under a health plan. This would otherwise cause the child to lose dependent status under the terms of the plan. Coverage will be continued until:

1. One year from the start of the medically necessary leave of absence, or
2. The date on which the coverage would otherwise terminate under the terms of the health plan; whichever is earlier.

MENTAL HEALTH PARITY AND ADDICTION EQUITY ACT OF 2008

This act expands the mental health parity requirements in the Employee Retirement Income Security Act, the Internal Revenue Code and the Public Health Services Act by imposing new mandates on group health plans that provide both medical and surgical benefits and mental health or substance abuse disorder benefits. Among the new requirements, such plans (or the health insurance coverage offered in connection with such plans) must ensure that:

The financial requirements applicable to mental health or substance abuse disorder benefits are no more restrictive than the predominant financial requirements applied to substantially all medical and surgical benefits covered by the plan (or coverage), and there are no separate cost sharing requirements that are applicable only with respect to mental health or substance abuse disorder benefits.

GENETIC INFORMATION NON-DISCRIMINATION ACT (GINA)

GINA broadly prohibits covered employers from discriminating against an employee, individual, or member because of the employee's "genetic information," which is broadly defined in GINA to mean (1) genetic tests of the individual, (2) genetic tests of family members of the individual, and (3) the manifestation of a disease or disorder in family members of such individual.

GINA also prohibits employers from requesting, requiring, or purchasing an employee's genetic information. This prohibition does not extend to information that is requested or required to comply with the certification requirements of family and medical leave laws, or to information inadvertently obtained through lawful inquiries under, for example, the Americans with Disabilities Act, provided the employer does not use the information in any discriminatory manner. In the event a covered employer lawfully (or inadvertently) acquires genetic information, the information must be kept in a separate file and treated as a confidential medical record and may be disclosed to third parties only in very limited situations.

NO SURPRISES ACT

When you get emergency care or are treated by an out-of-network provider at an in-network hospital or ambulatory surgical center, you are protected from balance billing. In these cases, you shouldn't be charged more than your plan's copayments, coinsurance and/or deductible.

What is "balance billing" (sometimes called "surprise billing")?

When you see a doctor or other health care provider, you may owe certain out-of-pocket costs, like a copayment, coinsurance, or deductible. You may have additional costs or have to pay the entire bill if you see a provider or visit a health care facility that isn't in your health plan's network.

"Out-of-network" means providers and facilities that haven't signed a contract with your health plan to provide services. Out-of-network providers may be allowed to bill you for the difference between what your plan pays, and the full amount charged for a service. This is called "balance billing." This amount is likely more than in-network costs for the same service and might not count toward your plan's deductible or annual out-of-pocket limit.

"Surprise billing" is an unexpected balance bill. This can happen when you can't control who is involved in your care—like when you have an emergency or when you schedule a visit at an in-network facility but are unexpectedly treated by an out-of-network provider. Surprise medical bills could cost thousands of dollars depending on the procedure or service.

You're protected from balance billing for:

Emergency services

If you have an emergency medical condition and get emergency services from an out-of-network provider or facility, the most they can bill you is your plan's in-network cost-sharing amount (such as copayments, coinsurance, and deductibles). You can't be balance billed for these emergency services. This includes services you may get after you're in stable condition, unless you give written consent and give up your protections not to be balance billed for these post-stabilization services.

Certain services at an in-network hospital or ambulatory surgical center

When you get services from an in-network hospital or ambulatory surgical center, certain providers there may be out-of-network. In these cases, the most those providers can bill you is your plan's in-network cost-sharing amount. This applies to emergency medicine, anesthesia, pathology, radiology, laboratory, neonatology, assistant surgeon, hospitalist, or intensivist services. These providers can't balance bill you and may not ask you to give up your protections not to be balance billed.

If you get other types of services at these in-network facilities, out-of-network providers can't balance bill you, unless you give written consent and give up your protections. You're never required to give up your protections from balance billing. You also aren't required to get out-of-network care. You can choose a provider or facility in your plan's network.

When balance billing isn't allowed, you also have these protections:

- You're only responsible for paying your share of the cost (like the copayments, coinsurance, and deductible that you would pay if the provider or facility was in-network). Your health plan will pay any additional costs to out-of-network providers and facilities directly.
- Generally, your health plan must:
 - Cover emergency services without requiring you to get approval for services in advance (also known as "prior authorization").
 - Cover emergency services by out-of-network providers.
 - Base what you owe the provider or facility (cost-sharing) on what it would pay an in-network provider or facility and show that amount in your explanation of benefits.
 - Count any amount you pay for emergency services or out-of-network services toward your in-network deductible and out-of-pocket limit.

HIPAA: Notice of Privacy Practices

We are required by applicable federal and state law to maintain the privacy of your protected health information. We are also required to give you this notice about our privacy practices, our legal duties and your rights concerning your medical information. This notice is available to you by contacting Human Resources.

PREMIUM ASSISTANCE UNDER MEDICAID AND 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).

DISCLOSURES

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, 2025. Contact your State for more information on eligibility –

ALABAMA – Medicaid

Website: <http://myalhipp.com/>
Phone: 1-855-692-5447

ALASKA – Medicaid

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

Website: <http://myarhipp.com/>
Phone: 1-855-MyARHIPP (855-692-7447)

CALIFORNIA – Medicaid

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.flmedicaidprecovery.com/flmedicaidprecovery.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)

DISCLOSURES

MAINE – Medicaid

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

MASSACHUSETTS – Medicaid and CHIP

Website: <https://www.mass.gov/masshealth/pa>
Phone: 1-800-862-4840
TTY: 711
Email: masspremassistance@accenture.com

MINNESOTA – Medicaid

Website:
<https://mn.gov/dhs/health-care-coverage/>
Phone: 1-800-657-3672

MISSOURI – Medicaid

Website: <http://www.dss.mo.gov/mhd/participants/pages/hipp.htm>
Phone: 573-751-2005

MONTANA – Medicaid

Website: <http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP>
Phone: 1-800-694-3084
Email: HSHIPPProgram@mt.gov

NEBRASKA – Medicaid

Website: <http://www.ACCESSNebraska.ne.gov>
Phone: 1-855-632-7633
Lincoln: 402-473-7000
Omaha: 402-595-1178

NEVADA – Medicaid

Medicaid Website: <http://dhcfp.nv.gov>
Medicaid Phone: 1-800-992-0900

NEW HAMPSHIRE – Medicaid

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

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)

NEW YORK – Medicaid

Website: https://www.health.ny.gov/health_care/medicaid/
Phone: 1-800-541-2831

NORTH CAROLINA – Medicaid

Website: <https://medicaid.ncdhhs.gov/>
Phone: 919-855-4100

NORTH DAKOTA – Medicaid

Website: <https://www.hhs.nd.gov/healthcare>
Phone: 1-844-854-4825

OKLAHOMA – Medicaid and CHIP

Website: <http://www.insureoklahoma.org>
Phone: 1-888-365-3742

OREGON – Medicaid and CHIP

Website: <http://healthcare.oregon.gov/Pages/index.aspx>
Phone: 1-800-699-9075

PENNSYLVANIA – 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)

RHODE ISLAND – Medicaid and CHIP

Website: <http://www.eohhs.ri.gov/>
Phone: 1-855-697-4347, or
401-462-0311 (Direct RItte Share Line)

DISCLOSURES

SOUTH CAROLINA – Medicaid

Website: <https://www.scdhhs.gov>
Phone: 1-888-549-0820

SOUTH DAKOTA - Medicaid

Website: <http://dss.sd.gov>
Phone: 1-888-828-0059

TEXAS – Medicaid

Website: [Health Insurance Premium Payment \(HIPP\) Program | Texas Health and Human Services](#)
Phone: 1-800-440-0493

UTAH – Medicaid and CHIP

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

Website: [Health Insurance Premium Payment \(HIPP\) Program | Department of Vermont Health Access](#)
Phone: 1-800-250-8427

VIRGINIA – Medicaid and CHIP

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

Website: <https://www.hca.wa.gov/>
Phone: 1-800-562-3022

WEST VIRGINIA – Medicaid and CHIP

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

Website: <https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm>
Phone: 1-800-362-3002

WYOMING – Medicaid

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 U.S. Department of Health and Human Services
Employee Benefits Security Administration Centers for Medicare & Medicaid Services
www.dol.gov/agencies/ebsa www.cms.hhs.gov
1-866-444-EBSA (3272) 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.



1/1/2026 - 12/31/2026

Employee Benefits Guide