2027 BENEFITS GUIDE

Chardon Local Schools

CHARDON
LOCAL SCHOOLS

If you 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 pages 27-28 for more details.

Contents

How to Enroll 3
Eligibility and Making Changes 4
Adding or Terminating Dependents 5
Medical Insurance 6
Health Savings Account (HSA) 8
FEDlogic 10
Flexible Spending Account (FSA) 12
Dental Coverage Aetna 13
Vision (Voluntary) 14
Basic Life and AD&D One America 15
Short-Term Disability (Voluntary) 16
Long-Term Disability (Voluntary) 17
Accident Coverage (Voluntary) 18
Critical Illness (Voluntary) 19
Hospital Indemnity Insurance (Voluntary) 20
Trustmark Universal Life 21
Identity Theft Protection (Voluntary) 22
Employee Assistance (EAP) ComPsych® 23
Gallagher Benefit Advocate Center 24
Annual Notices 25
Notices of Privacy Practices 26
Medicare D Creditable Coverage Notice 27
CHIP model notice 2027 29
Your Rights and Protections Against Surprise Medical Bills 34
Contacts 36

Open Enrollment for 2027 is 11/2 – 11/13/26

Like last year, we will have an **Active Open Enrollment**. This means that all employees are required to log into Employee Navigator, review their benefit options, and actively make benefit elections for the upcoming plan year.

Unlike in previous years, benefits will not automatically roll over (with the exception of certain plans, such as Basic Life/AD&D, EAP and Voluntary Plans). Employees must take action to ensure they are enrolled in the coverage they need. **If you do not actively enroll or decline coverage for Medical, HSA, Dental, FSA or Dependent Care FSA benefits during the open enrollment period, these benefits will automatically be marked as declined for the 2027 plan year.**

This change ensures that all employees have the opportunity to review updated plan options, rates, and coverage details, empowering you to make informed decisions about your benefits.

We encourage you to take the time to carefully review your options and complete your enrollment before the deadline.

Please note that if you choose to enroll in Voluntary STD, Voluntary LTD or Universal Life plans after initially declining coverage, your enrollment may be subject to Evidence of Insurability (EOI). If applicable, coverage will remain pending until the EOI is received and approved.

You have two ways to participate in open enrollment this year.

Self-Enroll Using our Employee Benefits Portal, Employee Navigator site

November 2 – November 13

This method will allow you to log in to your portal, walk through your benefit options and make your new elections or choose to continue with what you have currently elected. **https://ssultd.com/Char/**

Need Help With Your Benefits?

The Gallagher Benefit Advocate Center is available to help you enroll in benefits through Employee Navigator and answer questions about your coverage, claims, and other benefit-related topics. For personalized assistance, call (833) 887-4955, Monday through Friday from 8 am – 6 pm

Employee Benefits Portal:

The Benefits Portal is available all year long for new employee enrollments and existing employees who need to make a benefit change due to a life event. Our self-serve site places the control of your benefits in your hands and is accessible from any device with an internet connection, all year long, 24/7 – 365. Access our Benefits Site, Employee Navigator, at: **https://www.ssultd.com/CHAR/**

If you have not previously registered on Employee Navigator, click on the 'New User Registration' button on the login page. Enter your information as prompted and our **Company Identifier**: **CHAR**

Videos are available on the Home Page to walk you through as a First Time User and also to process Profile Changes & Mid-Year Life Events. Make sure to watch the video before you start enrollment

Annual Open Enrollment/Newly Eligible?

During your open enrollment window, you can make changes to your elections as *frequently as you wish*. Your online home page tells you how long you have to take action. To complete a new hire or open enrollment event – please select '**Start (or Finish) Enrollment**' found in the **main section of your home page**. And be sure to complete any 'required tasks' listed on your homepage. **Once you have begun your event**, the 'menu tree' on the right-hand side indicates the steps that must be completed to finalize your election.

Because we use a Benefit Portal system, you may need to provide information for dependents you enroll for coverage. This may include dates of birth and social security numbers.

Eligibility and Making Changes

Eligibility

The eligibility period for enrollment is the first day of your employment and elections must be completed within 30 days. Eligible employees may elect to cover a spouse and dependents. Dependent children can be covered until the age of 26 for medical and dental. The minimum hour requirement varies and is lower for the voluntary products.

How to Make Changes

You can only make changes to your benefits outside of Open Enrollment if you experience a Qualifying Life Event.

Qualifying Life Events include:

- Marriage or divorce
- Legal separation
- Birth or adoption of a child
- Change in a child's dependent status
- Death of a spouse, child, or other dependent
- Start or end of adoption proceedings
- Involuntary change in a spouse's benefits

You must notify your Payroll & Benefits Specialist within 30 days of a Qualifying Life Event to make changes. If you miss this deadline, changes must wait until the next Open Enrollment.

If you add a dependent to your medical coverage you will be required to verify his/her eligibility by providing documentation such as a birth certificate, marriage certificate, tax return, etc. Your benefits may be affected if there is a delay verifying the eligibility of your dependents. If you do not provide all the required documentation by the deadline, he/she will be dropped from your medical insurance coverage.

Medical Summary of Benefits and Coverage

You will be able to access an SBC on your home page in the Employee Navigator Portal, or you may obtain a copy of the SBC by contacting your Payroll & Benefits Specialist.

When Coverage Ends

If your employment terminates for any reason, all benefits end on the last day of the month. Under certain circumstances, you may continue your health coverage. This is called COBRA (Consolidated Omnibus Budget Reconciliation Act of 1985). Under COBRA you may continue your medical and dental insurance. Various voluntary benefits may be eligible to transfer to you for bill-at-home.

The following information included in this booklet is a brief overview of the benefit plans currently offered and is not to be interpreted as a complete disclosure of plan entitlement to any of the benefits described. The company reserves the right to adjust, amend and revise benefit plans. In all cases of specific plan interpretations, receipt of benefits or entitlements, the actual plan documents shall rule. You can contact your Treasurers department for actual plan documents.

Adding or Terminating Dependents

DOCUMENTATION IS REQUIRED when adding or terminating a dependent from your insurance coverage(s). Required documentation must be received and approved by the Treasurer's office before your dependent(s) will be added to, or terminated from, your plan.

REQUIRED DOCUMENTS NEEDED TO VERIFY ELIGIBILITY OF DEPENDENTS

To verify a legal spouse	A photocopy of a marriage certificate or an acceptably executed marriage license that identifies the couple, date of marriage, legal jurisdiction and has a signature or seal showing it has been properly recorded with the County and/or State. A church ceremony document will not be acceptable if it does not meet these requirements.
To verify a natural or adopted child, or stepchild who is eligible to age 26	Provide a legible photocopy of an acceptable birth certificate or hospital birth record that shows your name or the name of your enrolled spouse as the parent of the child and is signed by a hospital administrator or physician on staff. If you do not have the birth certificate you may send a copy of the pages of any court document that shows the parents and child's names, identifies the court, county or state, date of the action and the filing record or a court signature that have been signed and/or stamped by a member of the court or you may provide a paternity test. If your spouse is not enrolled and his/her name is on the birth certificate and your name is not listed, you must also provide a copy of your marriage certificate.
*__Medical/Rx insurance__: Dependent children may be covered up to the end of the month when they age 26 regardless of financial independence, student status, residence, or marital status. *__Dental insurance__: You can cover your dependent children on the dental coverage until age 26.	
To verify PERMANENT Legal Guardianship or Legal Custodian for children under age 18. NOTE: Children placed in temporary custody are not eligible	**Language states:** any child for whom either the Card Holder or Card Holder's spouse is the legal Guardian or Custodian. ****Definition of Custodian** = a person who, by court order, has permanent custody of a child. ****Definition of Legal Guardian** = an individual who is either the natural guardian of a child or who was appointed a guardian of a child in a legal proceeding by a court having the appropriate jurisdiction. **Standard document:** court document that is signed and/or stamped by a member of the court assigning minor child to employee or the employee's spouse.
To verify eligibility of a grandchild	This relationship is only allowed if the employee has either legal guardianship over the dependent or court-ordered custody. See above for required documentation.

REQUIRED DOCUMENTS NEEDED TO TERMINATE DEPENDENTS

To remove a spouse from your coverage	If divorced, a photocopy of the first/last page of your divorce decree with a signature or seal showing it has been properly recorded with the County and/or State. **If legally separated, proof that your spouse is enrolled in other coverage.
To remove a minor child Under the age of 19	Provide proof of other coverage.

Medical Insurance

MEDICAL MUTUAL OF OHIO

Reminder, The PPO Plan Was Discontinued As Of 12/31/25.	HDHP/HSA Plan **In Network**	Certified Bronze **In Network**
Dependent Child Age Limit	Dependent Children are covered to the end of the month when they turn 26, regardless of financial dependence, student status, residence, or marital status.	
Benefit Period	Calendar year	
Deductible (Individual/Family)	$2,000 / $4,000	$6,000 / $12,000
Max Out-of-Pocket (includes deductibles, coinsurance, medical and RX copays)	$2,500 / $5,000	$6,000 / $12,000
Inpatient/Outpatient Facility	100% After Deductible	100% After Deductible
Emergency Room (Emergency Use)	$100 Copay After Deductible	100% After Deductible
Urgent Care	100% After Deductible	100% After Deductible
Office Visits – Diagnostic	100% After Deductible	100% After Deductible
Express Care-On Line "Telehealth"	100% After Deductible	100% After Deductible
Routine Preventative and Wellness Services in accordance with State and Federal Law	Covered 100% Not subject to Deductible	
Diagnostic Lab/X-Ray	100% After Deductible	100 % After Deductible
CT Scan MRI/NMR and Nuclear Medicine: Coverage based on place of service	100% After Deductible	100% After Deductible
Prescription Drug Retails Copays - 30 Day Supply	Copay <u>After</u> Deductible: $10 - Generic $25 - Preferred Brand $60 – Non-Preferred	100% After Deductible
Mail Order - 90 Day Supply	Copay After Deductible: $25 – Generic $62.50 - Preferred Brand $150 – Non-Preferred	100% After Deductible
Lifetime Max	Unlimited	

Cost Per Pay	HDHP/HSA		Bronze	
	Single	Family	Single	Family
18 Deduction	$22.44	$85.88	$0	$0
24 Deductions	$16.83	$64.41	$0	$0

This is an outline of coverage and does not contain all benefits and provisions of the plans. Refer to the Certificate of Coverage for complete details.

Medical Insurance

MMO Nurseline

This program is available to all members enrolled in the medical plan (HDHP w/HSA or the Bronze Plan).
If you are unsure whether you should go to the emergency room, urgent care or be directed to another source of care, Nurseline will assist! A trained nurse will provide you with guidance. Since non-emergency visits to the emergency room is subject to the deductible and payable at 50%, it is important to call Nurseline for guidance on where to seek treatment.
Call (888) 912-0636.
Available 24 hours a day and 7 days per week.

SmartShopper

Helps you save money on several medical procedures. Earn $$$$$ when you use the program and choose a LOW cost, HIGH quality provider for service!

When you need a non-emergent medical procedure, start with SmartShopper.

- They provide you with the options you need to make good health care choices.
- If you choose a low cost, high quality provider – you will receive a check in the mail! Yes!
- Your Personal Assistant can also schedule your appointment.

Click this link to start shopping now SmartShopper OR call your SmartShopper Personal Assistant team at +1 (877) 292-1541 Monday through Thursday from 8 a.m. to 8 p.m. and Friday from 8 a.m. to 6 p.m. EST.

Access MMO's My Health Plan

- To view or order a certificate
- Check claim status and benefit information
- Review explanation of benefits (EOBs)
- Search providers
- Print duplicate ID cards. Your original ID card will be mailed to your home.
- Access Express Scripts for information on your prescriptions

https://medmutual.com/member

Access Express Scripts

You can also call the Rx Information number on your ID card to speak with a representative from Express Scripts, 24 hours a day, 7 days a week to help with any of your prescription drug concerns, including:

- Finding an in-network pharmacy
- Determining the cost of your medication and coverage tier
- Moving your medication to mail order
- Checking the status of mail order claims
- Any other prescription drug questions you may have

Health Savings Account (HSA)

If you enroll in the HDHP/HSA medical plan, you're eligible to open a Health Savings Account (HSA)); a tax-advantaged account that helps you save for current and future medical expenses .

District Contributions for 2027

Biometric Screening Status	Single Coverage	Family Coverage
Completed	$800	$1,600
Not Completed	$700	$1,400

Funds are deposited early in the year. New enrollees will have their HSA set up through inspira Financial (previously **Payflex**).

How Much Can You Contribute?

The IRS sets annual **total contribution limits**(including both employee and employer contributions):

- Single coverage: Up to $4,500
- Family coverage: Up to $9,000

To determine how much you can personally contribute, subtract the district's contribution. For example:

- Single (with screening): You may contribute up to $3,700
- Family (with screening): You may contribute up to $7,400

If you're age 55 or older, you can add an extra $1,000 as a "catch-up" contribution.
Note: IRS limits may change annually. Always check the latest guidelines.

Benefits of an HSA

- **You own the account –** it's yours to keep, even if you leave or retire.
- **No expiration –** unused funds roll over year to year.
- **Tax advantages –** contributions, earnings, and qualified withdrawals are all tax-free.
- **Lower premiums –** HDHP plans typically cost less than traditional plans.

Eligibility Rules

To qualify for an HSA, you must:

- Be enrolled in the HDHP/HSA medical plan.
- Not have other non-HSA-compatible coverage, (e.g., traditional PPO)
- Not be enrolled in Medicare Part A, B, or D

Important: Once you enroll in Medicare, you are no longer eligible to contribute to an HSA or receive employer contributions. Consider delaying Medicare enrollment if you wish to remain HSA-eligible—but consult a Medicare expert before making this decision.

- You cannot be claimed as a dependent on someone else's tax return.

Using Your HSA

- Use funds for medical, dental, and vision expenses (e.g., prescriptions, braces, contacts).
- Pay with your HSA debit card or reimburse yourself later.
- Keep receipts for tax purposes, even though the bank doesn't require them.
- You cannot use HSA funds for services received before your HSA plan started—even if you're still paying for them in the current year.

Important Notes

- **Non-medical use before age 65:** Subject to income tax + 20% penalty.
- **Non-medical use after age 65:** Subject to income tax only.
- **Long-term care:** Eligible expense.
- **Flexible Spending Account (FSA):** You cannot enroll in a regular FSA if you have an HSA, but you may use a **Limited Purpose FSA** for dental and vision only.

Special Situations

- If your **spouse has a Healthcare FSA**, you are **not eligible** for an HSA.
- If you have **secondary insurance** that's not HSA-compatible (e.g., traditional PPO), you must drop it to contribute to an HSA.
- You can only use HSA funds for yourself, your spouse, or **dependents you claim on your taxes.**
- If your child **is not a tax dependent**, you **cannot** use HSA funds for their expenses.
- If you and your ex-spouse alternate claiming your child, you may **only use HSA funds in the years you claim them.**
- You **cannot** use HSA funds for services received **before** your HSA start date.

FEDlogic

Introducing FEDlogic — an independent educational resource staffed by experienced professionals who can help employees and their household members better understand and navigate federal and state benefit programs.

Chardon Local School District offers FEDlogic as an unlimited and free resource for employees and their household members. **This service is available to all employees, whether or not you are eligible for benefits**. FEDlogic provides independent education and guidance to help you better understand and make the most of your federal and state benefit options.

FEDlogic can provide valuable guidance in situations such as:

- **Medicare Assistance:** You are approaching or have reached age 65 and need unbiased help understanding Medicare and the options available to you.
- **Retirement Planning:** You are age 62 or older and want to maximize your retirement benefits now or plan for the future.
- **Major Health Diagnoses:** You or a family member has been diagnosed with a major illness, such as cancer, ESRD, or ALS.
- **Family Support:** You have a child born prematurely or a family member with a disability.
- **Survivor Benefits:** You have lost a spouse and need help understanding survivor benefits.
- **Health Coverage Challenges:** You are unable to work or have lost access to affordable health coverage.
- **Dependent Coverage:** Your dependent child is no longer eligible for the medical plan due to turning age 26.

FEDlogic is available to help you make informed decisions about your benefit options. Understanding the programs and resources available to you can be difficult, and without education and advocacy, many individuals may not take full advantage of the benefits for which they may be eligible. FEDlogic's experts have worked for the Social Security Administration and have years of experience understanding these policies from the inside out.

FEDlogic does not sell, endorse, or promote any products or services. Their role is to provide unbiased education and practical guidance to support employees and their families through important life changes. Employees can feel confident that all conversations with FEDlogic are strictly confidential and will not be shared with their employer or anyone else.

How it works:

1. Complete a short questionnaire and schedule a private consultation using the link or QR code below.
   Click Here to Complete the FEDlogic Employee Questionnaire

You may also contact FEDlogic at **877-837-4196** or services@fedlogicgroup.com to schedule a private consultation. Consider scheduling the appointment at a time when household members are available to listen and ask questions as well.

2. FEDlogic will listen to your story and take the time to understand your needs, concerns, and goals.
3. Once you feel confident that you have the information needed to make the best decision for you and your family, FEDlogic can walk you through the application and approval process.

Visit the FEDlogic employee resource site at https://employees.fedlogicgroup.com/ or scan the QR code below.
Employee access code: clsd26

Recorded audio series and monthly webinar recordings are also available. Topics include:

- Retirement & Maximizing Benefits
- Disability/Unable to Work
- Medicare
- Survivor Benefits
- Children's Benefits
- Spousal & Ex-Spousal Benefits
- Premature Baby Birth
- Major Illnesses (such as cancer, ALS & ESRD)

We encourage you to take advantage of this valuable resource whenever you or a household member may need support navigating federal or state benefit programs. FEDlogic is here to provide education, answer questions, and help you better understand the options available to you and your family.

Flexible Spending Account (FSA)

An FSA lets you set aside money from your paycheck before taxes to pay for eligible healthcare or childcare expenses. This helps you save money by reducing your taxable income.

Types of FSAs Offered

1. Healthcare FSA – For medical, dental, and vision expenses.
2. Limited Purpose FSA – For dental and vision only (available if you're enrolled in the HDHP/HSA plan).
3. Dependent Care FSA – For childcare expenses (available to all employees).

Healthcare FSA *(These amounts can change when the IRS announces the 2027 limits)*

- Available **only if you're NOT enrolled in the HSA plan.**
- You can contribute up to **$3,400** in 2027
- Funds are **available immediately** after your first payroll deduction.
- Use it for out-of-pocket costs like copays, prescriptions, dental work, and vision care.
- Includes a **carryover feature**: You can roll over up to **$680** into the next year. Any unused amount above will be forfeited.

Limited Purpose FSA

- Available **only if you're enrolled in the HDHP/HSA plan**.
- Use it for **dental and vision expenses only**.
- You can contribute up to **$3,500** in 2027 (IRS limit).
- Helps you save even more while keeping your HSA eligibility.

Dependent Care FSA

- Available to **all employees**, regardless of medical plan.
- Use it to pay for **licensed childcare** for children under age 13.
- Maximum contribution: **$7,500 per household** (based on IRS rules).
- Helps reduce your taxable income while covering daycare, preschool, or after-school care costs.

FSA Advantages

- **Tax Savings** – Contributions are pre-tax, and withdrawals for eligible expenses are tax-free.
- **Immediate Access** – Healthcare FSA funds are available in full at the start of the year.
- **Over-the-Counter Items** – You can use FSA funds for items like bandages, allergy meds, and pain relievers (some restrictions apply).

Dental Coverage

Dental benefits provide you and your family with comprehensive coverage to keep your smile shining bright! The chart below provides you with a brief summary of the key benefits of the dental insurance available.

	Deductible & Benefit Maximum	
	In Network	**Out-of-network**
Deductibles: Individual / Family	$25 / $50	$25 / $50
Benefit Max Per Year	$1,500 per person	$1,500 per person
	Diagnostic & Preventative	
Diagnostic & Preventative - exams, cleanings, fluoride	100% Covered	100% Covered
Radiographs - x-rays	100% Covered	100% Covered
	Basic Services	
Minor Restorative Services - Fillings and crown repair	80% Covered	80% Covered
Endodontic Services - Root canals	80% Covered	80% Covered
Periodontic services - treat gum disease	80% Covered	80% Covered
Other basic services	80% Covered	80% Covered
Realign and Repairs - bridges, dentures, implants	80% Covered	80% Covered
	Major Services	
Major Restorative Services - Crowns	50% Covered	50% Covered
Prosthodontic Services - Bridges, Implants	50% Covered	50% Covered
	Orthodontic Services	
Braces	50% Covered	50% Covered
Age Limit	No Age Limit	No Age Limit
Orthodontia Lifetime Max	$850	$850

REMINDER: Your dependent children are eligible for dental coverage to age 26. There is no student requirement.

This dental coverage is a valuable benefit being offered that only costs a minimal amount. If you choose to select dental coverage, the total annual cost is a single deduction of $.50 for single coverage and $1.00 for family coverage the first payroll run of May.

Visit www.Aetna.com to locate a Dentist. The out-of-network dentist fee allowed by Aetna Dental may be less than what your dentist charges and you may be responsible for the difference.

This is an outline of coverage and does not contain all benefits and provisions of the plans. Refer to the Certificate of Coverage for complete details.

Sun Life

Vision (Voluntary)

Our vision plan can help reduce the cost of routine eye exams, eyeglasses, and contact lenses. Regular eye exams not only determine your need for corrective eyewear but also may detect general health problems in their earliest stages. **To find a local provider, visit: vsp.com and select the Choice Network**

Benefit	Frequency	VSP In-network Member	Out-of-network
Exam Services Well Vision Exam	1 per 12 months	$20	up to $45
Laser Vision Correction Discount	Once per eye per lifetime	• Average 15 % off the regular price or 5% off the promotional price. • Discounts are only available from contracted facilities.	N/A
Lenses	1 per 12 months		
Single Lined		$25 (Lenses and Frame)	up to $ 30
Bifocal Lined			up to $ 50
Trifocal			up to $ 60
Lenticular			up to $100
Necessary Contacts			up to $210
Lens Enhancements			
Standard Progressive		$55	
Premium Progressive		$95 - $105	
Custom Progressive		$150 - $175	
Frames	1 per 12 months	• $130 for the frame of your choice and 20% off the amount over your allowance. • $70 Allowance at Costco and Walmart	up to $70
Elective Contact Lenses Contact lenses are in place of lenses and frame.	1 per 12 months	• Up to $60 / 15% savings for your contact lens exam (fitting and evaluation). • $130 for contact lenses.	up to $105
Additional Glasses and Sunglasses Discount	20% off additional glasses and sunglasses, including lens options, from the same VSP doctor on the same day as your exam. Or get 20% off from any VSP doctor within 12 months of your last exam.		
Coverage with Retail Providers	*Coverage with retail providers may be different. Check with Costco and Walmart for VSP member pricing. The Costco and Walmart allowance are equivalent to the allowance at preferred providers and other retail providers.		

Note: dependent children are eligible for vision up to age 26

Cost Per Pay	Employee Only	Employee + Spouse	Employee + Child(ren)	Family
(18) Deductions	$5.16	$10.33	$11.36	$16.51
(24) Deductions	$3.87	$7.75	$8.52	$12.39

Basic Life and AD&D

Life Insurance is an important part of your financial security, especially if others are depending on you for financial support. Life Insurance protects your family from sudden loss of income in the event of your death, and even if you are single, your beneficiary can use your life insurance to pay off debts and other final expenses. That is why we provide you with a Basic Life and Accidental Death & Dismemberment insurance benefit. See your Payroll & Benefits Specialist for more information.

Life Benefit - AD&D Benefit
Basic life insurance pays a death benefit to named beneficiary Additional protection for loss due to Accidental Death and Dismemberment including Speech/Hearing loss, Loss of Limb, Loss of Thumb and Index Finger, and Loss of use of a limb due to Quadriplegia, Paraplegia, or Hemiplegia – all with a standard 365-day loss period.

Additional Benefits	
Living Benefit	You can request up to 75% of your group term life benefit to be paid while you are living, if you are terminally ill with less than 12 months to live. If you take a Living Benefit payment, the amount your beneficiary gets after your death will be reduced by the amount you were paid.
Additional AD&D Benefits	Additional Accidental Death Benefits include: Seat Belt Benefit, Air Bag Benefit, Repatriation Benefit, Child Higher Education Expenses and Child Care Benefit. See your certificate of coverage for details.

Short-Term Disability (Voluntary)

Short-Term Disability insurance pays you a portion of your salary during an unexpected injury or illness that occurs outside of work and leaves you unable to perform your job. This benefit replaces lost wages when you are not able to work and earn an income due to an accident, illness, or the birth of a child. This Short-Term Disability policy will pay residual benefits and a partial disability benefit based on your limited ability to return to work.

Income from other sources may reduce your benefit amount, including salary continuance or sick leave, return-to-work earnings, Social Security benefits, disability benefits from retirement, government plans, state disability income, etc.

Short-term Disability Benefit	Choice 1	Choice 2
Minimum Weekly Benefit	$100	$100
Maximum Weekly Benefit	60% of income up to $1,600 (Increments of $50)	60% of income up to $1,600 (Increments of $50)
Guarantee Issue Maximum	$1,600	$1,600
Elimination Period	14 Days	7 Days
Maximum Benefit Duration	11 weeks	12 weeks
Pre-Existing Condition	If you have been treated for a condition 3 months prior to your effective date, it will not be covered 12 months.	

Cost By Age Group Per $10 Of Weekly Benefit											
Cost per Pay	< 24	25-29	30-34	35-39	40-44	45-49	50-54	55-59	60-64	65-69	70+
Choice 1 (18)	$0.59	$0.62	$0.58	$0.44	$0.28	$0.28	$0.34	$0.43	$0.52	$0.71	$0.83
Choice 1 (24)	$0.45	$0.47	$0.44	$0.33	$0.21	$0.21	$0.25	$0.33	$0.39	$0.53	$0.62
Choice 2 (18)	$0.75	$0.77	$0.73	$0.55	$0.37	$0.36	$0.43	$0.57	$0.66	$0.81	$0.88
Choice 2 (24)	$0.57	$0.58	$0.55	$0.42	$0.27	$0.27	$0.33	$0.42	$0.50	$0.61	$0.66

Regular maternity leave is covered under this benefit for income replacement.[1]

[1] This is not a guarantee of coverage for claim. All claims are subject to a claims process with the insurance company and require specific stipulations be met for claim to be approved and benefits paid. Limitations and exclusions apply. Refer to the policy, certificate and riders for complete details.

Long-Term Disability (Voluntary)

Long-Term Disability insurance provides you with a monthly cash benefit to help pay for everyday expenses such as mortgage/rent, utilities, childcare, and groceries, if a covered disability such as a back injury or a chronic illness takes you away from work for an extended period of time. If you suffer a long-term disability, this could provide you with a monthly check to replace a portion of your income, which can help lessen the financial impact of a covered disability. This allows you the financial freedom to manage your expenses even when you cannot work, due to a covered disability, so that you do not have to rely solely on savings, friends, or family.

This policy is a Long-Term Disability policy, and it has a longer elimination period, the amount of time you must be disabled before the policy will pay. It pairs well with a short-term disability policy to cover this elimination period. However, this policy will provide a benefit for qualified disability claims up until normal social security retirement age. [2]

	Long-term Disability
Minimum Monthly Benefit	$100
Monthly Benefit	60% of Income
Maximum Monthly Benefit	$7,000
Elimination Period	90 days (12 weeks)
Benefit Duration	Social Security Normal Retirement Age or longer depending on your age at disability.
Own Occupation Provision	24 months
Pre-Existing Condition	If you have been treated for a condition in the 3 months prior to your effective date, it will not be covered for the next 12 months.

Cost by age group per $100 Covered Payroll											
Cost Per Pay	< 24	25-29	30-34	35-39	40-44	45-49	50-54	55-59	60-64	65-69	70+
(18) Deductions	$0.08	$0.10	$0.18	$0.28	$0.39	$0.47	$0.62	$0.77	$0.80	$0.50	$0.54
(24) Deductions	$0.06	$0.07	$0.14	$0.21	$0.29	$0.35	$0.47	$0.58	$0.60	$0.37	$0.41

The rates shown in this grid are for illustrative purposes and will vary based on multiplication due to rounding.

Disability Insurance Benefits paid are based on your earnings as reported by your employer, including deductions made for deferred compensation plans and contributions made to HSA/FSA. The premiums are paid after tax and therefore, taxes are not withheld from benefits paid.

How much do you need? Add up all your monthly expenses.
Monthly Income x Percentage Amount = Potential Benefit

[2] This is not a guarantee of coverage for claim. All claims are subject to a claims process with the insurance company and require specific stipulations be met for claim to be approved and benefits paid. Limitations and exclusions apply. Refer to the policy, certificate and riders for complete details.

Sun Life

Accident Coverage (Voluntary)

Accidents happen at any time, to anyone. When a serious injury unexpectedly occurs, a lump sum benefit from Sun Life provides protection for a wide range of covered benefits. Injured employees and their dependents may use the cash benefits however they want to satisfy deductibles, pay out-of-pocket medical expenses, or pay household bills. Coverage for accidents off the job only.

	High 24 Hour	
Wellness Benefit	$50 Once per year, per insured	
Accidental Death	$50,000	
Accidental Death Common Carrier	$100,000	
Dismemberment		
Loss of Fingers, Toes, Eye, Hand, Foot, Arm, Leg, etc.)	$750 - $15,000	
Dislocation	**Open**	**Closed**
Fingers/Toes, Wrist, Elbow, Ankle, Hip, Knee, etc.	$200 - $6,000	$100 - $3,000
Fractures	**Open**	**Closed**
Nose, Ribs, Fingers/Toes, Sternum, Kneecap, etc.	$350 - 10,000	$175 - $5,000
Burns	**2nd Degree**	**3rd Degree**
20-40 Sq cm	$400	$1,000
40-65 Sq cm	$800	$2,000
65-160 Sq cm	$1,200	$6,000
160 -225 Sq cm	$1,600	$14,000
More than 225 Sq cm	$2,000	$20,000
Skin Graft	50% of the applicable Burn Benefit	
Laceration		
No sutures & treated by doctor	$35	
Lacerations with Sutures	$65 - $500	
Additional Injuries		
Eye Injury/Object removal	$250	
Gunshot wound	$500	
Paralysis	$25,000 - $50,000	
Coma	$10,000	
Concussion	$100	
Medical services		
Diagnostic exams- Xray, MRI, EKG, EEG, etc.	$100 - $200	
Emergency Treatment	$150	
Follow-up Physician	$150 (6x per accident)	
Physical Therapy	$50 (10 per accident)	
Medical Devices	$500	
Blood, Plasma, Platelet	$200	
Admission	$1,500	
Confinement (365 days max)	$300	
Intensive Care Admission	$3,000	
Intensive Care (14 days max)	$750	
Ambulance	$400 - $2,000	
Surgery	$300 - $2,000	
Emergency Dental	$65 - $200	

Cost per Pay	Employee Only	Employee & Spouse	Employee & Child(ren)	Family
(18) Deductions	$11.35	$18.48	$19.99	$27.12
(24) Deductions	$8.52	$13.86	$15.00	$20.34

Critical Illness (Voluntary)

Sun Life

Cancer, heart attack, stroke, and the like, may be covered by medical insurance. What about other expenses that come along with those? Coinsurance and deductibles to name a few. Critical Illness offers an affordable way to pay expenses when the unexpected happens, by providing a single lump sum cash benefit that goes directly to you and can be used for any purpose – from paying rent to buying groceries to covering your deductible. You do not need to be enrolled in medical insurance or any other coverage to enroll in Critical Illness Insurance.

	Employee	Spouse	Child(ren)
Benefit Amount - GI Amount	$5,000 - $40,000	$5,000 - $40,000	$5,000 - $20,000
Wellness Benefit	$100 Once per Year	$100 Once per Year	$100 Once per Year
Core Conditions	**Initial Diagnosis**		**Recurrence**
Heart Attack	100%		100% of Face Amount
Stroke	100%		100% of Face Amount
Major Organ Failure	100%		100% of Face Amount
End-Stage Kidney Disease	100%		100% of Face Amount
Occupational HIV/Hepatitis B, C, D	100%		N/A
Coronary Artery bypass Graft	25%		25% of Face Amount
Angioplasty	5%		5% of Face Amount
Cancer Conditions			
Invasive Cancer	100%		100% of Face Amount
Non-invasive Cancer	25%		25% of Face Amount
Skin Cancer	5%		5% of Face Amount
Supplemental Conditions			
Complete Blindness	100%		N/A
Loss of Speech	100%		N/A
Complete Loss of Hearing	100%		N/A
Benign Brain Tumor	100%		N/A
Paralysis / Coma	100%		N/A
Severe Burns	100%		N/A
Advanced ALS or Lou Gehrig's	100%		N/A
Advanced Alzheimer's/Parkinson's	25%		N/A
Child Coverage Only			
Down Syndrome	100%		N/A
Cerebral Palsy	100%		N/A
Cystic Fibrosis	100%		N/A
Cleft Lip/Palate	100%		N/A
Type 1 Diabetes Mellitus	100%		N/A
Muscular Dystrophy	100%		N/A
Complex Congenital Heart Disease	100%		N/A
Spina Bifida	100%		N/A

Rates are based on employee attained age for their coverage election. Spousal rates are based on their own attained age. Spouse cannot exceed 100% of the employee amount and child cannot exceed 50% of the employee amount.

Per Pay	Cost by age group per $1,000 coverage						
Age Band	Child(ren)	<-29	30-39	40-49	50-59	60-69	70+
18 Deductions	$0.11	$0.47	$0.59	$.97	$1.74	$2.96	$5.41
24 Deductions	$0.09	$0.35	$0.45	$.73	$1.31	$2.22	$4.06

Hospital Indemnity Insurance (Voluntary)

Help you with out-of-pocket medical costs incurred with a hospital stay. Sun Life's Hospital Indemnity plan provides flexible options that make it easy to meet cost and coverage goals. Employees with hospital stays of 10 days or more may receive additional Extended Hospitalization benefits.

First Day Benefits Payable per benefit year	Low Plan	High Plan
First Day Hospital	$500 per day 1 day	$1,000 per day 1 day
First Day ICU	$500 per day 1 day Payable with First day hospital	$1,000 per day 1 day Payable with First day hospital
Hospital Confinement – Per year	$100 per day 15 days Payable with First Day Hospital	$200 per day 15 days Payable with First Day Hospital
Maternity Confinement This benefit is payable when an insured person: • has used up their normal Hospital Confinement days, and then • has an inpatient confinement for normal pregnancy and childbirth.	$50 per day Normal delivery – 2 days Caesarean delivery – 4 days	$50 per day Normal delivery – 2 days Caesarean delivery – 4 days
Newborn Nursery Confinement	$50 per day Normal delivery – 2 days Caesarean delivery – 4 days Not payable with any other confinement	$50 per day Normal delivery – 2 days Caesarean delivery – 4 days Not payable with any other confinement
ICU Confinement	$100 per day 15 days Payable with First Day Hospital Payable with Hospital Confinement	$200 per day 15 days Payable with First Day Hospital Payable with Hospital Confinement
Extended Hospitalization	$100 per day The additional benefit pays after 10 total days in a row of confinement beginning with your first day in: · a regular hospital rooms · the ICU	$200 per day The additional benefit pays after 10 total days in a row of confinement beginning with your first day in: · a regular hospital rooms · the ICU
Newborn Care	Routine care covered under newborn nursery confinement	

- **Covered conditions:** Plans can include coverage for hospital confinements due to accident and sickness, mental and nervous disorders, substance abuse, routine pregnancy, and newborn routine care.
- **First Day benefits:** Benefits can include a First Day Hospital &/or First Day ICU.
- **Benefits can add up:** Add additional value to your plan by including the option for benefits, such as First Day, Hospital Confinement, or ICU benefits, to be paid on the same day.
- **Extended Hospitalization benefit:** Covered employees and dependents with hospital/ICU confinements of 10 consecutive days or more can receive additional benefits for the duration of their confinement.
- **Complement other plans:** Hospital Indemnity complements Critical Illness, Cancer and Accident coverage in their goal to help protect employees from out-of-pocket medical expenses. Benefits are paid regardless of what other coverages employees may have.

	Employee only	Employee & spouse	Employee & Children	Employee & Family
Low (18) deductions	$8.19	$17.32	$14.21	$23.33
(24) deductions	$6.15	$12.99	$10.66	$17.50
High (18) deductions	$14.35	$29.99	$24.83	$40.47
(24) deductions	$10.77	$22.49	$18.63	$30.35

Hospital Indemnity Insurance is a limited benefit policy. It does NOT provide basic hospital, basic medical, or major medical insurance. It is not a Medicare Supplement policy. The certificate has exclusions, limitations, and benefit waiting periods for certain conditions that may affect any benefits payable. Benefits payable are subject to all terms and conditions of the certificate. The policy, certificate and any rider, if applicable, may not be available in all states and may vary based on state laws and regulations.

Trustmark Universal Life

Universal Life Insurance is designed to provide peace of mind that lasts a lifetime. It offers flexible benefits that combines life insurance protection with the ability to grow cash value over time. Your Universal life policy will include Long-Term Care coverage built-in, and an accelerated benefit for terminal illness. If your policy has earned sufficient cash value, you may borrow from it for any reason at a modest interest rate. You can use the loan for things such as college tuition or mortgage cost. Or you can elect to have a paid-up policy and leave the benefit to pay for final expenses.

Please note that if you choose to enroll in the Universal Life plan after initially declining coverage, your enrollment may require Evidence of Insurability (EOI). If applicable, coverage will remain pending until the EOI is submitted and approved.

Policy Highlights	Benefits
Guarantee Issue Limits Spouse and Child Coverage is Modified Guarantee to Issue	Employee (Ages 18-75): $75,000 Spouse (Ages 18-70): the face amount purchased by $3 per week or $5,000 whichever is greater Child (15 days – 18, or to 22 full-time student): the face amount purchased by $3.02 - $4.31 per week
Maximum Benefit Levels - Requires evidence of Insurability	Employee: $300,000 Spouse: $300,000
Additional Features	
Terminal Illness Rider	If a covered person is diagnosed with a terminal illness, when life expectancy is 24 months or less, up to 75% ($150,000 max) of the policy benefit will be paid.
Long-Term Care (LTC)	Accelerates at 4% monthly as needed, up to 25 months to pay for long-term care at home or in a facility. This benefit does reduce the death benefit.
Death Benefit Restoration	This built-in benefit restores the total amount of death benefit reduced by the LTC each time a benefit is paid. Allows beneficiary to receive the full death benefit.
Fully Portable	This is an individual policy, which belongs to you and when you leave, will simply convert to bill at home.

Rates will vary based on your age, whether you use tobacco, and which benefit amount you select. Spousal rates are based on spouse age; tobacco use and benefit amount.

Age at Purchase	$25,000 Universal Life Policy
30	from $5.06 - $6.27
40	from $7.42 - $9.44
50	from $11.92 - $15.44

Sample rates are shown for illustrative purposes only. Rates may vary by age, smoking status, state, and features included in this policy. An application for insurance must be completed to obtain coverage. Your rate is “locked in” at your age at purchase! Once you have a policy, your rate will never increase due to age.

This summary of benefits is intended only to be a highlight of some of the most elected benefits. Please refer to your certificate of coverage for an exact description of coverage, exclusions, and limitations.

Identity Theft Protection (Voluntary)

IdentityForce. A Sontiq™ Brand

A shocking amount of information can be found online. From Social Security numbers, bank account numbers and social media profiles. A savvy thief potentially has access to all the data they need to assume someone else's identity, top open credit cards, take out loans, receive medical treatment they do not pay for, collect tax refunds or otherwise cause financial and reputational damage.

Did you know identity theft claims more than 15 million victims a year, which is a new victim every 2 seconds? With identity theft taking months to resolve, it is as important as ever to get the protection you and your family deserve. You can count on IdentityForce for services that help you minimize threats, monitor personal information, and manage recovery if you are ever the victim of identity theft or fraud.

CREDIT PROTECTION SERVICES

Daily Credit Bureau Monitoring — Daily monitoring of your personal records from three credit bureaus.

Credit Report and Score — Provided annually by three credit bureaus.

Score Tracker — Ongoing tracking of your credit score. Downward trends may tell you that new accounts are being opened in your name.

PROACTIVE AND IDENTITY MONITORING SERVICES

Dark Web — Continuous monitoring of the internet – places such as black-market websites, underground chat rooms and forums – to detect suspicious activities before your personally identifiable information (PII) is stolen. You will receive alerts when your SSN, credit card numbers, financial account numbers, medical ID, email, phone number and more are detected.

Social Security Number Monitoring — Reviews names, aliases and addresses associated with your number for signs of fraud.

Credit and Debit Card Monitoring — Be notified when changes, such as your name, address, or a new account holder, are made to your credit or bank accounts.

Sex Offender Notification — Monitors registered sex offenders living near you to ensure an offender has not registered using your name and address.

Comprehensive Identity Monitoring — Additional sources are also monitored, including court records, payday loans, change-of-address and more.

ADVANCED MONITORING SERVICES

High-Risk Financial Monitoring — Receive alerts when new accounts are opened, or changes are made to an existing credit or bank account.

Child Monitoring — Monitors your child's PII to detect changes associated with your child's identity.

Social Monitoring — Proactively protecting your family's reputation and online activity by monitoring popular social media services for information that could be dangerous or damaging.

Password Protector — An easy way to track your account credentials and reduce hacking risks. It also offers a password generator and secure password storage.

Resolving identity theft or fraud can be time-consuming and can sometimes involve expenses, including lawyer fees, loss of wages and more. So, at IdentityForce, we are pleased to offer expense reimbursement insurance to pay covered costs associated with the resolution process.

Plus, as an IdentityForce subscriber, you'll have access to our 24/7, world-class Resolution Center Support Team. Our trusted, experienced fraud resolution team will work with you until your issues are completely resolved.

Cost Per Pay	UltraSecure Premium	
	Employee Only	Family
(18) Deductions	$6.33	11.67
(24) Deductions	$4.75	$8.75

This is just a brief summary of IdentityForce services. Limitations and exclusions apply. Refer to the policy, certificate and riders for complete details.

ComPsych®
GuidanceResources® Worldwide

Employee Assistance (EAP)

Personal issues, planning for life events or simply managing daily life can affect your work, health, and family. Your GuidanceResources program provides support, resources, and information for personal and work-life issues. The program is company-sponsored, confidential, and provided at no charge to you and your dependents.

This summary explains how GuidanceResources can help you and your family deal with everyday challenges.

Confidential Counseling - 3 Session Plan

This no-cost counseling service helps you address stress, relationship, and other personal issues you and your family may face. It is staffed by GuidanceConsultants©—highly trained master's and doctoral level clinicians who will listen to your concerns and quickly refer you to in-person counseling (up to 3 sessions per issue per year) and other resources for:

› Stress, anxiety and depression ›Job pressures ` › Relationship/marital conflicts › Grief and loss
› Problems with children › Substance abuse

Financial Information and Resources - *Discover your best options*.
Speak by phone with our Certified Public Accountants and Certified Financial Planners on a wide range of financial issues, including:

› Getting out of debt › Retirement planning › Credit card or loan problems › Estate planning
› Tax questions › Saving for college

Legal Support and Resources - Expert info when you need it.
Talk to our attorneys by phone. If you require representation, we'll refer you to a qualified attorney in your area for a free 30-minute consultation with a 25% reduction in customary legal fees thereafter. Call about:

› Divorce and family law › Real estate transactions › Debt and bankruptcy › Civil and criminal actions
› Landlord/tenant issues › Contracts

Work-Life Solutions - Delegate your "to-do" list.

Our Work-Life specialists will do the research for you, providing qualified referrals and customized resources for:
› Child and elder care › College planning › Home repair
› Moving and relocation › Pet care › Making major purchases

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GuidanceResources Online is your one stop for expert information on the issues that matter most to you... relationships, work, school, children, wellness, legal, financial, free time and more.

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EstateGuidance® lets you quickly and easily write a will on your computer. Just go to www.guidanceresources.com and click on the EstateGuidance link. Follow the prompts to create and download your will at no cost. Online support and instructions for executing and filing your will are included. You can:

› Name an executor to manage your estate › Choose a guardian for your children
› Specify your wishes for your property › Provide funeral and burial instructions

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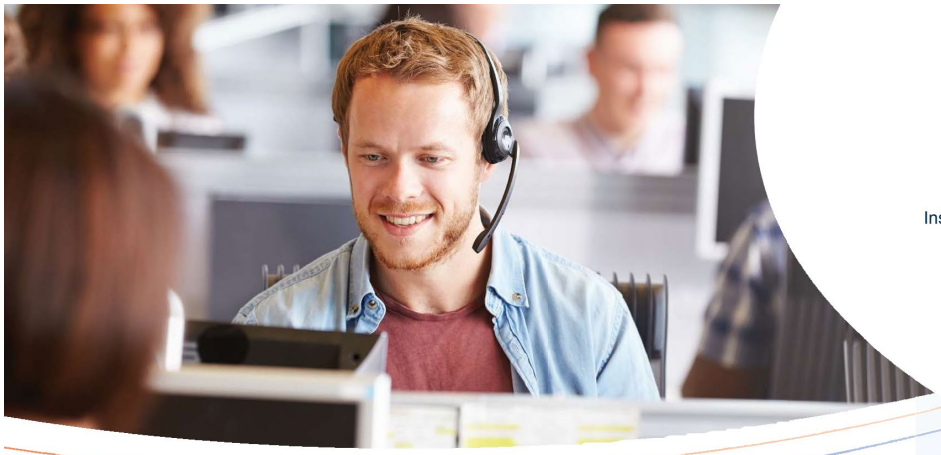

Gallagher

Insurance | Risk Management | Consulting

Ask Your Advocate Team

Maximize your healthcare benefits with the help of a team of licensed healthcare advocates.

Gallagher is ready to help you get the most from your benefits program by providing support from an advocate at no cost to you. Get assistance with:

1. **Enrollment support**
   Need help enrolling in your company's benefits during annual enrollment, a life event or if you're newly hired?
2. **Insurance cards**
   Are you missing your insurance cards, need replacement cards or need to get in touch with an insurance carrier?
3. **Benefits questions**
   Do you need help with specific benefits questions relating to how plans work, coverage questions or in-network benefits?
4. **Eligibility rules**
   Who can be covered under the plan and when?
5. **Provider search**
   Do you need help finding an in-network or specialty provider?
6. **Prescription/pharmacy issues**
   Is the pharmacy telling you that your medication is not covered or charging you the full price? Do you need help getting a pre-authorization for your medication?
7. **Claim/complex issues**
   Are you unsure if your insurance will pay for a certain procedure? Do you have a complex situation and need assistance with an appeal, billing coding issue or out-of-network claim?
8. **Nurse advocacy**
   Do you need assistance with a medical diagnosis, treatment options, pre-authorization issues, specific benefits or drug denial?

Hours of operation

Monday-Friday
8 a.m. – 6 p.m. in local time zone

Connect with us

Chardon Local Schools

(833) 887-4955
bac.chardon@ajg.com

Translation services available

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Notices

The following Notices are required by the laws surrounding health care plans. Please review these notices. If you have any questions, please contact Deb Armbruster at 440-286-0404 or Jennifer Roseberry at 440-285-8408.

Summary of Benefits and Coverage (SBC)
As part of the Affordable Care Act, healthcare companies and group health plans must now provide Summary of Benefits and Coverage documents, or SBCs, to help employers, their employees and their families, understand and compare health plans. The SBC and Uniform Glossary are meant to help consumers understand their healthcare coverage, as well as understand common terms used by health plans. Insurance companies and group health plans must provide SBCs in a standard format, and the SBCs can only differ regarding specific plan benefits. This standard format will make it easier for employers and employees to compare plans and shop for a plan that best meets their needs.
The Medical and Prescription drug plan SBC will be distributed during open enrollment and will also be posted to our benefits website.

Evergreen Election
For those employee benefit programs that allow for employee payroll deductions to be taken on a pre-tax basis, the district's Section 125 Plan allow for such pre-tax deductions. As allowable by law, employee's payroll deductions will be taken on a pre-tax basis unless the employee notifies the Plan Administrator and completes an election form declining participation. Any change will be effective as of the first day of the new plan year. The salary adjustment amounts will be adjusted automatically to reflect any increase or decrease in the cost of the plans selected. This "evergreen" election applies to all plans as allowable by law to be taken on a pre-tax basis.

USERRA
Your right to continued participation in the Plan during leaves of absence for active military duty is protected by the Uniformed Services Employment and Reemployment Rights Act (USERRA). Accordingly, if you are absent from work due to a period of active duty in the military for less than 31 days, your Plan participation will not be interrupted.

If you do not elect to continue to participate in the Plan during an absence for military duty that is more than 31 days, you and your covered family members will have the opportunity to elect COBRA Continuation Coverage only under the medical insurance policy for the 24-month period (18-month period if you elected coverage prior to December 10, 2004) that begins on the first day of your leave of absence. You must pay the premiums for Continuation Coverage with after-tax funds, subject to the rules that are set out in that plan.

Newborns and Mothers Health Protection Act (NMHPA)
Group health plans and health insurance issuers generally may not, under Federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or 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 insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

Your Rights After a Mastectomy
Women's Health and Cancer Rights Act of 1998
Under Federal law, Group Health Plans and health insurance issuers providing benefits for mastectomy must also provide, in connection with the mastectomy for which the participant or beneficiary is receiving benefits, coverage for:

- reconstruction of the breast on which the mastectomy has been performed; and
- surgery and reconstruction of the other breast to produce a symmetrical appearance; and
- prostheses and physical complications of mastectomy, including lymphedemas;

These services must be provided in a manner determined in consultation between the attending Physician and the patient. Contact your plan administrator for more information: Crystal King-Morrison at 440-286-0408.

HIPAA Special Enrollment Notice

Chardon Local Schools Health Plan Notice of Your HIPAA Special Enrollment Rights

Our records show that you are eligible to participate in the Chardon Local Schools Health Plan (to actually participate, you must complete an enrollment form and pay part of the premium through payroll deduction).

A federal law called HIPAA requires that we notify you about an important provision in the plan - your right to enroll in the plan under its "special enrollment provision" if you acquire a new dependent, or if you decline coverage under this plan for yourself or an eligible dependent while other coverage is in effect and later lose that other coverage for certain qualifying reasons.

Loss of Other Coverage (Excluding Medicaid or a State Children's Health Insurance Program). If you decline enrollment for yourself or for an eligible dependent (including your spouse) while other health insurance or group health plan coverage is in effect, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing toward your or your dependents' other coverage). However, you must request enrollment within 30 days after your or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage).

Loss of Coverage for Medicaid or a State Children's Health Insurance Program. If you decline enrollment for yourself or for an eligible dependent (including your spouse) while Medicaid coverage or coverage under a state children's health insurance program is in effect, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage. However, you must request enrollment within 60 days after your or your dependents' coverage ends under Medicaid or a state children's health insurance program.

New Dependent by Marriage, Birth, Adoption, or Placement for Adoption. 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 new dependents. However, you must request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption.

Eligibility for Premium Assistance Under Medicaid or a State Children's Health Insurance Program – If you or your dependents (including your spouse) become eligible for a state premium assistance subsidy from Medicaid or through a state children's health insurance program with respect to coverage under this plan, you may be able to enroll yourself and your dependents in this plan. However, you must request enrollment within 60 days after your or your dependents' determination of eligibility for such assistance.

To request special enrollment or to obtain more information about the plan's special enrollment provisions, contact Deb Armbruster - . Treasurer at 440.286.0404 or deb.armbruster@chardonschools.org.

Important Warning

If you decline enrollment for yourself or for an eligible dependent, you must complete our form to decline coverage. On the form, you are required to state that coverage under another group health plan or other health insurance coverage (including Medicaid or a state children's health insurance program) is the reason for declining enrollment, and you are asked to identify that coverage. If you do not complete the form, you and your dependents will not be entitled to special enrollment rights upon a loss of other coverage as described above, but you will still have special enrollment rights when you have a new dependent by marriage, birth, adoption, or placement for adoption, or by virtue of gaining eligibility for a state premium assistance subsidy from Medicaid or through a state children's health insurance program with respect to coverage under this plan, as described above. If you do not gain special enrollment rights upon a loss of other coverage, you cannot enroll yourself or your dependents in the plan at any time other than the plan's annual open enrollment period, unless special enrollment rights apply because of a new dependent by marriage, birth, adoption, or placement for adoption, or by virtue of gaining eligibility for a state premium assistance subsidy from Medicaid or through a state children's health insurance program with respect to coverage under this plan.

HIPAA Notice of Privacy Practices Reminder

Protecting Your Health Information Privacy Rights

Chardon Local Schools is committed to the privacy of your health information. The administrators of the Chardon Local Schools Health Plan (the "Plan") use strict privacy standards to protect your health information from unauthorized use or disclosure.

The Plan's policies protecting your privacy rights and your rights under the law are described in the Plan's Notice of Privacy Practices. You may receive a copy of the Notice of Privacy Practices by contacting Deb Armbruster – Treasurer at 440.286.0404 or deb.armbruster@chardonschools.org.

The Affordable Care Act

The Affordable Care Act requires most people to have health care coverage that qualifies as "minimum essential coverage." This plan does provide minimum essential coverage.

The Affordable Care Act establishes a minimum value standard of benefits of a health plan. The minimum value standard is 60% (actuarial value). This health coverage does meet the minimum value standard for the benefits it provides.

Notice of Creditable Coverage

Important Notice from Chardon Board of Education

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 Chardon Board of Education 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. **Chardon Board of Education has determined that the prescription drug coverage offered by the medical plan 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.**

When Can You Join a Medicare Drug Plan?

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

What Happens to Your Current Coverage if You Decide to Join a Medicare Drug Plan?

If you decide to join a Medicare drug plan, your current Chardon Board of Education coverage will not be affected.
If you do decide to join a Medicare drug plan and drop your current Chardon Board of Education coverage, be aware that you and your dependents will not be able to get this coverage back, until annual open enrollment.

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 Chardon Board of Education 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 Chardon Board of Education 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:	**October 15, 2026**
Name of Entity/Sender:	**Chardon Board of Education**
Contact—Position/Office:	**Deb Armbruster - Treasurer**
Office Address:	**428 North St** **Chardon, Ohio 44024-1036** **United States**
Phone Number:	**440.286.0404**

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

If you or your children are eligible for Medicaid or CHIP and you're eligible for health coverage from your employer, your state may have a premium assistance program that can help pay for coverage, using funds from their Medicaid or CHIP programs. If you or your children aren't eligible for Medicaid or CHIP, you won't be eligible for these premium assistance programs but you may be able to buy individual insurance coverage through the Health Insurance Marketplace. For more information, visit **www.healthcare.gov**.

If you or your dependents are already enrolled in Medicaid or CHIP and you live in a State listed below, contact your State Medicaid or CHIP office to find out if premium assistance is available.

If you or your dependents are NOT currently enrolled in Medicaid or CHIP, and you think you or any of your dependents might be eligible for either of these programs, contact your State Medicaid or CHIP office or dial **1-877-KIDS NOW** or **www.insurekidsnow.gov** to find out how to apply. If you qualify, ask your state if it has a program that might help you pay the premiums for an employer-sponsored plan.

If you or your dependents are eligible for premium assistance under Medicaid or CHIP, as well as eligible under your employer plan, your employer must allow you to enroll in your employer plan if you aren't already enrolled. This is called a "special enrollment" opportunity, and **you must request coverage within 60 days of being determined eligible for premium assistance**. If you have questions about enrolling in your employer plan, contact the Department of Labor at **www.askebsa.dol.gov** or call **1-866-444-EBSA (3272).**

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of July 31, 2026. Contact your State for more information on eligibility –

ALABAMA – Medicaid	ALASKA – Medicaid
Website: http://myalhipp.com/ Phone: 1-855-692-5447	The AK Health Insurance Premium Payment Program Website: http://myakhipp.com/ Phone: 1-866-251-4861 Email: CustomerService@MyAKHIPP.com Medicaid Eligibility: https://health.alaska.gov/dpa/Pages/default.aspx
ARKANSAS – Medicaid	**CALIFORNIA – Medicaid**
Website: http://myarhipp.com/ Phone: 1-855-MyARHIPP (855-692-7447)	Health Insurance Premium Payment (HIPP) Program Website: http://dhcs.ca.gov/hipp Phone: 916-445-8322 Fax: 916-440-5676 Email: hipp@dhcs.ca.gov

COLORADO – Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)	FLORIDA – Medicaid
Health First Colorado Website: https://www.healthfirstcolorado.com/ Health First Colorado Member Contact Center: 1-800-221-3943/State Relay 711 CHP+: https://hcpf.colorado.gov/child-health-plan-plus CHP+ Customer Service: 1-800-359-1991/State Relay 711 Health Insurance Buy-In Program (HIBI): https://www.mycohibi.com/ HIBI Customer Service: 1-855-692-6442	Website: https://www.flmedicaidtplrecovery.com/flmedicaidtplrecovery.com/hipp/index.html Phone: 1-877-357-3268

GEORGIA – Medicaid	ILLINOIS - 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	Illinois Medicaid Premium Assistance Information Medicaid application website: https://abe.illinois.gov HIPP Hotline Number: 217-524-8268 HIPP Email: hfs.boc.hipp@illinois.gov

INDIANA – Medicaid	IOWA – Medicaid and CHIP (Hawki)
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	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

KANSAS – Medicaid	KENTUCKY – Medicaid
Website: https://www.kancare.ks.gov/ Phone: 1-800-792-4884 HIPP Phone: 1-800-967-4660	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

LOUISIANA – Medicaid	MAINE – Medicaid
Louisiana Medicaid Website: https://www.ldh.la.gov/healthy-louisiana Medicaid Customer Service Line: 1-888-342-6207 Louisiana Medicaid email: healthy@la.gov Louisiana Health Insurance Premium Program (LaHIPP) Website: https://www.ldh.la.gov/lahipp LaHIPP phone: 1-877-697-6703 LaHIPP email: La.HIPP@la.gov LaHIPP fax: 1-888-716-9787 LaHIPP mailing address: 100 Crescent Centre Parkway, Suite 1000 Tucker, GA 30084	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	MINNESOTA – Medicaid
Website: https://www.mass.gov/masshealth/pa Phone: 1-800-862-4840 TTY: 711 Email: masspremassistance@accenture.com	Website: https://mn.gov/dhs/health-care-coverage/ Phone: 1-800-657-3672

MISSOURI – Medicaid	MONTANA – Medicaid
Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005	Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084 Email: HHSHIPPProgram@mt.gov

NEBRASKA – Medicaid	NEVADA – Medicaid
Website: http://www.ACCESSNebraska.ne.gov Phone: 1-855-632-7633 Lincoln: 402-473-7000 Omaha: 402-595-1178	Medicaid Website: http://dhcfp.nv.gov Medicaid Phone: 1-800-992-0900

NEW HAMPSHIRE – Medicaid	NEW JERSEY – Medicaid and CHIP
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	Medicaid Website: https://www.nj.gov/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	NORTH CAROLINA – Medicaid
Website: https://www.health.ny.gov/health_care/medicaid/ Phone: 1-800-541-2831	Website: https://medicaid.ncdhhs.gov/ Phone: 919-855-4100

NORTH DAKOTA – Medicaid	OKLAHOMA – Medicaid and CHIP
Website: https://www.hhs.nd.gov/healthcare Phone: 1-844-854-4825	Website: http://www.insureoklahoma.org Phone: 1-888-365-3742
OREGON – Medicaid	**PENNSYLVANIA – Medicaid and CHIP**
Website: http://healthcare.oregon.gov/Pages/index.aspx Phone: 1-800-699-9075	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	**SOUTH CAROLINA – Medicaid**
Website: http://www.eohhs.ri.gov/ Phone: 1-855-697-4347, or 401-462-0311 (Direct RIte Share Line)	Website: https://www.scdhhs.gov Phone: 1-888-549-0820
SOUTH DAKOTA - Medicaid	**TEXAS – Medicaid**
Website: http://dss.sd.gov Phone: 1-888-828-0059	Website: Health Insurance Premium Payment (HIPP) Program | Texas Health and Human Services Phone: 1-800-440-0493
UTAH – Medicaid and CHIP	**VERMONT– Medicaid**
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/	Website: Health Insurance Premium Payment (HIPP) Program | Department of Vermont Health Access Phone: 1-800-250-8427
VIRGINIA – Medicaid and CHIP	**WASHINGTON – Medicaid**
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	Website: https://www.hca.wa.gov/ Phone: 1-800-562-3022

WEST VIRGINIA – Medicaid and CHIP	WISCONSIN – 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)	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, 2026, or for more information on special enrollment rights, contact either:

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

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

Paperwork Reduction Act Statement

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

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

OMB Control Number 1210-0137 (expires 5/31/2029)

Your Rights and Protections Against Surprise Medical Bills

When you get emergency care or get treated by an out-of-network provider at an in-network hospital or ambulatory surgical center, or from an out-of-network air ambulance service, you are protected from surprise billing or balance billing.

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, such as a copayment, coinsurance, and/or a deductible. You may have other 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" describes providers and facilities that haven't signed a contract with your health plan. Out-of-network providers may be permitted to bill you for the difference between what your plan agreed to pay 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 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.

You are 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 the provider or facility may bill you is your plan's in-network cost-sharing amount (such as copayments and coinsurance). 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 balanced billed for these post-stabilization services.

If you believe you've been wrongly billed, or you did not receive the required disclosure form, please contact Customer Service number listed on your Member ID card. Unresolved issues can be directed to the Ohio Department of Insurance Monday through Friday 8 a.m. to 5 p.m. at 800.686.1526 or visit the ODI website to file a complaint.

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 may 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.

The contents of this document do not have the force and effect of law and are not meant to bind the public in any way, unless specifically incorporated into a contract. This document is intended only to provide clarity to the public regarding existing requirements under the law.

If you get other 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.

If you get other 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 care out-of-network. You can choose a provider or facility in your plan's network.

If you believe you've been wrongly billed, or you did not receive the required disclosure form, please contact Customer Service number listed on your Member ID card. Unresolved issues can be directed to the Ohio Department of Insurance Monday through Friday 8 a.m. to 5 p.m. at 800.686.1526 or visit the ODI website Surprise Billing Resources | Department of Insurance to file a complaint.

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

- You are only responsible for paying your share of the cost (like the copayments, coinsurance, and deductibles that you would pay if the provider or facility was in-network). Your health plan will pay out-of-network providers and facilities directly.
- Your health plan generally must:
    - Cover emergency services without requiring you to get approval for services in advance (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 deductible and out-of-pocket limit.

If you believe you've been wrongly billed, you may contact the Ohio Department of Insurance Monday through Friday 8 a.m. to 5 p.m. at 800.686.1526.

Visit the ODI website Surprise Billing Resources | Department of Insurance for more information about your rights under federal law.

Contacts

Vendor	Phone Number	Website
Medical Medical Mutual OH	(800) 585-2583	www.medmutual.com
FSA Inspira Financial (Previously Payflex)	(844) 729-3539	inspirafinancial.com
Dental Aetna Dental	(877) 238-6200	www.aetna.com
Vision Sun Life	(800) 877-7195	www.sunlife.com
Short-Term Disability Sun Life	(800) 247-6875	www.sunlife.com
Long-Term Disability Sun Life	(800) 247-6875	www.sunlife.com
Accident Sun Life	(800) 247-6875	www.sunlife.com
Critical Illness Hospital Indemnity Sun Life	(800) 247-6875	www.sunlife.com
Basic Life & Voluntary Life One America	(800) 553-5318	www.oneamerica.com
Universal Life Trustmark	(888) 763-7474	www.trustmark.com
Identity Theft Sontiq Identity Force	(855) 441-0270	www.identityforce.com
EAP ComPsych	(855) 387-9727	www.guidanceresources.com ID: ONEAMERICA3
Gallagher Benefit Advocate Center bac.chardon@ajg.com	(833) 887-4955	

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This benefit summary prepared by

Gallagher

Insurance | Risk Management | Consulting

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