

Warren County Public Schools

2025

BENEFIT GUIDE



**We will empower everyone to achieve
excellence by sparking inspiration and
learning through innovation.**



www.wcpsva.org



YOUR BENEFITS PACKAGE

Our most important asset is our people. That's why Warren County Public Schools offers a comprehensive benefits program to meet all your needs. Review this guide to learn about everything provided to you and to determine which benefits are best for you and your family. You will find many resources outlined in this guide available during enrollment and throughout the year to help you make the most of your benefits plans and answer your questions.

This Benefit Summary does not provide all of the details about all of the benefit programs. Additional information is available in each program's Certificate of Coverage (COC). The COC's are available by request from the Human Resources Department.

This brochure summarizes the coverage that is available during the upcoming 2025 plan year. If you have any questions, please contact Human Resources.

Have Questions or Need More Information:

Check out our Human Resource Page

wcpsva.org/hr

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ELIGIBILITY

You are eligible for Warren County Public School benefits on the first of the month following your date of hire.

You may enroll your eligible dependents in the same plans you choose for yourself. Eligible dependents include your legal spouse and your children up to age 26.

WHEN TO ENROLL

You can enroll for coverage within 30 days of your eligibility date or during the annual open enrollment period. If you do not enroll for coverage within 30 days of your eligibility date, you will not be able to elect coverages during the Plan Year unless you have a qualified change in family status.

MAKING CHANGES

The choices you make when you are first eligible remain in effect for the plan year which ends on September 30, 2024. Once you enroll for coverage, you must wait until the next open enrollment period to change your benefits and add or remove coverage for dependents, unless you have a qualified change in family status as defined by the IRS.

The following are a few examples:

- Marriage, divorce, legal separation, or annulment
- Birth or adoption of a child
- Loss of other health coverage
- Change in health coverage due to your spouse's annual Open Enrollment period
- Change in eligibility for you or a dependent for Medicaid or Medicare
- Change in your or your spouse's work status that affects your benefits or an eligible dependent's benefits

Under IRS code if you have experienced a qualifying event and need to make changes to your coverage you have 30 days from the event to notify Human Resources

All enrollments and changes made during open enrollment will begin on October 1, 2025.

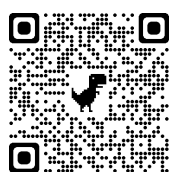


MEDICAL COVERAGE

As a foundation for your good health, Warren County Public Schools provides a selection of medical plans offering quality, flexibility and value. Choose the plan that best meets your needs. Visit www.Anthem.com or download the Anthem Sydney app for additional features such as Find a Provider, Manage Claims, Manage Prescriptions, View Health Programs, and much more!

This is a summary of benefits for informational purposes only. Please refer to the Carrier Certificate of Coverage for complete terms of coverage and eligibility.

Plan Details	\$250 Deductible Plan	\$1,000 Deductible Plan	\$3,300 HSA Plan
In Network Coverage			
Deductible (Single/Family)	\$250/\$500	\$1,000/\$2,000	\$3,300/\$6,600
Out of Pocket Max (Single/Family)	\$3,000/\$6,000	\$5,000/\$10,000	\$5,000/\$10,000
Coinsurance	20%	20%	20%
Physician Office Visit	\$20 copay	\$25 copay	Deductible then 20%
Specialist Office Visit	\$35 copay	\$40 copay	Deductible then 20%
Preventive Care	100% covered	100% covered	100% covered
Emergency Room	\$400 copay	Deductible then 20%	Deductible then 20%
Urgent Care	\$35 copay	\$40 copay	Deductible then 20%
Labs & X Rays	Deductible then 20%	Deductible then 20%	Deductible then 20%
Diagnostic Services (MRI, PET, etc.)	Deductible then 20%	Deductible then 20%	Deductible then 20%
Outpatient Hospital Services	\$150 copay	Deductible then 20%	Deductible then 20%
Inpatient Hospital Services	\$400 copay	Deductible then 20%	Deductible then 20%
Prescription Drugs			
Tier 1	\$10 copay	\$10 copay	Medical Deductible then 20%
Tier 2	\$30 copay	\$30 copay	Medical Deductible then 20%
Tier 3	\$45 copay	\$45 copay	Medical Deductible then 20%
Tier 4	\$55 copay	\$55 copay	Medical Deductible then 20%
Out of Network Coverage			
Deductible (Single/Family)	\$500/\$1,000	\$2,000/\$4,000	\$3,300/\$6,600
Coinsurance	30%	30%	40%
Out of Pocket Max (Single/Family)	\$5,000/\$10,000	\$9,000/\$18,000	\$10,000/\$20,000



Scan Now to Download the
Anthem Sydney App to
access your benefits online!



ANTHEM RESOURCES AND PROGRAMS

Sydney Health Mobile App

The Sydney Health mobile app acts like a personal health assistant, answering your questions and connecting you to the right resources at the right time. With just one click you can find care and check cost, check all benefits, view claims, view ID cards, and access LiveHealth Online.

Download from the App Store (iOS) or Google Play (Android).

LiveHealth Online Services

Available through the Sydney App, LiveHealth Online Services allows you to use your device to set up an appointment with a specialist or see an urgent care provider 24/7:

- LiveHealth Online Medical
- LiveHealth Online Psychology
- LiveHealth Online Psychiatry
- LiveHealth Online EAP
- LiveHealth Online Healthy Sleep
- LiveHealth Online Dermatology

ConditionCare

Take advantage of free and confidential support to manage these conditions: Asthma, Heart failure, Diabetes, Chronic obstructive pulmonary disease (COPD), Coronary artery disease (CAD), and Hypertension. You may receive a call from ConditionCare if your claims indicate you or an enrolled family member may be dealing with one or more of these conditions. While you're encouraged to enroll and take advantage of help from registered nurses and other healthcare professionals, you may also opt out of the program when they call.

Future Moms

Enroll within the first 16 weeks for free pre-and post-natal support. Access a nurse coach and other maternity support specially designed to help women have healthy pregnancies and healthy babies.

MyHealth Advantage

Receive personalized health-related suggestions, tips, and reminders via mail or email to alert you of potential health risks, care gaps or cost-saving opportunities.

24/7 NurseLine & Audio Health Library

Sometimes you need health questions answered right away – even in the middle of the night. Call 24/7 NurseLine (800-337-4770) to speak with a nurse. Or use the Audio Health Library if you want to learn about a health topic on your own. Your call is always free and completely confidential.



DENTAL COVERAGE

Strong teeth and gums are an important part of good health. Dental Insurance helps you pay for most necessary dental services and supplies, including diagnosis and preventive care, basic and restorative services and major services.

Visit Your Dentist Regularly

Regular preventive visits to your dentist can help protect your health. According to the Centers for Disease Control and Prevention, there may be associations between oral infections and diabetes, heart disease, stroke, and preterm, low-weight births. Research is underway to further examine these connections.

Find a Dentist

Visit www.DeltaDentalVA.com or download the Delta app



Remember!

If you enrolled in a medical plan you are also enrolled in one of the Dental plans and Vision plan



	Preventive Option	Comprehensive Option
Annual Deductible Individual Family	N/A	\$25 \$75
Annual Maximum Paid by Plan	N/A	\$1,500
Diagnostic and Preventive Services (X-rays, Cleanings, Exams)	100% covered	100%
Basic and Restorative Services (Fillings, Extractions, Root Canals)	No Benefits	80%
Major Services (Dentures, Crowns, Bridges, Implants)	No Benefits	50%
Orthodontia Adults & Children	No Benefits	50%
Orthodontia Lifetime Max	No Benefits	\$1,500



VISION CARE

The vision plan includes benefits for eye exams, eyeglasses, and contact lenses. Visit an in-network provider to take advantage of higher benefits coverage, or visit an out-of-network provider for a reduced benefit.

Visit www.anthem.com/tlc to find a vision provider.



Remember!

If you enrolled in a medical plan you are also enrolled in one of the Dental plans and Vision plan

Plan Features	In-Network Benefits
Exam (<i>once every 12 months</i>)	\$35 copay for the \$250 Deductible Plan \$40 copay for the \$1,000 Deductible Plan \$15 copay for the \$3,200 Deductible Plan
Frames (<i>once every 12 months</i>)	\$100 allowance + 20% off balance over allowance
Lenses (<i>once every 12 months</i>)	
Single Vision	\$20 copay
Bifocal	\$20 copay
Trifocal	\$20 copay
Progressive	\$65 copay
Contact Lenses—In lieu of lenses and frames (<i>once every 12 months</i>)	
Medically Necessary	\$250 allowance
Elective	\$100 allowance



EMPLOYEE ASSISTANCE PROGRAM (EAP)

It's good to know you aren't alone. Balancing your work and home life is not always easy. With Anthem's EAP, you don't have to face life's challenges alone. Anthem's EAP provides support and guidance for matters that range from personal issues you might be facing to providing information on every day topics that affect your life.

EAP consultants are trained to understand your concerns so they can connect you with the service best able to help you. Turn to your EAP for information and resources about:

- Emotional well-being
- Addiction and Recovery
- Work and Career
- Childcare and parenting
- Helping aging parents
- Financial issues
- Legal concerns
- Smoking cessation

One call puts you in touch with a clinician, counselor, mediator, lawyer, or financial adviser who could help change your life for the better.

Your EAP gives you, your covered dependents and members of your household up to 4 free confidential counseling sessions per issue each plan year.

To Access Services:
Call 855-223-9277, or visit
www.anthemEAP.com
Company Name: Commonwealth of Virginia
Select: The Local Choice



Allstate
Benefits

ALLSTATE SUPPLEMENTAL PLANS

ACCIDENT INSURANCE

Today, active lifestyles in or out of the home may result in bumps, bruises and sometimes breaks. Getting the right treatment can be vital to recovery, but it can also be expensive. And if an accident keeps you away from work during recovery, the financial worries can grow quickly. Allstate coverage can help pick up where other insurance leaves off and provide cash to help cover the expenses. Allstate coverage pays you cash benefits that correspond with hospital and intensive care confinement. The plan also includes coverage for a variety of occurrences, such as: dismemberment; dislocation or fracture; ambulance services; physical therapy and more. The cash benefits can be used to help pay for deductibles, treatment, rent and more.

VOLUNTARY CANCER INSURANCE

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 Allstate Benefits, you can rest a little easier. Allstate coverage pays you a cash benefit to help with the costs associated with treatments, to pay for daily living expenses, and more importantly, to empower you to seek the care you need. You choose the coverage that's right for you and your family. Allstate Cancer insurance pays cash benefits for cancer and 29 specified diseases to help with the cost of treatments and expenses as they happen. Benefits are paid directly to you.

CRITICAL ILLNESS INSURANCE

No one is ever really prepared for a life-altering critical illness diagnosis. The whirlwind of appointments, tests, treatments and medications can add to your stress levels. Critical Illness coverage helps provide financial support if you are diagnosed with a covered critical illness. With the expense of treatment often high, seeking the treatment you need could seem like a financial burden. When a diagnosis occurs, you need to be focused on getting better and taking control of your health, not stressing over financial worries. With Allstate you choose benefits to protect yourself and any family members if diagnosed with a critical illness. Then, if diagnosed with a covered critical illness, you will receive a cash benefit based on the percentage payable for the condition.

GROUP WHOLE LIFE INSURANCE

With Group Whole Life Insurance you can provide your family with financial peace of mind for the future and the journey to get there. Not only do you get protection for your lifetime, but you also have the ability to build cash value as you go. With Group Whole Life Insurance you get simplified and straightforward coverage. You decide how much coverage and who to cover. You get guaranteed rates for the life of the policy and a guaranteed death benefit to be paid to your beneficiaries. As the policy builds cash value, you can achieve your financial goals or borrow against it should you need to.

FLEXIBLE SPENDING ACCOUNTS (FSA)

Warren County Public Schools offers Flexible Spending Accounts (FSAs) through CPN Flex. FSAs help you pay for eligible medical, dental, vision, and dependent care out-of-pocket costs by allowing you to set aside pre-tax contributions

How It Works

You determine the amount you wish to have deducted from each paycheck, and the funds are automatically deposited to your account(s). You may only use Health Care FSA money for health care expenses and Dependent Care FSA for funds for dependent care expenses. You cannot mix funds from one account to another. You must re-enroll each year to continue funding the account(s), and you can incur expenses only during the plan year you are enrolled. Unused health care amounts over \$640, and all unused dependent care funds will be forfeited, so estimate wisely.

Contribution Limits

The Internal Revenue Service (IRS) sets the annual contribution levels for FSAs. You are responsible for monitoring the amounts deposited into your accounts not to exceed the maximum annual limits.

For 2025, the FSA contribution limits are as follows:

- **Health Care FSA: \$3,300**
- **Dependent Care FSA: \$5,000 per household (\$2,500 if married, filing separately)**

Eligible Expenses

Use your Health Care FSA funds to pay for out-of-pocket medical, dental, hearing, and vision expenses such as copays, prescriptions, supplies, appliances, and some OTC items. Visit irs.gov/forms-pubs/about-publication-502 to see a complete list of IRS-qualified healthcare expenses.

Use Dependent Care FSA funds to pay for qualified daycare expenses for children aged 12 and younger and a spouse or an adult-dependent incapable of self-care. Eligible expenses include daycare, preschool, summer day camp, elder care, and in-home aids. Visit irs.gov/publications/p503 to see a complete list of IRS-qualified dependent care expenses.



**Contact CPN Flex:
Visit www.cpnflex.com
Or Call 800-737-0125**



HEALTH SAVINGS ACCOUNT (HSA)

When you elect to enroll in the HDHP medical plan, you are eligible to open a Health Savings Account (HSA). An HSA allows you to save money on a tax-free basis to use for your out-of-pocket health care expenses. You are the owner of this account, and unlike a traditional Flexible Spending Account, your funds can roll over from year-to-year and build over time. You have the opportunity to have pre-tax dollars deducted from your paycheck and deposited into this account, or you can make post-tax deposits as you wish.

To help you build your HSA, Warren County Public Schools will make a contribution of \$1,000 when you enroll during annual open enrollment.

What are the advantages of participating?

- Pre-tax savings – never pay the federal government taxes on your HSA funds as long as you spend the money on eligible IRS 213(d) health care (medical, dental, vision) expenses
- Unused funds carry over from year to year and can build over time
- Complete control over how and when funds are used
- Balances over a certain amount may have investment opportunities
- Funds remaining in your account after you reach the age of 65 can be used for non-medical expenses with ordinary taxes paid, similar to a 401(k)
- HSAs are portable; if you leave the company, you can take the account and all funds in it with you

For the **2025** plan year, an individual can contribute up to \$4,300 or \$8,550 for a family.

Ages 55+ may contribute an additional \$1,000 catch-up.



McGriff HSA Member Services:
Phone: 800-768-4873
E-Mail: flexinquiry@mcgriff.com

RETIREMENT, LIFE, AND SHORT TERM DISABILITY

Virginia Retirement System (VRS)

Retirement benefits are offered through VRS.

VRS Plan 1 is a defined benefit plan. The retirement benefit is based on your age, creditable service and average final compensation at retirement using a formula. You are in VRS Plan 1 if your membership date is before July 1, 2010, and you were vested as of January 1, 2013.

VRS Plan 2 is a defined benefit plan. The retirement benefit is based on your age, creditable service and average final compensation at retirement using a formula. You are in VRS Plan 2 if your membership date is from July 1, 2010, to December 31, 2013, or your membership date is before July 1, 2010, and you were not vested as of January 1, 2013.

The Hybrid Retirement Plan combines the features of a defined benefit plan and a defined contribution plan. The plan applies to most members whose membership date is on or after January 1, 2014, and to VRS Plan 1 and VRS Plan 2 members who were eligible to opt into the plan during the special election window in 2014.

Please see Human Resources or the Personnel webpage for more details.

VRS Optional Life Insurance

Virginia Retirement System offers optional life insurance.

Employee Optional Life: 1-8x your salary
Spouse Life: .5x, 1x, 1.5x, or 2x your salary
Child Life: \$10,000, \$20,000, or \$30,000

To apply for the VRS Optional Life coverage go to myVRS.
Additional resources are available upon request.

VRS Short-Term Disability (STD)

Employees assigned to the VRS Hybrid Plan, “hired on or after January 1, 2014,” are automatically enrolled in the required VRS administered Local Disability Program.

Employees must complete one year of continuous employment with Warren County Public Schools in order to have coverage under the Short Term Disability plan (STD).

Employees who have reached the maximum period for which they are eligible to receive STD benefits may be eligible for long-term disability as prescribed by the VRS disability retirement program.

Please see Human Resources or the Personnel webpage for more details.



YOUR COST FOR COVERAGE: **WITH PREVENTIVE DENTAL**

Your monthly payroll deductions for health, dental and vision coverage are shown in the tables below:

Anthem \$250 Deductible Plan (includes health, preventive dental, and vision coverage)

Coverage Tier	Total Monthly Premium	WCPS Monthly Contribution	Employee Monthly Contribution
Employee Only	\$918	\$762	\$156
Employee & Child	\$1,699	\$1,201	\$498
Employee & Spouse	\$1,699	\$1,008	\$691
Family	\$2,480	\$1,261	\$1,219
Dual Emp & Spouse	\$1,699	\$1,699	\$0
Dual Family	\$2,480	\$2,480	\$0

Anthem \$1,000 Deductible Plan (includes health, preventive dental, and vision coverage)

Coverage Tier	Total Monthly Premium	WCPS Monthly Contribution	Employee Monthly Contribution
Employee Only	\$794	\$753	\$41
Employee & Child	\$1,469	\$1,333	\$136
Employee & Spouse	\$1,469	\$1,025	\$444
Employee & Children	\$2,142	\$1,988	\$154
Family	\$2,142	\$1,452	\$690
Dual Emp & Spouse	\$1,469	\$1,469	\$0
Dual Family	\$2,142	\$2,142	\$0

Anthem \$3,300 HDHP HSA Deductible Plan (includes health, preventive dental, and vision coverage)

Coverage Tier	Total Monthly Premium	WCPS Monthly Contribution	Employee Monthly Contribution
Employee Only	\$664	\$664	\$0
Employee & Child	\$1,230	\$1,200	\$30
Employee & Spouse	\$1,230	\$956	\$274
Employee & Children	\$1,795	\$1,747	\$48
Family	\$1,795	\$1,363	\$432
Dual Emp & Spouse	\$1,230	\$1,230	\$0
Dual Family	\$1,795	\$1,795	\$0

YOUR COST FOR COVERAGE: **WITH COMPREHENSIVE DENTAL**

Your monthly payroll deductions for health, dental and vision coverage are shown in the tables below:

Anthem \$250 Deductible Plan (includes health, comprehensive dental, and vision coverage)			
Coverage Tier	Total Monthly Premium	WCPS Monthly Contribution	Employee Monthly Contribution
Employee Only	\$939	\$762	\$177
Employee & Child	\$1,739	\$1,203	\$536
Employee & Spouse	\$1,739	\$1,011	\$728
Family	\$2,538	\$1,264	\$1,274
Dual Emp & Spouse	\$1,739	\$1,737	\$2
Dual Family	\$2,538	\$2,000	\$538

Anthem \$1,000 Deductible Plan (includes health, comprehensive dental, and vision coverage)			
Coverage Tier	Total Monthly Premium	WCPS Monthly Contribution	Employee Monthly Contribution
Employee Only	\$815	\$754	\$61
Employee & Child	\$1,507	\$1,316	\$191
Employee & Spouse	\$1,507	\$1,027	\$480
Employee & Children	\$2,200	\$2,008	\$191
Family	\$2,200	\$1,456	\$744
Dual Emp & Spouse	\$1,508	\$1,506	\$2
Dual Family	\$2,200	\$2,176	\$24

Anthem \$3,300 HDHP HSA Deductible Plan (includes health, comprehensive dental, and vision coverage)			
Coverage Tier	Total Monthly Premium	WCPS Monthly Contribution	Employee Monthly Contribution
Employee Only	\$687	\$687	\$0
Employee & Child	\$1,268	\$1,183	\$85
Employee & Spouse	\$1,268	\$958	\$310
Employee & Children	\$1,853	\$1,768	\$85
Family	\$1,853	\$1,366	\$487
Dual Emp & Spouse	\$1,269	\$1,268	\$1
Dual Family	\$1,853	\$1,852	\$1



























CONTACTS

Benefit	Contact	Telephone	Website
Human Resources	Maria Bolton	540-635-2171	mbolton@wcps.k12.va.us
Medical Pharmacy	Anthem	800-552-2682 833-267-3108	www.anthem.com/tlc
Dental	Delta Dental	888-335-8296	www.DeltaDentalVA.com
Vision	Anthem	800-552-2682	www.anthem.com/tlc
Health Savings Accounts (HSA)	McGriff	800-768-4873	flexinquiry@McGriff.com
Flexible Spending Accounts (FSAs)	CPN Flex	800-737-0125	www.cpnflex.com
Employee Assistance Program (EAP)	Anthem	855-223-9277	www.anthemEAP.com

NOTES

WHERE TO GO GUIDE

The cost for care and time you wait can vary greatly depending on where you go. Below is a simple guide to choosing the right place to go for health care

	Cost	Appointment Needed?	Wait Time	Severity	Conditions Treated
Nurseline	No cost	No			Minor health concerns such as cold and flu symptoms, allergies, sinus and ear infections, family health questions, rashes or skin conditions, minor burns, and vaccinations
Virtual Visit	\$	No			
Convenience Care Clinic	\$\$	No	 		
Primary Care Physician	\$\$	Yes	 		Routine or preventive care, track medications and get refills, or get a referral to see a specialist
Urgent Care	\$\$\$	No	  	  	Nausea and diarrhea, headaches, minor cuts and broken bones, back and joint pain
Emergency Room	\$\$\$\$	No	   	   	Trouble breathing, heart attack and stroke, sudden illness and serious accidents, and severe bleeding

If you need PRESCRIPTION MEDICATIONS

Choose generic medications whenever possible to keep your medication costs lower.



TAKE THIS



NOT THAT

If you need to SEE A DOCTOR

Remember, the bigger the building, the bigger the bill. Where you go makes a big difference.



GO HERE



NOT THERE

If you need AFTER HOURS CARE

For after hours care or non-life-threatening emergencies, visit a convenience care clinic or an urgent care center.



GO HERE



NOT THERE

If you need OUTPATIENT IMAGING

Visit an outpatient imaging center versus the hospital to save money when you need a CT or MRI.



GO HERE



NOT THERE

ANNUAL NOTICES

Medicare Part D Creditable Coverage Notice

Important Notice from Warren 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 offered by the Anthem Medical through Warren 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. Warren County Public Schools has determined that the prescription drug coverage offered by the Anthem Medical 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 through 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 coverage through Warren County Public Schools will not be affected. You can keep this coverage if you elect Part D, and this plan will coordinate with Part D coverage.

If you decide to join a Medicare drug plan and drop your current group health coverage through Warren County Public Schools, be aware that you and your dependents will be able to get this coverage back. If you are able to get this coverage back, reentry into the plan is subject to the underlying terms of the Plan.

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 group health coverage through Warren 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 Plan Administrator listed below for further information. **NOTE:** You'll get this notice each year or if the creditable coverage status of this plan through Warren County Public Schools changes. You 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).

For purposes of this notice, the Plan Administrator is: Maria Bolton, 540-635-2171

Notice of Privacy Practices

Your Information. Your Rights. Our Responsibilities.

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

Your Rights

You have the right to:

- Get a copy of your health and claims records
- Correct your health and claims records
- Request confidential communication
- Ask us to limit the information we share
- Get a list of those with whom we've shared your information
- Get a copy of this privacy notice
- Choose someone to act for you
- File a complaint if you believe your privacy rights have been violated

Your Choices

You have some choices in the way that we use and share information as we:

- Answer coverage questions from your family and friends
- Provide disaster relief
- Market our services and sell your information

Our Uses and Disclosures

We may use and share your information as we:

- Help manage the health care treatment you receive
- Run our organization
- Pay for your health services
- Administer your health plan
- Help with public health and safety issues
- Do research
- Comply with the law
- Respond to organ and tissue donation requests and work with a medical examiner or funeral director
- Address workers' compensation, law enforcement, and other government requests
- Respond to lawsuits and legal actions

Your Rights

When it comes to your health information, you have certain rights. This section explains your rights and some of our responsibilities to help you.

Get a copy of health and claims records

- You can ask to see or get a copy of your health and claims records and other health information we have about you. Ask us how to do this.
- We will provide a copy or a summary of your health and claims records, usually within 30 days of your request. We may charge a reasonable, cost-based fee.

Ask us to correct health and claims records

- You can ask us to correct your health and claims records if you think they are incorrect or incomplete. Ask us how to do this.
- We may say "no" to your request, but we'll tell you why in writing within 60 days.

Request confidential communications

- You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address.
- We will consider all reasonable requests, and must say "yes" if you tell us you would be in danger if we do not.

Ask us to limit what we use or share

- You can ask us not to use or share certain health information for treatment, payment, or our operations.
- We are not required to agree to your request, and we may say "no" if it would affect your care.

Get a list of those with whom we've shared information

- You can ask for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, who we shared it with, and why.
- We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

Get a copy of this privacy notice

You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.

Choose someone to act for you

- If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.
- We will make sure the person has this authority and can act for you before we take any action.

File a complaint if you feel your rights are violated

- You can complain if you feel we have violated your rights by contacting us using the information on page 1.
- You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting www.hhs.gov/ocr/privacy/hipaa/complaints/.
- We will not retaliate against you for filing a complaint.

Your Choices

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

In these cases, you have both the right and choice to tell us to:

- Share information with your family, close friends, or others involved in payment for your care
- Share information in a disaster relief situation

If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety. In these cases we never share your information unless you give us written permission:

- Marketing purposes
- Sale of your information

Our Uses and Disclosures

How do we typically use or share your health information?

We typically use or share your health information in the following ways.

Help manage the health care treatment you receive

We can use your health information and share it with professionals who are treating you.

Example: A doctor sends us information about your diagnosis and treatment plan so we can arrange additional services.

Run our organization

- We can use and disclose your information to run our organization and contact you when necessary.
- We are not allowed to use genetic information to decide whether we will give you coverage and the price of that coverage. This does not apply to long term care plans.

Example: We use health information about you to develop better services for you.

Pay for your health services

We can use and disclose your health information as we pay for your health services.

Example: We share information about you with your dental plan to coordinate payment for your dental work.

Administer your plan

We may disclose your health information to your health plan sponsor for plan administration.

Example: Your company contracts with us to provide a health plan, and we provide your company with certain statistics to explain the premiums we charge.

How else can we use or share your health information?

We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html.

Help with public health and safety issues

We can share health information about you for certain situations such as:

- Preventing disease
- Helping with product recalls
- Reporting adverse reactions to medications
- Reporting suspected abuse, neglect, or domestic violence
- Preventing or reducing a serious threat to anyone's health or safety

Do research

We can use or share your information for health research.

Comply with the law

We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.

Respond to organ and tissue donation requests and work with a medical examiner or funeral director

- We can share health information about you with organ procurement organizations.
- We can share health information with a coroner, medical examiner, or funeral director when an individual dies.

Address workers' compensation, law enforcement, and other government requests

We can use or share health information about you:

- For workers' compensation claims
- For law enforcement purposes or with a law enforcement official
- With health oversight agencies for activities authorized by law
- For special government functions such as military, national security, and presidential protective services

Respond to lawsuits and legal actions

We can share health information about you in response to a court or administrative order, or in response to a subpoena.

Our Responsibilities

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html.

Changes to the Terms of this Notice

We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, on our web site, and we will mail a copy to you.

WHCRA Enrollment/Annual Notice

Enrollment Notice

If you have had or are going to have a mastectomy, you may be entitled to certain benefits under the Women's Health and Cancer Rights Act of 1998 (WHCRA). For individuals receiving mastectomy-related benefits, coverage will be provided in a manner determined in consultation with the attending physician and the patient, for:

- All stages of reconstruction of the breast on which the mastectomy was performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance;
- Prostheses; and
- Treatment of physical complications of the mastectomy, including lymphedema.

These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under this plan. If you would like more information on WHCRA benefits, call your plan administrator as identified at the end of these notices.

Annual Notice

Do you know that your plan, as required by the Women's Health and Cancer Rights Act of 1998, provides benefits for mastectomy-related services including all stages of reconstruction and surgery to achieve symmetry between the breasts, prostheses, and complications resulting from a mastectomy, including lymphedema?

Newborns' Act Disclosure

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).

Special Enrollment Notice

If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance or group health plan coverage, 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).

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. However, you must request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption.

Finally, if you or an eligible dependent has coverage under a state Medicaid or child health insurance program and that coverage is terminated due to a loss of eligibility, or if you or an eligible dependent become eligible for state premium assistance under one of these programs, you may be able to enroll yourself and your eligible family members in the Plan. However, you must request enrollment no later than 60 days after the date the state Medicaid or child health insurance program coverage is terminated or the date you or an eligible dependent is determined to be eligible for state premium assistance.

For purposes of these notices, the plan administrator is: Maria Bolton 540-635-2171

Your Rights and Protections Against Surprise Medical Bills

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.

If you think you've been wrongly billed, contact the No Surprises Helpdesk, operated by the U.S. Department of Health and Human Services, at 1.800.985.3059.

Visit www.cms.gov/nosurprises/consumers for more information about your rights under federal law.

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 January 31, 2024. 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.mycchibi.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	Healthy Indiana Plan for low-income adults 19-64 Website: http://www.in.gov/fssa/hip/ Phone: 1-877-438-4479 All other Medicaid Website: https://www.in.gov/medicaid/ Phone: 1-800-457-4584
IOWA – Medicaid and CHIP (Hawki)	KANSAS – Medicaid
Medicaid Website: https://dhs.iowa.gov/ime/members Medicaid Phone: 1-800-338-8366 Hawki Website: http://dhs.iowa.gov/Hawki Hawki Phone: 1-800-257-8563 HIPP Website: https://dhs.iowa.gov/ime/members/medicaid-a-to-z/hipp 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: KIHIPPPROGRAM@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/la hipp Phone: 1-888-342-6207 (Medicaid hotline) or 1-855-618-5488 (LaHIPP)
MAINE – Medicaid	MASSACHUSETTS – Medicaid and CHIP
Enrollment Website: https://www.mymaineconnection.gov/benefits/s/?language=en_US Phone: 1-800-442-6003 TTY: Maine relay 711 Private Health Insurance Premium Webpage: https://www.maine.gov/dhhs/ofi/applications-forms Phone: 1-800-977-6740 TTY: Maine relay 711	Website: https://www.mass.gov/masshealth/pa Phone: 1-800-862-4840 TTY: 711 Email: masspremassistance@accenture.com
MINNESOTA – Medicaid	MISSOURI – Medicaid
Website: https://mn.gov/dhs/people-we-serve/children-and-families/health-care/health-care-programs/programs-and-services/other-insurance.jsp Phone: 1-800-657-3739	Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005
MONTANA – Medicaid	NEBRASKA – Medicaid
Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084 Email: HSHIPPProgram@mt.gov	Website: http://www.ACCESSNebraska.ne.gov Phone: 1-855-632-7633 Lincoln: 402-473-7000 Omaha: 402-595-1178
NEVADA – Medicaid	NEW HAMPSHIRE – Medicaid
Medicaid Website: http://dhcfp.nv.gov Medicaid Phone: 1-800-992-0900	Website: https://www.dhhs.nh.gov/programs-services/medicaid/health-insurance-premium-program Phone: 603-271-5218 Toll free number for the HIPP program: 1-800-852-3345, ext. 5218
NEW JERSEY – Medicaid and CHIP	NEW YORK – Medicaid
Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/ Medicaid Phone: 609-631-2392 CHIP Website: http://www.njfamilycare.org/index.html CHIP Phone: 1-800-701-0710	Website: https://www.health.ny.gov/health_care/medicaid/ Phone: 1-800-541-2831
NORTH CAROLINA – Medicaid	NORTH DAKOTA – Medicaid
Website: https://medicaid.ncdhhs.gov/ Phone: 919-855-4100	Website: https://www.hhs.nd.gov/healthcare Phone: 1-844-854-4825
OKLAHOMA – Medicaid and CHIP	OREGON – Medicaid and CHIP
Website: http://www.insureoklahoma.org Phone: 1-888-365-3742	Website: http://healthcare.oregon.gov/Pages/index.aspx Phone: 1-800-699-9075
PENNSYLVANIA – Medicaid and CHIP	RHODE ISLAND – Medicaid and CHIP
Website: https://www.dhs.pa.gov/Services/Assistance/Pages/HIPP-Program.aspx Phone: 1-800-692-7462 CHIP Website: Children's Health Insurance Program (CHIP) (pa.gov) CHIP Phone: 1-800-986-KIDS (5437)	Website: http://www.eohhs.ri.gov/ Phone: 1-855-697-4347, or 401-462-0311 (Direct Rlite Share Line)
SOUTH CAROLINA – Medicaid	SOUTH DAKOTA - Medicaid
Website: https://www.scdhhs.gov Phone: 1-888-549-0820	Website: http://dss.sd.gov Phone: 1-888-828-0059

TEXAS – Medicaid	UTAH – Medicaid and CHIP
Website: Health Insurance Premium Payment (HIPP) Program Texas Health and Human Services Phone: 1-800-440-0493	Medicaid Website: https://medicaid.utah.gov/ CHIP Website: http://health.utah.gov/chip Phone: 1-877-543-7669
VERMONT– Medicaid	VIRGINIA – Medicaid and CHIP
Website: Health Insurance Premium Payment (HIPP) Program Department of Vermont Health Access Phone: 1-800-250-8427	Website: https://coverva.dmas.virginia.gov/learn/premium-assistance/famis-select https://coverva.dmas.virginia.gov/learn/premium-assistance/health-insurance-premium-payment-hipp-programs Medicaid/CHIP Phone: 1-800-432-5924
WASHINGTON – Medicaid	WEST VIRGINIA – Medicaid and CHIP
Website: https://www.hca.wa.gov/ Phone: 1-800-562-3022	Website: https://dhhr.wv.gov/bms/ http://mywvhipp.com/ Medicaid Phone: 304-558-1700 CHIP Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)
WISCONSIN – Medicaid and CHIP	WYOMING – Medicaid
Website: https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm Phone: 1-800-362-3002	Website: https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/ Phone: 1-800-251-1269

To see if any other states have added a premium assistance program since January 31, 2024, or for more information on special enrollment rights, contact either:

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

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

Paperwork Reduction Act Statement

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

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

OMB Control Number 1210-0137 (expires 1/31/2026)

NOTES:

This image shows a blank sheet of white paper with horizontal ruling lines. The lines are evenly spaced and run across the width of the page. There are no margins, text, or other markings on the paper.

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This image shows a blank sheet of white paper with horizontal ruling lines. The lines are evenly spaced and run across the width of the page. There are no margins, text, or other markings on the paper.

This booklet highlights some of your Warren County Public Schools benefit plans. Your actual rights and benefits are governed by the official plan documents. If there are any discrepancies between this booklet and the official plan documents, the plan documents will prevail. Warren County Public Schools reserves the right to change any benefit plan without notice. Benefits are not a guarantee of employment.