



DERBY

PUBLIC SCHOOLS

2026 | Benefits Guide

RETIREE



Attention Retirees

The benefits you are eligible to continue as a retiree are determined by your categorization as a Retiree or a Bridge Retiree. You are able to retain coverage in the benefits that you are eligible for as a Retiree/Bridge Retirees; however, Retirees/Bridge Retirees may not add additional benefits. Please speak to your Derby Benefit Team in the District's Payroll/Benefits Department if you have questions about your eligibility.

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Your employer offers Hospital/Fixed Indemnity Plans through Reliance Standard and Aflac. Therefore, this notice is required on page one of benefit plan information you are provided.

Hospital/Fixed Indemnity Plan Notice

IMPORTANT: This is a fixed indemnity policy, NOT health insurance.

This fixed indemnity policy may pay you a limited dollar amount if you're sick or hospitalized. You're still responsible for paying the cost of your care.

- The payment you get isn't based on the size of your medical bill.
- There might be a limit on how much this policy will pay each year.
- This policy isn't a substitute for comprehensive health insurance.
- Since this policy isn't health insurance; it doesn't have to include most Federal consumer protections that apply to health insurance.

Looking for comprehensive health insurance?

- Visit [Healthcare.gov](https://www.healthcare.gov) or call 1-800-318-2596 (TTY:1-855-889-4325) to find health coverage options.
- To find out if you can get health insurance through your job, or a family member's job, contact the employer.

Questions about this policy?

For questions or complaints about this policy, contact your State Department of Insurance. Find their number on the National Association of Insurance Commissions' website ([naic.org](https://www.naic.org)) under "Insurance Departments". If you have this policy through your job, or a family member's job, contact the employer.

Dear Derby Public Schools Employees,

Our employees are the heart of everything we do, achieving our vision of *every student, every day, preparing for the future*. Your health, well-being and financial security are essential to our shared success. Each year, we carefully evaluate our benefits program to ensure it continues to provide meaningful support for you and your family.

Like many organizations, we've experienced rising healthcare costs across the nation. Despite these challenges, we remain committed to offering high-quality, comprehensive health coverage and a competitive benefits package. Our goal is to balance fiscal responsibility while maintaining dedicated to the health and wellness of every employee. We will continue to be proactive and strategic in managing these costs through ongoing conversations and by prioritizing resources responsibly. Ahead of the 2025-2026 school year, the Board of Education working in conjunction with DNEA through Interest Based Bargaining (IBB) approved \$450,000 for certified staff towards benefits. No employee will see an increase greater than \$40 per month, and there are no changes to the benefit offerings themselves.

In addition to medical, dental and vision coverage, we are proud to provide a wide range of other benefits designed to support you, including retirement savings and leave programs to wellness initiatives and professional growth opportunities. We encourage you to take full advantage of these resources and to review the details carefully in this year's benefits guide.

Thank you for the work you do each day to serve our students, families and community. Your dedication and care make all the difference!

With appreciation,



Heather Bohaty
Superintendent of Schools

Important Benefits Information

Benefits Information Access: Benefit Information is posted on the benefit portal, **THEbenefitsHUB**, and is available for review prior to making your benefit elections. For copies of the Summary of Benefits and Coverage (SBC), Summary Plan Description (SPD), HIPAA Privacy Policy, Benefit Summaries, links to provider website and forms, visit **THEbenefitsHUB** at mybenefitshub.com/usd260

Medicare Prescription Drug Information: Your Medicare Part D Notice is located in the Legal Notices of this Benefit Guide. Some other key notices include CHIPRA, HIPAA Privacy Reminder, and Notice of Coverage Options (Marketplace Notice). If you have any questions, please contact your Payroll/Benefits team at the District Office.

2026 | Medical Insurance

Derby Public Schools USD 260 offers a choice of three medical plan options through Blue Cross Blue Shield of Kansas ('BCBSKS'). You should consider the differences between the plans when choosing an option that will best suit the needs of you and your family.

IN-NETWORK BENEFITS	OPTION 1 \$1,500	OPTION 2 \$2,500	OPTION 3 \$3,500 QHDHP
Health Savings Account Eligible	No	No	Yes
Annual Deductible (Per Calendar Year)	\$1,500 Individual \$3,000 Family	\$2,500 Individual \$5,000 Family	\$3,500 Individual \$7,000 Family
Coinsurance	20%	20%	0%
Coinsurance is applicable until Annual Out-of-Pocket Maximum has been met			
Annual Out-of-Pocket Max Individual Family	\$6,350 \$12,700	\$6,350 \$12,700	\$6,350 \$12,700
Annual out-of-pocket max includes deductible, coinsurance, and copays. After the annual out-of-pocket max is reached, all in-network benefits will be paid at 100% for the remainder of the benefit period.			
DOCTOR'S OFFICE VISITS	OPTION 1	OPTION 2	OPTION 3
Home & Office Visit Copay	Primary Care ¹ : \$35 Specialist: \$70	Primary Care ¹ : \$35 Specialist: \$70	Deductible
Preventive Care ²	Paid at 100% of allowable charge		
MEDICAL SERVICES	OPTION 1	OPTION 2	OPTION 3
Emergency Room	\$250 copay; then subject to deductible/coinsurance	\$250 copay; then subject to deductible/coinsurance	Deductible
Emergency Medical Transportation	Deductible/Coinsurance	Deductible/Coinsurance	Deductible
Inpatient Surgery	Deductible/Coinsurance	Deductible/Coinsurance	Deductible
Inpatient Facility Fee	Deductible/Coinsurance	Deductible/Coinsurance	Deductible
Outpatient Surgery	Deductible/Coinsurance	Deductible/Coinsurance	Deductible
Outpatient Lab & Radiology (includes Advanced Imaging)	Paid at 100% up to \$300 max per covered person; then subject to deductible/coinsurance		Deductible
Outpatient Rehabilitation	Deductible/Coinsurance	Deductible/Coinsurance	Deductible
Hospice	Deductible/Coinsurance	Deductible/Coinsurance	Deductible
MENTAL/BEHAVIORAL HEALTH	OPTION 1	OPTION 2	OPTION 3
Inpatient ³	Deductible/Coinsurance	Deductible/Coinsurance	Deductible
Outpatient	\$35 copay	\$35 copay	Deductible



2026 | Medical Insurance

DRUG COVERAGE	OPTION 1 \$1,500	OPTION 2 \$2,500	OPTION 3 \$3,500 QHDHP
Prescription Drug List (PDL): BCBSKS Results Formulary List			
Retail Pharmacy (30-day supply)	Copays	Copays	Subject to Deductible <i>After deductible has been met copay will apply with the same copay tiers as stated on plan options 1, 2</i>
Generic	\$15	\$15	
Preferred Brand	\$50	\$50	
Non-preferred Brand	\$75	\$75	
Preferred Specialty	\$150	\$150	
Non-preferred Specialty	20% up to \$250	20% up to \$250	
Other drug coverage provisions include: mandatory generics ⁴ , mandatory designated specialty pharmacy ⁵ , FlexAccess program ⁶ , mail order ⁷ , extended supply network ⁸ , prescription refills ⁹			

¹Primary Care Providers include General Practice, Family Practice, Internal Medicine, Pediatricians, OB/Gyn and Mental/Behavioral Health Outpatient Services. One routine Eye Exam is paid as Primary Care Provider office visit copay. Any subsequent eye exam visits paid at Specialist Copay.

²The appropriate preventive care services can vary for each person based on age, gender and other risk factors, including family medical history. Additional guidance on covered ACA procedures are available on the BCBSKS website: www.bcbsks.com/health-and-wellness/preventive-health

³Required pre-admission certification from Lucet at 1-800-952-5906

⁴Generic medications are mandatory unless the prescription practitioner has provided the override to receive the brand name drug. If the member does not have the doctor override, the member is responsible for any cost difference above the copay. For any prescription drugs included on the Narrow Therapeutic Index, the member can receive the brand name drug and will not be charged for the cost difference between brand and generic.

⁵BCBSKS requires use of a Preferred Specialty Pharmacy, which benefits members with conditions requiring specialty medications. Call (833) 721-1620 or visit www.bcbsks.com/prescription-drugs/specialty for more information.

⁶When purchasing certain drugs, you may be contacted by a FlexAccess team member by phone to register you in the drug manufacturer's copay assistance program to help minimize our out-of-pocket expenses. If you choose not to register, if you are otherwise eligible for the assistance, then you will be responsible for the full cost of the drug.

⁷The Mail Order program is through Express Scripts and offers home delivery with the highest standards of quality, safety and service for your prescription drug needs. Mail-order allows up to a 90-day supply at 2¹/₂ the retail copay. Mail order is not available for all drugs. You can call (833) 599-0511 or visit www.bcbsks.com/prescription-drugs/mail-order to start the Mail-order process.

⁸Members have access to the Extended Supply Network which allows the purchase of prescription drugs, up to a 90-day supply, at participating retail pharmacies. The day supply is subject to the appropriate copay for each 30-day supply. Ask your pharmacy if they are a BCBSKS Extended Supply Network Pharmacy or call BCBSKS customer service for help locating an Extended Supply Network pharmacy.

⁹Effective January 1, 2026, BCBSKS will limit prescription refills to an oversupply of 9 days within a 180-day rolling period.

MEDICAL PLAN MONTHLY PREMIUMS			
	Plan 1 \$1,500	Plan 2 \$2,500	Plan 3 QHDHP \$3,500
Employee Only	\$789.65	\$767.54	\$746.22
Employee + Spouse	\$1,514.54	\$1,471.90	\$1,431.64
Employee + Child(ren)	\$1,426.90	\$1,386.62	\$1,348.73
Family	\$2,237.08	\$2,174.69	\$2,113.89

The medical plans that are offered at Derby Public Schools, through Blue Cross Blue Shield of Kansas, allow for in-and-out-of-network coverage. However, your out-of-pocket expenses are lower when obtaining services from participating, in-network providers and facilities. Be sure to evaluate the differences using the benefit summary grids on the previous pages or view the Summaries of Benefit Coverage (SBC's) that are available on the **THEbenefitsHUB** benefit portal.

Two out of the three medical plans offered are traditional "standard" medical plans (Options 1 & 2), meaning covered services will be subject to either a copayment (copay) and/or deductible/coinsurance. Prescription drugs on the "standard" plans are subject to a copay. The other plan offered (Option 3) is a "qualified high deductible health plan (QHDHP)". All covered services, including prescription drugs, are subject to the deductible. Enrollment in a QHDHP still comes with the advantage of discounts that BCBSKS has negotiated with providers for services/products, but the member is responsible for 100% of the billed amount until the deductible has been met.

BCBSKS Member BlueAccess Portal

For access to valuable tools and resources to enhance your membership with BCBSKS, you will want to establish a BlueAccess® account. Follow the steps below to get your account set-up.

1. Scan QR Code to the right or go to bcbsks.com/blueaccess. If you are signing up for the first time, you will need to have your BCBSKS ID card available for your ID number and Group Number
2. Complete the steps for Member Verification, Account Set-up & Preferences, Two-Step Verification Setup and Review and Create Account



Once you have created your account, you can login in anytime to access member specific information, including Blue Choice network provider search, view/print ID card, review your claims, access discounts and coupons, take health risk assessment set goals and monitor your progress, get assistance on a diet and exercise plan customized for you, and more.

If you are not yet enrolled under the plan, but want to look up a provider to check their in-network status, you can visit the BCBSKS website to find a Doctor/Hospital. Make sure to have the **Blue Choice Preferred-Care Blue Network** selected when you enter your search to find the care you need.

BCBSKS Prescription Drug Information

Find out if the prescription drug is covered by searching the **ResultsRx Medication** List through Prime Therapeutic's drug formulary.

To get the best result, specific to your coverage, login to your BlueAccess account and click on Rx Drugs. If you are not yet enrolled under the plan, you can look up medications at <https://www.myprime.com/en/medicines.html#find-medicine>

Prescription Drug Formulary List

The BCBSKS plans offered at your employer utilize the **ResultsRx Medication** formulary list. You should check to make sure that this is the drug list chosen when looking up prescription drug coverage.



Prescription Drug Refill Change—Effective 1/1/2026: Blue Cross Blue Shield will permit prescription refills limiting oversupply to 9-days within a 180-day rolling period. Previously, refills were permitted at 75% of the days' supply from the prior refill. Without oversight, this practice allowed members to refill prescriptions early each month, leading to an accumulation of excess medication. Given the high cost of medications, overall, this practice contributed to substantial waste and unnecessary expenditures.

Preventive Care

As a reminder, the Patient Protection and Affordable Care Act (ACA) requires non-grandfathered plans to cover certain preventive services at 100% so you do not have to pay anything beyond your monthly premium for these services. Preventive services must be provided by an eligible contracting provider. The appropriate preventive care services can vary for each person based on age, gender and other risk factors, including family medical history. Additional guidance on covered ACA procedures are available on the BCBSKS website: www.bcbsks.com/health-and-wellness/preventive-health



BCBSKS HealthyOptions

With your BCBSKS coverage, you have access to case management, disease management, wellness management programs and more. These programs that can help support living a healthy lifestyle. Visit www.bcbsks.com/health-and-wellness to learn more.



Disease Management: BCBSKS nurses provide one-on-one support to members via telephone to help individuals develop self-care habits. Consider enrolling if you have any of these health conditions: Asthma, COPD, Diabetes, Heart Disease, High Blood Pressure, High Cholesterol. For more information and to initiate participation, call (800) 520-3137

Case Management: A case manager will work with a member and the member's health care team to coordinate services to meet needs in a quality and cost-effective manner. For further information, send your request/comments to CMManagers@bcbsks.com or call (800)-432-0216, ext. 6628

Wellness Management: BCBSKS nurses provide one-on-one support to members via telephone calls to help them develop self-care habits. BCBSKS offers programs for Tobacco cessation, Weight Loss, Stress Management and Maternity. For more information, call (800) 520-3137 between 8 a.m. and 4:30 p.m., Monday through Friday.

Type 2 Diabetes Program

Blue Cross Blue Shield of Kansas realizes the toll that type 2 diabetes can have on a member and the cost associated with a type 2 diabetes diagnosis. That is why BCBSKS has partnered with Virta Health to provide support and treatment for individuals with type 2 diabetes. Virta is research-backed treatment that helps control blood sugar, reduce or eliminate diabetes medications, and is a safe and sustainable way to lose weight.

Members who are eligible should receive communications from BCBSKS (generally via email if on file with BCBSKS or via mail) with information on to enroll in the program. Members can also call BCBSKS Member Services to discuss eligibility for the program. Learn more about Virta by visiting info.virtahealth.com/bcbsks1

SmartShopper®

With SmartShopper®, you can easily compare convenient, high-quality, in-network locations for common medical care and be redirected to the most cost-effective facility of your choice. In addition to lowering costs, you can earn a share of the overall savings as cash rewards of \$20 - \$425. Access more information about the SmartShopper® program by visiting <https://www.bcbsks.com/mysmartshopper>

Note: covered incentivized procedures through the SmartShopper® program must be scheduled online by accessing through your BlueAccess account or scheduling through the SmartShopper® Care Concierge Team at 866-820-6426.



BCBSKS Telehealth Services through AmWell

Telehealth is a fast, convenient way to see a doctor virtually or connect via a phone call. **If you are covered on the medical plan offered by Derby USD 260 through Blue Cross Blue Shield of Kansas coverage you can have a live visit on your computer or mobile device with a doctor at a time that works for you.** You can also call for service if you do not have a smart-phone or tablet device. Blue Cross provides telehealth services through American Well® (Amwell). It's easy-to-use, affordable, private and secure.

\$0*

Telehealth Consultation for qualified Primary Care Providers. Fees may apply for other covered services. *Must be enrolled in medical plan Option 1 or 2 for \$0 telehealth consultations to apply.



Telehealth lets you interact with a doctor at your convenience for common conditions such as cold, sinus infection, flu, pink eye, ear infection, rash, migraine, stomach pain and more. Using AmWell services can be a convenient option to seek care without having to leave home or work. You, your spouse and/or children, who are covered under your BCBSKS plan, are eligible for telehealth services. A spouse should create their own Amwell account, but children or dependents under age 18 can be added to your account and have doctor visits on your behalf. You need to register first, and then your child or dependent can be added to the account. Children or dependents over the age of 18 must create their own Amwell account.

- Available nationwide, 24/7/365
- Convenient Prescriptions: If a medication is prescribed, all prescriptions can be picked up at your local pharmacy
- Easy Payment: Pay for the visit with credit, debit or HSA/FSA cards (if applicable)

Behavioral health and counseling services, known as teletherapy, is also available through Amwell's licensed therapists who can provide treatment for several conditions, including anxiety, attention deficit hyperactivity disorder (ADHD), stress, bereavement, obsessive-compulsive disorder (OCD), panic attacks, depression, trauma/post-traumatic stress disorder. Therapists will be available on demand or by appointment from 7 a.m. to 11 p.m. local time, 7 days a week.

***Virtual visits will have a \$0 copay for the consultation if you are enrolled in medical option 1 or 2; if you are enrolled in Option 3 the virtual consultation will be subject to your deductible at the allowed charge for the consultation. You should also ask your own doctor about their virtual visit options.**

Register for a telehealth visit and connect with a board-certified doctor in your area.

1. Download the Amwell app on any mobile device.
2. On a computer? Visit bcbsks.com/telehealth to get started.
3. Don't have a smart phone or tablet? Call (844) SEE-DOCS

Get More Information

Scan QR Code | bcbsks.com/telehealth | support@amwell.com | (844) 733-3627



2026 | Health Savings Account

Health savings accounts (HSAs) are a great way to save money and efficiently pay for medical expenses. HSAs are tax-advantaged savings accounts that accompany qualified high deductible health plans (HDHPs). An HSA can be a tremendous asset as you save for and pay medical bills because it gives you tax advantages, more control over your own spending and the ability to save for future expenses.

HSAs are employee-owned, meaning you take the HSA with you if you change employers. Unused funds can earn interest and can be invested until they are withdrawn for eligible expenses or at retirement. You set aside money on a pre-tax basis—this means as long as you use the money for eligible expenses, you won't pay income taxes on it.

Eligibility Requirements

- You are covered under **OPTION 3—\$3,500 High Deductible Health Plan**
- You are not covered under another medical plan that is not an QHDHP
- You are not enrolled in Medicare benefits
- You cannot be claimed on another person's tax return
- You have not received VA benefits in the last three months
- You are not participating in a healthcare FSA through your employer or any other healthcare FSA (i.e. spouse FSA)

HSA Advantages

- *Security*—your HSA can provide a savings buffer for unexpected or high medical bills
- *Flexibility*—you can use your HSA to pay for current medical expenses or you can save your funds for future medical expenses
- *Savings*—you can save the money in your HSA for future medical expenses, all while your account grows through tax-deferred investment earnings
- *Triple Tax Savings*— (1) tax deductions when you contribute to your account; (2) tax-free earnings through investment; (3) tax-free withdrawals for qualified medical expenses
- *Portability*—your HSA and the money in it belongs to you, not your employer or insurance company, which means if you change jobs or change medical coverage you keep your HSA
- *Ownership*—funds remain in the account from year to year. There are no “use it or lose it” rules

HSAs are subject to maximum annual contribution limits. The amounts vary depending on whether the individual has self-only or family HDHP coverage; and the limits are indexed annually by the IRS.

HEALTH SAVINGS ACCOUNT CONTRIBUTION LIMITS		
2026	Single Coverage	Family Coverage
Annual Limit	\$4,400	\$8,750
Catch-up Contributions (age 55+)	\$1,000	\$1,000

Other Considerations

- An HSA account must be established before you can use funds for qualified medical expenses. Medical costs incurred after your QHDHP is effective, but before your HSA is established cannot be paid with money deposited into your HSA account
- As the HSA owner, you are ultimately responsible for determining whether an expense is eligible for reimbursement. If an HSA expenditure is not used for a qualified medical expense, you will be required to pay income tax and a 20% penalty on the amount used (the 20% penalty tax does not apply to payments made after your death or disability, or after you reach age 65)
- You must keep proper records for your expenses to avoid tax headaches later on—to protect yourself in the event that you are audited by the IRS— keep records of all HSA documentation/expenditures for proof that funds were used for qualified expenses
- Consult the IRS or a legal/tax advisor for all tax inquiries
- For more information, refer to [IRS Publication 969](#)
- For a complete list of eligible expenses please visit: <http://www.irs.gov/pub/irs-pdf/p502.pdf>



2026 | Dental Insurance

Derby Public Schools offers the following comprehensive dental plan administered by Delta Dental of Kansas. You are free to go to any dentist of your choice; however, there may be a difference in the amount of payment if the dentist is not a Delta Dental participating dentist. Since nearly 4 out of 5 dentists nationwide contract with Delta Dental, the chances are excellent your dentist is already a member.

The maximum Benefit for all covered services for each enrolled person in any one contract year is \$1,500.

The contract year is January 1, 2025—December 31, 2025.

DIAGNOSTIC & PREVENTIVE SERVICES—YOU PAY 0%

DIAGNOSTIC

Includes the following procedures necessary to evaluate existing dental conditions and the dental care required:

Oral evaluations—two (2) times per contract year

Bitewing x-rays—bitewings two (2) times per contract year for dependents under age eighteen (18) and once each twelve (12) months for adults age eighteen (18) and over

Full mouth x-rays or panoramic x-rays—once each five (5) years

PREVENTIVE

Provides for the following:

Prophylaxis (Cleanings) - unlimited

Topical Fluoride—two (2) times per contract year for dependent children under age nineteen (19)

Sealants—once per lifetime for dependent children under age sixteen (16) when applied only to permanent molars with no caries (decay) or restorations on the occlusal surface and with the occlusal surface intact.

Space Maintainers—for dependent children under age fourteen (14) and only for premature loss of primary molars

Deductible applies to Basic and Major Services Only

Individual Deductible \$25 | Family Deductible Maximum \$75

BASIC SERVICES—YOU PAY 20% (SUBJECT TO DEDUCTIBLE)

Ancillary—Provides for one (1) emergency examination per contract year by the Dentist for the relief of pain

Oral Surgery—Provides for extractions and other oral surgery including pre and post-operative care

Regular Restorative Dentistry—Provides silver fillings, resin (white) fillings on all teeth; and stainless steel crowns for dependents under age twelve (12)

Endodontics—Includes procedures for root canal treatments and root canal fillings. When covered, payment for root canal therapy is limited to only once (1) in any twenty-four(24) month period, per tooth

Periodontics—Includes procedures for the treatment of diseases of the tissues supporting the teeth. Periodontal cleaning is unlimited if diagnosed with periodontal treatment history; surgical periodontal procedures

MAJOR SERVICES—YOU PAY 50% (SUBJECT TO DEDUCTIBLE)

Special Restorative Dentistry—When teeth cannot be restored with a filling material listed in Regular Restorative Dentistry, provides for individual crowns

Prosthodontics—Includes bridges, partial and complete dentures; repairs and adjustments of bridges and dentures

OTHER PLAN BENEFITS*

Right Start 4 Kids Program: The Right Start 4 Kids program removes the cost barriers for dental care by providing children, 12 and under, 100% coverage with no deductible, for all services covered under the plan when an in-network dentist (Delta Dental Premier or Delta Dental PPO) is seen. If an out-of-network dentist is seen, the underlying contract applies including deductibles and coinsurance levels.

Unlimited Cleanings: The plan will allow for unlimited cleanings. This includes regular/prophylaxis cleanings and periodontal maintenance cleaning.

**Annual Plan Maximums apply*

Maximum Rollover Feature

The Maximum Rollover Feature allows enrolled members to carryover 25% of their unused annual maximum benefit dollars into the following year.

How the Maximum Rollover Feature Works:

- Enrollees receive their regular annual benefit maximum dollars (\$1,500) at the beginning of the new plan year
- Enrollees must have one covered dental service during the benefit year (incentivizing you to visit the dentist)
- At the end of the plan year, 25% of your unused annual maximum will rollover into the next year
- The Benefit Rollover Balance accumulated from year-to-year for each individual cannot exceed \$1,500 , which means at the beginning of the new plan year you will have the new year annual benefit maximum + any available Rollover Balance (up to \$1,500)

Delta Dental Resources

Caring for smiles has been Delta Dental's focus for over 40 years. Educating members about of good oral health and giving back to the communities they serve drives the passion behind Delta Dental. Access Delta Dental's *Knowledge Center* as well as other valuable tools. Scan the QR code or visit www.deltadentalks.com to access information about your dental plan, including options to:



- Locate a participating Delta Dental Premier/ PPO dentist anywhere in the United States
- Check your eligibility and plan information
- Print an ID card
- Check claim status
- Estimate your out-of-pocket dental care costs with the Flexible Spending Account Estimator
- Sign up to receive your Explanation of Benefits electronically
- Learn about oral health and wellness
- And more...

Through Delta Dental's *Knowledge Center* you can learn about things such as...



Superfoods that can supercharge your oral health

Some benefits of a nutritious diet are more discussed than others, but the upside of healthy eating go far beyond the physical. Well-balanced nutrition can also increase your energy, help you feel more positive, and support your smile! That's where superfoods come in. They're packed with more nutrients than other foods, like vitamins, minerals, fiber, antioxidants, or omega-3 fatty acids. Eating these foods on a regular basis can give your daily diet a healthy boost.

Mobile App: Accessing information about your dental plan is easy and convenient through Delta Dental's mobile app. The Delta Dental Mobile App is optimized for iOS (Apple) and Android devices. To download our app on your device, visit the App Store (Apple) or Google Play (Android) and search for "Delta Dental Mobile App".



DENTAL PLAN PAYROLL DEDUCTIONS	
Employee Only	\$43.34
Employee + Spouse	\$86.54
Employee + Child(ren)	\$84.87
Family	\$118.41

2026 | Vision Insurance

Derby Public Schools offers vision coverage through Surency . You may choose from two plans: Exam & Materials Plan or Materials Only Plan.

OPTION 1—COMPREHENSIVE VISION PLAN Plan benefit(s) is available once every calendar year		
VISION CARE SERVICES	IN-NETWORK MEMBER COST	OUT-OF-NETWORK REIMBURSEMENT
Vision Examination with Dilation as Necessary (Retinal Imaging)	\$10 copay Up to \$39	\$35 N/A
Contact Lens Fit and Follow-Up: <i>(Contact lens fit and two (2) follow-up visits are available once a comprehensive eye exam has been completed)</i> Standard -spherical clear contact lenses in conventional wear and planned replacement (Examples include but not limited to disposable, frequent replacement, etc.) Premium -all lens designs, materials and specialty fittings other than Standard Contact Lenses (Examples include toric, multifocal, etc.)	\$0 copay, paid-in-full fit and two follow-up visits \$55 Allowance	\$40 \$40
Frames: Any available frame at provider location.	\$130 Allowance; 20% off balance	\$65
Standard Plastic Lenses: Single Vision Bifocal Trifocal Lenticular	\$25 Copay \$25 Copay \$25 Copay \$25 Copay	\$25 \$40 \$55 \$55
Lens Options: Standard Polycarbonate UV Coating Tint (Solid and Gradient) Standard Scratch-Resistance Standard Anti-Reflective Coating Standard Progressive (includes copay amount) Premium Progressive (includes copay amount) Other Add-Ons and Services	Adults: \$40, Dependents under 19: \$0 \$15 \$15 \$15 \$45 \$90 copay \$90 copay; \$120 Allowance 20% off balance 20% off Retail Price	\$25 \$25 Not Covered Not Covered Not Covered Not Covered \$40 \$40 Not Covered
Contact Lenses: (Contact lens allowance includes materials only; Allowance not available if eyeglass lenses are elected)		
Conventional	\$130 allowance, 15% off balance over allowance	\$100
Disposable	\$130 allowance	\$100
Medically Necessary	\$0 copay	\$200

This is a summary of Benefits only; various limitations and exceptions may apply.

OPTION 2—MATERIALS ONLY PLAN

Plan benefit(s) is available once every calendar year

MATERIALS COVERED	IN-NETWORK	OUT-OF-NETWORK
Frames, Lens & Options Package: Any frame, lenses and lens options available at the provider locations.	\$200 Allowance for frame, lenses and lens options 20% off balance over \$200	\$200 Allowance
Contact Lenses (In lieu of frames, lens & options)	\$200 Allowance <i>Declining Balance Allowed</i>	\$200 Allowance

Surency Vision is proud to collaborate with EyeMed Vision Care to provide a network that offers quality, convenience and choice. EyeMed has one of the largest, most diverse networks in the nation, which includes both independent private practitioners and nationally recognized retail chains.

Surency Vision Resources

Access Surency Vision provider network as well as other valuable resources by scan the QR code or visit www.surency.com/vision to access information about your vision plan.



- Find a doctor (Access Network)
- Check claim status or view how your claim paid
- Access your mobile ID card
- And More



Member Perks and Savings: Surency Vision members receive a number of perks and saving including discounts on vision products and vision correction all year long. Visit the **Member Perks and Savings** section on the Surency Vision website for additional information.

Online Vision Solutions: You have several in-network online shopping options. Shop and buy glasses, contacts and prescription sunglasses from your computer, smartphone, or tablet. Use your benefits at Glasses.com, Contacts Direct, Ray-Ban, Target Optical and Lenscrafters.

Mobile App: Accessing information about your vision plan is easy and convenient through Surency's mobile app. The Surency Vision Mobile App is optimized for iOS (Apple) and Android devices. To download our app on your device, visit the App Store (Apple) or Google Play (Android) and search for "Surency Vision".



VISION PLAN PAYROLL DEDUCTIONS	
OPTION 1—COMPREHENSIVE VISION PLAN	
Employee Only	\$10.22
Employee + Spouse	\$21.48
Employee + Child(ren)	\$18.41
Family	\$35.81
OPTION 2—MATERIALS ONLY VISION PLAN	
Employee Only	\$10.59
Employee + Spouse	\$20.77
Employee + Child(ren)	\$18.26
Family	\$28.46

2026 | 3-in-1 Supplemental Plan

Important Notice: This is a fixed indemnity policy, not health insurance, and does not satisfy the requirement of minimum essential coverage under the ACA.

Accidents, critical illnesses and hospitalizations happen without warning. When you or your family members are faced with these occurrences, the 3-in-1 Worksite Benefits Package can help with expenses that medical insurance doesn't cover like deductibles. The benefits offered through the Reliance Matrix worksite benefits included coverage for Accidents, certain Critical Illnesses and Hospitalizations. Benefits paid through these plans are paid directly to you and are not coordinated with any other insurance. You must be insured in order for dependents to be covered. You and your spouse, if applicable, must be under age 70 at time of enrollment to be eligible for coverage.

3-IN-1 SUPPLEMENTAL PLAN PAYROLL DEDUCTIONS				
	Employee Only	Employee + Spouse	Employee + Child(ren)	Family
12 Pay Monthly	\$24.00	\$47.18	\$39.30	\$62.62
21 Payrolls	\$13.71	\$26.96	\$22.46	\$35.78
26 Payrolls	\$11.08	\$21.78	\$18.14	\$28.90

1

Hospital Indemnity Plan—Voluntary hospital indemnity insurance provides a range of fixed, lump-sum daily benefits to help cover costs associated with a hospital admission, including room and board costs. **There are no pre-existing conditions exclusions.**

HOSPITAL INDEMNITY BENEFITS	
Room & Board Benefit	\$100 per day; 180 daily benefits per coverage year
Hospital Admission Benefit	\$1,000; one admission benefit per coverage year
Maternity Feature—When a covered member is admitted to the hospital and delivers a baby, the admission/daily benefit is paid for the mother as well as the newborn.	

2

Critical Illness Plan—Voluntary critical illness insurance provides a fixed, lump-sum benefit upon diagnosis of a covered critical illness. This plan is portable to employee age 70.

CRITICAL ILLNESS BASE BENEFIT AMOUNT	
Employee	\$5,000
Spouse	\$5,000
Dependent Child(ren)	\$1,250
Benefit Reduction Due to Age	Benefit reduces to 50% at age 70; Spouse coverage terminates at age 75
COVERED CRITICAL ILLNESSES	
100% Base Benefit Amount payable for:	Alzheimer's, Coma, Heart Attack, Life Threatening Cancer, Major Organ Failure, ALS; Lou Gehrig's Disease, Multiple Sclerosis, Parkinson's, Ruptured Cerebral; Carotid or Aortic Aneurysm, Stroke
25% Base Benefit Amount payable for:	Carcinoma In Situ, Coronary Disease
5% Base Benefit Amount payable for:	Skin Cancer
OTHER PLAN FEATURES	
Lifetime Maximum Benefit	1,000% of Insurance Amount
Subsequent Occurrence Benefit	50% of benefit if diagnosed 6 months or later
Recurrence Benefit (same illness)	100% if diagnosed 12 months or later
Pre-Existing Limitation	12-month look back period/12-month coverage period
WELLNESS BENEFIT	
\$50 Yearly Wellness Benefit (up to a maximum of four benefits per family)	Health screening tests covered include, but are not limited to: Blood test for triglycerides, DEXA scan, colonoscopy, mammography, Pap test, PSA, skin cancer screening—see the certificate of coverage for a full list of tests covered

3

Accident Plan—Voluntary accident insurance provides a range of fixed, lump-sum benefits for injuries resulting from a covered accident. The Accident Plan that is available to employees of Derby Public Schools has 24-hour coverage, which means that regardless of where the accident occurs—at work or outside of work—benefits can be payable for covered accident treatments. You must be insured in order for dependents to be covered. This plan is portable to employee age 70.

EMERGENCY CARE BENEFITS			
Ambulance Transportation		Ground—\$100; Air—\$500	
Emergency Treatment		\$150	
Diagnostic Examination (1x per covered accident)		\$100	
Initial Physician Office Visit (1x per covered accident)		\$50	
GENERAL TREATMENT BENEFITS			
Initial Hospital Admission (1x per covered accident)		\$500	
Initial ICU Hospital Admission		\$1,000	
Hospital Confinement per day		\$200; 365 days max	
ICU Confinement per day		\$400; 30 days max	
Rehabilitation Facility Confinement		\$50/day; 30 days max	
Follow-up Physician Office Visit (1x per covered accident)		\$50	
Transportation (more than 100 miles, 3 roundtrips max)		\$300	
Lodging (for 1 person, more than 100 miles from residence)		\$100; 30 days max	
SURGERY BENEFITS			
Exploratory—no repair	\$100	Abdominal or Thoracic Surgery	\$1,000
Knee Cartilage	\$300	Ruptured Disc	\$500
		Tendon, Ligament, or Rotator Cuff	Up to \$600
SPECIFIC COVERED INJURY & TREATMENT BENEFITS			
Fractures		Up to \$5,000 for certain surgical repair Up to \$2,500 for non-surgical (Chip—25%) Multiple Fractures—100% of highest sustained fracture	
Dislocations		Up to \$3,200 for surgical Up to \$1,600 for non-surgical (Partial—25%) Multiple—100% of highest dislocation benefit	
Burns		2nd degree—Up to \$800 3rd degree—Up to \$6,400 Skin graft—25% of payable burn benefit	
Blood/Plasma/Platelets	\$200	Dental Injury	Crown—\$150
Coma	\$5,000		Extraction—\$50
Concussion	\$100	Eye Injury	Removal of foreign object—\$100
Lacerations	Up to \$400		Surgical Repair—\$200
TRANSITIONAL BENEFITS			
Medical Appliance		\$100	
Prosthesis		One—\$500; Two-or-more—\$1,000;	
Physical Therapy		\$25 per session, up to 6 sessions	
PARALYSIS BENEFITS			
Paralysis Benefit		Paraplegia/Hemiplegia—\$5,000; Quadriplegia—\$10,000	

Limitation and Exclusions apply—For a comprehensive list of exclusions and limitations, please refer to the Certificate of Insurance. The Certificate also provides all requirements necessary to be eligible for benefits.

2026 | Aflac Accident Plan

Important Notice: This is a fixed indemnity policy, not health insurance, and does not satisfy the requirement of minimum essential coverage under the ACA.

An accident insurance plan provides benefits to help cover the costs associated with unexpected bills. Most people don't budget for accidents. When a Covered Accident occurs, the last thing on your mind is the charges that may be accumulating. These costs add up—fast. If that time comes, wouldn't it be nice to have an insurance plan that pays benefits regardless of any other insurance you have? The group accident plan through Aflac does just that.

Plan Features

- 24-hour coverage
- No limit on the number of claims
- Pays regardless of any other insurance plans you may have
- Benefits available for your Spouse and/or Dependent Children
- Benefits for both inpatient and outpatient treatment of Covered Accidents
- Guaranteed issue (No underwriting is required to qualify for coverage.)
- Portable coverage (You can continue coverage when you leave employment; see Accident brochure for guidelines.)

Enrollment Considerations

- Accident injury means bodily injury caused solely by or as the result of a Covered Accident
- Covered Accident means an accident that occurs **on or after the effective date** and is not specifically excluded
- Aflac will not pay benefits for a loss that is caused by, contributed to, or that results from a Pre-Existing Condition for 12-months after the Effective Date of your policy.
- Some benefits are reduced for spouse/children. See Accident brochure for guidelines.
- Additional benefits not highlighted on this page are available. See Accident brochure for details.

The Aflac Accident Brochure is available on
THEbenefitsHUB benefit portal.

AFLAC ACCIDENT PLAN PAYROLL DEDUCTIONS			
	12 PAY MONTHLY	21 PAYROLLS	26 PAYROLLS
EE Only	\$16.20	\$9.27	\$7.48
EE + SP	\$23.16	\$13.26	\$10.70
EE + CH	\$30.90	\$17.66	\$14.26
FAM	\$37.86	\$21.66	\$17.48

You must be under age 70 at time of enrollment to be eligible for coverage. Employee coverage terminates at employee's age 70. To cover your spouse, if applicable, your spouse must be between ages 18 and 64. Spouse coverage terminates at employee's age 70 or spouse's age 70, whichever occurs first.

Benefit Highlights

HOSPITAL BENEFITS

Admission-----	\$1,000
Confinement-----	\$200 per day
Intensive Care-----	\$400 per day
Medical Fees-----	\$125

FRACTURE BENEFITS (CLOSED REDUCTIONS)

Hip/Thigh-----	\$4,500
Pelvis-----	\$3,600
Leg-----	\$2,700
Forearm/Hand/Wrist-----	\$2,250
Foot/Ankle/Knee Cap-----	\$2,250
Collar Bone/Shoulder Blade-----	\$1,800
Upper Arm-----	\$1,575
Upper Jaw-----	\$1,575
Facial Bones (except teeth)-----	\$1,350
Rib/Finger/Toe-----	\$360

DISLOCATIONS (CLOSED REDUCTIONS)

Hip-----	\$3,600
Knee (not knee cap)-----	\$2,600
Shoulder-----	\$2,000

SPECIFIC INJURIES

Tendon/Ligaments (surgical repair)-----	\$400
Torn Knee Cartilage-----	Up to \$400
Concussion-----	\$200
Burns (2nd/3rd degree)-----	Up to \$10,000
Lacerations-----	Up to \$400

ADDITIONAL BENEFITS

Ambulance-----	Up to \$500
Follow-up treatment (6 visit limit)-----	\$25
Physical Therapy (6 visit limit)-----	\$25

WELLNESS BENEFIT (after 12-months paid premiums)

\$50

Benefit payable for preventive testing once each 12-month period (i.e. annual physical exams, mammograms, eye exams, immunizations, etc.)



2026 | Aflac Critical Illness Plan

Important Notice: This is a fixed indemnity policy, not health insurance, and does not satisfy the requirement of minimum essential coverage under the ACA.

A group critical illness plan, offered through Aflac, prepares you for the added costs of battling a specific critical illness. The good news is that many people with a critical illness survive these life threatening battles. Unfortunately, as the recovery process begins, people become aware of the medical bills that have piled up. Your With this plan, the goal is to help you and your family cope with and recover from the financial stress of surviving a critical illness.

PERSON COVERED	BASE BENEFIT AMOUNT
Employee	\$10,000
Spouse	\$ 5,000
Child(ren) to age 26	\$ 5,000

You and your spouse, if applicable, must be under age 70 at time of enrollment to be eligible for coverage.

Percentage of Base Benefit Amount

INITIAL CRITICAL ILLNESS	
Heart Attack (myocardial infarction)	100%
Stroke (apoplexy or cerebral vascular accident)	100%
Coronary Bypass Surgery	25%
End Stage Renal Failure	100%
Major Organ Transplant	100%
CANCER CRITICAL ILLNESS BENEFITS	
Cancer (internal or invasive)	100%
Carcinoma in Situ	25%
SUPPLEMENTAL CRITICAL ILLNESS BENEFITS	
Advanced Alzheimer's Disease	25%
Advanced Parkinson's Disease	25%
Benign Brain Tumor	100%
Coma	100%
Complete Blindness	100%
Complete Loss of Hearing	100%
Paralysis	100%

Other Features

First Occurrence Benefit

The plan contains a 30-day waiting period. After the waiting period, a lump sum benefit is payable upon initial diagnosis of a covered critical illness.

Additional Occurrence Benefit

If an insured collects full benefits for a critical illness under the plan and later has one of the remaining covered critical illness, then Aflac will pay the full benefit amount for each additional illness. Occurrences must be separated by at least six months.

Re-occurrence Benefit

If an insured collects full benefits for a covered condition and is later diagnosed with the same condition, Aflac will pay the full benefit again. The two dates of diagnosis must be separated by at least 12-months, or for cancer, 12-months treatment free. Cancer that has spread (metastasized) even though there is a new tumor, will not be considered an additional occurrence unless the insured has gone treatment free for 12-months.

Pre-existing Condition Limitation

Pre-existing Condition means a sickness or physical condition which, within the 12-month period prior to the Effective Date, resulted in the insured receiving medical advice or treatment. Aflac will not pay benefits for any critical illness starting within 12 months of the Effective Date which is caused by, contributed to, or resulting from a Pre-Existing Condition.

\$50 Wellness Benefit

An insured may receive a wellness benefit for any covered health screening test—per calendar year—regardless of the results of the test. This benefit is payable for a covered employee and spouse (no dependent children). Covered screenings include, but not limited to, mammography, colonoscopy, pap smear, chest x-ray, PSA, stress test, Cholesterol test.

The Aflac Critical Illness Brochure is available on THEbenefitsHUB benefit portal.

Limitation and Exclusions apply—For a comprehensive list of exclusions and limitations, please refer to the Certificate of Insurance. The Certificate also provides all requirements necessary to be eligible for benefits.

AFLAC CRITICAL ILLNESS PLAN MONTHLY PREMIUMS

Age Bands	Non-tobacco Users		Tobacco Users	
	Employee Coverage	Spouse Coverage	Employee Coverage	Spouse Coverage
18—29	\$5.45	\$3.60	\$7.95	\$4.85
30—39	\$8.55	\$5.15	\$13.45	\$7.60
40—49	\$15.55	\$8.65	\$30.75	\$16.25
50—59	\$26.68	\$14.22	\$51.75	\$26.75
60—69	\$41.75	\$21.75	\$81.75	\$41.75

Employee premium is based on employee issue age and tobacco status; spouse premium is based on spouse issue age and tobacco status. You must be under age 70 at time of enrollment to be eligible for coverage. To cover your spouse, if applicable, your spouse must be between ages 18 and 64. Child(ren) are covered at no additional charge—must elect coverage for the child(ren) for child(ren) to be covered.

2026 | Aflac Hospital Indemnity Plan

Important Notice: This is a fixed indemnity policy, not health insurance, and does not satisfy the requirement of minimum essential coverage under the ACA.

Does your major medical insurance cover all of your bills—probably not! Even a minor trip to the hospital can present you with unexpected expenses and medical bills. And though you may have major medical insurance, your plan may only pay a portion of what your entire stay entails. That’s how the Aflac group supplemental hospital indemnity insurance plan can help. It provides financial assistance to enhance your current coverage so you can avoid dipping into savings. Having group supplemental Hospital Indemnity Insurance from Aflac means that you will have added financial resources to help with medical costs or ongoing living expenses.

AFLAC HOSPITAL INDEMNITY BENEFITS	
Benefit Description	Benefit Amount
Hospital Admission This benefit is paid when a Covered Person is confined to a hospital because of a Covered Sickness or as the result of injuries received in a Covered Accident.	\$1,500
Hospital Confinement (up to 180 days per confinement) This benefit is paid when a Covered Person is confined to a hospital as a resident bed patient because of a Covered Sickness or as the result of injuries received in a Covered Accident. To receive this benefit for Injuries received in a Covered Accident, the Covered Person must be confined to a hospital within six months of the date of the Covered Accident. This benefit is payable for only one hospital confinement at a time even if caused by more than one Covered Accident, more than one Covered Sickness, or a Covered Accident and a Covered Sickness.	\$250 per day
Hospital Intensive Care (30 day maximum for any one period of confinement.) This benefit is paid when a Covered Person is confined in a hospital intensive care unit because of a Covered Sickness or due to an Injury received from a Covered Accident. To receive this benefit for injuries received in a Covered Accident, the Covered Person must be admitted to a hospital intensive care unit within six months of the date of the Covered Accident. Aflac will pay benefits for only one confinement in a hospital intensive care unit at a time, even if it is caused by more than one Covered Accident, more than one Covered Sickness, or a Covered Accident and a Covered Sickness. If Aflac pays benefits for confinement in a hospital intensive care unit and a Covered Person becomes confined to a hospital intensive care unit again within six months because of the same or related condition, we will treat this confinement as the same period of confinement.	\$250 per day

Admission/confinement is defined as being confined as a resident bed patient in a hospital. This does not include confinement to an observation unit or for emergency treatment or outpatient treatment.

AFLAC HOSPITAL INDEMNITY PLAN PAYROLL DEDUCTIONS			
	12 PAY MONTHLY	21 PAYROLLS	26 PAYROLLS
EE Only	\$27.55	\$15.74	\$12.72
EE + SP	\$54.15	\$30.94	\$24.99
EE + CH	\$39.25	\$22.43	\$18.12
FAM	\$65.85	\$37.63	\$30.39

You must be under age 65 at time of enrollment to be eligible for coverage. Employee coverage terminates at employee's age 70. To cover your spouse, if applicable, your spouse must be between ages 18 and 64. Spouse coverage terminates at employee's age 70 or spouse's age 70, whichever occurs first.

The Aflac Hospital Indemnity Plan Brochure is available on THEbenefitsHUB benefit portal.

Limitation and Exclusions apply—For a comprehensive list of exclusions and limitations, please refer to the Certificate of Insurance. The Certificate also provides all requirements necessary to be eligible for benefits.

Enrollment Considerations

New Hires/Newly Eligible—guarantee issue is available during the new hire/newly eligible enrollment period. Pre-existing condition limitations apply.

Pre-existing Condition Limitation
 Pre-existing Condition means a sickness or physical condition which, within the 12-month period prior to the Effective Date, resulted in the insured receiving medical advice or treatment. Aflac will not pay benefits for any hospital indemnity claim starting within 12 months of the Effective Date which is caused by, contributed to, or resulting from a Pre-existing Condition.



LegalShield was founded in 1972, with the mission to make equal justice under law a reality. As a member, you can talk to a lawyer on any personal legal matter, no matter how trivial or traumatic, all without worrying about high hourly costs.

LegalShield Services LegalShield

- **Dedicated Law Firm**
- **Legal Advice/Consultation** on an unlimited number of personal legal issues
- **Letters/Calls** made on your behalf
- **Contracts/Documents Reviewed** up to 10 pages each
- **Residential Loan Document Assistance**
- **Lawyers prepare your Will/Living Will/Health Care Power of Attorney**
- **Speeding Ticket Assistance** (15 day waiting period)
- **IRS Audit Assistance**
- **Trial Defense** (if named defendant/respondent in a covered civil action suit)
- **Uncontested Divorce, Separation, Adoption and/or Name Change Representation** (available 90 days after enrollment)
- **25% Preferred Member Discount** (bankruptcy, criminal charges, DUI, personal injury, etc.)
- **24/7 Emergency Access** for covered situations

LegalShield legal plans cover the member; member's spouse; never married dependent children under 21 living at home; dependent children under the age 18 for whom the member is the legal guardian; never married dependent children up to age 23 if a fulltime college student; or physically or mentally disabled dependent children. An individual rate is available for those enrollees who are not married, do not have a domestic partner and do not have minor children or dependents. No family benefits are available to individual plan members. Ask your Independent Associate for details. This is general overview and is for illustrative purposes only. Plans and services vary from state to state. See a plan contract for your state of residence for complete terms, coverage, amounts, conditions and exclusions.

IDShield Membership IDShield

- **Social Media Monitoring** allows you to monitor multiple social media accounts and content feeds for privacy and reputational risks.
- **Privacy and Security Monitoring** Internet monitoring of your name, date of birth, SSN, email address, phone numbers, and more. Monthly credit score tracking. With the family plan, Minor Identity protection is included and provides monitoring for up to 8 children under the age of 18 for no additional cost.
- **Consultation** Your identity protection plan includes 24/7/365 live support for covered emergencies, unlimited counseling, identity alerts, data breach notifications and lost wallet protection.
- **Full Identity Restoration** perform the bulk of the restoration work required to restore a member's identity to pre-theft status.
- **One Million Dollar Protection Policy** Covers costs incurred as a result of identity theft--such as lost wages, travel expenses, elder and child care, and initial legal consultation, and certified public accountant costs.

IDShield family coverage includes, the member, member's spouse and up to 8 minor children under the age of 18. Dependents age 18-26 receive consultation and restoration only. This is a general overview and is for illustrative purposes only. See plan details for complete terms, coverage, amounts, conditions and exclusions.



**Product
Overview Video**

LEGALSHIELD IDSHIELD MONTHLY RATES		
	Employee Only	Family
LegalShield	\$15.75	\$15.75
IDShield	\$8.95	\$18.95
Combined LegalShield IDShield	\$24.70	\$30.70

**For More Information Contact: Bob Pilcher
(316) 215-5100 | bobbilcher58@gmail.com**

NOTICE OF SPECIAL ENROLLMENT PROVISIONS

If you are declining enrollment for yourself or your dependents (including your spouse) because of other health plan coverage, you may in the future be able to enroll yourself and/or your dependents in this plan, provided that you request enrollment within 30 days after you or your dependents lose eligibility for that other coverage (or employer contributions toward that coverage end). In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents, provided that you request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption. To request special enrollment, contact your Payroll/Benefits Department.

WOMEN'S HEALTH AND CANCER RIGHTS ACT OF 1998

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

1. All stages of reconstruction of the breast on which the mastectomy was performed;
2. Surgery and reconstruction of the other breast to produce a symmetrical appearance;
3. Prostheses; and
4. Treatment of physical complications during all stages of the mastectomy, including lymphedemas.

These benefits will be provided, subject to the same deductible, copays, and coinsurance applicable to other medical and surgical benefits under the plan.

SPECIAL RULES FOR MOTHERS AND NEWBORNS

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).

HIPAA Privacy

The Derby Public Schools Welfare Plan is required by law to take reasonable steps to ensure the privacy of your personally identifiable health information and to inform you about the uses of protected health information (PHI) and your privacy rights. PHI use and disclosure by Derby Public Schools Welfare Plan is regulated by federal law known as HIPAA (the Health Insurance Portability and Accountability Act). A paper copy may be requested through the Payroll/Benefits Department.

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).

Contact your State for more information on eligibility—

KANSAS – Medicaid

Website: <https://www.kancare.ks.gov/>

Phone: 1-800-792-4884

HIPP Phone: 1-800-967-4660

For additional state information or for more information on special enrollment rights, you can visit <https://www.dol.gov/sites/dolgov/files/EBSA/laws-and-regulations/laws/chipra/model-notice.pdf> or 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.

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with Derby Public Schools USD 260 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. Blue Cross Blue Shield of Kansas has determined that the prescription drug coverage offered by Derby Public Schools USD 260 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 Derby Public Schools USD 260 coverage will not be affected. Plan participants can keep their prescription drug coverage under the group health plan if they select Medicare Part D prescription drug coverage. If they select Medicare Part D prescription drug coverage, the group health plan prescription drug coverage will coordinate with the Medicare Part D prescription drug coverage. If you do decide to join a Medicare drug plan and drop your current Derby Public Schools USD 260 coverage, be aware that you and your dependents will be able to get this coverage back.

When Will You Pay a Higher Premium (Penalty) to Join a Medicare Drug Plan?

You should also know that if you drop or lose your current coverage with Derby Public Schools USD 260 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.

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).

Name of Entity/Sender: Derby Public Schools USD 260
Contact--Position/Office: Payroll/Benefits Department
Address: 1550 E. Walnut Grove Rd. | Derby, KS 67037
Phone Number: (316) 788-8400
Print Date: November 2025

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).

2026 | Contact Information



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BLUE CROSS BLUE SHIELD OF KANSAS MEDICAL & PRESCRIPTION DRUG COVERAGE	www.bcbsks.com Member Services ----- 800-432-3990 Specialty Pharmacy ----- 833-721-1620 AmWell Telehealth ----- 844-733-3627
DELTA DENTAL OF KANSAS DENTAL COVERAGE	www.deltadentalks.com Customer Service ----- 800-234-3375
SURENCY LIFE & HEALTH VISION COVERAGE	www.surency.com Customer Service ----- 866-818-8805
RELIANCE STANDARD 3-IN-1 SUPPLEMENTAL PLAN	www.reliancestandard.com Customer Service ----- 800-351-7500
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Disclaimer: This Benefits Resource Guide is designed to provide basic information regarding benefit plans and programs available to eligible employees of Derby Public Schools USD 260. This document merely summarizes the employee benefit plans and programs and does not detail all of the terms, conditions, restrictions, and exclusions contained in the plan documents, carrier contracts and/or Summary Plan Descriptions (SPD) (the “plan documentation”) for the various benefit plans and programs. Every reasonable effort has been made to ensure the accuracy of the information contained in this document; however, in the event of a discrepancy between the information in this document and the plan documentation, the provisions described in the plan documentation will govern. This document does not create any contractual rights for any current or former employee of Derby Public Schools USD 260, or for any other individual. The provisions of the applicable plan documentation will govern the determination of any individual’s rights under any employee benefit plan or program. Derby Public Schools USD 260 reserves the right to amend or terminate any of its employee benefit plans and programs at any time and without notice or cause.



Brown & Brown Insurance Services, Inc.
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