



RETIREE **Benefits Guide**

2027

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www.mybenefits.com/usd260



2027 Benefits

About This Guide

This guide highlights your benefits. Official plan and insurance documents govern your rights and benefits under each plan. For more details about your benefits, including covered expenses, exclusions, and limitations, please refer to the individual summary plan descriptions (SPDs), plan document, or certificate of coverage for each plan. If any discrepancy exists between this guide and the official documents, the official documents will prevail. Your employer reserves the right to make changes at any time to the benefits, costs, and other provisions relative to benefits.

We are pleased to offer a comprehensive benefits program for you and your eligible family members. This guide provides an overview of benefits you may be eligible for as a retiree. **You may not be eligible for all benefits outlined in this guide. You should discuss your eligibility with the Payroll/Benefits Department personnel.** Official plan documents govern in the event of any discrepancies. You are encouraged you to review this guide and consult the plan documents for more detailed information.

This guide is best viewed in the electronic form so you can access links that will direct you to additional information through the carrier websites. Additionally, an audio-visual benefit overview video is available on the home page of www.mybenefitshub.com/usd260

Benefit 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

Summary of Benefits & Coverage (SBC)

As required by the Affordable Care Act, Summaries of Benefits and Coverage (SBCs) are available and can be accessed through the benefit portal - **THEbenefitsHUB**. SBCs summarize important information about the medical benefit plan options in a standard format, to help you compare across plans and make an informed choice. If you would like a paper copy of the SBCs (free of charge), please contact the Payroll/Benefits Department.

Medicare Prescription Drug Information

If you (and/or your dependents) have Medicare or will become eligible for Medicare in the next 12-months, a Federal law gives you more choices about your prescription drug coverage. Important information can be found in the [legal notices](#) of the benefit guide. Please read the notice carefully and keep it where you can find it. This notice has information about the prescription drug coverage offered by your employer through the medical plan and about your options, if applicable, under Medicare's prescription drugs coverage.

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2027 Premiums

Medical Monthly Premiums				
	Employee Only	Employee + Spouse	Employee + Child(ren)	Family
Total Monthly Premiums				
Option 1: \$1,500 Deductible	\$930.40	\$1,784.50	\$1,681.24	\$2,635.82
Option 2: \$3,500 Deductible	\$887.88	\$1,703.16	\$1,604.50	\$2,515.66
Option 3: \$5,000 QHDHP	\$823.42	\$1,579.78	\$1,487.58	\$2,332.41

Dental Plan Payroll Deductions	
Total Monthly Premiums	
Employee Only	\$45.51
Employee + Spouse	\$90.87
Employee + Child(ren)	\$89.11
Family	\$124.33

Vision Plan Payroll Deductions	
COMPREHENSIVE PLAN	Monthly
Employee Only	\$10.22
Employee + Spouse	\$21.48
Employee + Child(ren)	\$18.41
Family	\$35.81
MATERIALS ONLY PLAN	Monthly
Employee Only	\$10.59
Employee + Spouse	\$20.77
Employee + Child(ren)	\$18.26
Family	\$28.46



Attention Retirees

The benefits you are eligible to continue as a retiree are determined by your categorization as a Retiree or Bridge Retiree. You are able to retain coverage in the benefits that you are eligible for as a Retiree/Bridge Retiree; however, Retirees/Bridge Retirees may not add additional benefits.

Please speak to your Derby USD 260 Benefit Team in the District's Payroll/Benefits Department if you have questions about your eligibility or which benefits you are eligible to retain.

**You will be notified by the Payroll/
Benefits Department about
instructions on how to enroll/renew
your benefits as an eligible Retiree/
Bridge Retiree.**

Questions?

If you have questions or trouble with the enrollment process, please reach out to your Derby Benefit Team at the District's Payroll/Benefits Department or our Benefit Consultant Partner, Howden.

Payroll/Benefits Department

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Medical

Your employer provides medical and prescription drug coverage through **Blue Cross Blue Shield of Kansas**, offering comprehensive benefits within the **Blue Choice Preferred-Care Blue network**.

Benefits outlined below are coverage parameters for in-network, covered services.

Benefit Category	Option 1 \$1,500 Deductible	Option 2 \$3,500 Deductible	Option 3 \$5,000 QHDHP
Plan Year: January 1 - December 31			
Health Savings Account Eligible	No	No	Yes
Plan Year Deductible	\$1,500 Individual \$3,000 Family	\$3,500 Individual \$7,000 Family	\$5,000 Individual \$10,000 Family
Coinsurance	20%	20%	0%
Coinsurance is applicable until Annual Out-of-Pocket has been met			
Annual Maximum Out-of-Pocket	\$6,500 Individual \$13,000 Family		
Annual Maximum Out-of-Pocket includes deductible, coinsurance and copays. After the annual maximum is reached, all in-network covered services will be paid at 100% for the remainder of the plan year.			
Doctor's Office Visits Copay	Primary Care ¹ : \$35 Specialist: \$70	Primary Care ¹ : \$35 Specialist: \$70	Deductible
Preventive Care ²	Paid at 100% of allowable charge; includes routine screenings, immunizations, well-women visits, contraceptive methods		
Emergency Transportation	Subject to deductible/coinsurance		Deductible
Emergency Department	\$250 copay + deductible/coinsurance	\$250 copay + deductible/coinsurance	Deductible
Inpatient Surgery (Physician/Surgical)	deductible/coinsurance	deductible/coinsurance	Deductible
Inpatient Facility Fee	deductible/coinsurance	deductible/coinsurance	Deductible
Outpatient Surgery	deductible/coinsurance	deductible/coinsurance	Deductible
Outpatient Lab & Radiology	Paid at 100% up to \$300; then subject to deductible/coinsurance		Deductible
Outpatient Rehabilitation	deductible/coinsurance	deductible/coinsurance	Deductible
Hospice	deductible/coinsurance	deductible/coinsurance	Deductible
Home Social Work Visits	deductible/coinsurance	deductible/coinsurance	Deductible
Mental Health Inpatient ³	deductible/coinsurance	deductible/coinsurance	Deductible
Mental Health Outpatient	\$35 copay per visit	\$35 copay per visit	Deductible



Benefit Category	Option 1 \$1,500 Deductible	Option 2 \$3,500 Deductible	Option 3 \$5,000 QHDHP
Prescription Drug List	ResultsRx Formulary		
Retail Pharmacy (30-day supply)	Copays	Copays	Subject to Deductible After deductible has been met, copay will apply with the same copay tiers as stated on plan options 1 & 2
Tier 1	\$15 copay	\$15 copay	
Tier 2	\$50 copay	\$50 copay	
Tier 3	\$75 copay	\$75 copay	
Tier 4	\$150 copay	\$150 copay	
Tier 5	20% to \$250	20% to \$250	
Other drug coverage provisions: Mandatory Generic ⁴ , Mail Order ⁵ , Advocate+ Pharmacy Match for Specialty Drugs ⁶ , Flex Access ⁷ , Extended Supply Network ⁸			

¹ Primary Care Providers includes a Professional Provider who is engaged in family practice, general practice, gynecology (GYN), internal medicine, obstetrics (OB), OB/GYN, pediatrics, urgent care or Mental Illness or Substance Use Disorders. This includes the following Eligible Providers when performing for a primary physician: Advanced Registered Nurse Practitioner (ARNP), Advanced Practice Registered Nurse Generalist (APRN Generalist) and Physician Assistant (PA). One routine eye exam is paid as a Primary Care Provider office visit copay. Any subsequent eye exam visits paid at Specialist copay

² 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

³ Required pre-admission certification from Lucet at (800) 952-5906.

⁴ Mandatory Generic — Generic 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 Narrow Therapeutic Index, the member can receive the brand name drug and will not be charged for the cost difference between brand and generic.

⁵ The 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. You can call (833) 599-0511 or visit www.bcbsks.com/prescription-drugs/mail-order to start the mail-order process.

⁶ For each applicable specialty prescription claim, Pharmacy Match pinpoints a well-qualified pharmacy from Prime Therapeutics network of participating pharmacies. By using a configurable set of rules based on price, experience and care, this solution matches members and their specialty prescriptions to a pharmacy best suited to meet members' needs. The program guides members to the best-matched qualified specialty pharmacy on cost, experience and care.

⁷ When 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 your 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.

⁸ Members 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.

Medical Plan Resources

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.

BCBSKS Member BlueAccess Portal

For convenient access to tools and resources that support your BCBSKS membership, be sure to create a Member BlueAccess® account. You can visit www.bcbsks.com/blueaccess to get started. When registering for the first time, have your BCBSKS ID card ready so you can enter your ID number and Group Number.

With your BlueAccess account, you can look-up providers and covered prescription drugs, view and print your ID card, check claims, explore discounts and coupons, and access additional member-specific information.

Prescription Drug Information

To determine whether a prescription is covered, review the **ResultsRx Medication List** available through Prime Therapeutics drug formulary. To get the best result, login to your BlueAccess account and click on Rx Drugs.

You should make sure that the Drug List chosen is the **BCBSKS Results Medication List**.



Choose your drug list

BCBSKS ResultsRx Medication List

Specialty Drug Information: Advocate+ Pharmacy Match

The specialty pharmacy experience can be complex. The **Advocate+ Pharmacy Match** program uses an integrated approach to choose the right specialty pharmacy for each member, helping to reduce overall costs while improving member experience.

The **Advocate+ Pharmacy Match** program provides end-to-end support from a care specialist, who:

- Make welcome calls to new-to-therapy members and answer questions
- Keep members informed about where to get their prescriptions
- Promotes coordination between prescribers and pharmacies to deliver a more seamless experience
- And more

Members taking more than one specialty medication may be required to get their prescriptions from different pharmacies. Once the member is "matched" with a pharmacy for the specialty medication, the member will continue to get the specialty medication filled at that particular pharmacy for up to one year.

AmWell Telehealth Services

BCBSKS Telehealth Services through AmWell

Telehealth gives you a fast and convenient way to connect with a doctor—whether by video or phone—without leaving home. If you don't have a smart device, phone-based service is also available. Services are available nationwide, 24 hours per day.

Telehealth is an ideal option for everyday healthcare needs, such as cold and sinus infections, pink eye, ear infections, rashes, migraines, stomach pain, and more.

Download the AmWell app on your mobile device | Visit www.bcbsks.com/health-and-wellness/telehealth



Preventive Care

To be your healthiest you, it is important that you regularly see your doctor and discuss preventive care to help you avoid serious illnesses or diseases. Routine checkups and screenings can help you avoid serious health problems by working with your doctor to help you reach your personal health and wellness goals.

Preventive care includes immunizations, screenings, counseling and education to help prevent or minimize the effects of serious health conditions at no extra cost to you. The appropriate preventive care services can vary for each person based on age, gender and other risk factors, including family medical history.

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. You can visit the BCBSKS website at www.bcbsks.com/health-and-wellness/preventive-health Preventive services are subject to change.

BCBSKS HealthyOptions

Your BCBSKS coverage includes access to a variety of support programs aimed at helping you maintain a healthy lifestyle. To explore these programs and learn more, visit www.bcbsks.com/health-and-wellness.

Disease Management

BCBSKS nurses provide one-on-one support to members via telephone to help individuals develop self-care habits for conditions such as asthma, COPD, diabetes, heart disease, high blood pressure, and 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 in more complex situations in order to meet needs in a quality and cost-effective manner. For more 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 develop self-care habits. BCBSKS offers programs for tobacco cessation, weight loss, stress management and maternity care. 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 understands the impact that type 2 diabetes can have on both your health and your financial well-being. To support members managing this condition, BCBSKS partners with Virta Health to provide treatment designed to help stabilize blood sugar, reduce or eliminate diabetes medications, and promote safe, sustainable weight loss.

Eligible members will receive communication from BCBSKS—typically by email or mail—with instructions on how to enroll. You can also contact BCBSKS Member Services to confirm eligibility and learn more. Additional details about Virta Health are available at www.bcbsks.com/virta

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 on-line by accessing through your BlueAccess account or scheduling through the SmartShopper® Care Concierge Team at 866-820-6426.

Dental Insurance

Dental benefits are offered through **Delta Dental of Kansas**.

Benefit Category	In-network Benefits
Plan Year Benefit Maximum	\$1,500 for each enrolled member on the plan
Diagnostic & Preventive Services You pay 0% of the allowable charge	• Oral evaluations—two (2) times each calendar year • Bitewing x-rays—bitewings two (2) times each calendar 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 • Routine Cleanings—unlimited to plan maximum benefit • Topical Fluoride—two (2) times each calendar year for dependent children under age nineteen (19) • Space Maintainers—for dependent children under age fourteen (14) and only for premature loss of primary molars • 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
Basic and Major Services have a combined annual deductible of \$25 individual \$75 family	
Basic Services You pay 20% of the allowable charge	• Ancillary—Provides for one (1) emergency examination per calendar year by the Dentist for the relief of pain. • Oral Surgery • 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. • Periodontics—Includes procedures for the treatment of disease of the gums and bones.
Major Services You pay 50% of the allowable charge	• Special Restorative Dentistry—When teeth cannot be restored with a filling, provides for individual crowns • Prosthodontics—Includes bridges, partial and complete dentures; repairs and adjustments of bridges and dentures
Other Plan Benefit	Right Start 4 Kids Program: The Right Start 4 Kids program removes the cost barriers for dental care by providing children, 18 and under, 100% coverage with no deductible, for all services covered under the plan when an in-network dentist is seen. The Annual Plan Year Benefit Maximum applies.

This is a brief summary of the coverage available under this plan. The exact provisions of the benefits and exclusions are contained in the certificate.



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 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 tool by visiting www.deltadentalks.com

- 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
- Easy access to download Delta Dental's mobile app
- Learn about oral health and wellness
- And more...

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. It is to your advantage to choose a **Delta Dental PPO** or **Delta Dental Premier** network dentist.

Delta Dental PPO providers have a higher discount than Premier providers, which means your annual maximum benefit could go farther if using a PPO provider. Delta Dental network dentists also agree not to bill patients for differences between the Delta Dental contracted fees and their typical charges.

Vision Insurance

Vision benefits are offered through **Surency**. You can choose from two plans: Comprehensive Vision Plan or Materials Only Plan.

Comprehensive Vision Plan		
Plan Year: January 1 - December 31 Plan benefits are available once every calendar year.		
	In-network Member Cost (Access Network)	Out-of-Network Reimbursement
Exam Services		
Eye Exam	\$10 copay	Up to \$35
Retinal Imaging	Up to \$39	Not Covered
Contact Lens Fit & Follow-up		
Contact Lens Fit & Follow-up (Standard)	\$0 copay; fit & 2-follow up visits	Up to \$40
Contact Lens Fit & Follow-up (Premium)	\$55 allowance	Up to \$40
Frame		
Frame	\$130 allowance; 20% off balance	Up to \$65
Contact Lenses (in lieu of eye glass lenses; contact lens allowance includes materials only)		
Contacts - Conventional	\$130 allowance; 15% off balance	Up to \$100
Contacts - Disposable	\$130 allowance	Up to \$100
Contacts - Medically Necessary	\$0 copay	Up to \$200
Standard Plastic Lenses (in lieu of contacts)		
Single Vision	\$25 copay	Up to \$25
Bifocal	\$25 copay	Up to \$40
Trifocals or Lenticular	\$25 copay	Up to \$55
Progressive - Standard	\$90 copay	Up to \$40
Progressive - Premium	\$90 copay; \$120 allowance; 20% off balance	Up to \$40
Lens Options		
Anti-reflective Coating - Standard	\$45	Not covered
Polycarbonate - Standard	Adults: \$40 Children under 19: \$0	Up to \$25
Standard Scratch Resistance	\$15	Not covered
Tint - Solid and Gradient	\$15	Not covered
UV Coating	\$15	Not covered
All Other Lens Options	20% off retail price	Not covered

This is a brief summary of the coverage available under this plan. The exact provisions of the benefits and exclusions are contained in the certificate.



Materials Only Plan

Plan Year: January 1 - December 31

Plan benefits are available once every calendar year.

	In-network Member Cost (Access Network)	Out-of-Network Reimbursement
Frames, Lenses & Options Package	\$200 Allowance; 20% off balance over allowance	Up to \$200
Contact Lenses (in lieu of frames, lenses & options package)	\$200 Allowance	Up to \$200

Additional Discounts

Members enrolled in either vision plan option can access these additional discounts and perks when using in-network providers.

- **40% off** additional pair of eyeglasses or sunglasses
- **20% off** non-covered items such as cleaning cloths and solution
- **15% off** retail price for laser vision correction or 5% off promotional price; to use the LASIK discount, locate a LASIK provider by calling (800) 988-4221 or visit eyemedlasik.com
- **40% off** hearing exams and a low price guarantee on discounted hearing aids; to use the hearing discount, call (877) 203-0675 to find a hearing care provider and schedule an exam

Surency Vision Resources

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 national networks, which includes both independent private practitioners and nationally recognized retail chains. Access the Surency Vision provider network, as well as other valuable resources by visiting www.surency.com/our-products/vision

- Find a provider (**Access Network**)
- Access your mobile ID card
- Check claim status or view how your claim paid
- And more

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.

The 3-in-1 Worksite Benefits Package through **Reliance Matrix** provides cash benefits for Accidents, certain Critical Illnesses, and Hospitalizations—helping cover out-of-pocket costs like deductibles or daily expenses. 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 payroll cycle	\$24.00	\$47.18	\$39.30	\$62.62
21 payroll cycle	\$13.71	\$26.96	\$22.46	\$35.78
26 payroll cycle	\$11.08	\$21.78	\$18.14	\$28.90

1

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 Plan Benefits

Room & Board Benefits	\$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

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 Plan Benefits

Base Benefit Amounts	Employee: \$5,000 Spouse: \$5,000 Child(ren): \$1,250
Benefit Reductions due to age	Benefit reduces to 50% at age 70; Spouse coverage terminates at age 75
Covered Critical Illnesses	100% base benefit amount 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 for Carcinoma In Situ, Coronary Disease 5% base benefit amount for skin cancer
Lifetime Maximum Benefit	1,000% of Insurance Amount
Subsequent Occurrence	50% of benefit if diagnosed 6-months or later
Recurrence (same illness)	100% if diagnosed 12-months or later
Pre-existing Limitation	12-month look back period; 12 month coverage period
\$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, colonoscopy, mammography, Pap test, PSA, skin cancer screening—see the certificate of coverage for a full list of tests covered



3

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.

Accident Plan Benefits			
Ambulance Transportation		Ground: \$100 Air: \$500	
Emergency Treatment		\$150	
Diagnostic Exam (1x per covered accident)		\$100	
Initial Physician Office Visit (1x per covered accident)		\$50	
General Accident Treatment Benefits			
Initial Hospital Confinement (1x per covered accident)		\$500	
Initial ICU Hospital Admission		\$1,000	
Confinement per day		\$200; 365 days max ICU: \$400; 30 days max	
Rehab Facility Confinement per day		\$50; 30 days max	
Follow-up Physician Office Visit (1x per covered accident)		\$50	
Transportation (more than 100 miles, 3 round trips max)		\$300	
Lodging (for 1 person, more than 100 miles from residence)		\$100; 30 days max	
Accident Surgery Benefits			
Exploratory - no repair	\$100	Abdominal or Thoracic	\$1,000
Knee Cartilage	\$300	Ruptured Disc	\$500
		Tendon, Ligament or Rotator Cuff	Up to \$600
Specific Covered Accident Injury and Treatment Benefits			
Fractures		Surgical: Up to \$5,000 Non-surgical: Up to \$2,500	
Dislocations		Surgical: Up to \$3,200 Non-surgical: Up to \$1,600	
Burns		2nd degree: Up to \$500 3rd degree: up to \$6,400 Skin graft: 25% of payable burn benefit	
Blood/Plasma/Platelets	\$200	Dental Injury	Crown: \$150 Extraction: \$50
Coma	\$5,000		
Concussion	\$100	Eye Injury	Removal of object: \$100 Surgical repair: \$200
Lacerations	Up to \$400		
Other			
Medical Appliance		\$100	
Prosthesis		One: \$500 Two-or-more: \$1,000	
Physical Therapy		\$25 per session; up to 6 sessions	
Paralysis		Paraplegia/Hemiplegia: \$5,000 Quadriplegia: \$10,000	

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 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.

The **Aflac Group Accident Plan** provides cash benefits directly to you and help with out-of-pocket expenses - medical and non-medical - associated with treatment in the event of a covered accident. Below are some of the plan features of the Aflac Group Accident Plan. For a complete overview of your coverage, including limitations and exclusions, please review the [Plan Brochure](#).

Plan Features

- 24 hour coverage
- No waiting period once your policy is effective
- No reduction at any age
- Portable coverage

Benefits are not payable for accidents that occurred prior to the effective date of coverage.

Treatment for the accident generally has to be incurred within a certain time frame from the accident for benefits to be payable.

Examples of covered Accident Plan Benefits

Review the [Plan Brochure](#) for the full coverage offering

Initial Treatment (Hospital ER Urgent Care Doctor's Office)	\$200 \$200 \$100
Accident Follow-up Treatment (up to 6 visits)	\$100
Ambulance (Ground Air)	\$400 \$1,200
Major Diagnostic Exam	\$200
X-Ray	\$25
Concussion	\$200
Traumatic Brain Injury	\$5,000
Lacerations (requiring stitches: based on length of laceration) Lacerations not requiring stitches have a flat benefit of \$50	Up to \$1,000
Burns (based on degree and severity of burn)	Up to \$20,000
Eye Injury (removal of foreign body)	\$250
Dislocations (closed reduction - based on body part; open reduction pays 2x)	Closed Reduction: Up to \$3,600
Fractures (closed reduction - based on body part; open reduction pays 2x)	Closed Reduction: Up to \$4,500
Surgery and Anesthesia (outpatient inpatient)	\$400 \$1,000
Hospital Admission	\$1,000
Hospital Confinement (per day benefit, up to 365)	\$300
Appliances (examples: ankle brace, walking boot, crutches, knee scooter,)	\$100
Accidental Death Rider	EE: \$50,000 SP: \$25,000 CH: \$10,000
\$75 Wellness Benefit Once per calendar year, per insured (including children)	This benefit is only payable for health screening tests performed as the result of preventive care, including tests and diagnostic procedures ordered in connection with routine examinations.

Aflac Accident Plan Payroll Deductions

Total Monthly Premiums	12 payroll cycle	21 payroll cycle	26 payroll cycle
Employee Only	\$16.20	\$9.27	\$7.48
Employee + Spouse	\$23.16	\$13.26	\$10.70
Employee + Child(ren)	\$30.90	\$17.66	\$14.26
Family	\$37.86	\$21.66	\$17.48



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.

The **Aflac Group Critical Illness Plan** is a voluntary benefit that pays a lump sum cash benefit directly to you if you are diagnosed with a covered serious illness, such as cancer, heart attack, or stroke. You can use the money however you choose, for example medical costs not covered by health insurance, everyday bills, or travel for treatment. Below are some of the plan features of the Aflac Group Critical Illness Plan. For a complete overview of your coverage, including limitations and exclusions, please review the [Plan Brochure](#).

Person Covered	Base Benefit Amount
Employee	\$10,000
Spouse	\$5,000
Child(ren)	\$5,000

Percentage of base benefit amount payable

Examples of covered Critical Illness Benefits	
Review the Plan Brochure for the full coverage offering	
Cancer (internal or invasive)	100%
Heart Attack	100%
Stroke	100%
Kidney Failure	100%
Bone Marrow Transplant	100%
Major Organ Transplant	100%
Type I Diabetes	100%
ALS or Lou Gehrig's Disease	100%
Sustained Multiple Sclerosis	100%
Advanced Alzheimer's Disease	100%
Advanced Parkinson's Disease	100%
Non-invasive Cancer	25%
Childhood Conditions Cystic Fibrosis, Cerebral Palsy, Cleft Lip or Cleft Palate, Down Syndrome, PKU, Spina Bifida	50%
Other Benefits	
Skin Cancer Benefit	\$1,000 for the diagnosis of skin cancer
Autism Spectrum Disorder	\$3,000
\$50 Health Screening Benefit Once per calendar year, per insured (including children)	This benefit is only payable for health screening tests performed as the result of preventive care, including tests and diagnostic procedures ordered in connection with routine examinations.

Other Features

Additional Diagnosis Benefit

Aflac will pay benefits for each different critical illness after the first when the two dates of diagnoses are separated by at least six (6) consecutive months.

Reoccurrence Benefit

Aflac will pay benefits for the same critical illness after the first when the two dates of diagnosis are separated by at least six (6) consecutive months.

You must be diagnosed with the covered critical illness, or other conditions covered under this policy, after the effective date of the policy in order for applicable benefit to be payable.

Aflac Critical Illness Plan Monthly Premiums

Age Band	Employee Rate	Spouse Rate
18-25	\$4.50	\$2.25
26-30	\$5.83	\$2.91
31-35	\$7.29	\$3.64
36-40	\$9.36	\$4.68
41-45	\$12.31	\$6.16
46-50	\$15.88	\$7.94
51-55	\$24.56	\$12.28
56-60	\$29.36	\$14.68
61-65	\$46.77	\$23.39
66+	\$74.84	\$37.42

Rates are ATTAINED age rates, which means when the employee is applying for coverage, their age, respective age band and premiums will be based on the 1st day of the current plan year (i.e. January 1, 2027) that their coverage is effective in. Age is calculated separately for the Employee and their Spouse and is based on the employee and spouse's own age. New Hires throughout the year - age will be based on how old the covered employee/spouse was on January 1st of the year their coverage is effective (i.e. new hire coverage effective 4/1/2027 - age based on age as of 1/1/2027). Rates will increase each plan year if a new age band has been met. Children can be covered up to age 26.

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.

The **Aflac Group Hospital Indemnity Plan** provides cash benefits directly to you that help pay for costs associated with a covered hospital stay. For a complete overview of your coverage, including limitations and exclusions, please review the [Plan Brochure](#).

Hospital Indemnity Plan Benefits Review the Plan Brochure for the full coverage offering	
Hospital Admission (once per covered sickness or accident per calendar year for each insured); payable when an insured is admitted to a hospital and confined as in inpatient. Benefits are not payable for admission of a newborn child following his/her birth; however, benefits would be payable for a newborn's admission to a Hospital Intensive Care Unit if, following birth, the newborn is confined as an inpatient as a result of a covered accident injury or covered sickness (including congenital defects, birth abnormalities, and/or premature birth).	\$2,000
Hospital Confinement (maximum 31 days per confinement for each covered sickness or accident for each insured); payable when an insured is confined to a hospital as inpatient	\$300
Hospital Intensive Care Admission Benefit (once per covered sickness or accident per calendar year for each insured); payable when an insured is admitted to the Hospital ICU and confined as a patient. This benefit is payable in addition to the Hospital Admission Benefit.	\$2,000
Hospital Intensive Care Unit (maximum 10 days per confinement for each covered sickness or accident for each insured); payable when an insured is confined to a Hospital ICU. This benefit is payable in addition to the Hospital Confinement Benefit.	\$300
Intermediate Intensive Care Step-Down Unit (maximum 10 days per confinement for each covered sickness or accident for each insured); payable when an insured is confined in an Intermediate Intensive Care Step-Down Unit. This benefit is payable in addition to the Hospital Confinement Benefit.	\$100

- There are no pre-existing condition exclusions on this plan.
- There is no waiting period for benefits once the policy is effective.
- Newborn and newly adopted children are automatically covered from the moment of birth or adoption for 60 days.
- Guaranteed-issue coverage is offered to all eligible employees (and eligible dependents) during open enrollment or during the new hire period.

Aflac Hospital Indemnity Plan Payroll Deductions			
Total Monthly Premiums	12 payroll cycle	21 payroll cycle	26 payroll cycle
Employee Only	\$27.55	\$15.74	\$12.72
Employee + Spouse	\$54.15	\$30.94	\$24.99
Employee + Child(ren)	\$39.25	\$22.43	\$18.12
Family	\$65.85	\$37.63	\$30.39



LegalShield & IDShield

You have the option to enroll in **LegalShield** and **IDShield** plans with convenient payroll deductions.

To learn more about these benefits visit www.shieldbenefits.com/usd260

LegalShield Protection Plan

For over 50 years, LegalShield has made it affordable and easy for its members to connect with its network of vetted, dedicated law firms across the United States and parts of Canada. Lawyers average 22 years of experience. Please note that LegalShield provides access to legal services offered by a network of provider law firms to its members.

- Dedicated Law Firm
- Legal Advice/Consultation
- Letters/Calls
- Contracts/Documents reviewed
- Residential Loan Document assistance
- Will preparation
- Speeding Ticket assistance
- IRS Audit assistance
- Trial Defense (covered civil action suit)
- Uncontested Divorce/Separation, Adoption
- 25% Preferred Member Discount
- 24/7 Emergency Access

IDShield Protection Plan

IDShield believes everyone has a right to live life on-line without worry. While the internet has no shortage of threats, IDShield helps people rest easy. IDShield will always act with integrity and will only use your data to provide service to you. IDShield will always be clear and transparent about how your information is stored and handled. IDShield is part of PPLSI, established in 1972, which offers Legal and Identity protection plans and protects over 2 million North Americans.

- Continuous Credit monitoring
- Financial Account monitoring
- Consultation
- Identity restoration
- Unlimited Service Guarantee
- \$1 Million Protection Plan
- 24/7 Emergency Access

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 full-time 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 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.

Monthly LegalShield & IDShield Premiums		
	Individual	Family
LegalShield	\$15.75	\$15.75
ID Shield	\$8.95	\$18.95
Combined	\$24.70	\$30.70

For More Information Contact

Bob Pilcher
(316) 215-5100
bobpilcher58@gmail.com

Legal Notices

HIPAA Special Enrollment Notice

This notice is being provided to make certain that you understand your right to apply for group health coverage. You should read this notice even if you plan to waive health coverage at this time.

Loss of Other Coverage

If you are declining coverage 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).

Example: You waived coverage under this Plan because you were covered under a plan offered by your spouse's employer. Your spouse terminates employment. If you notify your employer within 30 days of the date coverage ends, you and your eligible dependents may apply for coverage under this Plan.

Marriage, Birth or Adoption

If you have a new dependent as a result of a 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, or placement for adoption.

Example: When you were hired, you were single and chose not to elect health insurance benefits. One year later, you marry. You and your eligible dependents are entitled to enroll in this Plan. However, you must apply within 30 days from the date of your marriage.

Medicaid or CHIP

If you or your dependents lose eligibility for coverage under Medicaid or the Children's Health Insurance Program (CHIP) or become eligible for a premium assistance subsidy under Medicaid or CHIP, you may be able to enroll yourself and your dependents. You must request enrollment within 60 days of the loss of Medicaid or CHIP coverage or the determination of eligibility for a premium assistance subsidy.

Example: When you were hired, your children received health coverage under CHIP and you did not enroll them in this Plan. Because of changes in your income, your children are no longer eligible for CHIP coverage. You may enroll them in this Plan if you apply within 60 days of the date of their loss of CHIP coverage.

For More Information or Assistance

To request special enrollment or obtain more information, please contact the Payroll/Benefits Department.



HIPAA Privacy Practices Reminder Notice

Your Organization's Medical and FSA 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 the Organization is regulated by federal law known as HIPAA (the Health Insurance Portability and Accountability Act). A paper copy may be requested through the Payroll/Benefit Department.

Women's Health and Cancer Rights Act

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:

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 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 the customer service phone number listed on your medical insurance ID card.

Newborns' and Mothers' Health Protection Act

Group health plans and health insurance issuers generally may not, under federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under federal law, require that a provider obtain authorization from the plan or the insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

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).



Legal Notices

Several states offer Premium assistance. If you live in one of the states, you may be eligible for assistance paying your employer health plan premiums. 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, visit <https://www.dol.gov/agencies/ebsa/lawa-and-regulations/laws/chipra> → click on **Model Notice for Employers Regarding Premium Assistance Opportunities** [here](#); or contact—

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



Health Insurance Marketplace Coverage Options and Your Health Coverage

Part A: General Information

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

What is Health Insurance Marketplace?

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

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

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

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

Yes. If you have an offer of health coverage from your employer that is considered affordable for you and meets certain minimum value standards, you will not be eligible for a tax credit, or advance payment of the tax credit, for your Marketplace coverage and may wish to enroll in your employment-based health plan. However, you may be eligible for a tax credit, and advance payments of the credit, that lowers your monthly premium, or a reduction in certain cost-sharing, if your employer does not offer coverage to you at all or does not offer coverage that is considered affordable for you or meet minimum value standards. If your share of the premium cost of all plans offered to you through your employment is more than 10.22%¹ of your annual household income, or if the coverage through your employment does not meet the “minimum value” standard set by the Affordable Care Act, you may be eligible for a tax credit, and advance payment of the credit, if you do not enroll in the employment-based health coverage. For family members of the employee, coverage is considered affordable if the employee’s cost of premiums for the lowest-cost plan that would cover all family members does not exceed 10.22% of the employee’s household income.^{1, 2}

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

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



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

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

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

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

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

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

What about alternative to Marketplace Health Insurance coverage?

If you or your family are eligible for coverage in an employment-based health plan (such as an employer-sponsored health plan), you or your family may also be eligible for a Special Enrollment Period to enroll in that health plan in certain circumstances, including if you or your dependents were enrolled in Medicaid or CHIP coverage and lost that coverage. Generally, you have 60 days after the loss of Medicaid or CHIP coverage to enroll in an employment-based health plan, but if you and your family lost eligibility for Medicaid or CHIP coverage between March 31, 2023 and July 10, 2023, you can request this special enrollment in the employment-based health plan through September 8, 2023. Confirm the deadline with your employer or your employment-based health plan.

Alternatively, you can enroll in Medicaid or CHIP coverage at any time by filling out an application through the Marketplace or applying directly through your state Medicaid agency. Visit <https://www.healthcare.gov/medicaid-chip/getting-medicaid-chip/> for more details.

How Can I Get More Information?

For more information about your coverage offered through your employment, please check your health plan's summary plan description or contact your employer as indicated in Part B.

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

(Continued on next page)

Legal Notices

Part B: Information About Health Coverage Offered by Your Employer

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

3. Employer Name Derby Public Schools USD 260		4. Employee Identification Number (EIN) 48-0727674
5. Employer Address 1550 E. Walnut Grove		6. Employer Phone Number (316) 788-8400
7. City Derby	8. State KS	9. Zip Code 67037
10. Who can we contact about employee health coverage at this job? Payroll/Benefits Department		
11. Phone number (if different from above)		12. Email address mshannon@usd260.com

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

- We offer a health plan to employees working 20 hours or more per week
- Eligible dependents are: Legal Spouse and Children to age 26, including step, adopted and foster children, and any child you have legal guardianship or court-ordered custody. A child who is incapable of self-support due to handicap resulting from a physical condition or mental illness may be approved over the allowed age limit of 26.
- This coverage is intended to meet the minimum value standard, and the cost of this coverage to you is meant to be affordable, based on employee wages.

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

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



Medicare Part D Notice of Creditable Coverage

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with Blue Cross Blue Shield of Kansas 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. Your employer has determined that the prescription drug coverage through Blue Cross Blue Shield of Kansas 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 Join a Medicare Drug Plan?

If you decide to join a Medicare drug plan, your current employer coverage will not be affected. If you do decide to join a Medicare drug plan and drop your current coverage, be aware that you and your dependents may not be able to get this coverage back.

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

You should also know that if you drop or lose your current coverage with your employer 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 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 for personalized help. See the inside back cover of your copy of the "Medicare & You" handbook for their telephone number.
- 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, visit Social Security on the web at www.socialsecurity.gov or call: 1-800-772-1213 (TTY: 1-800-325-0778)

Remember: If you decide to join one of the Medicare drug plans, you may be required to provide a copy of this notice when pay a higher premium (a penalty).

Name of Entity/Sender: Derby Public Schools USD 260
Contact: Payroll/Benefits Department
Address: 1550 E. Walnut Grove Rd. | Derby, KS 67037
Phone: (316) 788-8400
Print Date: October 2026



Notes

[illegible]



Payroll/Benefits Department

Mary Shannon

mshannon@usd260.com | (316) 788-8413

Korie Wannow

kwannow@usd260.com | (316) 788-8422

Denise Bird

dbird@usd260.com | (316) 788-8444

Wellness Program

Annie Vigil

avigil@usd260.com | (316) 788-8535

Benefit Broker Partners

Jennifer Kurth

jennifer.kurth@howdengroup.com | (316) 200 - 6121

Ruth Shank

ruth.shank@howdengroup.com | (316) 644-6382

Carrier Contacts

Lucet Employee Assistance Program	eap.lucethealth.com EAP Company Login Code: usd 260	(800) 624-5544
AmWell Telehealth (part of BCBSKS coverage)	https://patients.amwell.com/	(844) 733-3627
Blue Cross Blue Shield of Kansas Medical, Prescription Drug and Dental	www.bcbsks.com	(800) 432-3990
Delta Dental of Kansas Dental	www.deltadentalks.com	(800) 243-3375
Surency Life & Health Vision	www.surency.com	(866) 818-8805
Reliance Matrix 3-in-1 Supplemental Plan	www.reliancematrix.com	(800) 351-7500
Aflac Accident Plan Critical Illness Plan Hospital Indemnity Plan	www.aflac.com	(800) 433-3036
LegalShield IDShield Legal Services & Identity Theft Protection	www.shieldbenefits.com/usd260	Bob Pilcher (316) 215-5100 bobpilcher58@gmail.com



Derby Public Schools

1550 E. Walnut Grove Rd.
Derby, KS 67037
(316) 788-8400



HOWDEN

