



**DEPARTMENT OF FINANCE**

**LISA LEWIS, DIRECTOR**

STEPHANIE BONNETT, ASSISTANT FINANCE OFFICER

FREDA HOLDERMAN, ACCOUNTING SUPERVISOR

TO: Board Members

FROM: Lisa Lewis, Director of Finance *Lew*

DATE: June 5, 2025

RE: Voluntary Insurance Change

I am requesting approval for an emergency change to the district's voluntary dental and vision insurance provider, effective July 1, 2025. This change applies only to employees who elected the district's coverage and does not affect state-sponsored benefit plans.

Due to ongoing issues with Delta Dental PPO—including network limitations that have disrupted access for many employees—we recommend moving to Ameritas as the provider for both dental and vision benefits. This will be a passive rollover, requiring no action from employees.

Key Benefits:

- No change in coverage – same benefits at a lower cost
- Expanded provider network, including those who left Delta PPO
- Ameritas will manage both dental and VSP vision plans
- New ID cards will be mailed before the effective date

We believe this change is necessary and beneficial for our employees. Thank you for your consideration.

**OUR MISSION IS TO INSPIRE AND EQUIP OUR STUDENTS TO SUCCEED IN LIFE**

**BULLITT COUNTY PUBLIC SCHOOLS IS AN EQUAL EDUCATION AND EMPLOYMENT INSTITUTION**



## **BULLITT COUNTY PUBLIC SCHOOLS**

| PLAN NAME               | PPO 116/185<br>100/100/60 In Network<br>100/80/50 Out-of-Network<br>\$50/\$50 in/oon deductible | PPO 185/163<br>100/80/50 In Network<br>100/60/30 Out-of-<br>Network<br>\$25/\$50 in/oon<br>deductible | Preventive Plus<br>100/50/5 In Network<br>100/50/5 Out-of-Network<br>\$50/\$50 in/oon deductible |
|-------------------------|---|---|--|
| PLAN DESIGN             |   |   |  |
| DEDUCTIBLE<br>SINGLE    |   |   |  |
| In-Network              | \$ 50   | \$ 25   | \$ 50  |
| Out-Of-Network          | \$ 50   | \$ 50   | \$ 50  |
| DEDUCTIBLE<br>FAMILY    |   |   |  |
| In-Network              | \$ 150  | \$ 75   | \$ 150   |
| Out-Of-Network          | \$ 150  | \$ 150  | \$ 150   |
| PREVENTIVE<br>SERVICES  |   |   |  |
| In-Network              | 100%  | 100%  | 100%   |
| Out-Of-Network          | 100%  | 100%  | 100%   |
| BASIC                   |   |   |  |
| In-Network              | 100%  | 80%   | 50%(fillings,extractions and   |
| Out-Of-Network          | 80%   | 60%   | 50% emergency svcs.only)   |
| MAJOR                   |   |   |  |
| In-Network              | 60%   | 50%   | 5%   |
| Out-Of-Network          | 50%   | 30%   | 5%   |
| ORTHODONTIA             |   |   |  |
| In-Network              | 50%   | 50%   | 0%   |
| Out-Of-Network          | 50%   | 50%   | 0%   |
| MAXIMUMS                |   |   |  |
| Dental (Annual)         | \$ 1000   | \$ 1000   | \$ 1000  |
| Orthodontia             | \$ 1000   | \$ 1000   | \$ Discounts only  |
| CARRIER<br>COST / MONTH | AMERITAS  | AMERITAS  | AMERITAS   |
| Employee                | 27.82   | 24.86   | 15.06  |
| EE + Spouse             | 63.16   | 56.69   | 34.15  |
| EE + Child(ren)         | 60.99   | 54.45   | 32.65  |
| Family                  | 97.81   | 87.32   | 52.37  |

- No waiting period on major services OR orthodontia
- Deductible is waived on preventive
- Implants are covered
- Missing teeth are covered immediately
- 2.5 year rate guarantee
- Acceptance: \_\_\_\_\_



## **BULLITT COUNTY PUBLIC SCHOOLS**

| PLAN NAME                      | VSP – VISION SERVICE PLAN                |                          |
|--------------------------------|--|--------------------------|
| <b>FREQUENCIES</b>             |  |                          |
| Exam                           | Every 12 months                          |                          |
| Lenses                         | Every 12 months                          |                          |
| Frames                         | Every 12 months                          |                          |
| <b>COPAYMENT</b>               |  |                          |
| Exam                           | \$ 10                                    |                          |
| Lenses                         | \$ 25                                    |                          |
| Frames                         | \$ 0                                     |                          |
|                                | In-Network                               | Out-Of-Network Allowance |
| <b>MAXIMUM ALLOWANCES EXAM</b> |  |                          |
|                                | \$ 10 Copay                              | \$35                     |
| <b>LENSES</b>                  | \$ 25 Copay then:                        |                          |
| Single                         | Paid in full                             | \$25                     |
| Bifocal                        | Paid in full                             | \$40                     |
| Trifocal                       | Paid in full                             | \$65                     |
| Lenticular                     | 20% off retail price                     | N/A                      |
| Progressives                   | 20% off retail less \$55 Allowance       | \$95                     |
| <b>CONTACTS</b>                | \$ 25 Copay then:                        |                          |
| <b>MEDICALLY NECESSARY</b>     | \$ 0 Copay; Paid in full                 | \$200                    |
| <b>ELECTIVE</b>                |  |                          |
| Conventional                   | \$135 Allowance; 15% discount thereafter | \$108                    |
| Disposable                     | \$135 Allowance                          | \$108                    |
| <b>FRAMES</b>                  |  |                          |
| Wholesale                      | <b>\$ 48 Assumed</b>                     |                          |
| Retail                         | \$120 Allowance; 20% discount thereafter | \$ 60                    |
| <b>LASIK</b>                   | 15% Discount; or 5% off Promotional cost | No Benefit               |
| <b>CARRIER/COST/MTH</b>        | AMERITAS – VSP                           |                          |
| Employee                       | 6.47                                     |                          |
| EE + Spouse                    | 12.27                                    |                          |
| EE + Child(ren)                | 12.92                                    |                          |
| Family                         | 18.99                                    |                          |

- No waiting periods
- Ameritas will adjudicate the benefits for VSP.
- Acceptance: \_\_\_\_\_



# application Group Dental and/or Eye Care Insurance

Ameritas Life Insurance Corp. P.O. Box 81889, Lincoln, NE 68501-1889



See reverse side for additional information

1. Applicant's Legal Name BULLITT COUNTY PUBLIC SCHOOLS

2. Doing business as N/A

3. N/A

P.O. Box / ZIP Code

1040 HWY 44 EAST

Street Address

SHEPHERDSVILLE KY 40165

City / State / ZIP

(502) 869-8000

(502) 869-8079

Phone No.

Fax No.

616001357

E-mail Address

Tax I.D. No.

4. What is the nature of your business or industry?

SCHOOL DISTRICT

5. Eligibility

Total Number of Eligible Employees 1787

Employees in Waiting Period 0

6. Are any classes or locations excluded? ☐ Yes ☒ No

Are domestic partners included? ☐ Yes ☒ No

Are retirees included? ☐ Yes ☒ No

(If yes, please use reverse side for explanation.)

7. Are any subsidiary and/or affiliated companies to be insured? ☐ Yes ☒ No

(If yes, please use reverse side to list name and location.)

8. How many hours per week equals full time employment? 20

9. Employee Participation

Employer contributes 0 % of employee premium.

☐ **Tied-to-Medical** (All employees covered on employer's medical plan must be insured, except those listed under excluded classes or locations.)

☐ **Non-Contributory** (Policyholder contributes 100% of premiums. All employees must be insured, except those listed under excluded classes or locations.)

☐ **Non-Contributory**, except covered elsewhere (If policyholder contributes 100% of premiums, all employees must be insured, except those listed under excluded classes or locations and those covered elsewhere.)

☐ **Contributory** (Policyholder is required to contribute to the employee premium and must contribute at least 25% of the total employee and dependent premium.)

☒ **Voluntary** (Policyholder does not contribute towards premium, 100% contribution by employee.)

10. Dependent Participation:

Employer contributes 0 % of dependent premium.

☐ **Tied-to-Medical** (All eligible dependents covered on employer's medical plan must be insured, except those listed under excluded classes or locations.)

☐ **Non-Contributory** (Policyholder contributes 100% of premiums. All eligible dependents must be insured, except those listed under excluded classes or locations.)

☐ **Non-Contributory**, except covered elsewhere (If policyholder contributes 100% of premiums, all eligible dependents must be insured, except those listed under excluded classes or locations and those covered elsewhere.)

☐ **Contributory** (Policyholder is required to contribute to the employee premium and must contribute at least 25% of the total employee and dependent premium.)

☒ **Voluntary** (Policyholder does not contribute towards premium, 100% contribution by employee.)

11. Section 125 Plan

Election Period THE FALL PRIOR TO CALENDAR YEAR

Plan Year CALENDAR YEAR

12. Employee welfare benefit plans that are subject to ERISA must satisfy various reporting, disclosure and related obligations. These requirements include the provisioning of a Summary Plan Description or SPD. The certificate of coverage can serve as an SPD if certain information is additionally disclosed. Please check one of the following (failure to respond shall be considered a positive response for A. and a negative response for B.).

A. ☐ Plan is subject to ERISA (complete question 12.B.)

☒ Plan is NOT subject to ERISA — Church or Govt. employer or other safe-harbor exception (see DOL Reg. §2510.3-1(j))

B. ☐ Applicant requests that Ameritas Life Ins. Corp. prepare a SPD for its dental and/or vision plan ☐ Yes ☐ No

If yes, the company is to prepare a SPD. The following information is required under ERISA and MUST be included in the SPD.

Plan No. \_\_\_\_\_ Plan Fiscal Year End Date \_\_\_\_\_

Plan Administrator:

Name: \_\_\_\_\_

Address: \_\_\_\_\_

City, State, ZIP \_\_\_\_\_

Phone No. \_\_\_\_\_ Plan Fiscal Year \_\_\_\_\_

**Please Note:** Applicant remains responsible for ensuring that SPD form provided by Ameritas Life Insurance Corp. is complete and accurate and satisfies applicable laws and regulations. Moreover, applicant remains responsible for providing its plan participants with SPD updates as required by applicable law and regulations.



**13. Waiting Period**

\_\_\_\_\_ for those employed on or before the policy effective date.  
 \_\_\_\_\_ for those employed after the new policy effective date.  
☐ month(s) ☐ calendar days ☐ working days

**14. Effective Date and Termination Date**

☐ Immediate  
☐ First of Month Effective date / End of Month Termination date  
☒ Other **WP=FO 2ND MTH FOL DATE OF HIRE**  
**TERM DT = DATE GIVEN BY DIRECTIVE**

**15. Premium Payment Mode (In advance)**

☒ Monthly ☐ Quarterly ☐ Semi-Annual ☐ Annual  
☐ Payroll Deduction (To choose this option, employee must pay employee and dependent premium.)

If policy effective date is other than first of the month, is a first of the month premium due date desired? . . . ☐ Yes ☐ No

**Billing Options**

☒ Home Office ☐ Third-Party Administration

**Sara Summerville**

Contact Name

**BENEFITS COORDINATOR**

Title

**1040 Highway 44 East**

Street Address

**Shepherdsville, Ky 40165**

City / State / ZIP

**(502) 869-8071**

**(502) 869-8079**

Phone No.

Fax No.

**sara.summerville@bullitt.kyschools.us**

E-mail Address

**16. The following coverages are applied for:****Employee & Dependents Benefits**

☒ Dental ☒ Orthodontia ☒ Eye Care

☐ Other \_\_\_\_\_

**Employee Only Benefits**

☒ Dental ☐ Orthodontia ☒ Eye Care

☐ Other \_\_\_\_\_

This insurance shall be effective on: 07/01/2025

(Premiums due prior to the coverage period.)

**17. Policy and Certificate Delivery (select one)****A. eCert\*/ePolicy (\*generic cert, non-personalized)**

☒ via PDF format sent via e-mail to:

sara.summerville@bullitt.kyschools.us

☐ via eService and member portal

**B. Paper policy/personalized certificates**

☐ Initial employees only

☐ Subsequently added employees

**Note:** eCert will be available on member portal for all members.

**18. Insurance requested on this application will replace the coverage(s) checked.**

Coverages: ☒ Dental ☒ Orthodontia ☒ Eye Care

☐ Other \_\_\_\_\_

Name of Current Carrier Dental - Delta Dental Vision - VSP

Policy No. 711810 & 71181V Accordingly

☒ Coverage applied for is replacing comparable coverage now or previously in force with another carrier.

07/01/2025

07/01/2020

Termination Date

Original Effective Date

**Item 6: Exclusions**

a. Classes, include reason for exclusion.

N/A

b. Locations, if location is different from applicant's, list city and state.

N/A

**Item 7: Subsidiary and/or affiliated companies to be insured. List names and locations.**

N/A

Plan Design and Proposed Rates: **PLEASE SEE THE ATTACHED RATE PAGES FOR BOTH DENTAL AND VISION THAT ARE SIGNED AND DATED**

Additional Remarks: **FIRST MONTHS ADVANCED PREMIUM WILL BE WAIVED. THEY WILL PAY ACCORDING TO DEDUCTIONS - AT THE END OF JULY - THEIR LAST PAY DAY OF THE MONTH. THE PREMIUM ITSELF IS NOT WAIVED. WHEN IT IS ADJUDICATED IS THE EXCEPTION.**

**Agreements**

This application will be subject to review and approval by the Home Office of Ameritas Life Insurance Corp. If this application is accepted, the final rates and benefits will be based on verification of this information and final enrollment numbers. This applicant represents that he/she has read the statements and answers to the above questions and that they are complete and true to the best of his/her knowledge and belief. Any policy including riders issued as a result of this application will, with this application, be the entire insurance contract. If this application is accepted at the Home Office of Ameritas Life Insurance Corp., group insurance at the Company's rates and under the terms applied for shall take effect as of the date set forth in the policy. If this application is not accepted, any premium advanced shall be refunded.



## Statements

**In several states, we are required to advise you of the following:** Any person who knowingly and with intent to defraud provides false, incomplete, or misleading information in an application for insurance, or who knowingly presents a false or fraudulent claim for payment of a loss or benefit, is guilty of a crime and may be subject to fines and criminal penalties, including imprisonment. In addition, insurance benefits may be denied if false information provided by an applicant is materially related to a claim. (See state-specific statements.)

**Note for California Residents:** For your protection California law requires the following to appear on this form: Any person who knowingly presents false or fraudulent information to obtain or amend insurance coverage or to make a claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

**California law prohibits an HIV test from being required or used by health insurance companies as a condition of obtaining health insurance coverage.**

For group policies issued, amended, delivered, or renewed in California, dependent coverage includes individuals who are registered domestic partners and their dependents.

**No Cost Language Services.** You can get an interpreter and have documents read to you in your language. For help, call us at the number listed on your ID card or 877-233-3797. For more help call the CA Dept. of Insurance at 800-927-4357.

**Servicios de idiomas sin costo.** Puede obtener un intérprete y que le lean los documentos en español. Para obtener ayuda, llámenos al número que figura en su tarjeta de identificación o al 877-233-2797. Para obtener más ayuda, llame al Departamento de Seguros de CA al 800-927-4357.

**Note for Colorado Residents:** It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies.

**Note for Florida Residents:** Any person who knowingly and with intent to injure, defraud or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

**Note for Georgia, Kansas, Nebraska, Oregon, Vermont and Virginia Residents:** Any person who, with intent to defraud or knowing that he is facilitating a fraud against insurer, submits an application or files a claim containing a false or deceptive statement may have violated state law.

**Note for Kentucky Residents:** Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime.

**Note for Louisiana Residents:** Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

**Note for Maryland Insureds:** Any person who knowingly and willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly and willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

**Note for New Jersey Residents:** Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.

**Note for New Mexico Residents:** Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to civil fines and criminal penalties. **This is a limited benefits health plan. The benefits provided are supplemental to, and not a substitute for, major medical coverage, even in combination with other limited benefit plans. To apply for an individual or small-group major medical plan, please visit the website of the New Mexico Health Insurance Exchange at [www.bewellnm.com](http://www.bewellnm.com) or call 1-833-862-3935 (TTY: 711).**

**This plan may contain limitations for replacement of missing teeth. Please see LIMITATIONS for details.**

**Note for North Carolina Residents:** After 2 years from the date of issue or reinstatement of this policy, no misstatements made by the applicant in the application shall be used to void the policy or deny a claim for loss commencing after the expiration of such 2 year period.

**Note for Pennsylvania Residents:** Any person who knowingly and with intent to defraud any insurance company or other person, files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

**Note for Rhode Island Residents:** Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to civil fines and criminal penalties.

**Note for Tennessee Residents:** It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purposes of defrauding the company. Penalties include imprisonment, fines and denial of coverage.

**Note for Texas Residents:** Any person who knowingly and with intent to defraud provides false, incomplete or misleading information in an application for insurance, or who knowingly presents a false or fraudulent claim for payment of a loss or benefit, may be guilty of a crime and may be subject to fines and criminal penalties, including imprisonment. In addition, insurance benefits may be denied if false information provided by an applicant is materially related to a claim.

**Note for Washington, D.C. Residents:** Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

**Note for Washington Residents:** For groups policies issued, amended, delivered, or renewed in Washington, dependent coverage includes individuals who are registered domestic partners and their dependents.

☐ If you do not want your company name used by Ameritas Life Insurance Corp. in our effort to recruit Network providers, check this box.

Signed at: City SHEPHERDSVILLE State KY Date \_\_\_\_\_

Signed by: (Policyholder Representative)

Printed name and title \_\_\_\_\_

Signature \_\_\_\_\_

**Soliciting Agent:** I understand and agree that if I'm not already appointed with Ameritas Life Insurance Corp., I must apply to and be appointed with Ameritas before I present this product to any client.

Printed Name TORY JOYCE - INSURANCE GROUP For FL agents only, provide FL license # \_\_\_\_\_

Signature \_\_\_\_\_

**The policy provides dental and/or vision benefits only. Review your policy carefully.**

**Was a binder check received?** ☐ Yes ☒ No If yes, then amount \$ N/A

**Check received by (agent)** N/A **Authorized by (policyholder)** N/A

ALL PREMIUM CHECKS MUST BE MADE PAYABLE TO AMERITAS LIFE INSURANCE CORP.  
DO NOT MAKE CHECKS PAYABLE TO THE AGENT OR LEAVE PAYEE BLANK.



# Electronic Delivery Terms and Disclosures



Ameritas Life Insurance Corp. ("Company") P.O. Box 81889 / Lincoln, NE 68501-1889 / 800-659-2223 / Fax 402-467-7338

Ameritas Life Insurance Corp. ("Ameritas", "we", "our", or "us") is required by law to provide its policyholder ("policyholder" or "you") with certain documents related to your policy with us. In order to streamline how you do business with us, we are providing you with the option to receive the following documents electronically. These documents may include the following:

- Policy(s) documents, forms, endorsements, and certificates
- Policyholder notices
- Renewal notices
- ID Cards
- Lapsed Payment notice
- Policyholder or member related communications

By selecting electronic delivery on the application, you give us your consent to allow Ameritas to deliver all documents relating to your insurance policy(s) electronically. This consent for electronic delivery is effective until you withdraw it all or in-part through the method described below.

The delivery of insurance related documents to you electronically rather than sending paper copies shall not affect the validity, legal effect or enforceability of such insurance related documents.

## Method of Delivery

We may make electronic documents available to you and/or your plan members by posting them to a secure portal website, or we may send them via email to the email address that you and/or your plan members provide to us. In some unique circumstances, we may also send paper copies of documents to you and/or your plan members, even though we have provided them to you electronically.

## Request for Paper Copy

You may request a paper copy of any required policy document that was originally provided to you electronically. To request a copy of any document provided electronically please send us a request through one of the methods below. Include your policy number and the particular notice or document you are requesting.

Mail: Ameritas Group Administration  
5900 O Street  
Lincoln, NE 68510

Email: [group\\_assistants@ameritas.com](mailto:group_assistants@ameritas.com)  
Phone: 1-800-659-2223

## Withdrawal of Consent

You may withdraw your consent to electronic delivery by providing written notice to us at any time. Your withdrawal will not affect or change in any way the legal effectiveness, validity or enforceability of any documents that were delivered to you electronically before your withdrawal became effective.

## Updating Contacts

You are responsible for providing us with updated information on how we may contact you electronically should your information change from what was previously provided. To update your information, please contact us by one of the methods listed above.

## Hardware and System Requirements

To ensure delivery of your policy documents, it requires a computer with the following minimum hardware and system requirements necessary to sign, print, retain and receive such documents.

|                           |  |
|---------------------------|--|
| System                    | Computer or mobile device with access to the internet and adequate storage available to save and/or print documents            |
| Operating Systems         | Microsoft Windows®, MAC OS, Apple iOS, Android (within 2 versions of current)  |
| Browsers                  | Microsoft Edge, Google Chrome, Firefox (within 2 versions of current); with support for minimum 128-bit SSL encryption enabled |
| PDF Reader                | Acrobat Reader® or similar software to view and print PDF files  |
| Enabled Security Settings | Allow strictly necessary cookies   |
| Email                     | Email service with valid email account   |

## Terms and Conditions

By selecting electronic delivery on the application, you are confirming that you and/or the affected plan members have a computer or electronic device that meets the system requirements necessary to print, store and receive these documents electronically and that you and/or the affected plan members may be able to access such documents for future reference. Consent does not mean Ameritas must provide documents electronically and Ameritas reserves the right to cancel or no longer provide information electronically to preserve systems or protect data. If we modify these terms, you will receive notice of any modified changes in advance. The modified terms will apply to your insurance policy(s) and be binding on you unless you withdraw your consent utilizing one of the methods listed above. There may be fees associated related to internet service or data limitations that Ameritas is not responsible for. Ameritas may record certain data or metadata related to any transaction or request for history, to resolve disputes, or for other business reasons. This includes but is not limited to: IP address, answers to questions or prompts, mouse clicks, keystrokes, audit trails showing history or requests that may be submitted by the user. Electronic signatures on electronic records submitted to Ameritas Life Insurance or Ameritas Life Insurance of NY by the policyholder or its plan members must comply with all applicable laws and regulations including without limitation to the federal Electronic Signatures in Global and National Commerce Act ("EUTA") or similar state electronic signature laws. If a policyholder with a self-funded Plan requests we post self-funded plan documents on the Ameritas website, Ameritas will post as a matter of convenience to the policyholder and does not assume any Plan Administrator duties related to ERISA including the distribution of Summary Plan Descriptions (SPDs) or other ERISA-required reports or disclosures.

*For groups choosing electronic delivery.*

# Memorandum

**To:** Billing Department, Delta Dental PPO of KY  
**CC:** Tory Joyce, Agent  
**From:** Bullitt County Public Schools  
**Date:** 6/1/2025  
**Re:** 711810 & 71181V

---

Effective 7/1/25, please cancel our dental and vision plans. We have switched to different carrier due to various service issues, plan design and rates.

Please call our agent Tory Joyce at 502-649-3069 should you have any questions or concerns.

Thanking you in advance.

Bullitt County Public Schools

Jesse Bacon, Superintendent of Bullitt County Public Schools

X\_\_\_\_\_