Kentucky Public Pensions Authority

CERS KERS SPRS

PLAN YEAR 2025

Qualifying Events

A Guide for Changing Your Health Insurance Coverage Outside of Open Enrollment

For Retirees not eligible for Medicare

HAZARDOUS NOTICE

Hazardous retirees must submit Form 6256 for an eligible spouse and dependents to receive health insurance contribution.

LIVINGWELL PROMISE REQUIRED

All planholders must take the online Health Assessment at mycastlight.com/mybenefits between January 1, 2025 - July 1, 2025.

This is summary information. Visit our website for details.

KYRET.KY.GOV

MYRETIREMENT.KY.GOV

502-696-8800
1-800-928-4646

Changing Your Health Insurance

WHAT IS A QUALIFYING EVENT?

- Marriage or divorce
- Having or adopting a child
- Legal Guardianship or Court Order
- Loss of other group health insurance
- Your spouse has a different Open Enrollment period

The Kentucky Employees' Health Plan (KEHP) is operated as a federally regulated, Section 125 Cafeteria Plan. In exchange for this benefit, there are only three times you can change your benefit elections during the plan year:

1. During the enrollment period when you first become eligible for benefits;
2. During the annual enrollment period; or
3. If you experience a life event, referred to as a "Qualifying Event."

YOUR COST FOR COVERAGE

In order to determine your cost for coverage, please refer to the worksheets in this guide. Recipients eligible for the dollar contribution benefit who do not elect coverage through KPPA may be eligible to have premiums reimbursed for insurance coverage not with KPPA. Visit our website for additional information and examples.

Notice for Hazardous Retirees

In most cases, when a dependent turns age 22 and is no longer eligible for the health insurance contribution, you have 30 days to submit an enrollment form dropping that dependent from your insurance if you wish to do so.

30 Calendar Day Deadline

If you do not sign, date, and submit the required Form to the KPPA office within 30 calendar days of the qualifying event date, you will not be permitted to change your coverage election until the next enrollment period.

SUBMITTING YOUR FORM

To submit your enrollment form using Self Service, go to KYRET.KY.GOV and click LOGIN. Forms may be uploaded using the Documents feature in Self Service, or can be faxed or mailed to KPPA.

WHEN YOU HAVE A QUALIFYING EVENT

In all cases, any change in your plan option or coverage level must be consistent with the qualifying event. For most events, you must complete a Retiree Health Insurance Enrollment/Change Form and submit it to the KPPA office within 30 calendar days of the event date. The only exception is gaining Medicaid which has a signature date of 60 days. You must submit spouse and dependent eligibility documentation, such as a marriage certificate or birth certificate, together with your Retiree Health Insurance Enrollment/Change Form.

Qualifying events are complicated and, at times, difficult to understand. There are restrictions on the types of changes you may make due to federal qualifying event rules. If you do not sign and date the required Forms in a timely manner, you will not be permitted to revise your coverage election until the next enrollment period.

RESOURCES AT KYRET.KY.GOV

SCAN ME

2025 Plan Information: Use your mobile phone camera to scan the QR code or from our homepage go to Retirees and select Insurance, then Non-Medicare Plan Year 2025.

Go to KYRET.KY.GOV and select Retirees, then Insurance and look for Qualifying Events.

KEHP Tobacco User Fee, Disclosures & Legal Declarations: To view these documents, scan the QR code or from our homepage go to Retirees and select Insurance, then Non-Medicare Plan Year 2025.

You may be eligible to cross reference if:

- You are a new retiree who was enrolled in KEHP coverage prior to January 1, 2025 and your spouse is currently enrolled in a KEHP plan.
- You were enrolled in a KEHP plan prior to January 1, 2025 and experience a qualifying event.

Overview of Qualifying Events

VISIT OUR WEBSITE FOR DETAILED INFORMATION ABOUT QUALIFYING EVENTS AND DEPENDENT ELIGIBILITY.
FROM THE HOMEPAGE AT **KYRET.KY.GOV** GO TO **RETIREES** AND SELECT **INSURANCE**, THEN QUALIFYING EVENTS.

QUALIFYING EVENTS: KEHP is provided through a Section 125 plan per the Internal Revenue Code. This allows Employees to pay for their Health Insurance premiums with pre-tax dollars. Section 125 plans are federally regulated, and the guidelines state that if an Employees' Health Insurance or Flexible Spending Account is offered through a Section 125 plan, they cannot make a change to their Health Insurance or Flexible Spending Account options outside of the annual Open Enrollment period, unless they experience a permitted election change (referred to as a "Qualifying Event").

A. To Enroll in KEHP Outside of the Annual Open Enrollment Period, the Individual:

1. Must Lose Coverage From:

- An employer-sponsored group health plan;
- An individual Health Insurance plan (must lose eligibility – failure to pay premiums is not a loss of eligibility);
- A short-term, limited-duration insurance policy also known as "gap" insurance;
- A student Health Insurance policy; or
- A government coverage (TRICARE, Medicare, Medicaid, KCHIP)

Losing coverage from one of the following does not allow the individual to enroll outside of the annual Open Enrollment period:

- Coverage only for accident or disability income insurance;
- Coverage issued as a supplement to liability insurance;
- Liability insurance;
- Workers' compensation or similar insurance;
- Automobile medical payment insurance;
- Credit-only insurance;
- VA Benefits;
- Coverage for on-site medical clinics; or
- Other similar insurance coverage under which benefits for medical care are secondary or incidental to other insurance benefits.

2. Must Lose Coverage Due To:

- A maximum benefits level being reached;
- An insurance agency canceling the policy (other than for non-payment);
- Coverage being provided under COBRA and COBRA has expired;

Coverage was non-COBRA and the coverage terminated due to loss of eligibility for coverage including but not limited to:

- *Legal separation, divorce, end* of Dependent status, death of an Employee, termination of employment, reduction in hours or employer contributions for coverage were terminated; or
- The plan no longer offers benefits for a group of individuals.

Not Due To:

- *Non-payment of insurance premiums – choosing to stop payment of a plan for any reason;*
- *Non-renewal – choosing to stop renewal of a plan for any reason;*
- *Cancellation of coverage by policyholder for policyholder or for a Dependent;*
- *Increase in cost of coverage; or*
- *Reduction of contributions or level of benefits.*

B. General Guidelines

1. Event Date: The event date is the date the event occurs. It is not the date the Employee or Dependent is notified of the event. The only exceptions to this are entitlement to Medicare and Medicaid. In the instances above, the Qualifying Event date can be the date the Employee or Dependent is notified.

2. Signature Date: The signature date is the date the Employee's signature is on the applicable documentation. With the exception of gaining Medicaid, which has a signature date of 60 days, all Qualifying Events have a signature deadline of 30 calendar days from the event date.

It is important to know the deadlines for the signature date for all Qualifying Events. To calculate the number of calendar days, begin counting on the day after the Qualifying Event.

Example: If the Employee gets married on March 5, the Employee must sign the applicable forms **within 30 calendar days** from the event (marriage). Day one would be March 6, and day 30 would be April 9. The Employee's signature must be on the applicable forms no later than April 9.

Pre-Signing: Applicable forms may not be signed prior to the event date, except for the following:

- Loss of other health coverage;
- Gaining other health coverage;
- Entitlement to Medicare; and
- Spouse's different Open Enrollment period

The timing of the signature date is critical. Employees must complete the enrollment forms and sign the applicable forms before the signature date deadline. The Employee does not need to wait for any supporting documentation to arrive before the form is signed.

3. Effective Date: The effective date is the date the coverage takes effect. Most effective dates are the first day of the month following the signature date. Coverage can NEVER be effective prior to the event date.

Always consider the following:

- If the Qualifying Event date is the first of the month, the Employee may pre-sign during the previous month.

Example: If "loss of coverage" occurs on April 1, the Employee may sign the applicable documentation during the month of March. The effective date of the change will be April 1.

- If the Qualifying Event date is any other day of the month, the Employee may pre-sign during that month only.

Example: If "loss of coverage" occurs on April 18, the Employee may sign the applicable documentation during the month of April. The effective date of the change will be May 1. The Employee is not permitted to sign in March since that would make the effective date April 1, which is effective prior to the event of April 18.

4. Supporting Documentation: Most all Qualifying Events must be validated with supporting documentation such as, but not limited to, marriage certificates, divorce agreements, or letters from employers. Before a Dependent can be added to a health insurance plan, verification documents must be provided. See Dependent Eligibility Chart on our website at kyret.ky.gov. Go to Retirees and select Insurance, then Qualifying Events.

5. Qualifying Event Charts: The Qualifying Event chart is your guide in knowing what mid-year election changes are permitted under a Section 125 plan, and the documentation that is required.

Nonhazardous Percentage Contribution Premium Calculation Worksheet

Use this worksheet if you meet all of the following:

- You have nonhazardous service.
- You are a retiree or a beneficiary* receiving benefits.
- Your participation date with KPPA was PRIOR to July 1, 2003.

1. Select Plan

Select one. Determine your monthly premium beginning January 1, 2025.

Plan Option	Single	Parent Plus	Couple	Family	Family X-Ref**
LivingWell CDHP	$930.76	$1,269.28	$1,866.24	$2,078.08	$1,068.66
LivingWell PPO	$949.04	$1,320.40	$1,981.62	$2,185.78	$1,126.28
LivingWell Basic CDHP	$901.04	$1,234.80	$1,863.04	$2,069.88	$1,057.40
LivingWell HDHP	$835.42	$1,144.86	$1,727.36	$1,919.14	$980.38

**Retiree Portion. If you need assistance calculating your family cross-reference premium, contact KPPA. You must contact your spouse's insurance coordinator for information for spouse's portion of the premium.

Box 1

2. Service Credit

Subtract the following based upon your months of service.

Applicant's Months of Service		
240+ months *Contribution amount is based on the plan selected.* If you elect Parent Plus, Couple, Family or Family Cross Reference coverage, this amount is the maximum contribution for each plan (single premium for that plan).	LivingWell CDHP	$930.76
	LivingWell PPO	$949.04
	LivingWell Basic CDHP	$901.04
	LivingWell HDHP	$835.42
180 - 239 months		$711.78
120 - 179 months		$474.52
48 - 119 months		$237.26
0 - 47 months		$0.00

*KPPA does not pay a contribution for coverage on behalf of a beneficiary. Beneficiaries should enter "$0.00" in Box 2. Exception: If you are a spouse beneficiary or a dependent child receiving a monthly benefit under the Fred Capps Memorial Act, contact KPPA.

Box 2

Your Subtotal

Box 1 subtract Box 2

3. Tobacco Status

Select one, based upon tobacco usage in the past six months. If you are a tobacco user, you will be required to pay the amount in box 3.

Non-tobacco user	+$0.00
Retiree or beneficiary uses tobacco selecting Single coverage	+$40.00
Retiree or beneficiary uses tobacco selecting Family, Parent Plus, or Couple coverage	+$80.00

Box 3

4. LivingWell Promise

Select one. If you did not fulfill the LivingWell Promise for Plan Year 2024, you will be required to pay the amount in Box 4 in 2025.

Promise Completed	+$0.00
Applicant failed to complete Promise	+$40.00

Box 4

Total Monthly Premium
Subtotal (Box 1 - Box 2) + Box 3 + Box 4 = Total

Kentucky Employees' Health Plan
Department of Employee Insurance
KPPA 800-928-4646
TRS 800-618-1687
LRP/JRP 502-564-5310

TEAM KENTUCKY PERSONNEL CABINET | Kentucky Employees' Health Plan

Form 6200
Revised 09/24

Plan Year 2025 RETIREE HEALTH INSURANCE ENROLLMENT/CHANGE FORM

Section 1: To Be Completed by Insurance Coordinator

KHRIS Personnel Number	Hazardous Duty ☐	Date of Retirement	Qualifying Event Date	Coverage Effective Date

☐ KPPA 80000 10006416	☐ TRS 85000 10006418	☐ KCTCRS 81000 10006417	☐ JRP 86000 10006419	☐ LRP 87000 10006420	☐ KPPA RTW 80100 10006464

KPPA Only: ☐ KPPA-KERS ☐ CERS - Oth.Ag ☐ KPPA-SPRS

Reason(s) for Application:
- ☐ Open Enrollment
- ☐ New Retiree
- ☐ Returning Retiree
- ☐ Applicant becomes the PH
- ☐ Qualifying Event
- ☐ Exception
- ☐ Demographic Change
- ☐ Termination

Qualifying Event:
- ☐ Marriage
- ☐ Birth/Adoption/Placement
- ☐ Court Order for Child
- ☐ Divorce
- ☐ Death - Date: _____
- ☐ Loss of Individual Health
- ☐ Loss of Group Health
- ☐ Spouse turned 65
- ☐ Begin Medicare/Medicaid
- ☐ End Medicare/Medicaid
- ☐ Loss of KCHIP
- ☐ Spouse/Dependent Starting Employment
- ☐ Spouse/Dependent Terminating Employment
- ☐ Special Enrollment
- ☐ Other:

Termination:
Coverage End Date

Section 2: Demographic Information - Changes or Current (Circle one)

Retiree's SSN	Retiree's Name (Last, First, MI)	Retiree's Date of Birth

Applicant's SSN	Applicant's Name (Last, First, MI) **If plan holder is not the Retiree**	Applicant's Date of Birth

KPPA will update contact information for your retirement account based on the details provided below.

Mailing Address	Primary Phone #	Secondary Phone #

City, State, ZIP	Home County	Home Email Address

Sex: ☐ Male ☐ Female Married: ☐ Yes ☐ No

***Required information for processing. Are you Medicare eligible due to Social Security disability? ☐ Yes ☐ No

Section 3: Spouse Information - Skip to Section 5 if electing single coverage - Changes or Current (Circle one)

Spouse's SSN	Spouse's Name (Last, First, MI)	Date of Birth (mm/dd/yyyy)	☐ Male ☐ Female	☐ Add ☐ Drop ☐ Remain

***Required information for processing. Is Spouse Medicare eligible due to Social Security disability? ☐ Yes ☐ No

☐ I wish to utilize the Cross-reference payment option (two KEHP members, married with children). ***Not available to new retirees (new to KEHP) after 1/1/2025***

KPPA Only: ☐ KPPA-KERS ☐ CERS - Oth.Ag ☐ KPPA-SPRS

Spouse's Date of Hire/Retirement	Spouse's Organizational Unit #	Spouse's Company #

Spouse's Home Email Address	Spouse Work Email Address

Section 4: Dependent Information Changes or Current (Circle one)

***Required information for processing: Are any dependents Medicare eligible due to Social Security disability? ☐ Yes ☐ No

If yes, who?

	Name (Last, First, MI)			Date of Birth		
Child #1 SSN		☐ Natural ☐ Adopted ☐ Court Ordered	☐ Foster ☐ Step ☐ Disabled		☐ Male ☐ Female	☐ Add ☐ Drop ☐ Remain
Child #2 SSN		☐ Natural ☐ Adopted ☐ Court Ordered	☐ Foster ☐ Step ☐ Disabled		☐ Male ☐ Female	☐ Add ☐ Drop ☐ Remain
Child #3 SSN		☐ Natural ☐ Adopted ☐ Court Ordered	☐ Foster ☐ Step ☐ Disabled		☐ Male ☐ Female	☐ Add ☐ Drop ☐ Remain
Child #4 SSN		☐ Natural ☐ Adopted ☐ Court Ordered	☐ Foster ☐ Step ☐ Disabled		☐ Male ☐ Female	☐ Add ☐ Drop ☐ Remain
Child #5 SSN		☐ Natural ☐ Adopted ☐ Court Ordered	☐ Foster ☐ Step ☐ Disabled		☐ Male ☐ Female	☐ Add ☐ Drop ☐ Remain

Retiree's SSN: _____ Applicant's SSN: _____

Section 5: Tobacco Use Declaration Rules governing the Tobacco Use Declaration can be found in your Benefits Selection Guide or at kehp.ky.gov. You are eligible for the non-tobacco user premium contribution rates provided you certify that you or any other person to be covered under your plan has not regularly used tobacco within the past six months.

Planholder: Within the past 6 months, have you used tobacco regularly? ☐ Yes ☐ No	Has your spouse, if covered under this plan, used tobacco regularly within the past 6 months? ☐ Yes ☐ No	Have any children covered under this plan age 18 or older used tobacco regularly within the past 6 months? ☐ Yes ☐ No If yes, who? _____

Section 6: Coverage Level - Verification documents may be required; check with your Insurance Coordinator or HR office.
Note: If adding newly covered dependents you may be required to provide verification documents.

☐ Single (self only)	☐ Parent Plus (self and child(ren))	☐ Couple (self and spouse)	☐ Family (self, spouse and child(ren))

Section 7: Plan Options - All plans require the LivingWell Promise to receive the monthly premium discount for the next plan year. Instructions on fulfilling your Promise can be found at kehp.ky.gov in the benefits selection guide.

- ☐ LivingWell CDHP
- ☐ LivingWell PPO
- ☐ LivingWell Basic CDHP
- ☐ LivingWell High Deductible Health Plan
- ☐ Default LivingWell Basic CDHP (no HRA funds) - INSURANCE COORDINATOR USE ONLY
- ☐ Waive Coverage, No HRA - without $ Reason for Waiving: _____

Section 8: Signatures - Please submit this application to your retirement agency Insurance Coordinator - ADDRESS BELOW By signing this application, I certify that the information provided in this application is true and correct to the best of my knowledge. I also certify that I have read, understand and agree to the Terms and Conditions of participation in the KEHP, the KEHP Legal Notices, and the Tobacco Use Declaration. These documents can be found in your benefits Selection Guide or online at kehp.ky.gov.
By typing my name in the space provided below, I am signing this application electronically and am agreeing to conduct this transaction by electronic means.

The electronic signature must be in the following format: "/s/ First-Name Last-Name".

Applicant Signature - if plan holder is not the retiree	Date
Employee/Retiree Signature	Date
Spouse Signature - REQUIRED if electing the cross-reference payment option	Date
IC/HRG Signature	Date
IC/HRG Printed Name	IC/HRG Phone Number
Spouse's IC/HRG Signature - REQUIRED if electing the cross-reference payment option	Date
Spouse's IC/HRG Printed Name	Spouse's IC/HRG Phone Number

Kentucky Public Pensions Authority 1260 Louisville Road Frankfort, KY 40601	Teachers' Retirement Systems 479 Versailles Road Frankfort, KY 40601	Judicial Retirement Plan Legislators Retirement Plan 305 Ann Street, Suite 302 Frankfort, KY 40601

KENTUCKY PUBLIC PENSIONS AUTHORITY
1260 Louisville Road • Frankfort, KY 40601
Phone: (502) 696-8800 • Fax: (502) 696-8822 • kyret.ky.gov

Form 6256
Revised 04/2024

Designation of Spouse and/or Dependent Child for Health Insurance Contributions

Only dependents who meet the definition of a Dependent Child as defined by KRS 16.505(17) and 78.510(49) are eligible to receive health insurance contributions.

The Form 6256 DOES NOT enroll you or your dependents in a health insurance plan. The Form 6256 DOES NOT remove you or your dependents from a health insurance plan. This form ONLY establishes health insurance contribution for Spouse and Dependent Children.

Complete this form if you are a General Assembly Retiree, Hazardous Duty Retiree, Surviving Spouse Beneficiary receiving General Assembly, Hazardous Duty, or duty related benefits under the Fred Capps Memorial Act and electing to cover a spouse and/or dependent child on health insurance.

If you are a recipient as outlined above, you must complete and submit Form 6256 Designation of Spouse and/or Dependent Child for Health Insurance Contributions to the Kentucky Public Pensions Authority (KPPA):

- During the annual open enrollment period prior to January 1 each year.
- Upon your health insurance dependent child obtaining 18 years of age.
- Upon initial enrollment of your health insurance dependent(s).
- When requesting reimbursement or premiums paid for a spouse and/or dependent child under a qualifying reimbursement plan.

You are required to notify KPPA when your health insurance dependent has a change in marital or full-time student status.

Member Information Please provide your Member ID or Social Security Number in the Member ID box below

Member Name:	Member ID:

KPPA will update contact information for your retirement account based on the details provided below.

Address:	City:	State:	Zip Code:

Is this a new address? ◯ Yes ◯ No

Phone (select type) ◯ Mobile ◯ Home ◯ Work	Email:

Spouse Information

Spouse Name:	Social Security Number:	Spouse Date of Birth:

Only dependents who meet the definition of a Dependent Child as defined by KRS 16.505(17) and 78.510(49) are eligible to receive health insurance contributions. KRS 16.505(17) and 78.510(49) states “Dependent Child” means a child in the womb and a natural or legally adopted child of the member who has neither attained age eighteen (18) nor married or who is an unmarried full-time student who has not attained age twenty-two (22). Solely in the case of a member who dies or becomes totally and permanently disabled as a direct result of an act in line of duty or as a result of a duty-related injury and is eligible for the benefits provided by KRS 61.621(5)(a), "Dependent Child" also means a naturally or legally adopted disabled child regardless of age, to the member if the child has been determined to be eligible for federal Social Security disability benefits or is being claimed as a qualifying child for tax purposes due to the child's total and permanent disability. **Note: Stepchildren and Grandchildren must be legally adopted in order to qualify as Dependent Child per this statute.**

Dependent Child Information (Age 18-22 Dependent Information Only)

Dependent Child Name:	Social Security Number:	Dependent Child Date of Birth:

Address:	City:	State:	Zip Code:

Relationship to Member: ◯ Natural Child ◯ Adopted Child

Is this dependent child married or has this dependent child been married previously? ◯ Yes ◯ No

Is this dependent child age 18 or older? ◯ Yes ◯ No

Is this dependent child a full-time student? ◯ Yes ◯ No

Dependent Child Information (Age 18-22 Dependent Information Only)

Dependent Child Name:	Social Security Number:	Dependent Child Date of Birth:

Address:	City:	State:	Zip Code:

Relationship to Member: ◯ Natural Child ◯ Adopted Child

Is this dependent child married or has this dependent child been married previously? ◯ Yes ◯ No

Is this dependent child age 18 or older? ◯ Yes ◯ No

Is this dependent child a full-time student? ◯ Yes ◯ No

Dependent Child Information (Age 18-22 Dependent Information Only)

Dependent Child Name:	Social Security Number:	Dependent Child Date of Birth:

Address:	City:	State:	Zip Code:

Relationship to Member: ◯ Natural Child ◯ Adopted Child

Is this dependent child married or has this dependent child been married previously? ◯ Yes ◯ No

Is this dependent child age 18 or older? ◯ Yes ◯ No

Is this dependent child a full-time student? ◯ Yes ◯ No

Certification

I, _____ (Member Name) , do hereby certify that the person(s) designated above is the retiree's spouse* and/or dependent child** as defined by law as, "a child in the womb and a natural or legally adopted child of the member who has neither attained age eighteen(18) nor married or who is an unmarried full-time student who has not attained age twenty-two (22). Solely in the case of a member who dies or becomes totally and permanently disabled as a direct result of an act in line of duty or as a result of a duty-related injury and is eligible for the benefits provided by KRS 61.621(5)(a), "dependent child" also means a naturally or legally adopted disabled child regardless of age, of the member if the child has been determined to be eligible for federal Social Security disability benefits or is being claimed as a qualifying child for tax purposes due to the child's total and permanent disability. I agree that I will immediately provide written notification to Kentucky Public Pensions Authority as soon as the person(s) designated above no longer qualifies as a spouse* and/or dependent child** as defined by KRS 16.505(17) and 78.510(49). I understand that Kentucky Public Pensions Authority shall immediately cease to pay the portion of the health insurance premium made on behalf of the person designated above when that person no longer qualifies as a spouse* or dependent child** as defined by KRS 16.505(17) and 78.510 (49). I understand and agree that I will be responsible for and shall be required to repay any insurance benefits paid on behalf of the person(s) designated above if the said person is not a spouse* or dependent child** as defined by KRS 16.505(17) and 78.510(49) or if I fail to notify Kentucky Public Pensions Authority when a dependent child marries, ceases to be a full-time student, or otherwise ceases to qualify as a dependent child as defined by KRS 16.505(17) and 78.510(49).

*105 KAR 1:411
**KRS 16.505(17)
***KRS 78.510(49)

I hereby certify that the information provided on this Form 6256, Designation of Spouse and/or Dependent Child for Health Insurance Contributions, is true and correct. I further acknowledge that I have full understanding that any person who provides a false statement, report, or representation to a governmental entity such as KPPA is subject to the penalty or perjury in accordance with KRS 523.010, et seq. I further acknowledge that if I knowingly submit or cause to be submitted a false or fraudulent claim for the payment or receipt of benefits, including reimbursements, I may be liable not only to repay the reimbursements I was not entitled to receive, but also liable for civil payments, legal fees, and costs.

Member Signature: _____ Date: _____

You are required to notify KPPA when your health insurance dependent has a change in marital or full-time student status.

Dollar Contribution Premium Calculation Worksheet

The dollar contribution amounts below will increase by 1.5% on July 1st. Visit our website for contribution examples.

Use this worksheet if you meet all of the following:

- You have hazardous or nonhazardous service.
- You are a retiree or beneficiary* receiving benefits.
- You are Tier 1 with a participation date with KPPA between July 1, 2003 and August 31, 2008. You must have a minimum of 120 months of service to be eligible for insurance benefits, OR
- You are Tier 2 with a participation date with KPPA on or AFTER September 1, 2008. You must have a minimum of 180 months of service to be eligible for insurance benefits.

If you have hazardous and nonhazardous service, you will receive contribution based on full years of service for each. If you have partial years of service, please contact KPPA.

1. Select Plan

Select one. Determine your monthly premium beginning January 1, 2025.

Plan Option	Single	Parent Plus	Couple	Family	Family X-Ref**
LivingWell CDHP	$930.76	$1,269.28	$1,866.24	$2,078.08	$1,068.66
LivingWell PPO	$949.04	$1,320.40	$1,981.62	$2,185.78	$1,126.28
LivingWell Basic CDHP	$901.04	$1,234.80	$1,863.04	$2,069.88	$1,057.40
LivingWell HDHP	$835.42	$1,144.86	$1,727.36	$1,919.14	$980.38

** Retiree Portion. If you need assistance calculating your family cross-reference premium, contact KPPA. You must contact your spouse's insurance coordinator for information for spouse's portion of the premium.

Box 1

2. Nonhazardous Service Credit

Subtract the following, based on the calculation of Dollar Contribution Amount multiplied by the Years of Nonhazardous Service.

Dollar Contribution Amount	X	FULL Years of Nonhazardous Service	=	BOX 2 TOTAL
$14.63	X		=	

*KPPA does not pay a contribution for coverage on behalf of a beneficiary. Beneficiaries should enter "$0.00" in Box 2. Exception: If you are a spouse beneficiary or a dependent child receiving a monthly benefit under the Fred Capps Memorial Act, contact KPPA.

Box 2

3. Hazardous Service Credit

Subtract the following, based on the calculation of Dollar Contribution Amount multiplied by the Years of Hazardous Service.

Dollar Contribution Amount	X	FULL Years of Hazardous Service	=	BOX 3 TOTAL
$21.94	X		=	

Calculate the Service Credit Dollar Amount by multiplying the Years of Service by the Dollar Contribution Amount, using the appropriate Nonhazardous and Hazardous service credit.

Box 3

Your Subtotal**

Box 1 subtract Box 2 and/or subtract Box 3**

**ADDITIONAL AMOUNTS

Refer to items 4 and 5 on page 11 for details about Tobacco Status and LivingWell Promise costs. If these apply, you must add the additional amounts to the subtotal to determine your total monthly premium.

Hazardous Percentage Contribution Premium Calculation Worksheet

Use this worksheet if you meet all of the following:

- You have hazardous service, or combined hazardous and nonhazardous service.
- You are a retiree or a beneficiary receiving benefits.
- Your participation date with KPPA was PRIOR to July 1, 2003.

1. Select Plan

Select one. Determine your monthly premium beginning January 1, 2025.

Box 1

Plan Option	Single	Parent Plus	Couple	Family	Family X-Ref*
LivingWell CDHP	$930.76	$1,269.28	$1,866.24	$2,078.08	$1,068.66
LivingWell PPO	$949.04	$1,320.40	$1,981.62	$2,185.78	$1,126.28
LivingWell Basic CDHP	$901.04	$1,234.80	$1,863.04	$2,069.88	$1,057.40
LivingWell HDHP	$835.42	$1,144.86	$1,727.36	$1,919.14	$980.38

*Retiree Portion. If you need assistance calculating your family cross-reference premium, contact KPPA. If Cross-Reference option is selected and the retiree has a surplus of contribution to cover the retiree's portion of the premium, it will be applied to the spouse's portion of the premium.

2. Service Credit

Subtract the following, based upon your months of service.

Box 2

Applicant's Months of Service	Contribution
240+ months	$949.04
180 - 239 months	$711.78
120 - 179 months	$474.52
48 - 119 months	$237.26
0 - 47 months	$0.00

PLEASE READ THE HAZ NOTICE BELOW BEFORE CONTINUING TO BOX 3

HAZ NOTICE — HAZARDOUS RETIREES WITH HEALTH INSURANCE DEPENDENTS FORM 6256 YEARLY REQUIREMENT

You must submit a Form 6256 every year. You must provide eligibility documentation for your spouse and dependent(s) if not already on file with KPPA:

- If your **dependent child** is between the ages of 18 and 22, you must complete Form 6256. If you cover your **spouse**, you must complete Form 6256.
- A birth certificate, marriage certificate, or other supporting documentation for your spouse and/or dependent(s) must be filed with KPPA.

If you fail to notify KPPA of changes in your dependent's eligibility (child and spouse), you will BE REQUIRED TO REPAY any insurance benefits paid on behalf of the ineligible person.

You may continue to cover dependents between the ages of 22 and 26, however, they are not eligible for premium contribution. You will be responsible for paying the additional cost for coverage.

UPLOAD

MYRETIREMENT.KY.GOV

Members have three options for submitting documents to our office:

1. Use the upload feature in Self Service
2. Mail to 1260 Louisville Road, Frankfort, KY 40601
3. Fax to 502-696-8822

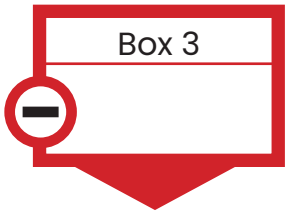
3. Spouse & Dependent Coverage

Select one. If you retired August 1, 1998 or after, your additional contribution toward Parent Plus, Couple or Family coverage is based upon hazardous duty service credit only. Apply your service credit to the table below to determine your additional contribution if selecting Parent Plus, Couple or Family coverage. Please enter this value in Box 3.

If you retired prior to August 1, 1998, your additional contribution toward Parent Plus, Couple or Family coverage is based upon total service credit. Apply your total service credit to the table below to determine your additional contribution if selecting Parent Plus, Couple or Family coverage. Please enter this value in Box 3.

Hazardous Service Only[1]	Parent Plus	Couple	Family	Family X-Ref
240+ months	$371.36	$1,032.58	$1,236.74	$1,303.52
180 - 239 months	$278.52	$774.44	$927.56	$977.64
120 - 179 months	$185.68	$516.29	$618.37	$651.76
48 - 119 months	$92.84	$258.15	$309.19	$325.88
0 - 47 months	$0.00	$0.00	$0.00	$0.00

If you retired prior to August 1, 1998, your additional contribution toward Parent Plus, Couple or Family coverage is based upon total service credit.



Your Subtotal

Box 1 subtract Box 2 and Box 3

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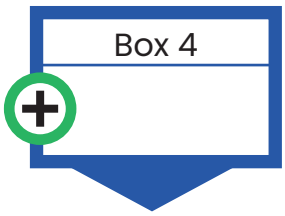
4. Tobacco Status

Select one, based upon tobacco usage in the past six months. If you are a tobacco user, you will be required to pay the amount in box 4.

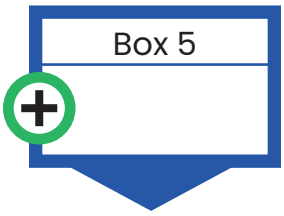
Non-tobacco user	+$0.00
Retiree or beneficiary uses tobacco selecting Single coverage	+$40.00
Retiree or beneficiary uses tobacco selecting Family, Parent Plus, or Couple coverage	+$80.00



5. LivingWell Promise

Select one. If you did not fulfill the LivingWell Promise for Plan Year 2024, you will be required to pay amount in Box 5 in 2025.

Promise Completed	+$0.00
Applicant failed to complete Promise	+$40.00



Total Monthly Premium
Subtotal (Box 1 - Box 2 - Box 3) + Box 4 + Box 5 = Total

KPPA
Kentucky Public Pensions Authority
1260 Louisville Road
Frankfort, KY 40601

For a complete list of vendors and contact information, visit our website at KYRET.KY.GOV

KEHP kehp.ky.gov Open Enrollment Hotline 888-581-8834	Castlight mycastlight.com/mybenefits 800-681-6758
Anthem Health insurance anthem.com/kehp 844-402-5347	SmartShopper - Shop for better pricing SmartShopper.com 855-869-2133
CVS Caremark - Prescriptions caremark.com 866-601-6934	HealthEquity - HRA and COBRA healthequity.com HRA 877-430-5519 COBRA 888-678-4881

OFFICE HOURS
Monday - Friday 8:00am - 4:30pm ET
502-696-8800 or 1-800-928-4646
Fax 502-696-8822

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