



Kentucky Public  
Pensions Authority



**CERS**



**KERS**



**SPRS**

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# Plan Year 2026 New Retiree Enrollment

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](http://mycastlight.com/mybenefits) between January 1, 2026 - July 1, 2026.

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This is summary information.  
Visit our website for details.



[KYRET.KY.GOV](http://KYRET.KY.GOV)  
[MYRETIREMENT.KY.GOV](http://MYRETIREMENT.KY.GOV)



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

# Deadlines for Newly Retired Members

KPPA offers group medical insurance for retired members. Participation in the insurance program may be waived at the time of retirement or during open enrollment. KPPA provides access to group health insurance coverage through the Kentucky Employees' Health Plan (KEHP) for recipients until they become eligible for Medicare. After a recipient becomes eligible for Medicare, coverage is available through a Medicare eligible plan offered by KPPA. Please see the Medicare notice on page 15 for additional information.

In order to cover a spouse or dependent on a plan, you must also be enrolled and covered by a KPPA plan. If you waive coverage, your spouse and/or eligible dependents cannot be enrolled in the health insurance plans offered by KPPA.

## HEALTH INSURANCE ENROLLMENT FORM

For insurance coverage to begin the same month as your retirement payment, you must file a Form 6200 with our office by the last day of the month prior to the month you retire. If you miss the deadline, you will be placed on the default plan. New retirees are allowed to change their health insurance plan coverage within the first month of their retirement.

For Example:

Retirement Date	Form 6200 Due By	Insurance Effective Date
May 1	April 30	May 1

If you miss the above deadline, you can still submit a Form 6200. Your Form 6200 must be filed with our office by the last day of the month in which you retire.

Retirement Date	Form 6200 Due By	Insurance Effective Date
May 1	May 30	June 1

### If you miss both deadlines:

If you miss both deadlines you will remain in the default health insurance single plan and will not be eligible to select a new health insurance plan until the next open enrollment period, unless you experience a qualifying event.

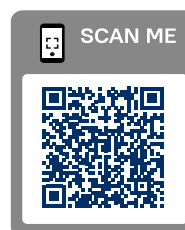
### PLEASE REMEMBER:

- If you do not return a health insurance application **either waiving coverage or selecting a plan**, you will be defaulted into a single health insurance plan.
- Your retirement can be effective without insurance coverage.
- You are responsible for filing your insurance application by the due date.
- Retirees may only enroll with one retirement system (Judicial, Legislators, Teachers, or KPPA).
- Documentation for health insurance dependents/spouse is required.
- Waiting until the last minute to file an enrollment form will cause delays in receiving your insurance card and accessing benefits.

### HEALTH INSURANCE PREMIUMS AND BENEFITS

#### 2026 Plan Information:

Pick from four health insurance plan options. See the benefits grid on pages 4-5, scan the QR code below, or from our homepage go to Retirees > Insurance > [Non-Medicare Plan Year 2026](#).



## YOUR COST FOR COVERAGE

In order to determine your cost for coverage, please refer to the worksheets on pages 11-14. 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.

## LIVINGWELL PROMISE REQUIRED

All planholders who are 18 or older must fulfill the LivingWell Promise between January 1, 2026 - July 1 2026 to earn premium discounts in 2027.

To fulfill the LivingWell Promise, all planholders must take the online Health Assessment at [mycastlight.com/mybenefits](http://mycastlight.com/mybenefits) by July 1, 2026 or you will be responsible for paying an additional \$40 LivingWell fee every month in 2027.



## HAZARDOUS YEARLY REQUIREMENT

Hazardous members with insurance dependents have to complete a Form 6256 every year. Please refer to our website for details. Form 6256 can be submitted with your online enrollment, uploaded using the Documents feature in Self Service, or can be faxed or mailed to KPPA.

## CROSS REFERENCE

Effective January 1, 2025, the cross-reference payment option is no longer available for new retirees who are not currently on a cross-reference plan.

If you currently have the cross reference option:

- You and your spouse must both fulfill the LivingWell Promise;
- If you both fulfill the Promise, you and your spouse will not be responsible for paying an additional \$40 LivingWell fee every month in 2027;
- If only one of you fulfills the Promise, then the other person will be responsible for paying an additional \$40 LivingWell fee every month in 2027.

## PERSONAL IDENTIFICATION NUMBER (PIN)

You will need your PIN to submit your enrollment form. You can request a new PIN in Self Service. If you have an email on file with KPPA, your PIN may be emailed to you, otherwise it will be mailed to the address on file with KPPA.

## EMPLOYMENT AFTER RETIREMENT

Go to [KYRET.KY.GOV](http://KYRET.KY.GOV) and select Retirees, then [Reemployment after Retirement](#). Refer to the information included with your retirement paperwork.

## CHANGING OR CANCELING YOUR BENEFITS

Read more about qualifying events on our website. Go to [KYRET.KY.GOV](http://KYRET.KY.GOV) > Retirees> Insurance> [Qualifying Events](#).

## FORMS

Go to [KYRET.KY.GOV](http://KYRET.KY.GOV) > Publications & Forms > Forms> [Insurance Forms](#).

## WEBINARS

Check our website for the webinar schedule.

## VIDEOS

Go to [KYRET.KY.GOV](http://KYRET.KY.GOV) > Retirees> [Retiree Outreach](#) > [Videos](#).

## KEHP TOBACCO USER FEE, DISCLOSURES & LEGAL DECLARATIONS

To view these documents online, use your mobile phone camera to scan the QR code or go to [KYRET.KY.GOV](http://KYRET.KY.GOV) > Retirees > Insurance> [Non Medicare Plan Year 2026](#).

## SUBMITTING DOCUMENTS

Members have three options for submitting documents to our office:

- Use the upload feature in Self Service at [MyRetirement.ky.gov](http://MyRetirement.ky.gov)
- Mail to 1260 Louisville Road, Frankfort, KY 40601
- Fax to 502-696-8822

## VENDORS

Visit our website for a complete list of vendors and their contact information.

# Benefits Grid

Plan Options	LivingWell CDHP		LivingWell PPO		LivingWell Basic CDHP		LivingWell HDHP	
	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network
<b>Lifetime Maximum</b>	Unlimited							
<b>HRA</b>	Single \$500; Family \$1,000	No HRA	Single \$250; Family \$500	No HRA	Single \$250; Family \$500	No HRA. Can use a non-KEHP HSA with this plan.	Single \$2,100 Family \$4,200*	Single \$2,100 Family \$4,200*
<b>Annual Deductible</b>	Single \$1,550 Family \$2,900	Single \$2,900 Family \$5,550	Single \$1,850 Family \$3,450	Single \$1,850 Family \$3,450	Single \$2,100 Family \$3,950	Single \$3,450 Family \$6,650	Single \$2,100 Family \$4,200*	Single \$2,100 Family \$4,200*
<b>Annual Maximum Out-of-Pocket</b>	Applies to Medical and Pharmacy	Applies to Medical and Pharmacy	Applies to Medical	Applies to Medical	Applies to Medical and Pharmacy	Applies to Medical and Pharmacy	Applies to Medical and Pharmacy	Applies to Medical and Pharmacy
	Single \$3,150 Family \$6,050	Single \$6,050 Family \$11,900	Single \$3,150 Family \$6,050	Single \$6,050 Family \$11,900	Single \$4,200 Family \$8,200	Single \$8,200 Family \$11,900	Single \$8,300 Family \$16,650	Single \$16,650 Family \$33,300
<b>Deductibles and Maximum Out-of-Pocket for In-Network and Out-of-Network Providers accumulate separately and do not cross-apply</b>								
<b>Co-insurance</b>	Plan: 80% Member: 20%	Plan: 50% Member: 50%	Plan: 75% Member: 25%	Plan: 50% Member: 50%	Plan: 70% Member: 30%	Plan: 50% Member: 50%	Plan: 70% Member: 30%	Plan: 50% Member: 50%
<b>Doctor's Office Visit</b>	Deductible, then 20%	Deductible, then 50%	Co-pay: \$25 PCP \$50 Specialist	Deductible, then 50%	Deductible, then 30%	Deductible, then 50%	Deductible, then 30%	Deductible, then 50%
<b>Annual Prescription Drug Maximum Out-of-Pocket</b>	Combined with Medical	Combined with Medical	Single \$2,500 Family \$5,000	Single \$5,000 Family \$10,000	Combined with Medical	Combined with Medical	Combined with Medical	Combined with Medical
<b>30-Day Supply Tier 1 - Generic Tier 2 - Formulary</b>	Deductible, then 20%	Deductible, then 50%	\$20 \$40	\$40 \$80	Deductible, then 30%	Deductible, then 50%	Deductible, then 30%	Deductible, then 50%
<b>90-Day Supply (Retail or Mail Order)</b>	Deductible, then 20%	Not Covered	\$40 \$80	Not Covered	Deductible, then 30%	Not Covered	Deductible, then 30%	Not Covered
<b>GLP-1 Weight Loss Drugs</b>	Deductible, then 25%	Deductible, then 50%	Deductible, then 25%	Deductible, then 50%	Deductible, then 30%	Deductible, then 50%	Deductible, then 30%	Deductible, then 50%
<b>Covered Services</b>								
<b>Preventive Care Office Visits</b>								
Well-baby, well-child visits, as recommended	100%	Deductible, then 50%	100%	Deductible, then 50%	100%	Deductible, then 50%	100%	Deductible, then 50%
Adult annual physical exam	100%	Deductible, then 50%	100%	Deductible, then 50%	100%	Deductible, then 50%	100%	Deductible, then 50%
Immunizations, as recommended	100%	Deductible, then 50%	100%	Deductible, then 50%	100%	Deductible, then 50%	100%	Deductible, then 50%
Screenings including Pap smears, and labs, as part of the preventive office visit	100%	Deductible, then 50%	100%	Deductible, then 50%	100%	Deductible, then 50%	100%	Deductible, then 50%
<b>Outpatient Services</b>								
Primary Care and Specialist Office Visits	Deductible, then 20%	Deductible, then 50%	Co-pay \$25 PCP \$50 Specialist	Deductible, then 50%	Deductible, then 30%	Deductible, then 50%	Deductible, then 30%	Deductible, then 50%
LiveHealth Online telehealth for Medical and Behavioral Health	100%	N/A	100%	N/A	100%	N/A	100%	N/A
Telehealth with provider other than LiveHealth Online	Deductible, then 20%	Deductible, then 50%	Co-pay \$25 PCP \$50 Specialist	Deductible, then 50%	Deductible, then 30%	Deductible, then 50%	Deductible, then 30%	Deductible, then 50%

# Benefits Grid

Plan Options	LivingWell CDHP		LivingWell PPO		LivingWell Basic CDHP		LivingWell HDHP	
	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network
Diagnostic tests in doctor's office	Deductible, then 2 0%	Deductible, then 50%	Office Visit Co-pay	Deductible, then 50%	Deductible, then 30%	Deductible, then 50%	Deductible, then 30%	Deductible, then 50%
Surgery in Office Setting	Deductible, then 2 0%	Deductible, then 50%	Deductible, then 2 5%	Deductible, then 50%	Deductible, then 30%	Deductible, then 50%	Deductible, then 30%	Deductible, then 50%
Behavioral Health and Substance Abuse Use	Deductible, then 2 0%	Deductible, then 50%	Deductible, then 2 5%	Deductible, then 50%	Deductible, then 30%	Deductible, then 50%	Deductible, then 30%	Deductible, then 50%
Autism Services	Deductible, then 2 0%	Deductible, then 50%	Deductible, then 2 5%	Deductible, then 50%	Deductible, then 30%	Deductible, then 50%	Deductible, then 30%	Deductible, then 50%
Allergy Injection without Office Visit	Deductible, then 2 0%	Deductible, then 50%	\$15 Co-pay	Deductible, then 50%	Deductible, then 30%	Deductible, then 50%	Deductible, then 30%	Deductible, then 50%
Allergy Serum	Deductible, then 2 0%	Deductible, then 50%	\$15 Co-pay	Deductible, then 50%	Deductible, then 30%	Deductible, then 50%	Deductible, then 30%	Deductible, then 50%
Chiropractic Care (manipulation therapy) (maximum of 26 visits per year, no more than one visit a day)	Deductible, then 2 0%	Deductible, then 50%	\$25 Co-pay	Deductible, then 50%	Deductible, then 30%	Deductible, then 50%	Deductible, then 30%	Deductible, then 50%
Therapy Services (per visit: physical, occupational, speech - maximum combined limit of 90 visits per year)	Deductible, then 2 0%	Deductible, then 50%	Deductible, then 2 5%	Deductible, then 50%	Deductible, then 30%	Deductible, then 50%	Deductible, then 30%	Deductible, then 50%
<b>Emergency Services</b>								
Urgent Care Center	Deductible, then 20%	Deductible, then 20%	\$50 Co-pay	Deductible, then 50%	Deductible, then 30%	Deductible, then 30%	Deductible, then 30%	Deductible, then 30%
Emergency Room (emergency medical treatment only)	\$250 Co-pay, then Deductible, then 25%. Co-pay waived if admitted	Deductible, then 25%.	\$250 Co-pay, then Deductible, then 25%. Co-pay waived if admitted.	Deductible, then 25%.	\$250 Co-pay, then Deductible, then 30%. Waived if admitted.	Deductible, then 30%.	Deductible, then 30%	Deductible, then 30%
Emergency Room Physician	Deductible, then 20%	Deductible, then 20%	Deductible, then 25%	Deductible, then 25%	Deductible, then 30%	Deductible, then 30%	Deductible, then 30%	Deductible, then 30%
Ambulance	Deductible, then 20%	Deductible, then 20%	Deductible, then 25%	Deductible, then 25%	Deductible, then 30%	Deductible, then 30%	Deductible, then 30%	Deductible, then 30%
<b>Other Services</b>								
Inpatient Hospital (Semi-private room)	Deductible, then 20%	Deductible, then 50%	Deductible, then 25%	Deductible, then 50%	Deductible, then 30%	Deductible, then 50%	Deductible, then 30%	Deductible, then 50%
Outpatient Hospital/Surgery	Deductible, then 2 0%	Deductible, then 50%	Deductible, then 2 5%	Deductible, then 50%	Deductible, then 30%	Deductible, then 50%	Deductible, then 30%	Deductible, then 50%
Outpatient/Ambulatory Surgery Center	Deductible, then 2 0%	Deductible, then 50%	Deductible, then 2 5%	Deductible, then 50%	Deductible, then 30%	Deductible, then 50%	Deductible, then 30%	Deductible, then 50%
Maternity Care	Deductible, then 2 0%	Deductible, then 50%	\$25 Co-pay (office visit pregnancy diagnosed) Delivery Charge: Deductible, then 2 5%	Deductible, then 50%	Deductible, then 30%	Deductible, then 50%	Deductible, then 30%	Deductible, then 50%
Durable Medical Equipment and Supplies	Deductible, then 2 0%	Deductible, then 20%	Deductible, then 2 5%	Deductible, then 20%	Deductible, then 30%	Deductible, then 30%	Deductible, then 30%	Deductible, then 30%
Home Health Care	Deductible, then 2 0%	Deductible, then 50%	Deductible, then 2 5%	Deductible, then 50%	Deductible, then 30%	Deductible, then 50%	Deductible, then 30%	Deductible, then 50%
X-ray, Lab, and Diagnostics including MRI, CT, and PET scans	Deductible, then 2 0%	Deductible, then 50%	Deductible, then 2 5%	Deductible, then 50%	Deductible, then 30%	Deductible, then 50%	Deductible, then 30%	Deductible, then 50%

Notes: The boxed areas of the grid are components of each plan most often used by members when choosing a plan option, but are not all inclusive. You can refer to the Summary of Benefits and Coverage (SBC) for more information. KEHP has made every attempt to ensure the accuracy of the benefits outlined in this Benefits Grid. If an error has occurred, the benefits outlined in the 2026 Summary Plan Descriptions (SPDs) and Medical Benefit Booklets will determine how benefits are paid. Benefits are subject to the terms, conditions, limitations, and exclusions set forth in the SPDs.

- Co-pays do not accumulate toward the Deductible, but they do accumulate toward the applicable Maximum Out-of-Pocket. Once your Maximum Out-of-Pocket is met, you do not have to pay any more Co-pays.
- Certain drugs to treat diabetes, COPD, asthma, and hypertension are subject to reduced Co-pays and Co-insurance with no Deductibles. A 90-day supply of maintenance drugs may be subject to lower Co-pays and Co-insurance. Select preventive/maintenance drugs bypass the Deductible on the CDHPs.
- Claims are processed based on provider billing type, which may include separate charges from a lab performing services outside of the doctor's office visit.

\*The HDHP has a non-embedded Deductible which means all family members share a Deductible and out-of-pocket (OOP) maximum, regardless of the number of family members. The entire Deductible must be met before any one family member receives benefits. The entire OOP must be met before the family has satisfied the OOP maximum.

# Your Self Service Account

KPPA, and all associated vendors, have telephone, email and website access for any questions you may have. All documents, including forms, are available online. Please refer to our website for a complete list.

## CONNECT TO YOUR ACCOUNT

Go to [KYRET.KY.GOV](http://KYRET.KY.GOV) and click LOGIN or use your mobile phone camera to scan the QR code. Click Register and complete the required steps or log in with your User ID and Password.



Watch a [short video](#) for step by step registration instructions.



## CREATE LOGIN INFORMATION

We will ask you to create a User ID and Password, which you will use each time you log in to your account. For additional security, you will answer a secret question. This answer will be used if you need to reset your User ID or Password.

When the setup steps are complete, you are ready to manage your retirement account online.

## SECURITY FEATURES

A Personal Identification Number, or PIN, is required to take advantage of some Self Service features (see above). A new PIN can be requested through Self Service and sent to your mailing address or email on file at KPPA.

The PIN is void after 3 unsuccessful attempts to log in. If this occurs, KPPA cannot reset the same PIN.

A security timer will begin after you log in. After 15 minutes of inactivity you will be logged out and will need to sign in again.

## UPLOAD DOCUMENTS

Use the convenient Documents feature to immediately upload your retirement documents.

## AFTER RETIREMENT

After retirement, members can access their account through Retiree Self Service using the same User ID and Password you created for Member Self Service.



## RETIREES can:

- View account details
- Maintain contact information
- View and update tax withholdings
- View and print 1099-Rs
- View and update direct deposit
- Upload documents
- Access secure message center
- View payment history
- Request income verification
- Register for seminars
- Enroll in health insurance during open enrollment
- Update retirement account beneficiary and payment option, if eligible.



**Plan Year 2026 RETIREE HEALTH INSURANCE ENROLLMENT/CHANGE FORM**

**Section 1: To Be Completed by Insurance Coordinator**

KHRIS Personnel Number		Hazardous Duty <input type="checkbox"/>		Date of Retirement		Qualifying Event Date		Coverage Effective Date					
<input type="checkbox"/> KPPA 80000 10006416	<input type="checkbox"/> TRS 85000 10006418	<input type="checkbox"/> KTCRS 81000 10006417	<input type="checkbox"/> JRP 86000 10006419	<input type="checkbox"/> LRP 87000 10006420	<input type="checkbox"/> KPPA RTW 80100 10006464								
KPPA Only:		<input type="checkbox"/> KPPA-KERS		<input type="checkbox"/> CERS - Oth.Ag		<input type="checkbox"/> KPPA-SPRS							
<b>Reason(s) for Application:</b>		<b>Qualifying Event:</b>				<b>Termination:</b>							
<input type="checkbox"/> Open Enrollment <input type="checkbox"/> New Retiree <input type="checkbox"/> Returning Retiree <input type="checkbox"/> Applicant becomes the PH <input type="checkbox"/> Qualifying Event <input type="checkbox"/> Exception <input type="checkbox"/> Demographic Change <input type="checkbox"/> Termination		<input type="checkbox"/> Marriage <input type="checkbox"/> Birth/Adoption/Placement <input type="checkbox"/> Court Order for Child <input type="checkbox"/> Divorce <input type="checkbox"/> Death - Date: _____ <input type="checkbox"/> Loss of Individual Health <input type="checkbox"/> Loss of Group Health <input type="checkbox"/> Spouse turned 65				<input type="checkbox"/> Begin Medicare/Medicaid <input type="checkbox"/> End Medicare/Medicaid <input type="checkbox"/> Loss of KCHIP <input type="checkbox"/> Spouse/Dependent Starting Employment <input type="checkbox"/> Spouse/Dependent Terminating Employment <input type="checkbox"/> Special Enrollment <input type="checkbox"/> Other: _____				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) <i>If plan holder is not the Retiree</i>		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: <input type="checkbox"/> Male <input type="checkbox"/> Female			Married: <input type="checkbox"/> Yes <input type="checkbox"/> No		
***Required information for processing. Are you Medicare eligible due to Social Security disability? <input type="checkbox"/> Yes <input type="checkbox"/> No					

Race/Ethnicity Data: The Commonwealth of Kentucky does not discriminate on the basis of race, color, religion, sex, national origin, sexual orientation, gender identity or expression, ancestry, age, pregnancy or related medical condition, marital or familial status, disability, veteran status, political affiliation, or genetic information, in accordance with state and federal laws. **Completion of the questions below is OPTIONAL and will NOT affect the terms or conditions of your medical coverage or your eligibility for medical coverage.** The federal government strongly encourages employers and health plans to collect social data about individuals to better identify environmental and personal conditions that affect a wide range of health and quality-of-life outcomes. **This data will be kept private and used only to help the Commonwealth of Kentucky better understand how to provide healthcare services to you. Please select the one category with which you identify.**

Hispanic or Latino  
  White (Non-Hispanic or Latino)  
  Asian (Non-Hispanic or Latino)  
  Black or African American (Non-Hispanic or Latino)  
 Native Hawaiian or Other Pacific Islander (Non-Hispanic or Latino)  
  American Indian or Alaska Native (Non-Hispanic or Latino)  
  Two or more races  
 I choose not to answer

**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)		<input type="checkbox"/> Male <input type="checkbox"/> Female		<input type="checkbox"/> Add <input type="checkbox"/> Drop <input type="checkbox"/> Remain	
***Required information for processing. Is Spouse Medicare eligible due to Social Security disability? <input type="checkbox"/> Yes <input type="checkbox"/> No									
<input type="checkbox"/> I wish to utilize the Cross-reference payment option (two members, married with children). <i>Not available to new retirees (new to KEHP) after 1/1/2025</i>									
KPPA Only:		<input type="checkbox"/> KPPA-KERS		<input type="checkbox"/> CERS - Oth.Ag		<input type="checkbox"/> 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)**

<b>Section 4: Dependent Information Changes or Current (Circle one)</b>		***Required information for processing: Are any dependents Medicare eligible due to Social Security disability? <input type="checkbox"/> Yes <input type="checkbox"/> No				If yes, who?							
Child #1 SSN		Name (Last, First, MI)		<input type="checkbox"/> Natural <input type="checkbox"/> Adopted <input type="checkbox"/> Court Ordered		<input type="checkbox"/> Foster <input type="checkbox"/> Step <input type="checkbox"/> Disabled		Date of Birth		<input type="checkbox"/> Male <input type="checkbox"/> Female		<input type="checkbox"/> Add <input type="checkbox"/> Drop <input type="checkbox"/> Remain	
Child #2 SSN		Name (Last, First, MI)		<input type="checkbox"/> Natural <input type="checkbox"/> Adopted <input type="checkbox"/> Court Ordered		<input type="checkbox"/> Foster <input type="checkbox"/> Step <input type="checkbox"/> Disabled		Date of Birth		<input type="checkbox"/> Male <input type="checkbox"/> Female		<input type="checkbox"/> Add <input type="checkbox"/> Drop <input type="checkbox"/> Remain	

Retiree's SSN: \_\_\_\_\_

Applicant's SSN: \_\_\_\_\_

Child #3 SSN	Name (Last, First, MI)	<input type="checkbox"/> Natural <input type="checkbox"/> Adopted <input type="checkbox"/> Court Ordered	<input type="checkbox"/> Foster <input type="checkbox"/> Step <input type="checkbox"/> Disabled	Date of Birth	<input type="checkbox"/> Male <input type="checkbox"/> Female	<input type="checkbox"/> Add <input type="checkbox"/> Drop <input type="checkbox"/> Remain
Child #4 SSN	Name (Last, First, MI)	<input type="checkbox"/> Natural <input type="checkbox"/> Adopted <input type="checkbox"/> Court Ordered	<input type="checkbox"/> Foster <input type="checkbox"/> Step <input type="checkbox"/> Disabled	Date of Birth	<input type="checkbox"/> Male <input type="checkbox"/> Female	<input type="checkbox"/> Add <input type="checkbox"/> Drop <input type="checkbox"/> Remain
Child #5 SSN	Name (Last, First, MI)	<input type="checkbox"/> Natural <input type="checkbox"/> Adopted <input type="checkbox"/> Court Ordered	<input type="checkbox"/> Foster <input type="checkbox"/> Step <input type="checkbox"/> Disabled	Date of Birth	<input type="checkbox"/> Male <input type="checkbox"/> Female	<input type="checkbox"/> Add <input type="checkbox"/> Drop <input type="checkbox"/> Remain

**Section 5: Tobacco Use Declaration** Rules governing the Tobacco Use Declaration can be found in your Benefits Selection Guide or at [kehp.ky.gov](http://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? <input type="checkbox"/> Yes <input type="checkbox"/> No	Has your spouse, if covered under this plan, used tobacco regularly within the past 6 months? <input type="checkbox"/> Yes <input type="checkbox"/> No	Have any children covered under this plan age 18 or older used tobacco regularly within the past 6 months? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, who? _____
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**Section 6: Coverage Level**

**Note: If adding newly covered dependents you will be contacted later to provide verification documents to our dependent eligibility audit vendor.**

<input type="checkbox"/> Single (self only)	<input type="checkbox"/> Parent Plus (self and child(ren))	<input type="checkbox"/> Couple (self and spouse)	<input type="checkbox"/> Family (self, spouse and child(ren))
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**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](http://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](http://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.

\_\_\_\_\_  
Employee/Retiree Signature \_\_\_\_\_  
Date

\_\_\_\_\_  
Applicant Signature - if plan holder is not the retiree \_\_\_\_\_  
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
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**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? <input type="radio"/> Yes <input type="radio"/> No			
Phone (select type) <input type="radio"/> Mobile <input type="radio"/> Home <input type="radio"/> Work		Email:	

**Spouse Information**

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

## Hazardous Percentage Contribution Premium Calculation Worksheet

Use this worksheet if you meet all of the following:

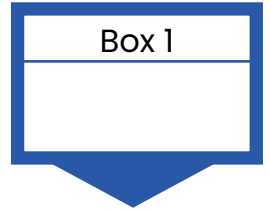
- You have hazardous service, or combined hazardous and nonhazardous service.
- You are a retiree or a beneficiary receiving benefits.
- Your participation date with KPPA was PRIOR to July 1, 2003.

### 1. Select Plan

Select one. Determine your monthly premium beginning January 1, 2026.

Plan Option	Single	Parent Plus	Couple	Family	Family X-Ref*
LivingWell CDHP	\$1,090.42	\$1,475.34	\$2,144.14	\$2,383.68	\$1,247.34
LivingWell PPO	\$1,105.54	\$1,514.46	\$2,238.22	\$2,453.16	\$1,300.24
LivingWell Basic CDHP	\$1,059.88	\$1,447.24	\$2,150.90	\$2,385.14	\$1,244.12
LivingWell HDHP	\$983.66	\$1,343.02	\$1,996.16	\$2,213.58	\$1,153.50

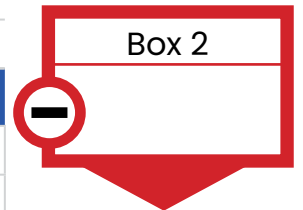
\*Retiree Portion. If you need assistance calculating your family cross-reference premium, contact KPPA. If Cross-Reference option is selected and the retiree has a surplus of contribution to cover the retiree's portion of the premium, it will be applied to the spouse's portion of the premium.



### 2. Service Credit

Subtract the following, based upon your months of service.

Applicant's Months of Service	Contribution
240+ months	\$1,105.54
180 - 239 months	\$829.16
120 - 179 months	\$552.77
48 - 119 months	\$276.39
0 - 47 months	\$0.00



PLEASE READ  
THE HAZARDOUS  
NOTICE BELOW  
BEFORE  
CONTINUING TO  
BOX 3



### 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 a premium contribution. You will be responsible for paying the additional cost for coverage.



Members have three options for submitting documents to our office:

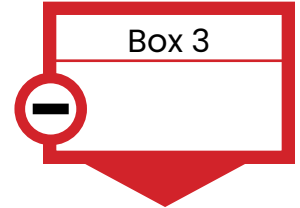
1. Use the upload feature in Self Service
2. Mail to 1260 Louisville Road, Frankfort, KY 40601
3. Fax to 502-696-8822

### 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 <sup>1</sup>	Parent Plus	Couple	Family	Family X-Ref
240+ months	\$408.92	\$1,132.68	\$1,347.62	\$1,494.94
180 - 239 months	\$306.69	\$849.51	\$1,010.72	\$1,121.21
120 - 179 months	\$204.46	\$566.34	\$673.81	\$747.47
48 - 119 months	\$102.23	\$283.17	\$336.91	\$373.74
0 - 47 months	\$0.00	\$0.00	\$0.00	\$0.00

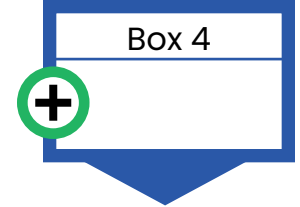


Your Subtotal  
Box 1 subtract Box 2 and Box 3

### 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.

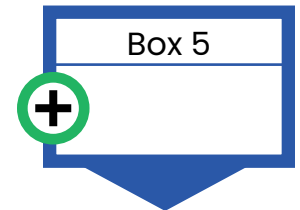
Non-tobacco user	+\$0.00
Retiree or beneficiary uses tobacco selecting Single coverage	+\$40.00
Retiree or beneficiary uses tobacco selecting Family, Parent Plus, or Couple coverage	+\$80.00



### 5. LivingWell Promise

Select one. If you did not fulfill the LivingWell Promise for Plan Year 2025, you will be required to pay the amount in Box 5 in 2026.

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



#### LIVINGWELL PROMISE REQUIRED

All planholders who are 18 or older must fulfill the LivingWell Promise between January 1, 2026 - July 1, 2026 to earn premium discounts in 2027. Go to [mycastlight.com/mybenefits](https://mycastlight.com/mybenefits) to complete the online Health Assessment.

## 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, 2026.

Plan Option	Single	Parent Plus	Couple	Family	Family X-Ref**
LivingWell CDHP	\$1,090.42	\$1,475.34	\$2,144.14	\$2,383.68	\$1,247.34
LivingWell PPO	\$1,105.54	\$1,514.46	\$2,238.22	\$2,453.16	\$1,300.24
LivingWell Basic CDHP	\$1,059.88	\$1,447.24	\$2,150.90	\$2,385.14	\$1,244.12
LivingWell HDHP	\$983.66	\$1,343.02	\$1,996.16	\$2,213.58	\$1,153.50

\*\*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	\$1,090.42
	LivingWell PPO	\$1,105.54
	LivingWell Basic CDHP	\$1,059.88
	LivingWell HDHP	\$983.66
180 - 239 months		\$829.16
120 - 179 months		\$552.77
48 - 119 months		\$276.39
0 - 47 months		\$0.00

Box 2

-

Your Subtotal  
Box 1 Subtract  
Box 2

\*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.

### 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 2025, you will be required to pay the amount in Box 4 in 2026.

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

## Dollar Contribution Premium Calculation Worksheet

*The dollar contribution amounts below will increase by 1.5% on July 1<sup>st</sup>. 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 a 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, 2026.

Plan Option	Single	Parent Plus	Couple	Family	Family X-Ref**
LivingWell CDHP	\$1,090.42	\$1,475.34	\$2,144.14	\$2,383.68	\$1,247.34
LivingWell PPO	\$1,105.54	\$1,514.46	\$2,238.22	\$2,453.16	\$1,300.24
LivingWell Basic CDHP	\$1,059.88	\$1,447.24	\$2,150.90	\$2,385.14	\$1,244.12
LivingWell HDHP	\$983.66	\$1,343.02	\$1,996.16	\$2,213.58	\$1,153.50

\*\* 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
\$14.85	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

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### 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
\$22.27	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

---

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

Your Subtotal\*\*\*

### \*\*\*ADDITIONAL AMOUNTS

Refer to items on pages 12 and 13 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.

SB 10 - 2025 Legislative Changes

Information about a change in the CERS monthly contribution amount paid toward non-Medicare insurance coverage through KPPA for January 1, 2026 can be found at Retirees > Insurance > [Non-Medicare Plan Year 2026](#).

# Transitioning to Medicare

## WHAT HAPPENS WHEN I TURN AGE 65 AND BECOME ELIGIBLE FOR MEDICARE?

The Retiree Health Care Division provides videos for prospective Medicare eligible members on the topic of transitioning to Medicare eligible health insurance coverage. These videos explain:

- What to expect when transitioning to Medicare,
- How to enroll to ensure a smooth transition, and
- The current Humana Medicare Advantage options available through KPPA.



Access the videos on our website at Retirees > Insurance > [Medicare Plan Year 2026](#).

From this page, you can view three helpful videos:

- Part 1 - Transitioning to KPPA Medicare Eligible Insurance Coverage
- Part 2 - Humana Medicare Advantage Benefits
- Humana Medicare Dental Benefits

To learn more about the current Medicare plans available through KPPA, go to [KYRET.KY.GOV](http://KYRET.KY.GOV):

- Click [Retirees](#)
- Click [Insurance](#)
- Click [Medicare Plan Year 2026](#)

### MEDICARE ELIGIBLE NOTICE

Medicare eligible retirees reemployed full-time by a participating employer may not qualify for a KPPA Medicare Advantage Plan due to federal law but could be eligible for an alternative health plan. If you have questions about your health insurance options, visit our website, email [kppa.mail@kyret.ky.gov](mailto:kppa.mail@kyret.ky.gov), or call our office at 1-800-928-4646.



# 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](http://KYRET.KY.GOV)

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KEHP <a href="http://kehpa.ky.gov">kehpa.ky.gov</a> Open Enrollment Hotline 888-581-8834	Castlight <a href="http://mycastlight.com/mybenefits">mycastlight.com/mybenefits</a> 800-681-6758
Anthem Health insurance <a href="http://anthem.com/kehpa">anthem.com/kehpa</a> 844-402-5347	SmartShopper - Shop for better pricing <a href="http://SmartShopper.com">SmartShopper.com</a> 855-869-2133
CVS Caremark - Prescriptions <a href="http://caremark.com">caremark.com</a> 866-601-6934	HealthEquity - HRA and COBRA <a href="http://healthequity.com">healthequity.com</a> 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



[KYRET.KY.GOV](http://KYRET.KY.GOV)



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@KYretirement



@kentucky-public-pensions-authority

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