# Kentucky Employees Health Plan

For new regularly employed employees who are eligible for health insurance benefits at the time they are hired, coverage will begin on the first day of the second calendar month following the employee's hire date. Example: if employment begins anytime in August, the employee is eligible for coverage October 1.

**New employees must complete an Enrollment Application within the first 35 calendar days of employment.**

Employees who fail to make their Health Insurance elections or waive their coverage within the designated time frame will not be allowed to enroll until the next Open Enrollment period, unless an appropriate Qualifying Event occurs. **Employees who fail to enroll will automatically be enrolled in the Single Coverage Level of the Standard PPO.**

Employees should visit the KEHP website at kehp.ky.gov to locate the Benefits Selection Guide, Summary Plan Descriptions, benefit booklets, and Summary of Benefits and Coverage. Both documents will provide necessary information in making their benefit selections.

If you enroll in either the Living Well CDHP or Living Well PPO for 2017, you must complete one of the following from January 1, 2017 through July 1, 2017:

- Take the Go365 Health Assessment (HA)
  Or
- Complete a biometric screening

If you enroll in a Living Well plan option in 2017, but you do not take the Go365 Health Assessment or have a biometric screening, you will not receive a premium discount in plan year 2018.

**Form Required:**

- Active Employee Health Insurance Enrollment Application (New Employees)
- KEHP Update Form (Transfers Only)

**Process:**

- Paperwork is submitted to Insurance Coordinator
- Insurance Coordinator enters in KHRIS system
- DEI processes and submits file to Anthem
- Anthem processes within 10 business days and then sends ID cards
- DEI sends file to district payroll to import premium

**The KEHP offers four health insurance plan options.**

- Living Well CDHP
- Living Well PPO
- Standard PPO
- Standard CDHP

If you don't need health insurance through the KEHP, you have the option to waive your health insurance. If you waive your health insurance, you may be eligible to elect an employer-funded Health Reimbursement Arrangement (HRA). An HRA is an account that is available to you to assist in paying for certain medical services. The KEHP offers two pre-funded HRAs that you may be able to elect:

- Waiver General Purpose HRA – covers qualified medical expenses; or
- Waiver Dental/Vision only HRA – covers qualified dental and vision expenses.

If you choose the Waiver General Purpose HRA, per federal law, you must declare that you and your spouse and dependents, if applicable, have other group health plan coverage that provides minimum value. A "group health plan" refers to coverage provided by an employer, an employer organization, or a union. A "group health plan" does not include individual policies purchased through the Marketplace or governmental plans such as TRICARE, Veterans Benefits, Medicare, or Medicaid.

The KEHP offers Flexible Spending Accounts (FSAs) to employees of state agencies, boards of education, and certain quasi-governmental agencies. You contribute pre-tax dollars into an FSA and use the funds to pay for certain eligible expenses. There are two types of FSAs available:

- Healthcare FSA – for medical expenses not covered by your health insurance plan such as your deductible, co-pays, and co-insurance; and
- Dependent Care FSA – for dependent and adult daycare expenses while you are working.

Kentucky Employees' Health Plan
Department of Employee Insurance
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# 2017 ACTIVE EMPLOYEE HEALTH INSURANCE ENROLLMENT APPLICATION

## Section 1: To Be Completed by IC/HRG

| KHRIS Personnel Number | Organizational Unit # | Company Name | Company # | Cost Center # |
|---|---|---|---|---|
| | 10006058 | Fleming County Schools | 171 | 9200100171 |
| Reason for Application ☐New Hire ☐Open Enrollment ☐New Group | | Date of Hire | Coverage Effective Date | Home County Code 035 |

## Section 2: Demographic Information

| Employee's SSN | Employee Name (Last, First, MI) | | Date of Birth (mm/dd/yyyy) |
|---|---|---|---|
| Street Address | | Primary Phone # | Work Email Address |
| City, State Zip | County | Secondary Phone # | Home Email Address |
| Sex: ☐Male ☐Female | | Married: ☐Yes ☐No | |

## Section 3: Spouse Information

| Spouse's SSN | Spouse's Name (Last, First, MI) | Date of Birth (mm/dd/yyyy) | Sex ☐Male ☐Female |
|---|---|---|---|

☐ I wish to utilize the Cross reference payment option (two KEHP members, married with children – no LRP or JRP).

| Spouse's Date of Hire/Retirement | Spouse's Organizational Unit # | Spouse's Company # |
|---|---|---|
| Spouse's Work Email Address | Spouse's Home Email Address | |

## Section 4: Dependent Information

| | | | |
|---|---|---|---|
| Child #1 SSN | Name (Last, First, MI) | Date of Birth (mm/dd/yyyy) | ☐Male ☐Female ☐Disabled Dependent |
| Child #2 SSN | Name (Last, First, MI) | Date of Birth (mm/dd/yyyy) | ☐Male ☐Female ☐Disabled Dependent |
| Child #3 SSN | Name (Last, First, MI) | Date of Birth (mm/dd/yyyy) | ☐Male ☐Female ☐Disabled Dependent |
| Child #4 SSN | Name (Last, First, MI) | Date of Birth (mm/dd/yyyy) | ☐Male ☐Female ☐Disabled Dependent |
| Child #5 SSN | Name (Last, First, MI) | Date of Birth (mm/dd/yyyy) | ☐Male ☐Female ☐Disabled Dependent |
| Child #6 SSN | Name (Last, First, MI) | Date of Birth (mm/dd/yyyy) | ☐Male ☐Female ☐Disabled Dependent |

**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 |
|---|---|---|

**Employee Name:** **Employee SSN:**

## Section 6: Coverage Level

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

## Section 7: Plan Options

☐ LivingWell CDHP

☐ LivingWell PPO

☐ Standard PPO

☐ Standard CDHP

☐ Waiver (General Purpose) HRA – with $ (By choosing a waiver General Purpose HRA and checking this box, I declare that I and, if applicable, my spouse and my dependents, have other group health plan coverage that provides minimum value. To the extent applicable, I have listed my spouse and all dependents whose medical expenses may be reimbursed under the HRA in Sections 3 and 4 of this application.)

☐ Waiver Dental/Vision ONLY HRA – with $

☐ Waiver without HRA – No $

☐ Default Standard PPO – IC/HRG USE ONLY

## Section 8: LivingWell Promise (required for selecting a LivingWell Plan)

☐ I agree to the LivingWell Promise. Electing a LivingWell Promise plan in 2017 means you are required to complete either the Go365 Health Assessment (HA) or biometric screening from January 1, 2017 through July 1, 2017. Instructions on fulfilling your Promise can be found at LivingWell.ky.gov.

## Section 9: Signatures – Please submit this application to your Company IC/HRG

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.

| | |
|---|---|
| Employee Signature | Date |
| Spouse Signature – REQUIRED if electing the cross-reference payment option | Date |
| IC/HRG Signature | Date |
| **Angie Stephens** | **606-845-5851 ext. 2220** |
| 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 |

Transfers Only

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# 2017 KEHP UPDATE FORM

**To be completed by Insurance Coordinator/HR Generalist only. DO NOT use this form to add or drop dependents.**

This form is to be used to update information on health insurance, FSA and HRAs.

## General Information (required)

| Name: | Personnel Number: | SSN: |
|---|---|---|
| Organizational Unit: 10006058 | Company Number: 171 | Company Name: Fleming County Schools |

## Update Reason

☐ **Termination:** Date Employment Ends _____ Date Health Insurance Terminates _____

*Reason:* ☐Resigned ☐Retired ☐ LWOP ☐ Death ☐Military Leave ☐Other _____

☐ **Reinstate Coverage:** Date Returned to Work _____ Date Health Insurance Effective _____

*Reason:* ☐Rehired ☐FMLA ☐LWOP ☐ Military Leave ☐Other _____

☐ **Transfer or Summer Transfer:** Is member Cross Reference? ☐ Yes ☐ No

- To be completed by the **NEW** company
- No changes to current coverage allowed

| Prior Company Number | New Company Number |
|---|---|
| Last Day Worked at Prior Company | Date Hired at New Company |
| Coverage End Date at Prior Company | Coverage Begin Date at New Company |

| Current Health Benefit Option | | Current Coverage Level | Current FSA Option |
|---|---|---|---|
| ☐ LivingWell CDHP | ☐ Waiver Dental/Vision ONLY HRA | ☐ Single(self only) | ☐ Healthcare FSA |
| ☐ LivingWell PPO | ☐ Waiver without HRA - No $ | ☐ Parent Plus (self and child(ren)) | ☐ Dependent Care FSA |
| ☐ Standard PPO | ☐ Waiver (General Purpose) HRA | ☐ Couple (self and spouse) | Total Calendar Year Contribution: |
| ☐ Standard CDHP | | ☐ Family (self, spouse and child(ren)) | $ _____ |

## Other Changes or Corrections

For: ☐ Member ☐ Spouse ☐ Child(ren)

| | | | | |
|---|---|---|---|---|
| Name | New: | | | |
| | Previous: | | | |
| New Address (Where mail received) | Street Address: | | | |
| | City: | State: | ZIP Code: | County: |
| E-Mail Address | | | | |
| SSN | Correct: | Incorrect: | | |
| Date of Birth | Correct: | Incorrect: | | |

## Other

I acknowledge and understand that DEI will comply with HIPAA rules and that disclosure of information will be done under the rules of such Federal law. I further authorize DEI to use such information and to disclose such information to third party administrators, vendors, consultants, governmental authorities with jurisdiction and other necessary parties when necessary for my care or treatment, payment for services, the operation of my health plan or to conduct related activities.

Employee Signature _____ Date _____

IC/HRG Signature _____ Date _____

Angie Stephens — IC/HRG Printed Name

606-845-5851 ext. 2220 — IC/HRG Phone Number



**Insurance Coordinator/HRG: Mail this form to DEI, 501 High Street, 2nd Floor, Frankfort, KY 40601**

# KEHP 2017 Benefits Grid

| Plan Options | LivingWell CDHP | | LivingWell PPO | | Standard PPO | | Standard CDHP | |
|---|---|---|---|---|---|---|---|---|
| | In-Network | Out-of-Network | In-Network | Out-of-Network | In-Network | Out-of-Network | In-Network | Out-of-Network |
| **Lifetime Maximum** | Unlimited | Unlimited | Unlimited | Unlimited | Unlimited | Unlimited | Unlimited | Unlimited |
| **Health Reimbursement Arrangement (HRA)** | Single $500; Family $1,000 | | Not Applicable | | Not Applicable | | Single $250; Family $500 | |
| **Annual Deductible*** | Single $1,250<br>Family $2,500 | Single $2,500<br>Family$5,000 | Single $750<br>Family $1,500 | Single $1,500<br>Family $3,000 | Single $750<br>Family $1,500 | Single $1,500<br>Family $3,000 | Single $1,750<br>Family $3,500 | Single $3,000<br>Family $6,000 |
| | Applies to Medical and Pharmacy | | Applies to Medical | | Applies to Medical | | Applies to Medical and Pharmacy | |
| **Annual Medical Out-of-Pocket Maximum**** | Single $2,750<br>Family $5,500 | Single $5,500<br>Family $11,000 | Single $2,750<br>Family $5,500 | Single $5,500<br>Family $11,000 | Single $3,750<br>Family $7,500 | Single $7,500<br>Family $11,000 | Single $3,750<br>Family $7,500 | Single $7,500<br>Family $11,000 |
| Deductibles & Out-of-Pocket Maximums for In-Network and Out-of-Network providers accumulate separately and do not cross apply. | | | | | | | | |
| **Co-Insurance** | Plan: 85%<br>Member: 15% | Plan: 60%<br>Member: 40% | Plan: 80%<br>Member: 20% | Plan: 60%<br>Member: 40% | Plan: 70%<br>Member: 30% | Plan 50%<br>Member: 50% | Plan: 70%<br>Member: 30% | Plan: 50%<br>Member: 50% |
| **Doctor's Office Visits** | Deductible then 15% | Deductible then 40% | Co-Pay: $25 PCP; $45 Specialist | Deductible then 40% | Deductible then 30% | Deductible then 50% | Deductible then 30% | Deductible then 50% |
| Physician Care (Inpatient/ Outpatient/Other) | Deductible then 15% | Deductible then 40% | Deductible then 20% | Deductible then 40% | Deductible then 30% | Deductible then 50% | Deductible then 30% | Deductible then 50% |
| Diagnostic Tests In Doctor's Office**** | Deductible then 15% | Deductible then 40% | Office Visit Co-Pay | Deductible then 40% | Deductible then 30% | Deductible then 50% | Deductible then 30% | Deductible then 50% |
| Other Laboratory | Deductible then 15% | Deductible then 40% | Deductible then 20% | Deductible then 40% | Deductible then 30% | Deductible then 50% | Deductible then 30% | Deductible then 50% |
| Inpatient Hospital (Semi-Private Room) | Deductible then 15% | Deductible then 40% | Deductible then 20% | Deductible then 40% | Deductible then 30% | Deductible then 50% | Deductible then 30% | Deductible then 50% |
| Outpatient Hospital/Surgery | Deductible then 15% | Deductible then 40% | Deductible then 20% | Deductible then 40% | Deductible then 30% | Deductible then 50% | Deductible then 30% | Deductible then 50% |
| Outpatient/ Ambulatory Surgery Center | Deductible then 15% | Deductible then 40% | Deductible then 20% | Deductible then 40% | Deductible then 30% | Deductible then 50% | Deductible then 30% | Deductible then 50% |
| Emergency Room (Benefit for emergency medical treatment only) | Deductible then 15% | | $150 Co-Pay then Deductible then 20% Co-Pay waived if admitted. | | $150 Co-Pay then Deductible then 30% Co-Pay waived if admitted. | | Deductible then 30% | |
| ER Physician Care | Deductible then 15% | | Deductible then 20% | | Deductible then 30% | | Deductible then 30% | |
| Ambulance | Deductible then 15% | | Deductible then 20% | | Deductible then 30% | | Deductible then 30% | |
| Urgent Care Center | Deductible then 15% | | $50 Co-Pay | | Deductible then 30% | | Deductible then 30% | |
| Routine Well Child | Covered at 100% | Deductible then 40% | Covered at 100% | Deductible then 40% | Covered at 100% | Deductible then 50% | Covered at 100% | Deductible then 50% |

# KEHP 2017 Benefits Grid

| Plan Options | LivingWell CDHP | | LivingWell PPO | | Standard PPO | | Standard CDHP | |
|---|---|---|---|---|---|---|---|---|
| | In-Network | Out-of-Network | In-Network | Out-of-Network | In-Network | Out-of-Network | In-Network | Out-of-Network |
| **Routine Well Adult** | Covered at 100% | Deductible then 40% | Covered at 100% | Deductible then 40% | Covered at 100% | Deductible then 50% | Covered at 100% | Deductible then 50% |
| **Mental Health** | Treated the same as any other health condition. See specifics related to PCP office visit, inpatient and outpatient services. | | | | | | | |
| **Autism Services** | Treated the same as any other health condition. See specifics related to PCP office visit, inpatient and outpatient services. | | | | | | | |
| **Allergy Injections** | Deductible then 15% | Deductible then 40% | $15 Co-Pay | Deductible then 40% | Deductible then 30% | Deductible then 50% | Deductible then 30% | Deductible then 50% |
| **Allergy Serum** | Deductible then 15% | Deductible then 40% | $15 Co-Pay | Deductible then 40% | Deductible then 30% | Deductible then 50% | Deductible then 30% | Deductible then 50% |
| **Maternity Care** (See SPD for Specifics) | Deductible then 15% | Deductible then 40% | $25 Co-Pay (office visit pregnancy diagnosed)<br>Delivery Charge: Deductible then 20% | Deductible then 40% | Deductible then 30% | Deductible then 50% | Deductible then 30% | Deductible then 50% |
| **Durable Medical Equipment** | Deductible then 15% | Deductible then 40% | Deductible then 20% | Deductible then 40% | Deductible then 30% | Deductible then 50% | Deductible then 30% | Deductible then 50% |
| **Therapy Services** (Per Visit; Physical, Occupational, Speech) | Deductible then 15% | Deductible then 40% | Deductible then 20% | Deductible then 40% | Deductible then 30% | Deductible then 50% | Deductible then 30% | Deductible then 50% |
| | Maximum of 30 visits per calendar year, per therapy service type | | Maximum of 30 visits per calendar year, per therapy service type | | Maximum of 30 visits per calendar year, per therapy service type | | Maximum of 30 visits per calendar year, per therapy service type | |
| **Chiropractic Care** | Deductible then 15% | Deductible then 40% | $25 Co-Pay | Deductible then 40% | Deductible then 30% | Deductible then 50% | Deductible then 30% | Deductible then 50% |
| | Maximum of 26 visits per calendar year; no more than 1 visit per day | | Maximum of 26 visits per calendar year; no more than 1 visit per day | | Maximum of 26 visits per calendar year; no more than 1 visit per day | | Maximum of 26 visits per calendar year; no more than 1 visit per day | |
| **Prescription Drugs — *Administered by CVS/Caremark*** | | | | | | | | |
| **Annual Rx Out-of-Pocket Maximum** | **Combined with Medical** | **Combined with Medical** | **Single $2,500 Family $5,000** | **Not Applicable** | **Single $2,500 Family $5,000** | **Not Applicable** | **Combined with Medical** | **Combined with Medical** |
| **30-Day Supply*****<br>Tier 1 - Generic<br>Tier 2 - Formulary<br>Tier 3 - Non-Formulary | Deductible then 15% | Deductible then 40% | $10<br>$35<br>$55 | Not Applicable | 30%<br>Min $10-Max $25<br>Min $20-Max $50<br>Min $60-Max $100 | Not Applicable | Deductible then 30% | Deductible then 50% |
| **90-Day Supply**<br>(Retail or Mail Order)*****<br>Tier 1 - Generic<br>Tier 2 - Formulary<br>Tier 3 - Non Formulary | Deductible then 15% | Not Applicable | $20<br>$70<br>$110 | Not Applicable | 30%<br>Min $20-Max $50<br>Min$40-Max $100<br>Min$120-Max$200 | Not Applicable | Deductible then 30% | Not Applicable |

**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. However, if an error has occurred, the benefits outlined in the 2017 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 out-of-pocket maximum.

**For the **LivingWell CDHP** and the **Standard CDHP**, all covered expenses apply to the out-of-pocket maximum. For the **LivingWell PPO** and the **Standard PPO** plans, the out-of-pocket maximum accumulates separately and independently for medical and prescription drug benefits.

*** Certain diabetic drugs are subject to reduced co-pays and co-insurance with no deductibles. A 90-day supply of maintenance drugs is subject to lower co-pays and co-insurance. Select preventive therapy drugs bypass the deductible on both 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.

# 2017 Monthly Premiums and Contributions

## Non-Tobacco User Rates

All employee contributions are per employee, per month

| LivingWell CDHP | Total Premium | Completing LivingWell Promise Rates* | | Without Completing LivingWell Promise Rates | |
|---|---|---|---|---|---|
| | | Employer Contribution | Employee Contribution | Employer Contribution | Employee Contribution |
| *Single* | $702.10 | $654.12 | **$47.98** | $614.12 | **$87.98** |
| *Parent Plus* | $967.18 | $844.20 | **$122.98** | $804.20 | **$162.98** |
| *Couple* | $1,302.74 | $1,014.76 | **$287.98** | $974.76 | **$327.98** |
| *Family* | $1,453.94 | $1,115.96 | **$337.98** | $1,075.96 | **$377.98** |
| *Family Cross-Reference* | $810.00 | $732.02 | **$77.98** | $692.02 | **$117.98** |

| LivingWell PPO | Total Premium | Employer Contribution | Employee Contribution | Employer Contribution | Employee Contribution |
|---|---|---|---|---|---|
| *Single* | $721.14 | $641.16 | **$79.98** | $601.16 | **$119.98** |
| *Parent Plus* | $1,023.04 | $795.06 | **$227.98** | $755.06 | **$267.98** |
| *Couple* | $1,564.20 | $1,051.22 | **$512.98** | $1,011.22 | **$552.98** |
| *Family* | $1,738.40 | $1,095.42 | **$642.98** | $1,055.42 | **$682.98** |
| *Family Cross-Reference* | $865.64 | $712.66 | **$152.98** | $672.66 | **$192.98** |

| Standard PPO | Total Premium | Employer Contribution | Employee Contribution |
|---|---|---|---|
| *Single* | $678.22 | $629.76 | **$48.46** |
| *Parent Plus* | $964.58 | $840.38 | **$124.20** |
| *Couple* | $1,477.72 | $1,186.86 | **$290.86** |
| *Family* | $1,644.22 | $1,302.86 | **$341.36** |
| *Family Cross-Reference* | $815.50 | $736.74 | **$78.76** |

| Standard CDHP | Total Premium | Employer Contribution | Employee Contribution |
|---|---|---|---|
| *Single* | $663.80 | $650.70 | **$13.10** |
| *Parent Plus* | $930.94 | $870.36 | **$60.58** |
| *Couple* | $1,431.76 | $1,179.28 | **$252.48** |
| *Family* | $1,594.52 | $1,291.54 | **$302.98** |
| *Family Cross-Reference* | $793.18 | $764.92 | **$28.26** |

**Notes:** The monthly premiums and contributions in this guide do not apply to retirees. Please check with your retirement system.

* First-time LivingWell Plan enrollees use these rates.

# 2017 Monthly Premiums and Contributions

## Tobacco User Rates

All employee contributions are per employee, per month

| LivingWell CDHP | Total Premium | Completing LivingWell Promise Rates* | | Without Completing LivingWell Promise Rates | |
|---|---|---|---|---|---|
| | | Employer Contribution | Employee Contribution | Employer Contribution | Employee Contribution |
| *Single* | $702.10 | $614.12 | **$87.98** | $574.12 | **$127.98** |
| *Parent Plus* | $967.18 | $764.20 | **$202.98** | $724.20 | **$242.98** |
| *Couple* | $1,302.74 | $934.76 | **$367.98** | $894.76 | **$407.98** |
| *Family* | $1,453.94 | $1,035.96 | **$417.98** | $995.96 | **$457.98** |
| *Family Cross-Reference* | $810.00 | $692.02 | **$117.98** | $652.02 | **$157.98** |

| LivingWell PPO | Total Premium | Employer Contribution | Employee Contribution | Employer Contribution | Employee Contribution |
|---|---|---|---|---|---|
| *Single* | $721.14 | $601.16 | **$119.98** | $561.16 | **$159.98** |
| *Parent Plus* | $1,023.04 | $716.06 | **$307.98** | $675.06 | **$347.98** |
| *Couple* | $1,564.20 | $971.22 | **$592.98** | $931.22 | **$632.98** |
| *Family* | $1,738.40 | $1,015.42 | **$722.98** | $975.42 | **$762.98** |
| *Family Cross-Reference* | $865.64 | $672.66 | **$192.98** | $632.66 | **$232.98** |

| Standard PPO | Total Premium | Employer Contribution | Employee Contribution |
|---|---|---|---|
| *Single* | $678.22 | $589.76 | **$88.46** |
| *Parent Plus* | $964.58 | $760.38 | **$204.20** |
| *Couple* | $1,477.72 | $1,106.86 | **$370.86** |
| *Family* | $1,644.22 | $1,222.86 | **$421.36** |
| *Family Cross-Reference* | $815.50 | $696.74 | **$118.76** |

| Standard CDHP | Total Premium | Employer Contribution | Employee Contribution |
|---|---|---|---|
| *Single* | $663.80 | $610.70 | **$53.10** |
| *Parent Plus* | $930.94 | $790.36 | **$140.58** |
| *Couple* | $1,431.76 | $1,099.28 | **$332.48** |
| *Family* | $1,594.52 | $1,211.54 | **$382.98** |
| *Family Cross-Reference* | $793.18 | $724.92 | **$68.26** |

**Notes:** The monthly premiums and contributions in this guide do not apply to retirees. Please check with your retirement system.

* First-time LivingWell Plan enrollees use these rates.