



KPPA

Kentucky Public Pensions Authority



PLAN YEAR 2027

Mandatory Open Enrollment

Retirees not eligible for Medicare



ENROLLMENT REQUIRED

If you do not submit an enrollment form by October 31, you will not have coverage in 2027.

HAZARDOUS NOTICE



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

LIVINGWELL PROMISE REQUIRED



All planholders must take the online Health Assessment at mycastlight.com/mybenefits between January 1 - July 1, 2027 to earn premium discounts for 2028.

This is summary information.

Visit our website for details.

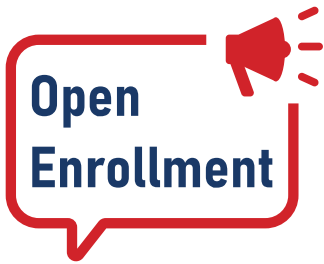
KYRET.KY.GOV

(502) 696-8800

MYRETIREMENT.KY.GOV

1-800-928-4646

Enrollment Form Required in October



PREMIUMS AND BENEFITS

Review the benefits grid and details for each of the four plans online. To view these documents, use your phone camera to scan the QR code or go to kyret.ky.gov>Retirees>Insurance



If you - or your eligible dependents - are not eligible for Medicare and need health insurance coverage for 2027, you must submit Form 6200 during Open Enrollment October 1-31, 2026.

There is no default plan which means your current coverage will not continue automatically. An enrollment form is not required to waive coverage.

Electing or canceling coverage after the Open Enrollment period is limited to qualifying events. Visit our website at kyret.ky.gov for additional information.

YOUR COST FOR COVERAGE

Costs may vary depending on your individual retirement account (refer to pages 4-7). Visit our website for additional information and examples. Please note, the cross-reference payment option is only available to retirees who chose this option for Plan Year 2026.

HAZARDOUS YEARLY REQUIREMENT

Hazardous members with insurance dependents must complete a Form 6256 every year. The deadline is November 30, 2026.

ENROLL ONLINE

An enrollment form is required for coverage in 2027. Enrolling online gives you same-day confirmation so you can be confident your enrollment was successfully submitted, and there is no need to mail any forms.



MyRetirement.ky.gov

Your online retirement account

PERSONAL IDENTIFICATION NUMBER (PIN)

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

WEBINARS

Check our website for the October webinar schedule by going to kyret.ky.gov>Retirees>Retiree Outreach>Webinars.

ATTEND A BENEFIT FAIR

KPPA representatives will be attending KEHP Benefit Fairs across the state from September 28 through October 15 to assist you. You can view the full schedule on our website by visiting kyret.ky.gov>Retirees>Insurance.

SUBMITTING DOCUMENTS

KPPA offers three options for submitting documents:

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

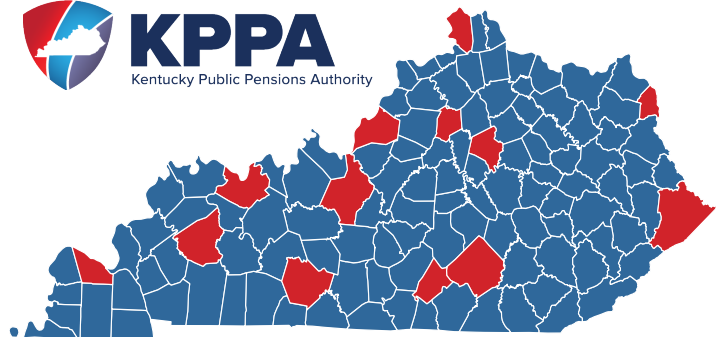
MEDICARE ELIGIBLE NOTICE

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. Read more about reemployment after retirement on our website. If you have questions about your options email kppa.mail@kyret.ky.gov or call our office at 1-800-928-4646.



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Plan Highlights

- The LivingWell PPO has changes to Co-Pays, Prescription Deductible, and Prescription Supply Co-Pay.
- The LivingWell CDHP and the LivingWell Basic CDHP will have a separate prescription Deductible and Maximum Out-of-Pocket.
- Prescriptions covered under the Value Benefit program (e.g., diabetes, COPD, asthma and hypertension) will only be available as a 90-day supply. Any supply less than a 90-day supply will not be processed under the Value Benefit program.

Retirees may only enroll with one retirement system (Judicial, Legislators, Teachers, or KPPA).

The information below applies to In-Network Medical and Prescription benefits. Changes to the plan are highlighted in yellow.

Plan Option	LivingWell CDHP	LivingWell PPO	LivingWell Basic CDHP	LivingWell HDHP*
HRA	Single \$500 Family \$1,000	No HRA	Single \$250 Family \$500	No HRA (can use a non-KEHP HSA with this plan)
Medical Deductible	Single \$1,550 Family \$2,900	Single \$1,050 Family \$1,850	Single \$2,100 Family \$3,950	Single \$2,100 Family \$4,200*
Medical Annual Maximum Out-of-Pocket (OOP)	Single \$3,150 Family \$6,050	Single \$3,150 Family \$6,050	Single \$4,200 Family \$8,200	Single \$8,300 Family \$16,650*
Doctor's Office Visit	Deductible, then 20%	Co-pay \$30; Specialist \$55	Deductible, then 30%	Deductible, then 30%
Emergency Room Facility	\$250 Co-Pay, then Deductible, then 25%	\$250 Co-Pay, then Deductible, then 25%	\$250 Co-Pay, then Deductible, then 30%	Deductible then 30%
Co-insurance	20%	25%	30%	30%
Prescription Deductible	\$500 Single \$900 Family	\$500 Single \$1,000 Family	\$500 Single \$1,000 Family	Combined with Medical Maximum Out-of-Pocket
Prescription Maximum Out-of-Pocket	\$1,000 Single \$2,000 Family	Single \$2,500 Family \$5,000	\$1,000 Single \$2,000 Family	Combined with Medical Maximum Out-of-Pocket
Prescription 30-day Supply Co-Pay	Deductible, then 20%	Tier 1: \$30 Tier 2: \$50 Tier 3: Deductible, then 30%	Deductible, then 30%	Deductible, then 30%
GLP-1 Weight Loss Drugs	Deductible then 25%	Deductible, then 25%	Deductible, then 30%	Deductible then 30%

*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 in a plan. 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.

KEHP Tobacco User Fee, Disclosures & Legal Declarations: To view these documents, go to kyret.ky.gov>Retirees>Insurance>Non-Medicare Plan Year 2027.



LIVINGWELL PROMISE REQUIRED

All planholders who are 18 or older must fulfill the LivingWell Promise between January 1, 2027 - July 1, 2027 to earn premium discounts in 2028. Go to 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, 2027.

Plan Option	Single	Parent Plus	Couple	Family	Family X-Ref**
LivingWell CDHP	\$1,180.16	\$1,593.22	\$2,307.72	\$2,564.34	\$1,348.58
LivingWell PPO	\$1,194.62	\$1,629.22	\$2,397.02	\$2,622.26	\$1,401.38
LivingWell Basic CDHP	\$1,148.42	\$1,566.54	\$2,318.24	\$2,569.32	\$1,348.14
LivingWell HDHP	\$1,066.12	\$1,454.08	\$2,152.06	\$2,385.16	\$1,249.94

**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.

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	\$1,180.16
	LivingWell PPO	\$1,194.62
	LivingWell Basic CDHP	\$1,148.42
	LivingWell HDHP	\$1,066.12
180 - 239 months	75%	\$895.97
120 - 179 months	50%	\$597.31
48 - 119 months	25%	\$298.66
0 - 47 months	0%	\$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.

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

4. LivingWell Promise

Select one. If you did not fulfill the LivingWell Promise for Plan Year 2026, you will be required to pay the amount in Box 4 in 2027.

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

Box 1

Box 2

Your Subtotal
Box 1 Subtract
Box 2

Box 3

Box 4

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



Plan Year 2027 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	Termination: Coverage End Date ☐ Begin Medicare/Medicaid ☐ End Medicare/Medicaid ☐ Loss of KCHIP ☐ Spouse/Dependent Starting Employment ☐ Spouse/Dependent Terminating Employment ☐ Special Enrollment ☐ Other:			

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

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

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

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

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

Retiree's SSN: _____

Applicant's SSN: _____

Child #3 SSN	Name (Last, First, MI)	☐ Natural ☐ Adopted ☐ Court Ordered	☐ Foster Step ☐ Disabled	Date of Birth	☐ Male ☐ Female	☐ Add ☐ Drop ☐ Remain
Child #4 SSN	Name (Last, First, MI)	☐ Natural ☐ Adopted ☐ Court Ordered	☐ Foster Step ☐ Disabled	Date of Birth	☐ Male ☐ Female	☐ Add ☐ Drop ☐ Remain
Child #5 SSN	Name (Last, First, MI)	☐ Natural ☐ Adopted ☐ Court Ordered	☐ Foster Step ☐ Disabled	Date of Birth	☐ Male ☐ Female	☐ Add ☐ Drop ☐ 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. 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? _____
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Section 6: Coverage Level

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

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

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

**KENTUCKY PUBLIC PENSIONS AUTHORITY**

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

**Form 6256**

Revised 09/2026

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:
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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 ChildIs this dependent child married or has this dependent child been married previously? ☐ Yes ☐ NoIs this dependent child age 18 or older? ☐ Yes ☐ NoIs 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 ChildIs this dependent child married or has this dependent child been married previously? ☐ Yes ☐ NoIs this dependent child age 18 or older? ☐ Yes ☐ NoIs 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 1:511

**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 have a participation date with KPPA between July 1, 2003, and August 31, 2008, and minimum of 120 months of service, OR
- You have a participation date with KPPA on or AFTER September 1, 2008, and a minimum of 180 months of service.

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, 2027.

Plan Option	Single	Parent Plus	Couple	Family	Family X-Ref**
LivingWell CDHP	\$1,180.16	\$1,593.22	\$2,307.72	\$2,564.34	\$1,348.58
LivingWell PPO	\$1,194.62	\$1,629.22	\$2,397.02	\$2,622.26	\$1,401.38
LivingWell Basic CDHP	\$1,148.42	\$1,566.54	\$2,318.24	\$2,569.32	\$1,348.14
LivingWell HDHP	\$1,066.12	\$1,454.08	\$2,152.06	\$2,385.16	\$1,249.94

** 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
\$15.07	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
\$22.60	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 on pages 5 and 6 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.

Senate Bill 10 - 2025 Legislative Changes

Senate Bill 10 increases the CERS monthly contribution amount paid toward non-Medicare insurance coverage through KPPA if all career threshold requirements are met. Learn more at kyret.ky.gov/Retirees/Insurance.

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, 2027.

Plan Option	Single	Parent Plus	Couple	Family	Family X-Ref*
LivingWell CDHP	\$1,180.16	\$1,593.22	\$2,307.72	\$2,564.34	\$1,348.58
LivingWell PPO	\$1,194.62	\$1,629.22	\$2,397.02	\$2,622.26	\$1,401.38
LivingWell Basic CDHP	\$1,148.42	\$1,566.54	\$2,318.24	\$2,569.32	\$1,348.14
LivingWell HDHP	\$1,066.12	\$1,454.08	\$2,152.06	\$2,385.16	\$1,249.94

*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.

Box 1

2. Service Credit

Subtract the following, based upon your months of service.

Applicant's Months of Service	Contribution
240+ months	\$1,194.62
180 - 239 months	\$895.97
120 - 179 months	\$597.31
48 - 119 months	\$298.66
0 - 47 months	\$0.00

Box 2

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.



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	\$434.60	\$1,202.40	\$1,427.64	\$1,608.14
180 - 239 months	\$325.95	\$901.80	\$1,070.73	\$1,206.11
120 - 179 months	\$217.30	\$601.20	\$713.82	\$804.07
48 - 119 months	\$108.65	\$300.60	\$356.91	\$402.04
0 - 47 months	\$0.00	\$0.00	\$0.00	\$0.00

Box 3

-

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

Box 4

+

5. LivingWell Promise

Select one. If you did not fulfill the LivingWell Promise for Plan Year 2026, you will be required to pay the amount in Box 5 in 2027.

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

Box 5

+

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, 2027 - July 1, 2027 to earn premium discounts in 2028. Go to mycastlight.com/mybenefits to complete the online Health Assessment.



KPPA

Kentucky Public Pensions Authority

1260 Louisville Road
Frankfort, KY 40601

PRESORTED
FIRST CLASS
U.S. POSTAGE PAID
LEXINGTON, KY
PERMIT #000

Name
Address Line 1
Address Line 2
City, State Zipcode

**KENTUCKY EMPLOYEES' HEALTH PLAN (KEHP)
OPEN ENROLLMENT HOTLINE
1-888-581-8834 or 502-564-6534
Service is only available October**

There are five options when you call. The options listed below apply to retirees:

Option 1: Kentucky Public Pensions Authority (KPPA)

Option 3: Benefit questions for Anthem (medical), HealthEquity or CVS Caremark

Option 5: Department of Employee Insurance (DEI) for all other inquiries

Department of Employee Insurance Call Center Hours

Monday, October 5 - Friday, October 9: 7:30 a.m. to 4:30 p.m. ET

Monday, October 12 - Friday, October 16: 7:30 a.m. to 7:00 p.m. ET

Monday, October 19 - Friday, October 23: 7:30 a.m. to 8:00 p.m. ET

Monday, October 26: 7:30a.m. to 8:00 p.m. ET

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

KEHP kehpn.ky.gov Open Enrollment Hotline 888-581-8834	Castlight mycastlight.com/mybenefits 800-681-6758
Anthem Health insurance anthem.com/kehpn 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



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09/2026