

Selection Sheet for PEBB Insurance Deductions - Klickitat County

Full Time - Effective January 1, 2025 premiums reflected on your Dec. 25th payroll check

| | | | | | | | | | |
|--|---|----------------|---|---|--|-----------------|-------------|--|-------|
| Print Last Name: | | | | | | Emp No: | | | |
| Signature: | | | | | | Date: | | | |
| <i>I hereby authorize the deductions below and acknowledge that I have been informed of my COBRA rights.</i> | | | | | | | | | |
| County contributes 100% for Employee Medical, Dental, Vision, Life Insurance & LTD & 70% of the Additional Cost for Dependent Medical, Dental, Vision, Life Ins & LTD Coverage (County Pays an Avg of 86% for Dep) | | | | | | | | | |
| C h e c k (X) O n e P l a n | CLASSIC MEDICAL PLANS - Administered by Regence \$250 ind/\$750 fam ded, \$2000 ind/\$4000 fam out of pocket max, 15% office visit co-pay, 15%/40% hospital co-insurance 5%/10%/\$100 ded/30%/50%, \$2000 OOP, Prescription | | | Uniform Medical Plan (UMP) - Classic Premium Includes: Dental, Vision, Life Insurance & EE LTD Coverage | | MARK ONE (X) | Ded Code | | |
| | EMPLOYEE | 1,076.01 | 1,076.01 | 0.00 | | | | | 300-1 |
| | EMPLOYEE & SPOUSE | 1,980.42 | 1,709.10 | 271.32 | | | | | 300-2 |
| | EMPLOYEE & CHILDREN | 1,754.32 | 1,550.83 | 203.49 | | | | | 300-3 |
| | EMPLOYEE & FAMILY | 2,658.73 | 2,183.91 | 474.82 | | | | | 300-4 |
| | SELECT MEDICAL PLANS - Administered by Regence \$750 ind/\$2250 fam ded, \$3500 ind/\$7000 fam out of pocket max, 20% office visit co-pay, 15%/40% hospital co-insurance 5%/10%/\$100 ded/30%/50%, \$2000 OOP, Prescription | | | Uniform Medical Plan (UMP) - Select Premium Includes: Dental, Vision, Life Insurance & EE LTD Coverage | | MARK ONE (X) | Ded Code | | |
| | EMPLOYEE | 1,025.41 | 1,025.41 | 0.00 | | | | | 303-1 |
| | EMPLOYEE & SPOUSE | 1,879.22 | 1,709.10 | 170.12 | | | | | 303-2 |
| | EMPLOYEE & CHILDREN | 1,665.77 | 1,550.83 | 114.94 | | | | | 303-3 |
| | EMPLOYEE & FAMILY | 2,519.58 | 2,183.91 | 335.67 | | | | | 303-4 |
| HEALTH SAVINGS ACCOUNT (HSA) PLANS - Administered by Regence Must Pay ALL of Ded 1st, then pays 15%/40% of medical, hospital, emergency room, prescriptions until total out of pocket is met. \$1650 ind/\$3300 fam ded, plus \$4200/\$8400 out of pocket max, 5%/10%/\$100 ded/30%/50%, \$2000 OOP, Prescription Contribution Limits: Under 55-\$4150 ind/\$8300 fam. | | | UMP Consumer-Directed Health Plan (CDHP) (HSA) - Premium Includes: Dental, Vision, Basic Life Insurance & EE LTD Coverage | | MARK IF CONTRIB. TO HSA | Ded Code | | | |
| Emp HSA Contribution: \$ | | | | | | | | 306-1 | |
| | PREMIUM | COUNTY PAYS | PAYS TO HSA 305-1 | EMPLOYEE PAYS | MARK ONE (X) | Ded Code | | | |
| EMPLOYEE | 993.91 | 1,076.01 | 82.10 | 0.00 | | | | 301-1 | |
| EMPLOYEE & SPOUSE | 1,814.86 | 1,709.10 | 0.00 | 105.76 | | | | 301-2 | |
| EMPLOYEE & CHILDREN | 1,624.21 | 1,550.83 | 0.00 | 73.38 | | | | 301-3 | |
| EMPLOYEE & FAMILY | 2,386.83 | 2,183.91 | 0.00 | 202.92 | | | | 301-4 | |
| Waiver Fee: If you waive Medical, you must be on Dental, Life & LTD | | | 171.60 | | | | 302-1 | | |
| Tobacco Surcharge: If you, or a dependent covered by the plan, use tobacco products | | | | | 25.00 | | 302-90 | | |
| Spouse or Dom. Partner Coverage Surcharge (go to Spousal Plan Calculator on the web) | | | | | 50.00 | | 302-91 | | |
| C h e c k O n e P l a n | 1) <input type="checkbox"/> Uniform Dental Plan (Group 3000), OR, | | 2) <input type="checkbox"/> WILLAMETTE, (Group 0), OR, | | MARK ONE PLAN CARRIER AND ONE EMPLOYEE GROUP (X) | | | | |
| | \$50 deductible in-network, 100% Preventive, \$1750 annual max, 80% basic, 50% major, adult & child orthodontia | | 3) <input type="checkbox"/> DELTA CARE GROUP (Group 3100) | | | | | | |
| | | | IN NETWORK ONLY - Managed Care Plans, Set Rates & No Max Benefit | | | | | | |
| | EMPLOYEE | | | 0.00 | | | | | |
| | EMPLOYEE & SPOUSE | | | 0.00 | | | | | |
| EMPLOYEE & CHILDREN | | | 0.00 | | | | | | |
| EMPLOYEE & FAMILY | | | 0.00 | | | | | | |
| O n e C h e c k P l a n | 1) <input type="checkbox"/> MetLife Vision | | 2) <input type="checkbox"/> EyeMed | | 3) <input type="checkbox"/> Davis Vision by MetLife | | | | |
| | Vision: No co-pay on annual exam, up to \$200 hardware or contact lenses. Renews every January 1 of odd years | | | | | | | MARK ONE PLAN CARRIER AND ONE EMPLOYEE GROUP (X) | |
| | EMPLOYEE | | | 0.00 | | | | | |
| | EMPLOYEE & SPOUSE | | | 0.00 | | | | | |
| | EMPLOYEE & CHILDREN | | | 0.00 | | | | | |
| EMPLOYEE & FAMILY | | | 0.00 | | | | | | |
| LIFE INSURANCE & AD & D - Administered by Metlife | | | | EMPLOYEE PAYS | | MARK ONE (X) | | | |
| Life Insurance Amounts: Employee \$35,000 & Additional \$5,000 for accidental death | | | | 0.00 | | | X | | |
| LONG TERM DISABILITY (LTD) - Administered by Standard Insurance Co. | | | | 0.00 | | | X | | |
| After 90 days being disabled, 60% of 1st \$400 of current earnings. Min \$50 & Max \$240 per month | | | | | | | | | |
| VOLUNTARY TAX SAVING PLANS OR ADDITIONAL INSURANCE SELECTION | | | | Monthly Amount | | Mark "X" | DC | | |
| Flexible Spending Account (FSA), Max \$3,200 - Plus Point | | | FSA/DCR Fee | \$5.00 | 92-95 | \$ | 92-5 | | |
| Dependent Care Reimbursement (DCR) Max \$2,500/\$5,000 - Plus Point | | | All Self- Paid | | \$ | | 92-15 | | |
| Voluntary Long Term Disability Plan (Income protection if disable) | | | All Self- Paid | | | | 316-1 | | |

Selection Sheet for PEBB Insurance Deductions - Klickitat County

.8 FTE/32 hrs per week - Effective January 1, 2025, premiums reflected on your Dec. 25th payroll check

| | | | | | | | | |
|---|--|----------|---|---|--|-------------------------------|-------------|-------|
| Print Last Name: | | | | | Emp No: | | | |
| Signature: | | | | | Date: | | | |
| <i>I hereby authorize the deductions below and acknowledge that I have been informed of my COBRA rights.</i> | | | | | | | | |
| County contributes 100% for Employee Medical, Dental, Vision, Life Insurance & LTD & 70% of the Additional Cost for Dependent Medical, Dental, Vision, Life Ins & LTD Coverage (County Pays an Avg of 86% for Dep) | | | | | | | | |
| C h e c k (X) O n e P l a n | CLASSIC MEDICAL PLANS - Administered by Regence \$250 ind/\$750 fam ded, \$2000 ind/\$4000 fam out of pocket max, 15% office visit co-pay, 15%/40% hospital co-insurance 5%/10%/\$100 ded/30%/50%, \$2000 OOP, Prescription | | | Uniform Medical Plan (UMP) - Classic Premium <u>Includes:</u> Dental, Vision, Life Insurance & EE LTD Coverage | | MARK ONE (X) | Ded Code | |
| | EMPLOYEE | PREMIUM | COUNTY PAYS | EMPLOYEE PAYS | | | | 300-1 |
| | EMPLOYEE & SPOUSE | 1,076.01 | 860.81 | 215.20 | | | | 300-2 |
| | EMPLOYEE & CHILDREN | 1,980.42 | 1,367.28 | 613.14 | | | | 300-3 |
| | EMPLOYEE & FAMILY | 1,754.32 | 1,240.66 | 513.66 | | | | 300-4 |
| | SELECT MEDICAL PLANS -Administered by Regence \$750 ind/\$2250 fam ded, \$3500 ind/\$7000 fam out of pocket max, 20% office visit co-pay, 15%/40% hospital co-insurance 5%/10%/\$100 ded/30%/50%, \$2000 OOP, Prescription | | | Uniform Medical Plan (UMP) - Select Premium <u>Includes:</u> Dental, Vision, Life Insurance & EE LTD Coverage | | MARK ONE (X) | Ded Code | |
| | EMPLOYEE | PREMIUM | COUNTY PAYS | EMPLOYEE PAYS | | | | 303-1 |
| | EMPLOYEE & SPOUSE | 1,025.41 | 860.81 | 164.60 | | | | 303-2 |
| | EMPLOYEE & CHILDREN | 1,879.22 | 1,367.28 | 511.94 | | | | 303-3 |
| | EMPLOYEE & FAMILY | 1,665.77 | 1,240.66 | 425.11 | | | | 303-4 |
| | HEALTH SAVINGS ACCOUNT (HSA) PLANS - Administered by Regence Must Pay ALL of Ded 1st, then pays 15%/40% of medical, hospital, emergency room, prescriptions until total out of pocket is met. \$1650 ind/\$3300 fam ded, plus \$4200/\$8400 out of pocket max, 5%/10%/\$100 ded/30%/50%, \$2000 OOP, Prescription Contribution Limits: Under 55-\$4150 ind/\$8300 fam. | | | UMP Consumer-Directed Health Plan (CDHP) (HSA) - Premium <u>Includes:</u> Dental, Vision, Basic Life Insurance & EE LTD Coverage | | MARK IF CONTRIB. TO HSA | Ded Code | |
| | | | | Emp HSA Contribution: \$ | | | | 306-1 |
| | EMPLOYEE | PREMIUM | COUNTY PAYS | PAYS TO HSA 305-1 | EMPLOYEE PAYS | MARK ONE (X) | Ded Code | |
| | EMPLOYEE & SPOUSE | 993.91 | 860.81 | 0.00 | 133.10 | | | 301-1 |
| | EMPLOYEE & CHILDREN | 1,814.86 | 1,367.28 | 0.00 | 447.58 | | | 301-2 |
| | EMPLOYEE & FAMILY | 1,624.21 | 1,240.66 | 0.00 | 383.55 | | | 301-3 |
| | 2,386.83 | 1,747.13 | 0.00 | 639.70 | 301-4 | | | |
| Waiver Fee: If you waive Medical, you must be on Dental, Life & LTD | | | 171.60 | | | 302-1 | | |
| Tobacco Surcharge: If you, or a dependent covered by the plan, use tobacco products | | | | 25.00 | | 302-90 | | |
| Spouse or Dom. Partner Coverage Surcharge (go to Spousal Plan Calculator on the web) | | | | 50.00 | | 302-91 | | |
| C h e c k O n e | 1) <input type="checkbox"/> Uniform Dental Plan (Group 3000), OR, | | 2) <input type="checkbox"/> WILLAMETTE, (Group 0), OR, | | MARK ONE PLAN CARRIER AND ONE EMPLOYEE GROUP (X) | | | |
| | \$50 deductible in-network, 100% Preventive, \$1750 annual max, 80% basic, 50% major, adult & child orthodontia | | 3) <input type="checkbox"/> DELTA CARE GROUP (Group 3100) | | | | | |
| | IN NETWORK ONLY - Managed Care Plans, Set Rates & No Max Benefit | | | | | | | |
| | EMPLOYEE | | | 0.00 | | | | |
| | EMPLOYEE & SPOUSE | | | 0.00 | | | | |
| EMPLOYEE & CHILDREN | | | 0.00 | | | | | |
| EMPLOYEE & FAMILY | | | 0.00 | | | | | |
| O n e P l a n | 1) <input type="checkbox"/> MetLife Vision | | 2) <input type="checkbox"/> EyeMed | | MARK ONE PLAN CARRIER AND ONE EMPLOYEE GROUP (X) | | | |
| | 3) <input type="checkbox"/> Davis Vision by MetLife | | Vision: No co-pay on annual exam, up to \$200 hardware or contact lenses. Renews every January 1 of odd years | | | | | |
| | EMPLOYEE | | | 0.00 | | | | |
| | EMPLOYEE & SPOUSE | | | 0.00 | | | | |
| | EMPLOYEE & CHILDREN | | | 0.00 | | | | |
| EMPLOYEE & FAMILY | | | 0.00 | | | | | |
| LIFE INSURANCE & AD & D - Administered by Metlife | | | EMPLOYEE PAYS | | MARK ONE (X) | | | |
| Life Insurance Amounts: Employee \$35,000 & Additional \$5,000 for accidental death | | | 0.00 | | X | | | |
| LONG TERM DISABILITY (LTD) - Administered by Standard Insurance Co. | | | 0.00 | | X | | | |
| After 90 days being disabled, 60% of 1st \$400 of current earnings. Min \$50 & Max \$240 per month | | | | | | | | |
| VOLUNTARY TAX SAVING PLANS OR ADDITIONAL INSURANCE SELECTION | | | | | Monthly Amount | | | |
| Flexible Spending Account (FSA), Max \$3,200 - Plus Point | | | FSA/DCR Fee | \$5.00 | 92-95 | \$ | | |
| Dependent Care Reimbursement (DCR) Max \$2,500/\$5,000 - Plus Point | | | All Self- Paid | | \$ | 92-15 | | |
| Voluntary Long Term Disability Plan (Income protection if disable) | | | All Self- Paid | | | 316-1 | | |

Selection Sheet for PEBB Insurance Deductions - Klickitat County

.75 FTE/30 hrs per week - Effective January 1, 2025, premiums reflected on your Dec. 25th payroll check

| | | | | | | | |
|---|--|----------|--|---|--|-------------------------------|-------------|
| Print Last Name: | | | | | Emp No: | | |
| Signature: | | | | | Date: | | |
| <i>I hereby authorize the deductions below and acknowledge that I have been informed of my COBRA rights.</i> | | | | | | | |
| County contributes 100% for Employee Medical, Dental, Vision, Life Insurance & LTD & 70% of the Additional Cost for Dependent Medical, Dental, Vision, Life Ins & LTD Coverage (County Pays an Avg of 86% for Dep) | | | | | | | |
| C h e c k (X) O n e P l a n | CLASSIC MEDICAL PLANS - Administered by Regence \$250 ind/\$750 fam ded, \$2000 ind/\$4000 fam out of pocket max, 15% office visit co-pay, 15%/40% hospital co-insurance 5%/10%/\$100 ded/30%/50%, \$2000 OOP, Prescription | | | Uniform Medical Plan (UMP) - Classic Premium <u>Includes:</u> Dental, Vision, Life Insurance & EE LTD Coverage | | MARK ONE (X) | Ded Code |
| | | PREMIUM | COUNTY PAYS | EMPLOYEE PAYS | | | |
| | EMPLOYEE | 1,076.01 | 807.01 | 269.00 | | | |
| | EMPLOYEE & SPOUSE | 1,980.42 | 1,281.83 | 698.59 | | | |
| | EMPLOYEE & CHILDREN | 1,754.32 | 1,163.12 | 591.20 | | | |
| | EMPLOYEE & FAMILY | 2,658.73 | 1,637.93 | 1,020.80 | | | |
| | SELECT MEDICAL PLANS -Administered by Regence \$750 ind/\$2250 fam ded, \$3500 ind/\$7000 fam out of pocket max, 20% office visit co-pay, 15%/40% hospital co-insurance 5%/10%/\$100 ded/30%/50%, \$2000 OOP, Prescription | | | Uniform Medical Plan (UMP) - Select Premium <u>Includes:</u> Dental, Vision, Life Insurance & EE LTD Coverage | | MARK ONE (X) | Ded Code |
| | | PREMIUM | COUNTY PAYS | EMPLOYEE PAYS | | | |
| | EMPLOYEE | 1,025.41 | 807.01 | 218.40 | | | |
| | EMPLOYEE & SPOUSE | 1,879.22 | 1,281.83 | 597.39 | | | |
| | EMPLOYEE & CHILDREN | 1,665.77 | 1,163.12 | 502.65 | | | |
| | EMPLOYEE & FAMILY | 2,519.58 | 1,637.93 | 881.65 | | | |
| | HEALTH SAVINGS ACCOUNT (HSA) PLANS - Administered by Regence Must Pay ALL of Ded 1st, then pays 15%/40% of medical, hospital, emergency room, prescriptions until total out of pocket is met. \$1650 ind/\$3300 fam ded, plus \$4200/\$8400 out of pocket max, 5%/10%/\$100 ded/30%/50%, \$2000 OOP, Prescription Contribution Limits: Under 55-\$4150 ind/\$8300 fam. | | | UMP Consumer-Directed Health Plan (CDHP) (HSA) - Premium <u>Includes:</u> Dental, Vision, Basic Life Insurance & EE LTD Coverage | | MARK IF CONTRIB. TO HSA | Ded Code |
| | | | | Emp HSA Contribution: \$ | | | |
| | | PREMIUM | COUNTY PAYS | PAYS TO HSA 305-1 | EMPLOYEE PAYS | MARK ONE (X) | Ded Code |
| | EMPLOYEE | 993.91 | 807.01 | 0.00 | 186.90 | | |
| EMPLOYEE & SPOUSE | 1,814.86 | 1,281.83 | 0.00 | 533.03 | | | |
| EMPLOYEE & CHILDREN | 1,624.21 | 1,163.12 | 0.00 | 461.09 | | | |
| EMPLOYEE & FAMILY | 2,386.83 | 1,637.93 | 0.00 | 748.90 | | | |
| Waiver Fee: If you waive Medical, you must be on Dental, Life & LTD | | 171.60 | | | | 302-1 | |
| Tobacco Surcharge: If you, or a dependent covered by the plan, use tobacco products | | | | 25.00 | | 302-90 | |
| Spouse or Dom. Partner Coverage Surcharge (go to Spousal Plan Calculator on the web) | | | | 50.00 | | 302-91 | |
| C h e c k O n e | 1) <input type="checkbox"/> Uniform Dental Plan (Group 3000), OR, \$50 deductible in-network, 100% Preventive, \$1750 annual max, 80% basic, 50% major, adult & child orthodontia | | 2) <input type="checkbox"/> WILLAMETTE, (Group 0), OR, | | MARK ONE PLAN CARRIER AND ONE EMPLOYEE GROUP (X) | | |
| | | | 3) <input type="checkbox"/> DELTA CARE GROUP (Group 3100) | | | | |
| | <small>IN NETWORK ONLY - Managed Care Plans, Set Rates & No Max Benefit</small> | | | | | | |
| | EMPLOYEE | | | 0.00 | | | |
| | EMPLOYEE & SPOUSE | | | 0.00 | | | |
| EMPLOYEE & CHILDREN | | | 0.00 | | | | |
| EMPLOYEE & FAMILY | | | 0.00 | | | | |
| O n e C h e c k O n | 1) <input type="checkbox"/> MetLife Vision | | 2) <input type="checkbox"/> EyeMed | | 3) <input type="checkbox"/> Davis Vision by MetLife | | |
| | <small>Vision: No co-pay on annual exam, up to \$200 hardware or contact lenses. Renews every January 1 of odd years</small> | | | | | | |
| | EMPLOYEE | | | 0.00 | | | |
| | EMPLOYEE & SPOUSE | | | 0.00 | | | |
| | EMPLOYEE & CHILDREN | | | 0.00 | | | |
| EMPLOYEE & FAMILY | | | 0.00 | | | | |
| LIFE INSURANCE & AD & D - Administered by Metlife | | | | EMPLOYEE PAYS | | MARK ONE (X) | |
| <small>Life Insurance Amounts: Employee \$35,000 & Additional \$5,000 for accidental death</small> | | | | 0.00 | | X | |
| LONG TERM DISABILITY (LTD) - Administered by Standard Insurance Co. | | | | 0.00 | | X | |
| <small>After 90 days being disabled, 60% of 1st \$400 of current earnings. Min \$50 & Max \$240 per month</small> | | | | | | | |
| VOLUNTARY TAX SAVING PLANS OR ADDITIONAL INSURANCE SELECTION | | | | Monthly Amount | | Mark "X" | DC |
| Flexible Spending Account (FSA), Max \$3,200 - Plus Point | | | FSA/DCR Fee | \$5.00 | 92-95 | \$ | 92-5 |
| Dependent Care Reimbursement (DCR) Max \$2,500/\$5,000 - Plus Point | | | All Self- Paid | | \$ | | 92-15 |
| Voluntary Long Term Disability Plan (Income protection if disable) | | | All Self- Paid | | | | 316-1 |

Selection Sheet for PEBB Insurance Deductions - Klickitat County

.7 FTE/28 hrs per week - Effective January 1, 2024, premiums reflected on your Dec. 25th payroll check

| | | | | | | | |
|---|--|----------|--|---|--|-------------------------------|-------------|
| Print Last Name: | | | | | Emp No: | | |
| Signature: | | | | | Date: | | |
| <i>I hereby authorize the deductions below and acknowledge that I have been informed of my COBRA rights.</i> | | | | | | | |
| County contributes 100% for Employee Medical, Dental, Vision, Life Insurance & LTD & 70% of the Additional Cost for Dependent Medical, Dental, Vision, Life Ins & LTD Coverage (County Pays an Avg of 86% for Dep) | | | | | | | |
| C h e c k (X) O n e P l a n | CLASSIC MEDICAL PLANS - Administered by Regence \$250 ind/\$750 fam ded, \$2000 ind/\$4000 fam out of pocket max, 15% office visit co-pay, 15%/40% hospital co-insurance 5%/10%/\$100 ded/30%/50%, \$2000 OOP, Prescription | | | Uniform Medical Plan (UMP) - Classic Premium <u>Includes:</u> Dental, Vision, Life Insurance & EE LTD Coverage | | MARK ONE (X) | Ded Code |
| | | PREMIUM | COUNTY PAYS | EMPLOYEE PAYS | | | |
| | EMPLOYEE | 1,076.01 | 753.21 | 322.80 | | | |
| | EMPLOYEE & SPOUSE | 1,980.42 | 1,196.37 | 784.05 | | | |
| | EMPLOYEE & CHILDREN | 1,754.32 | 1,085.58 | 668.74 | | | |
| | EMPLOYEE & FAMILY | 2,658.73 | 1,528.74 | 1,129.99 | | 300-4 | |
| | SELECT MEDICAL PLANS -Administered by Regence \$750 ind/\$2250 fam ded, \$3500 ind/\$7000 fam out of pocket max, 20% office visit co-pay, 15%/40% hospital co-insurance 5%/10%/\$100 ded/30%/50%, \$2000 OOP, Prescription | | | Uniform Medical Plan (UMP) - Select Premium <u>Includes:</u> Dental, Vision, Life Insurance & EE LTD Coverage | | MARK ONE (X) | Ded Code |
| | | PREMIUM | COUNTY PAYS | EMPLOYEE PAYS | | | |
| | EMPLOYEE | 1,025.41 | 753.21 | 272.20 | | | |
| | EMPLOYEE & SPOUSE | 1,879.22 | 1,196.37 | 682.85 | | | |
| | EMPLOYEE & CHILDREN | 1,665.77 | 1,085.58 | 580.19 | | | |
| | EMPLOYEE & FAMILY | 2,519.58 | 1,528.74 | 990.84 | | 303-4 | |
| | HEALTH SAVINGS ACCOUNT (HSA) PLANS - Administered by Regence Must Pay ALL of Ded 1st, then pays 15%/40% of medical, hospital, emergency room, prescriptions until total out of pocket is met. \$1650 ind/\$3300 fam ded, plus \$4200/\$8400 out of pocket max, 5%/10%/\$100 ded/30%/50%, \$2000 OOP, Prescription Contribution Limits: Under 55-\$4150 ind/\$8300 fam. | | | UMP Consumer-Directed Health Plan (CDHP) (HSA) - Premium <u>Includes:</u> Dental, Vision, Basic Life Insurance & EE LTD Coverage | | MARK IF CONTRIB. TO HSA | Ded Code |
| | | | | Emp HSA Contribution: \$ | | | |
| | | PREMIUM | COUNTY PAYS | PAYS TO HSA 305-1 | EMPLOYEE PAYS | MARK ONE (X) | Ded Code |
| | EMPLOYEE | 993.91 | 753.21 | 0.00 | 240.70 | | 301-1 |
| | EMPLOYEE & SPOUSE | 1,814.86 | 1,196.37 | 0.00 | 618.49 | | 301-2 |
| | EMPLOYEE & CHILDREN | 1,624.21 | 1,085.58 | 0.00 | 538.63 | | 301-3 |
| | EMPLOYEE & FAMILY | 2,386.83 | 1,528.74 | 0.00 | 858.09 | | 301-4 |
| | Waiver Fee: If you waive Medical, you must be on Dental, Life & LTD | | 171.60 | | | | 302-1 |
| Tobacco Surcharge: If you, or a dependent covered by the plan, use tobacco products | | | | 25.00 | | 302-90 | |
| Spouse or Dom. Partner Coverage Surcharge (go to Spousal Plan Calculator on the web) | | | | 50.00 | | 302-91 | |
| C h e c k O n e P l a n | 1) <input type="checkbox"/> Uniform Dental Plan (Group 3000), OR, \$50 deductible in-network, 100% Preventive, \$1750 annual max, 80% basic, 50% major, adult & child orthodontia | | 2) <input type="checkbox"/> WILLAMETTE, (Group 0), OR, | | MARK ONE PLAN CARRIER AND ONE EMPLOYEE GROUP (X) | | |
| | | | 3) <input type="checkbox"/> DELTA CARE GROUP (Group 3100) | | | | |
| | <small>IN NETWORK ONLY - Managed Care Plans, Set Rates & No Max Benefit</small> | | | | | | |
| | EMPLOYEE | | | 0.00 | | | |
| | EMPLOYEE & SPOUSE | | | 0.00 | | | |
| EMPLOYEE & CHILDREN | | | 0.00 | | | | |
| EMPLOYEE & FAMILY | | | 0.00 | | | | |
| O n e C h e c k P l a n | 1) <input type="checkbox"/> MetLife Vision | | 2) <input type="checkbox"/> EyeMed | | 3) <input type="checkbox"/> Davis Vision by MetLife | | |
| | <small>Vision: No co-pay on annual exam, up to \$200 hardware or contact lenses. Renews every January 1 of odd years</small> | | | | | | |
| | EMPLOYEE | | | 0.00 | | | |
| | EMPLOYEE & SPOUSE | | | 0.00 | | | |
| | EMPLOYEE & CHILDREN | | | 0.00 | | | |
| EMPLOYEE & FAMILY | | | 0.00 | | | | |
| LIFE INSURANCE & AD & D - Administered by Metlife | | | | EMPLOYEE PAYS | | MARK ONE (X) | |
| <small>Life Insurance Amounts: Employee \$35,000 & Additional \$5,000 for accidental death</small> | | | | 0.00 | | X | |
| LONG TERM DISABILITY (LTD) - Administered by Standard Insurance Co. | | | | 0.00 | | X | |
| <small>After 90 days being disabled, 60% of 1st \$400 of current earnings. Min \$50 & Max \$240 per month</small> | | | | | | | |
| VOLUNTARY TAX SAVING PLANS OR ADDITIONAL INSURANCE SELECTION | | | | Monthly Amount | | Mark "X" | DC |
| Flexible Spending Account (FSA), Max \$3,200 - Plus Point | | | FSA/DCR Fee | \$5.00 | 92-95 | \$ | 92-5 |
| Dependent Care Reimbursement (DCR) Max \$2,500/\$5,000 - Plus Point | | | All Self- Paid | | \$ | | 92-15 |
| Voluntary Long Term Disability Plan (Income protection if disable) | | | All Self- Paid | | | | 316-1 |

Selection Sheet for PEBB Insurance Deductions - Klickitat County

.6 FTE/24 hr per week - Effective January 1, 2025, premiums reflected on your Dec. 25th payroll check

| | | | | | | | |
|---|--|----------|--|---|--|-------------------------------|-------------|
| Print Last Name: | | | | | Emp No: | | |
| Signature: | | | | | Date: | | |
| <i>I hereby authorize the deductions below and acknowledge that I have been informed of my COBRA rights.</i> | | | | | | | |
| County contributes 100% for Employee Medical, Dental, Vision, Life Insurance & LTD & 70% of the Additional Cost for Dependent Medical, Dental, Vision, Life Ins & LTD Coverage (County Pays an Avg of 86% for Dep) | | | | | | | |
| C h e c k (X) O n e p l a n | CLASSIC MEDICAL PLANS - Administered by Regence \$250 ind/\$750 fam ded, \$2000 ind/\$4000 fam out of pocket max, 15% office visit co-pay, 15%/40% hospital co-insurance 5%/10%/\$100 ded/30%/50%, \$2000 OOP, Prescription | | | Uniform Medical Plan (UMP) - Classic Premium <u>Includes:</u> Dental, Vision, Life Insurance & EE LTD Coverage | | MARK ONE (X) | Ded Code |
| | | PREMIUM | COUNTY PAYS | EMPLOYEE PAYS | | | |
| | EMPLOYEE | 1,076.01 | 645.61 | 430.40 | | | 300-1 |
| | EMPLOYEE & SPOUSE | 1,980.42 | 1,025.46 | 954.96 | | | 300-2 |
| | EMPLOYEE & CHILDREN | 1,754.32 | 930.50 | 823.82 | | | 300-3 |
| | EMPLOYEE & FAMILY | 2,658.73 | 1,310.35 | 1,348.38 | | | 300-4 |
| | SELECT MEDICAL PLANS -Administered by Regence \$750 ind/\$2250 fam ded, \$3500 ind/\$7000 fam out of pocket max, 20% office visit co-pay, 15%/40% hospital co-insurance 5%/10%/\$100 ded/30%/50%, \$2000 OOP, Prescription | | | Uniform Medical Plan (UMP) - Select Premium <u>Includes:</u> Dental, Vision, Life Insurance & EE LTD Coverage | | MARK ONE (X) | Ded Code |
| | | PREMIUM | COUNTY PAYS | EMPLOYEE PAYS | | | |
| | EMPLOYEE | 1,025.41 | 645.61 | 379.80 | | | 303-1 |
| | EMPLOYEE & SPOUSE | 1,879.22 | 1,025.46 | 853.76 | | | 303-2 |
| | EMPLOYEE & CHILDREN | 1,665.77 | 930.50 | 735.27 | | | 303-3 |
| | EMPLOYEE & FAMILY | 2,519.58 | 1,310.35 | 1,209.23 | | | 303-4 |
| | HEALTH SAVINGS ACCOUNT (HSA) PLANS - Administered by Regence Must Pay ALL of Ded 1st, then pays 15%/40% of medical, hospital, emergency room, prescriptions until total out of pocket is met. \$1650 ind/\$3300 fam ded, plus \$4200/\$8400 out of pocket max, 5%/10%/\$100 ded/30%/50%, \$2000 OOP, Prescription Contribution Limits: Under 55-\$4150 ind/\$8300 fam. | | | UMP Consumer-Directed Health Plan (CDHP) (HSA) - Premium <u>Includes:</u> Dental, Vision, Basic Life Insurance & EE LTD Coverage | | MARK IF CONTRIB. TO HSA | Ded Code |
| | | | Emp HSA Contribution: \$ | | | | |
| | | PREMIUM | COUNTY PAYS | PAYS TO HSA 305-1 | EMPLOYEE PAYS | MARK ONE (X) | Ded Code |
| | EMPLOYEE | 993.91 | 645.61 | 0.00 | 348.30 | | 301-1 |
| | EMPLOYEE & SPOUSE | 1,814.86 | 1,025.46 | 0.00 | 789.40 | | 301-2 |
| | EMPLOYEE & CHILDREN | 1,624.21 | 930.50 | 0.00 | 693.71 | | 301-3 |
| | EMPLOYEE & FAMILY | 2,386.83 | 1,310.35 | 0.00 | 1,076.48 | | 301-4 |
| | Waiver Fee: If you waive Medical, you must be on Dental, Life & LTD | | 171.60 | | | | 302-1 |
| Tobacco Surcharge: If you, or a dependent covered by the plan, use tobacco products | | | | 25.00 | | 302-90 | |
| Spouse or Dom. Partner Coverage Surcharge (go to Spousal Plan Calculator on the web) | | | | 50.00 | | 302-91 | |
| C h e c k O n e p l a n | 1) <input type="checkbox"/> Uniform Dental Plan (Group 3000), OR, | | 2) <input type="checkbox"/> WILLAMETTE, (Group 0), OR, | | MARK ONE PLAN CARRIER AND ONE EMPLOYEE GROUP (X) | | |
| | \$50 deductible in-network, 100% Preventive, \$1750 annual max, 80% basic, 50% major, adult & child orthodontia | | 3) <input type="checkbox"/> DELTA CARE GROUP (Group 3100) IN NETWORK ONLY - Managed Care Plans, Set Rates & No Max Benefit | | | | |
| | EMPLOYEE | | | 0.00 | | | |
| | EMPLOYEE & SPOUSE | | | 0.00 | | | |
| | EMPLOYEE & CHILDREN | | | 0.00 | | | |
| EMPLOYEE & FAMILY | | | 0.00 | | | | |
| O n e p l a n | 1) <input type="checkbox"/> MetLife Vision | | 2) <input type="checkbox"/> EyeMed | | MARK ONE PLAN CARRIER AND ONE EMPLOYEE GROUP (X) | | |
| | 3) <input type="checkbox"/> Davis Vision by MetLife | | Vision: No co-pay on annual exam, up to \$200 hardware or contact lenses. Renews every January 1 of odd years | | | | |
| | EMPLOYEE | | | 0.00 | | | |
| | EMPLOYEE & SPOUSE | | | 0.00 | | | |
| | EMPLOYEE & CHILDREN | | | 0.00 | | | |
| EMPLOYEE & FAMILY | | | 0.00 | | | | |
| LIFE INSURANCE & AD & D - Administered by Metlife | | | EMPLOYEE PAYS | | MARK ONE (X) | | |
| Life Insurance Amounts: Employee \$35,000 & Additional \$5,000 for accidental death | | | 0.00 | | X | | |
| LONG TERM DISABILITY (LTD) - Administered by Standard Insurance Co. | | | 0.00 | | X | | |
| After 90 days being disabled, 60% of 1st \$400 of current earnings. Min \$50 & Max \$240 per month | | | | | | | |
| VOLUNTARY TAX SAVING PLANS OR ADDITIONAL INSURANCE SELECTION | | | | Monthly Amount | | Mark "X" | DC |
| Flexible Spending Account (FSA), Max \$3,200 - Plus Point | | | FSA/DCR Fee | \$5.00 | 92-95 | \$ | 92-5 |
| Dependent Care Reimbursement (DCR) Max \$2,500/\$5,000 - Plus Point | | | All Self- Paid | | \$ | | 92-15 |
| Voluntary Long Term Disability Plan (Income protection if disable) | | | All Self- Paid | | | | 316-1 |