

# Selection Sheet for PEBB Insurance Deductions - Klickitat County

**Full Time** - Effective January 1, 2022 premiums reflected on your Dec. 25th payroll check

[www.hca.wa.gov/pebb](http://www.hca.wa.gov/pebb)

<b>Print Last Name:</b>					<b>Emp No:</b>		
<b>Signature:</b>					<b>Date:</b>		
<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)							
<b>C h e c k  ( X )  O n e  P l a n</b>	<b>CLASSIC MEDICAL &amp; VISION PLANS</b> \$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 <b>Vision:</b> No co-pay on annual exam, \$150 hardware every 24 months			<b>Uniform Medical Plan (UMP) - Classic</b> Premium <u>Includes:</u> Dental, Vision, Life Insurance & EE LTD Coverage - Administered by Regence		MARK ONE (X)	Ded Code
		PREMIUM	COUNTY PAYS	EMPLOYEE PAYS			
	EMPLOYEE	884.84	884.84	0.00		300-1	
	EMPLOYEE & SPOUSE	1,610.51	1,392.81	217.70		300-2	
	EMPLOYEE & CHILDREN	1,429.09	1,265.82	163.27		300-3	
EMPLOYEE & FAMILY	2,154.77	1,773.79	380.98		300-4		
	<b>SELECT MEDICAL &amp; VISION PLANS</b> \$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 <b>Vision:</b> No co-pay on annual exam, \$150 hardware every 24 months			<b>Uniform Medical Plan (UMP) - Select</b> Premium <u>Includes:</u> Dental, Vision, Life Insurance & EE LTD Coverage - Administered by Regence		MARK ONE (X)	Ded Code
	PREMIUM	COUNTY PAYS	EMPLOYEE PAYS				
EMPLOYEE	813.89	813.89	0.00		303-1		
EMPLOYEE & SPOUSE	1,468.61	1,392.81	75.80		303-2		
EMPLOYEE & CHILDREN	1,304.93	1,265.82	39.11		303-3		
EMPLOYEE & FAMILY	1,959.66	1,773.79	185.87		303-4		
	<b>HEALTH SAVINGS ACCOUNT (HSA) &amp; VISION PLANS</b> Must Pay ALL of Ded 1st, then pays 15%/40% of medical, hospital, emergency room, prescriptions until total out of pocket is met. \$1400 ind/\$2800 fam ded, plus \$4200/\$8400 out of pocket max, 5%/10%/100 ded/30%/50%, \$2000 OOP, Prescription <b>Vision:</b> No co-pay on annual exam, \$150 hardware every 24 months Contribution Limits: Under 55-\$3600 ind/\$7200 fam.			<b>UMP Consumer-Directed Health Plan (CDHP)</b> <b>(HSA)</b> - Premium <u>Includes:</u> Dental, Vision, Basic Life Insurance & EE LTD Coverage - Regence		MARK IF CONTRIB. TO HSA	
	<b>Emp HSA Contribution:</b> \$				306-1		
	PREMIUM	COUNTY PAYS	COUNTY PAYS TO HSA 305-1	EMPLOYEE PAYS	MARK ONE (X)	Ded Code	
EMPLOYEE	804.85	884.84	79.99	0.00		301-1	
EMPLOYEE & SPOUSE	1,448.45	1,392.81	0.00	55.64		301-2	
EMPLOYEE & CHILDREN	1,302.13	1,265.82	0.00	36.31		301-3	
EMPLOYEE & FAMILY	1,887.40	1,773.79	0.00	113.61		301-4	
	<b>Waiver Fee:</b> If you waive Medical, you must be on Dental, Life & LTD			159.16		302-1	
	<b>Tobacco Surcharge:</b> If you, or a dependent covered by the plan, use tobacco products			25.00		302-90	
	<b>Spouse or Dom. Partner Coverage Surcharge</b> (go to Spousal Plan Calculator on the web)			50.00		302-91	
<b>C h e c k  O n e</b>	<b>1) <input type="checkbox"/> Uniform Dental Plan (Group 3000), OR, Administered by Delta Dental</b>		<b>2) <input type="checkbox"/> WILLAMETTE, (Group 0), OR, 3) <input type="checkbox"/> DELTA CARE GROUP (Group 3100)</b>		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		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				
	<b>LIFE INSURANCE &amp; AD &amp; D - Administered by Metlife</b>			EMPLOYEE PAYS	MARK ONE (X)		
	Life Insurance Amounts: Employee \$35,000 & Additional \$5,000 for accidental death			0.00	X		
	<b>LONG TERM DISABILITY (LTD) - Administered by Standard Insurance Co.</b>			0.00	X		
	After 90 days being disabled, 60% of 1st \$400 of current earnings. Min \$50 & Max \$240 per month						
	<b>VOLUNTARY TAX SAVING PLANS OR ADDITIONAL INSURANCE SELECTION</b>			Monthly Amount		Mark "X"	DC
	Flexible Spending Account (FSA), Max \$2,750 - Plus Point	FSA/DCR Fee	<b>\$5.00</b>	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, 2022, premiums reflected on your Dec. 25th payroll check

[www.hca.wa.gov/pebb](http://www.hca.wa.gov/pebb)

<b>Print Last Name:</b>					<b>Emp No:</b>		
<b>Signature:</b>					<b>Date:</b>		
<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)							
<b>C h e c k  ( X )  O n e  P l a n</b>	<b>CLASSIC MEDICAL &amp; VISION PLANS</b> \$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 <b>Vision:</b> No co-pay on annual exam, \$150 hardware every 24 months			<b>Uniform Medical Plan (UMP) - Classic Premium</b> <u>Includes:</u> Dental, Vision, Life Insurance & EE LTD Coverage - Administered by Regence		MARK ONE (X)	Ded Code
	EMPLOYEE	884.84	707.87	176.97		300-1	
	EMPLOYEE & SPOUSE	1,610.51	1,114.25	496.26		300-2	
	EMPLOYEE & CHILDREN	1,429.09	1,012.66	416.43		300-3	
	EMPLOYEE & FAMILY	2,154.77	1,419.03	735.74		300-4	
	<b>SELECT MEDICAL &amp; VISION PLANS</b> \$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 <b>Vision:</b> No co-pay on annual exam, \$150 hardware every 24 months			<b>Uniform Medical Plan (UMP) - Select Premium</b> <u>Includes:</u> Dental, Vision, Life Insurance & EE LTD Coverage - Administered by Regence		MARK ONE (X)	Ded Code
	EMPLOYEE	813.89	707.87	106.02		303-1	
	EMPLOYEE & SPOUSE	1,468.61	1,114.25	354.36		303-2	
	EMPLOYEE & CHILDREN	1,304.93	1,012.66	292.27		303-3	
	EMPLOYEE & FAMILY	1,959.66	1,419.03	540.63		303-4	
<b>HEALTH SAVINGS ACCOUNT (HSA) &amp; VISION PLANS</b> Must Pay ALL of Ded 1st, then pays 15%/40% of medical, hospital, emergency room, prescriptions until total out of pocket is met. \$1400 ind/\$2800 fam ded, plus \$4200/\$8400 out of pocket max, 5%/10%/\$100 ded/30%/50%, \$2000 OOP, Prescription <b>Vision:</b> No co-pay on annual exam, \$150 hardware every 24 months Contribution Limits: Under 55-\$3600 ind/\$7200 fam.			<b>UMP Consumer-Directed Health Plan (CDHP) (HSA) - Premium</b> <u>Includes:</u> Dental, Vision, Basic Life Insurance & EE LTD Coverage - Regence		MARK IF CONTRIB. TO HSA		
			<b>Emp HSA Contribution: \$</b>			306-1	
	PREMIUM	COUNTY PAYS	COUNTY PAYS TO HSA 305-1	EMPLOYEE PAYS	MARK ONE (X)	Ded Code	
EMPLOYEE	804.85	707.87	0.00	96.98		301-1	
EMPLOYEE & SPOUSE	1,448.45	1,114.25	0.00	334.20		301-2	
EMPLOYEE & CHILDREN	1,302.13	1,012.66	0.00	289.47		301-3	
EMPLOYEE & FAMILY	1,887.40	1,419.03	0.00	468.37		301-4	
<b>Waiver Fee:</b> If you waive Medical, you must be on Dental, Life & LTD		159.16				302-1	
<b>Tobacco Surcharge:</b> If you, or a dependent covered by the plan, use tobacco products				25.00		302-90	
<b>Spouse or Dom. Partner Coverage Surcharge</b> (go to Spousal Plan Calculator on the web)				50.00		302-91	
<b>C h e c k  O n e</b>	<b>1) <input type="checkbox"/> Uniform Dental Plan (Group 3000), OR, Administered by Delta Dental</b>		<b>2) <input type="checkbox"/> WILLAMETTE, (Group 0), OR,</b>		MARK ONE PLAN CARRIER AND ONE EMPLOYEE GROUP (X)		
	<b>3) <input type="checkbox"/> DELTA CARE GROUP (Group 3100)</b>		IN NETWORK ONLY - Managed Care Plans, Set Rates & No Max Benefit				
	\$50 deductible in-network, 100% Preventive, \$1750 annual max, 80% basic, 50% major, adult & child orthodontia						
	EMPLOYEE			0.00			
	EMPLOYEE & SPOUSE			0.00			
EMPLOYEE & CHILDREN			0.00				
EMPLOYEE & FAMILY			0.00				
<b>LIFE INSURANCE &amp; AD &amp; D - Administered by Metlife</b>			EMPLOYEE PAYS		MARK ONE (X)		
Life Insurance Amounts: Employee \$35,000 & Additional \$5,000 for accidental death			0.00		X		
<b>LONG TERM DISABILITY (LTD) - Administered by Standard Insurance Co.</b>			0.00		X		
After 90 days being disabled, 60% of 1st \$400 of current earnings. Min \$50 & Max \$240 per month							
<b>VOLUNTARY TAX SAVING PLANS OR ADDITIONAL INSURANCE SELECTION</b>				Monthly Amount		Mark "X"	DC
Flexible Spending Account (FSA), Max \$2,750 - Plus Point		FSA/DCR Fee	<b>\$5.00</b>	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

.75 FTE/30 hrs per week - Effective January 1, 2022, premiums reflected on your Dec. 25th payroll check

[www.hca.wa.gov/pebb](http://www.hca.wa.gov/pebb)

<b>Print Last Name:</b>					<b>Emp No:</b>		
<b>Signature:</b>					<b>Date:</b>		
<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)							
<b>C h e c k  ( X )  O n e  P l a n</b>	<b>CLASSIC MEDICAL &amp; VISION PLANS</b> \$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 <b>Vision:</b> No co-pay on annual exam, \$150 hardware every 24 months			<b>Uniform Medical Plan (UMP) - Classic</b> Premium <u>Includes:</u> Dental, Vision, Life Insurance & EE LTD Coverage - Administered by Regence		MARK ONE (X)	Ded Code
		PREMIUM	COUNTY PAYS	EMPLOYEE PAYS			
	EMPLOYEE	884.84	663.63	221.21		300-1	
	EMPLOYEE & SPOUSE	1,610.51	1,044.61	565.90		300-2	
	EMPLOYEE & CHILDREN	1,429.09	949.37	479.72		300-3	
	EMPLOYEE & FAMILY	2,154.77	1,330.34	824.43		300-4	
	<b>SELECT MEDICAL &amp; VISION PLANS</b> \$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 <b>Vision:</b> No co-pay on annual exam, \$150 hardware every 24 months			<b>Uniform Medical Plan (UMP) - Select</b> Premium <u>Includes:</u> Dental, Vision, Life Insurance & EE LTD Coverage - Administered by Regence		MARK ONE (X)	Ded Code
		PREMIUM	COUNTY PAYS	EMPLOYEE PAYS			
	EMPLOYEE	813.89	663.63	150.26		303-1	
	EMPLOYEE & SPOUSE	1,468.61	1,044.61	424.00		303-2	
EMPLOYEE & CHILDREN	1,304.93	949.37	355.56		303-3		
EMPLOYEE & FAMILY	1,959.66	1,330.34	629.32		303-4		
<b>HEALTH SAVINGS ACCOUNT (HSA) &amp; VISION PLANS</b> Must Pay ALL of Ded 1st, then pays 15%/40% of medical, hospital, emergency room, prescriptions until total out of pocket is met. \$1400 ind/\$2800 fam ded, plus \$4200/\$8400 out of pocket max, 5%/10%/\$100 ded/30%/50%, \$2000 OOP, Prescription <b>Vision:</b> No co-pay on annual exam, \$150 hardware every 24 months Contribution Limits: Under 55-\$3600 ind/\$7200 fam.			<b>UMP Consumer-Directed Health Plan (CDHP) (HSA)</b> - Premium <u>Includes:</u> Dental, Vision, Basic Life Insurance & EE LTD Coverage - Regence		MARK IF CONTRIB. TO HSA		
			<b>Emp HSA Contribution:</b> \$				306-1
	PREMIUM	COUNTY PAYS	COUNTY PAYS TO HSA 305-1	EMPLOYEE PAYS	MARK ONE (X)	Ded Code	
EMPLOYEE	804.85	663.63	0.00	141.22		301-1	
EMPLOYEE & SPOUSE	1,448.45	1,044.61	0.00	403.84		301-2	
EMPLOYEE & CHILDREN	1,302.13	949.37	0.00	352.76		301-3	
EMPLOYEE & FAMILY	1,887.40	1,330.34	0.00	557.06		301-4	
<b>Waiver Fee:</b> If you waive Medical, you must be on Dental, Life & LTD		159.16				302-1	
<b>Tobacco Surcharge:</b> If you, or a dependent covered by the plan, use tobacco products				25.00		302-90	
<b>Spouse or Dom. Partner Coverage Surcharge</b> (go to Spousal Plan Calculator on the web)				50.00		302-91	
<b>C h e c k  O n e</b>	<b>1) <input type="checkbox"/> Uniform Dental Plan (Group 3000), OR, Administered by Delta Dental</b>		<b>2) <input type="checkbox"/> WILLAMETTE, (Group 0), OR,</b>		MARK ONE PLAN CARRIER AND ONE EMPLOYEE GROUP (X)		
	<b>3) <input type="checkbox"/> DELTA CARE GROUP (Group 3100)</b>		IN NETWORK ONLY - Managed Care Plans, Set Rates & No Max Benefit				
	\$50 deductible in-network, 100% Preventive, \$1750 annual max, 80% basic, 50% major, adult & child orthodontia						
	EMPLOYEE			0.00			
	EMPLOYEE & SPOUSE			0.00			
EMPLOYEE & CHILDREN			0.00				
EMPLOYEE & FAMILY			0.00				
<b>LIFE INSURANCE &amp; AD &amp; D - Administered by Metlife</b>			EMPLOYEE PAYS	MARK ONE (X)			
Life Insurance Amounts: Employee \$35,000 & Additional \$5,000 for accidental death			0.00	X			
<b>LONG TERM DISABILITY (LTD) - Administered by Standard Insurance Co.</b>			0.00	X			
After 90 days being disabled, 60% of 1st \$400 of current earnings. Min \$50 & Max \$240 per month							
<b>VOLUNTARY TAX SAVING PLANS OR ADDITIONAL INSURANCE SELECTION</b>					Monthly Amount	Mark "X"	DC
Flexible Spending Account (FSA), Max \$2,750 - Plus Point		FSA/DCR Fee	<b>\$5.00</b>	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, 2022, premiums reflected on your Dec. 25th payroll check

[www.hca.wa.gov/pebb](http://www.hca.wa.gov/pebb)

<b>Print Last Name:</b>					<b>Emp No:</b>		
<b>Signature:</b>					<b>Date:</b>		
<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)							
<b>C h e c k  ( X )  O n e  P l a n</b>	<b>CLASSIC MEDICAL &amp; VISION PLANS</b> \$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 <b>Vision:</b> No co-pay on annual exam, \$150 hardware every 24 months			<b>Uniform Medical Plan (UMP) - Classic</b> Premium <u>Includes:</u> Dental, Vision, Life Insurance & EE LTD Coverage - Administered by Regence		MARK ONE (X)	Ded Code
		PREMIUM	COUNTY PAYS	EMPLOYEE PAYS			
	EMPLOYEE	884.84	619.39	265.45		300-1	
	EMPLOYEE & SPOUSE	1,610.51	974.97	635.54		300-2	
	EMPLOYEE & CHILDREN	1,429.09	886.07	543.02		300-3	
	EMPLOYEE & FAMILY	2,154.77	1,241.65	913.12		300-4	
	<b>SELECT MEDICAL &amp; VISION PLANS</b> \$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 <b>Vision:</b> No co-pay on annual exam, \$150 hardware every 24 months			<b>Uniform Medical Plan (UMP) - Select</b> Premium <u>Includes:</u> Dental, Vision, Life Insurance & EE LTD Coverage - Administered by Regence		MARK ONE (X)	Ded Code
		PREMIUM	COUNTY PAYS	EMPLOYEE PAYS			
	EMPLOYEE	813.89	619.39	194.50		303-1	
	EMPLOYEE & SPOUSE	1,468.61	974.97	493.64		303-2	
EMPLOYEE & CHILDREN	1,304.93	886.07	418.86		303-3		
EMPLOYEE & FAMILY	1,959.66	1,241.65	718.01		303-4		
<b>HEALTH SAVINGS ACCOUNT (HSA) &amp; VISION PLANS</b> Must Pay ALL of Ded 1st, then pays 15%/40% of medical, hospital, emergency room, prescriptions until total out of pocket is met. \$1400 ind/\$2800 fam ded, plus \$4200/\$8400 out of pocket max, 5%/10%/\$100 ded/30%/50%, \$2000 OOP, Prescription <b>Vision:</b> No co-pay on annual exam, \$150 hardware every 24 months Contribution Limits: Under 55-\$3600 ind/\$7200 fam.			<b>UMP Consumer-Directed Health Plan (CDHP) (HSA) - Premium</b> <u>Includes:</u> Dental, Vision, Basic Life Insurance & EE LTD Coverage - Regence		MARK IF CONTRIB. TO HSA		
			<b>Emp HSA Contribution: \$</b>			306-1	
	PREMIUM	COUNTY PAYS	COUNTY PAYS TO HSA 305-1	EMPLOYEE PAYS	MARK ONE (X)	Ded Code	
EMPLOYEE	804.85	619.39	0.00	185.46		301-1	
EMPLOYEE & SPOUSE	1,448.45	974.97	0.00	473.48		301-2	
EMPLOYEE & CHILDREN	1,302.13	886.07	0.00	416.06		301-3	
EMPLOYEE & FAMILY	1,887.40	1,241.65	0.00	645.75		301-4	
<b>Waiver Fee:</b> If you waive Medical, you must be on Dental, Life & LTD		159.16				302-1	
<b>Tobacco Surcharge:</b> If you, or a dependent covered by the plan, use tobacco products				25.00		302-90	
<b>Spouse or Dom. Partner Coverage Surcharge</b> (go to Spousal Plan Calculator on the web)				50.00		302-91	
<b>C h e c k  O n e</b>	<b>1) <input type="checkbox"/> Uniform Dental Plan (Group 3000), OR, Administered by Delta Dental</b>		<b>2) <input type="checkbox"/> WILLAMETTE, (Group 0), OR,</b>		MARK ONE PLAN CARRIER AND ONE EMPLOYEE GROUP (X)		
	<b>3) <input type="checkbox"/> DELTA CARE GROUP (Group 3100)</b>		IN NETWORK ONLY - Managed Care Plans, Set Rates & No Max Benefit				
	\$50 deductible in-network, 100% Preventive, \$1750 annual max, 80% basic, 50% major, adult & child orthodontia						
	EMPLOYEE			0.00			
	EMPLOYEE & SPOUSE			0.00			
EMPLOYEE & CHILDREN			0.00				
EMPLOYEE & FAMILY			0.00				
<b>LIFE INSURANCE &amp; AD &amp; D - Administered by Metlife</b>				EMPLOYEE PAYS	MARK ONE (X)		
Life Insurance Amounts: Employee \$35,000 & Additional \$5,000 for accidental death				0.00	X		
<b>LONG TERM DISABILITY (LTD) - Administered by Standard Insurance Co.</b>				0.00	X		
After 90 days being disabled, 60% of 1st \$400 of current earnings. Min \$50 & Max \$240 per month							
<b>VOLUNTARY TAX SAVING PLANS OR ADDITIONAL INSURANCE SELECTION</b>					Monthly Amount	Mark "X"	DC
Flexible Spending Account (FSA), Max \$2,750 - Plus Point			FSA/DCR Fee	<b>\$5.00</b>	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, 2022, premiums reflected on your Dec. 25th payroll check

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<b>Print Last Name:</b>					<b>Emp No:</b>		
<b>Signature:</b>					<b>Date:</b>		
<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)							
<b>C h e c k  ( X )  O n e  P l a n</b>	<b>CLASSIC MEDICAL &amp; VISION PLANS</b> \$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 <b>Vision:</b> No co-pay on annual exam, \$150 hardware every 24 months			<b>Uniform Medical Plan (UMP) - Classic</b> Premium <u>Includes:</u> Dental, Vision, Life Insurance & EE LTD Coverage - Administered by Regence		MARK ONE (X)	Ded Code
		PREMIUM	COUNTY PAYS	EMPLOYEE PAYS			
	EMPLOYEE	884.84	530.90	353.94		300-1	
	EMPLOYEE & SPOUSE	1,610.51	835.69	774.82		300-2	
	EMPLOYEE & CHILDREN	1,429.09	759.49	669.60		300-3	
	EMPLOYEE & FAMILY	2,154.77	1,064.27	1,090.50		300-4	
	<b>SELECT MEDICAL &amp; VISION PLANS</b> \$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 <b>Vision:</b> No co-pay on annual exam, \$150 hardware every 24 months			<b>Uniform Medical Plan (UMP) - Select</b> Premium <u>Includes:</u> Dental, Vision, Life Insurance & EE LTD Coverage - Administered by Regence		MARK ONE (X)	Ded Code
		PREMIUM	COUNTY PAYS	EMPLOYEE PAYS			
	EMPLOYEE	813.89	530.90	282.99		303-1	
	EMPLOYEE & SPOUSE	1,468.61	835.69	632.92		303-2	
EMPLOYEE & CHILDREN	1,304.93	759.49	545.44		303-3		
EMPLOYEE & FAMILY	1,959.66	1,064.27	895.39		303-4		
<b>HEALTH SAVINGS ACCOUNT (HSA) &amp; VISION PLANS</b> Must Pay ALL of Ded 1st, then pays 15%/40% of medical, hospital, emergency room, prescriptions until total out of pocket is met. \$1400 ind/\$2800 fam ded, plus \$4200/\$8400 out of pocket max, 5%/10%/\$100 ded/30%/50%, \$2000 OOP, Prescription <b>Vision:</b> No co-pay on annual exam, \$150 hardware every 24 months Contribution Limits: Under 55-\$3600 ind/\$7200 fam.			<b>UMP Consumer-Directed Health Plan (CDHP) (HSA) - Premium</b> <u>Includes:</u> Dental, Vision, Basic Life Insurance & EE LTD Coverage - Regence		MARK IF CONTRIB. TO HSA		
			<b>Emp HSA Contribution: \$</b>				
	PREMIUM	COUNTY PAYS	COUNTY PAYS TO HSA 305-1	EMPLOYEE PAYS	MARK ONE (X)	Ded Code	
EMPLOYEE	804.85	530.90	0.00	273.95		301-1	
EMPLOYEE & SPOUSE	1,448.45	835.69	0.00	612.76		301-2	
EMPLOYEE & CHILDREN	1,302.13	759.49	0.00	542.64		301-3	
EMPLOYEE & FAMILY	1,887.40	1,064.27	0.00	823.13		301-4	
<b>Waiver Fee:</b> If you waive Medical, you must be on Dental, Life & LTD		159.16				302-1	
<b>Tobacco Surcharge:</b> If you, or a dependent covered by the plan, use tobacco products				25.00		302-90	
<b>Spouse or Dom. Partner Coverage Surcharge</b> (go to Spousal Plan Calculator on the web)				50.00		302-91	
<b>C h e c k  O n e</b>	<b>1) <input type="checkbox"/> Uniform Dental Plan (Group 3000), OR, Administered by Delta Dental</b>		<b>2) <input type="checkbox"/> WILLAMETTE, (Group 0), OR,</b>		MARK ONE PLAN CARRIER AND ONE EMPLOYEE GROUP (X)		
	<b>3) <input type="checkbox"/> DELTA CARE GROUP (Group 3100)</b>		IN NETWORK ONLY - Managed Care Plans, Set Rates & No Max Benefit				
	\$50 deductible in-network, 100% Preventive, \$1750 annual max, 80% basic, 50% major, adult & child orthodontia						
	EMPLOYEE			0.00			
	EMPLOYEE & SPOUSE			0.00			
EMPLOYEE & CHILDREN			0.00				
EMPLOYEE & FAMILY			0.00				
<b>LIFE INSURANCE &amp; AD &amp; D - Administered by Metlife</b>			EMPLOYEE PAYS	MARK ONE (X)			
Life Insurance Amounts: Employee \$35,000 & Additional \$5,000 for accidental death			0.00	X			
<b>LONG TERM DISABILITY (LTD) - Administered by Standard Insurance Co.</b>			0.00	X			
After 90 days being disabled, 60% of 1st \$400 of current earnings. Min \$50 & Max \$240 per month							
<b>VOLUNTARY TAX SAVING PLANS OR ADDITIONAL INSURANCE SELECTION</b>				Monthly Amount		Mark "X"	DC
Flexible Spending Account (FSA), Max \$2,750 - Plus Point		FSA/DCR Fee	<b>\$5.00</b>	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