AFFORDABLE CARE ACT COVERAGE

Name: _____

Employee ID# : _____

Coverage Start Date: _____

Employee Type: _____

Rates as of 10/1/2024:

Medical Plan	Check one	Coverage Election	Monthly Premium	Employer Cost	Employee Cost
Kaiser Permanente HMO	☐	Single	$ 908.00	$ 802.71	$ 105.29
	☐	Double	$1,896.00	$ 0.00	$1,896.00
	☐	Family	$2,633.00	$ 0.00	$2,633.00
Kaiser ABHP/HSA	☐	Single	$ 724.00	$ 0.00	$ 724.00
	☐	Double	$1,510.00	$ 0.00	$1,510.00
	☐	Family	$2,096.00	$ 0.00	$2,096.00
Blue Shield ABHP/HSA	☐	Single	$ 801.00	$ 695.71	$ 105.29
	☐	Double	$1,685.00	$ 0.00	$1,685.00
	☐	Family	$2,340.00	$ 0.00	$2,340.00
Blue Shield HMO	☐	Single	$ 1,012.00	$ 0.00	$ 1,012.00
	☐	Double	$ 2,410.00	$ 0.00	$ 2,410.00
	☐	Family	$3,008.00	$ 0.00	$ 3,008.00
Blue Shield PPO	☐	Single	$ 1,127.00	$ 0.00	$1,127.00
	☐	Double	$2,410.00	$ 0.00	$2,410.00
	☐	Family	$3,365.00	$ 0.00	$3,365.00

I elect the coverage as indicated above.

I understand that the employee portion is subject to change based upon the Federal poverty Level, or changes to the ACA legislation or during open enrollment.

_____ _____

Employee Signature Date