KENTUCKY-AMERICAN WATER COMPANY
CASE NO. 2023-00191
COMMISSION STAFF'S FIRST REQUEST FOR INFORMATION

Witness: John Watkins

39. Provide a listing of all health care plan categories, dental plan categories, and vision plan categories available to corporate officers individually and to groups defined as Directors, Managers, Supervisors, Exempt, Non-Exempt, Union, and Non-Union Hourly employees, i.e., single, married no dependents, single parent with dependents, family, etc. Include the associated employee contribution rates and employer contribution rates of the total premium cost for each category, and each plan's deductible(s) amounts.

Response:

Health care, dental and vision plans are outlined below. They are equally available to all categories of employees, as described below. Certain portions of the response are confidential and provided pursuant to a Petition for Confidential Protection.

Medical/Pharmacy – Two Plan Options:

- See chart below for information on both plan options:
  - Consumer-Directed Health Plan (CDHP)
  - Preferred Provider Organization (PPO)

	CDHP		PPO	
Medical	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**
American Water Contribution to HSA (single/family)*	$750/$1,500		None	
Deductible (single/family)**	$1,500/$3,000	$3,000/$6,000	$175/$350	$300/$600
Coinsurance Paid by Company	80%	50%	80%	50%
Coinsurance Paid by You	20%	50%	20%	50%
Annual Out-of-pocket Maximum (single/family) Includes Prescription Costs	$3,500/$7,000	$7,000 per individual	$2,500/$5,000	$5,000 per individual
Prescription Drugs				
Deductible	Combined with Medical		None	
Generic Drugs	20% after deductible		Covered in Full	
Brand Name Drugs	20% after deductible		20%	

Dental – Two Plan Options:

Dental				
	Basic Plan		Enhanced Plan	
	In-Network	Out-of-Network	In-Network	Out-of-Network
Deductible	$50/$100	$50/$100	$50/$100	$50/$100
Calendar Year Maximum	$1,500 per individual		$2,500 per individual	
Preventative Care	100% no deductible		100% no deductible	
Basic Services	80%		80%	
Major Services	50%		50%	
Orthodontia (for dependent children up to age 19)	$1,500 lifetime		$2,500 lifetime	

Vision – Two Plan Options:

Vision				
	Basic Plan		Enhanced Plan	
	In-Network	Out-of-Network	In-Network	Out-of-Network
Exam	$15 copay	no benefit	Covered in full	no benefit
Frequency	24 months		12 months	
Lenses				
Single	$35 copay	Up to $25	$30 copay	Up to $30
Bifocal, Trifocal, Lenticular	$50 copay	Up to $70	$40 copay	Up to $80
Frames	$50 copay, $200 max	Up to $120	$25 copay, $200 max	Up to $120
Contact Lenses*	$100 allowance	Up to $65	$200 allowance	Up to $100

2023 Rates:

Medical - Union - Monthly Rates

PPO Plan	Total Cost	ER Cost	EE Cost
Employee Only	$821.77	$666.25	$155.52
Employee + Spouse	$1,725.71	$1,439.55	$286.16
Employee + Child(ren)	$1,479.18	$1,179.02	$300.16
Family	$2,383.14	$2,037.87	$345.27
CDHP	**Total Cost**	**ER Cost**	**EE Cost**
Employee Only	$774.83	$694.55	$80.28
Employee + Spouse	$1,627.15	$1,458.59	$168.56
Employee + Child(ren)	$1,394.70	$1,250.23	$144.47
Family	$2,247.01	$2,014.25	$232.76

Medical - Non-Union - Monthly Rates

PPO Plan	Total Cost	ER Cost	EE Cost
Employee Only	$826.35	$686.68	$139.67
Employee + Spouse	$1,816.52	$1,509.25	$307.27
Employee + Child(ren)	$1,902.13	$1,580.88	$321.25
Family	$2,314.60	$1,923.51	$391.09
CDHP	**Total Cost**	**ER Cost**	**EE Cost**
Employee Only	$779.01	$692.54	$86.47
Employee + Spouse	$1,713.81	$1,523.55	$190.26
Employee + Child(ren)	$1,791.29	$1,592.40	$198.89
Family	$2,182.35	$1,940.20	$242.15

Dental - Union - Monthly Rates

Basic	Total Cost	ER Cost	EE Cost
Employee Only	$36.85	$30.65	$6.20
Employee + Spouse	$77.38	$64.34	$13.04
Employee + Child(ren)	$66.33	$55.15	$11.18
Family	$106.85	$88.85	$18.00
Enhanced	**Total Cost**	**ER Cost**	**EE Cost**
Employee Only	$36.85	$28.86	$7.99
Employee + Spouse	$77.38	$60.59	$16.79
Employee + Child(ren)	$66.33	$51.94	$14.39

Dental - Non-Union - Monthly Rates

Basic	Total Cost	ER Cost	EE Cost
Employee Only	$37.90	$32.13	$5.77
Employee + Spouse	$83.42	$70.73	$12.69
Employee + Child(ren)	$87.08	$73.81	$13.27
Family	$106.23	$90.07	$16.16
Enhanced	**Total Cost**	**ER Cost**	**EE Cost**
Employee Only	$5.50	$4.28	$1.22
Employee + Spouse	$12.09	$9.43	$2.66
Employee + Child(ren)	$12.65	$9.85	$2.80

Family	$106.85	$83.68	$23.17

Family	$15.40	$11.99	$3.41

Vision - Union - Monthly Rates

Basic	Total Cost	ER Cost	EE Cost
Employee Only	$5.19	$4.35	$0.84
Employee + Spouse	$10.90	$9.15	$1.75
Employee + Child(ren)	$9.33	$7.83	$1.50
Family	$15.04	$12.62	$2.42

Vision - Non-Union - Monthly Rates

Basic	Total Cost	ER Cost	EE Cost
Employee Only	$5.11	$4.27	$0.84
Employee + Spouse	$11.26	$9.43	$1.83
Employee + Child(ren)	$11.77	$9.86	$1.91
Family	$14.32	$11.99	$2.33

Enhanced	Total Cost	ER Cost	EE Cost
Employee Only	$5.59	$4.35	$1.24
Employee + Spouse	$11.74	$9.14	$2.60
Employee + Child(ren)	$10.06	$7.84	$2.22
Family	$16.20	$12.62	$3.58

Enhanced	Total Cost	ER Cost	EE Cost
Employee Only	$5.50	$4.28	$1.22
Employee + Spouse	$12.09	$9.43	$2.66
Employee + Child(ren)	$12.65	$9.85	$2.80
Family	$15.40	$11.99	$3.41