

2017 Open Enrollment FAQs

General Open Enrollment & Eligibility Questions

1. When is Open Enrollment for Plan Year 2017?

October –10-24, 2016.

2. Do I have to enroll?

Yes. This is an active, mandatory Open Enrollment and everyone must enroll in or waive health insurance coverage. If you do not make an election, you will be defaulted to the Standard PPO plan for 2017 at the same level as your 2016 plan (single, couple, parent plus, family). Flexible Spending Account elections must be made every year.

3. How do I enroll if I need to make changes to my plan, elect the Waiver General Purpose HRA, or an FSA?

Online KHRIS ESS: Active employees, KTRS retirees, JRP/LRP and KCTCS retirees may enroll online at openenrollment.ky.gov.

Paper Application: If you are beginning or ending a cross-reference payment option, adding a disabled dependent covered on your plan, or are a KRS retiree who needs to make changes to your plan, you must complete a paper application and may mail it directly to the Department of Employee Insurance.

Note: If you do not need health insurance, you must actively waive your health insurance coverage and choose one of the three waiver options; a Waiver General Purpose Health Reimbursement Arrangement (HRA), a Waiver Dental/Vision Only HRA, or Waiver without HRA. If you do not choose a waiver option, you will be automatically enrolled in the Standard PPO with the same coverage level (single, parent-plus, couple, or family) you previously had in 2016. If you currently have one of the Waiver options in 2016 and do not waive coverage or elect a plan in 2017, you will be automatically defaulted to the Standard PPO, single coverage level for 2017.

4. Who do I call for assistance?

KEHP Open Enrollment Hotline	Outside Frankfort 888-581-8834 In Frankfort 502-564-6534 The options below are only available October 10-24, 2016. The KEHP phone message will prompt you to choose from one of the following three options: Option 1 KHRIS User ID, password, computer & technical assistance Option 2 Benefit questions for Anthem, CVS/Caremark or WageWorks Option 3 KEHP Member Services and Eligibility
Health Insurance Benefits Anthem Customer Service	844-402-KEHP (5347)
Prescription Benefits CVS/Caremark Customer Service	866-601-6934

FSA & HRA Benefits WageWorks	877-430-5519
Wellness Information Go365	855-478-1623
Shopper Discounts Vitals SmartShopper	855-869-2133
LRP & JRP Retiree Questions	502-564-5310
KCTCS Retiree Questions	859-256-3100
KRS Retiree Questions	800-928-4646 502-696-8800 kyret.ky.gov
TRS Retiree Questions	800-618-1687 502-848-8500 ktrs.ky.gov

5. What are the Open Enrollment customer service hours

Oct. 10-14/Monday - Friday: 8 a.m. to 6 p.m. ET

Oct. 15 Saturday: 8 a.m. to 1 p.m. ET

Oct. 17-21/Monday - Friday: 8 a.m. to 8 p.m. ET

Oct. 22 Saturday: 8 a.m. to 1 p.m. ET

Oct. 24/Monday: 8 a.m. to 6 p.m. ET

6. When and where are the KEHP Benefit Fairs?

Benefit fairs will be held at 13 locations from Oct. 3 through Oct. 14 with representatives available from KEHP, Anthem, CVS/Caremark, WageWorks, Go365, and Vitals SmartShopper. Free flu shots are available on a first-come, first-served basis at Franklin and Jefferson County benefit fairs. All locations will have online enrollment assistance available for active employees and TRS retirees under age 65.

7. What plan options are available?

The same four plans are available for 2017.

- LivingWell CDHP
- LivingWell PPO
- Standard PPO
- Standard CDHP

The LivingWell CDHP and the LivingWell PPO require the Planholder to fulfill the LivingWell Promise.

8. What changes can I make during Open Enrollment?

You may enroll yourself and your children and/or spouse in a health plan or waive coverage. If your employer participates in KEHP's FSA/HRA program, you may also enroll in a Healthcare or Dependent Care Flexible Spending Account (FSA). You can also change your tobacco use status. NOTE: You may not remove a dependent from your plan if the child is enrolled due to an administrative or court order, including National Medical Support Orders.

9. Who can I cover on my health plan?

You may cover your legal spouse or dependent child under age 26.

10. Can children under age 26 be covered as dependents on their parent's plan if they are eligible for their own coverage (e.g., at another job)?

Yes, KEHP has expanded dependent eligibility to include dependents under age 26 who may be eligible for health insurance coverage through their full-time employer. This includes children who are eligible for KEHP as an employee.

11. Can disabled dependents be covered beyond age 26?

A Dependent child who is totally and permanently disabled may be covered by KEHP beyond the end of the month in which he/she turns 26, provided the disability (a) started before his/her 26th birthday and (b) is medically-certified in writing by a physician. A Dependent child will be considered totally and permanently disabled if, in the judgment of KEHP, the written certification adequately demonstrates that the Dependent child is unable to engage in any substantial gainful activity by reason of medically determinable physical or mental impairment that can be expected to result in death or that has lasted or can be expected to last for a continuous period of not less than 12 months.

A Dependent child who is not already covered by KEHP at the time of his/her 26th birthday may not later be enrolled in KEHP on grounds of total and permanent disability unless and until he/she sustains a loss of other insurance coverage. In such a case, a request to enroll a Dependent child in KEHP on grounds of total and permanent disability must be made no later than 35 calendar days following the loss of other insurance coverage.

Anthem will make all dependent child disability determinations. If a Dependent child is approved for coverage in KEHP on grounds of total and permanent disability, the Planholder will periodically be required to produce written proof of the continuing nature(s) of the child's dependency and/or disability in order to maintain the child's KEHP coverage.

12. Can I waive coverage and not elect a KEHP health plan?

Yes, you may waive coverage and elect one of the three Waiver options. If you choose the Waiver General Purpose Health Reimbursement Arrangement (HRA), per federal law, you must declare that you and your spouse and dependents, if applicable, have other group health plan coverage that provides minimum value. A "group health plan" refers to coverage provided by an employer, an employer organization, or a union. A "group health plan" does not include individual policies purchased through the Marketplace, or governmental plans such as TRICARE, Veterans Benefits, Medicare, or Medicaid.

When waiving coverage you have three options:

- Waive coverage and elect the Waiver General Purpose HRA. With this option you will receive \$175 per month up to \$2,100 annually to pay for qualified medical expenses. You will receive a WageWorks Healthcare Card pre-funded on January 1 with \$1,050, and funded again on July 1 with an additional \$1,050. More information on the WageWorks Healthcare Card and eligible expenses can be found in the Benefits Selection Guide.

NOTE: This option is not available to retirees. If you or your spouse or dependent is contributing funds to a Health Savings Account (HSA), you should consult a tax advisor prior to establishing an HRA or FSA.

- Waive coverage and elect the Dental/Vision Only HRA. With this option you will receive \$175 per month up to \$2,100 annually to pay for qualified dental and vision only expenses. You will receive a WageWorks Healthcare Card pre-funded on January 1 with \$1,050, and funded again on July 1 with an additional \$1,050. More information on the WageWorks Healthcare Card and eligible expenses can be found in the Benefits Selection Guide.

NOTE: This option is not available to retirees.

- Waive coverage with no HRA. With this option you do not receive any employer funds.

13. What is the cross-reference payment option?

The cross-reference payment option is a legislatively mandated payment option that offers lower employee premiums which are deducted from both employees' paychecks. Employees must satisfy all requirements to elect the cross-reference payment option.

Requirements

- The employees must be legally married with at least one eligible dependent;
- The employees must be eligible employees or retirees* of a group participating in KEHP;
- The employees must elect the same coverage option

Failure to meet any one of the above requirements will make the employees ineligible for the cross-reference payment option.

*Per the Judicial and Legislators Retirement System, Retirees of the Judicial Retirement Plan (JRP) and the Legislators' Retirement Plan (LRP) are not eligible to elect the Cross-Reference Payment Option.

14. May I drop a dependent from coverage in the middle of the plan year?

Coverage elections may only be changed during the Annual Open Enrollment period or if a member has a qualifying event. A list of qualifying events is included on the KEHP Enrolling or Changing Coverage website page.

LivingWell Promise

1. What are the LivingWell Promise requirements for 2017?

The LivingWell plans are very popular and keeping the Promise is easy – more than 98% of planholders completed the LivingWell Promise in 2016!

Electing a LivingWell Promise plan in 2017 means you are required to complete either the Go365 Health Assessment (HA) or a biometric screening from January 1, 2017 through July 1, 2017. Both only take a few minutes to complete and give you a better understanding of your health status, access to the best benefit plan options, and information to help you stay healthy. If you have a cross-reference payment option, you and your spouse both must complete the HA or the biometric screening.

A new federal law requires health plans with wellness benefits to change how members are rewarded for their participation.

Impact on your 2017 enrollment

If you enrolled in a LivingWell Plan option for 2016 and:

- You fulfilled your LivingWell Promise, you will receive a monthly premium discount of \$40 during 2017; or
- You did not fulfill your LivingWell Promise, you will not receive the monthly premium discount.

You may choose from any of the four plan options for 2017.

2. If I am a new employee and choose a LivingWell plan option after open enrollment, how long do I have to complete the LivingWell Promise?

New employees who elect a LivingWell plan after Open Enrollment must complete the Health Assessment or biometric screening within 90 days of the effective date of their coverage.

3. What is the Go365 Health Assessment?

More than 122,000 KEHP planholders have already taken their Health Assessment (HA) as part of their 2016 LivingWell Promise! The Health Assessment (HA) is a series of questions about your current physical and mental well-being, your day-to-day lifestyle, and how you feel about your current health levels. It takes about 10-15 minutes to complete, and once finished, the HA results will tell you your Go365 Age.

First time users

Click on “Register” and be prepared with your HumanaVitality/Go365 ID number (or social security number) and additional personal information. Follow the steps, create a username and password, and return to Go365 to login. (Tip: Write down your username and password somewhere safe for reference in the future when you login again.)

Returning users

After you sign in, start your HA. If you know your medical history and key measurements, have them ready to help you complete your HA. If you don't have your key measurements, don't worry, you'll still be able to complete the HA. If you had a biometric screening within the last 18 months, you will see those results populated into your HA. The results cannot be updated until a new biometric screening is submitted. To find a biometric screening location near you, visit livingwell.ky.gov. After you receive your Go365 Age, you will receive recommended goals.

4. What is a biometric screening?

A biometric screening consists of: lab work to test your cholesterol and blood glucose; a blood pressure check; and height, weight and waist circumference measurements to learn your Body Mass Index (BMI). For more accurate results, fast for at least nine hours prior to the biometric screening.

Go365 rewards you up to 4,000 Points and Bucks for completing a biometric screening. You will receive 2,000 Bucks just for having a biometric screening and an additional 2,000 Bucks for being in healthy ranges. You will also receive points for taking each test (cholesterol, blood glucose, blood pressure).

5. Where can I get a (biometric screening)?

Location	Cost
At select onsite work locations.	No cost to you
<ul style="list-style-type: none">See your local wellness champ to find out your worksite screening date	The biometric screening vendor will submit your results to Go365.
Through the local Health Department	No cost to you
<ul style="list-style-type: none">Go to livingwell.ky.gov to find a locationPresent your Go365 ID number at the health	The Health Department will submit your results to Go365.

3. At a retail clinic (e.g. Krogers' Little Clinics, Walgreens' Take Care Clinics, Concentra)

- Go to livingwell.ky.gov

- Click on the 'get a biometric screening' box

No cost to the member.

The retail clinic location will submit your results to HumanaVitality.

- Choose from the locations listed

- Print the associated biometric screening voucher

- Present the voucher and your Go365 ID number at the retail clinic

4. At your Primary Care Physician (PCP)

- Go to livingwell.ky.gov

- Click on the "primary care physician" tab

Preventive Services are at no cost to you if you use an in-network provider; however, there may be a charge if the provider submits the claim other than for preventive services.

- Print a copy of the "PCP biometric screening voucher located at livingwell.ky.gov

- Follow the instructions on the form to mail, fax, or submit via your online Go365 portal..

6. Who must complete the LivingWell Promise?

Only the Planholder is required to complete the LivingWell Promise. Non-employee spouses and dependents covered under your plan will not be required to complete the Promise. If you have the cross-reference payment option, both you and your spouse must complete the LivingWell Promise.

7. Are spouses or adult children (age 18 and up) required to fulfill the LivingWell Promise?

No. Only you, the Planholder, are required to complete the LivingWell Promise. The only exception to this requirement is if you have elected a cross-reference payment option, in which case both Planholders must fulfill the Promise.

8. When do I have to take the Health Assessment or biometric screening?

If you make the LivingWell Promise during Open Enrollment you must take your Health Assessment or biometric screening January 1, 2017 and July 1, 2017. New employees who elect a LivingWell plan option after Open Enrollment must complete the Health Assessment within 90 days of the effective date of their coverage.

9. What happens with the information collected through the Health Assessment?

KEHP takes your personal health information seriously and has measures in place to protect this information. All responses to your HA are strictly confidential and protected under HIPAA. KEHP will not collect, access, or retain your personal health information, nor will KEHP share your personal health information with your employer. KEHP may receive aggregate information from Go365 that does not identify any individual in order to design and offer health programs aimed at improving the health of KEHP members.

10. Can I take the Health Assessment or biometric screening if I don't choose a LivingWell Plan?

Yes, if you participate in one of the four health plan options, you are automatically enrolled in Go365. Once you log in and activate your account, you can begin earning Vitality Points toward movie tickets, hotel stays, and other reward. You can also take the Health Assessment which gives you your Go365 Age and helps you set goals for a healthy lifestyle.

11. If I can't take the Health Assessment due to medical or mental health conditions, can I still choose a LivingWell plan?

Yes, if it is unreasonably difficult because of a medical or mental health condition for you to complete the Health Assessment you also have the option of completing a biometric screening. If it is unreasonably difficult for you to complete either one, call customer service at 855-478-1623, and we will work with you to develop an alternative solution.

12. If I do not fulfill the LivingWell Promise, will my health insurance claims still be paid?

Yes. The plan will continue to pay eligible claims for the plan year, even if you do not fulfill the LivingWell Promise.

13. What happens if I fail to complete the LivingWell Promise from January 1 through July 1, 2017?

If you elect a LivingWell plan option and fail to fulfill the LivingWell Promise, you will not receive the monthly premium discount in 2018.

14. If I choose a LivingWell plan option and take the Health Assessment or biometric screening, may I change my plan option mid-year?

Mid-year plan changes can only be made if you experience a life event referred to as a qualifying event. If you experience a qualifying event that allows you to change your plan, you can elect another LivingWell plan option or a Standard plan option. If you experience a qualifying event during the 2017 plan year and elect a LivingWell plan option for the first time as a result of the qualifying event, you have 90 days from the effective date of the LivingWell plan to complete the LivingWell Promise. The primary rule for completion of the LivingWell Promise is that the first, or original election of the LivingWell plan option is the controlling factor for whether you are eligible to receive the premium discount the following year. If you change plans during the 2017 plan year, whether that change is because of retirement, a qualifying event or a break in service, the first, or original election of the LivingWell plan follows you throughout the plan year. The same rule would apply to newly eligible members.

For example, at open enrollment you elect a LivingWell plan option. You experience a qualifying event in June and change to a Standard plan option. Your election of the LivingWell plan option, and whether you completed your LivingWell Promise, will be tracked regardless of the mid-year change to a Standard

plan option. If you did not complete the LivingWell Promise from Jan. 1 through July 1, 2017, you will not be eligible for the premium discount in 2018.

15. How does electing a LivingWell plan option for 2017 and making the LivingWell Promise impact my eligibility for the wellness plan premium discount for future years?

Please review the following for specific information:

What happens if I terminate employment and am hired at another KEHP participating agency three months later?

The first/original election of a LivingWell plan option will follow you throughout the plan year. The first/original election of a plan requiring the LivingWell Promise is the controlling element. You don't have to complete the promise twice in the event of a qualifying event, termination, re-hire, etc.

What happens if I elect a LivingWell plan option at Open Enrollment, fulfill the LivingWell Promise, then retire or have a qualifying event in 2017 and continue with my LivingWell plan – do I have to fulfill the LivingWell Promise again to be eligible for a LivingWell plan in 2018?

No. Because you completed the LivingWell Promise with your first/original election of a LivingWell plan option in 2017, you are eligible for the premium discount in 2018.

Would I be able to elect a LivingWell plan option during Open Enrollment, NOT fulfill my LivingWell Promise from January 1 through July 1, then retire (or have a qualifying event) after July 1, 2017 and continue to receive the premium discount when I retire?

Yes. Despite not completing the Health Assessment or biometric screening, you would still receive the premium discount during the same plan year. Again, because the first/original election requiring the LivingWell Promise was not fulfilled and you will not be eligible for the LivingWell plan premium discount for the next plan year.

16. If I elect a LivingWell plan option and agree to the LivingWell Promise, am I required to participate if I'm contacted by a nurse with one of the Anthem Personal Health Nurse Programs?

No, electing a LivingWell plan option only requires you to complete the Go365 Health Assessment or biometric screening. However, the Personal Health Nurse Programs are free to KEHP members and provide valuable services such as personalized support for reaching healthy living goals or managing complex medical conditions.

Plan Information

1. What is a Consumer Driven Health Plan (CDHP)?

CDHPs put you, the consumer, in more control of managing your healthcare expenses. CDHPs feature lower premiums and include an employer-funded, pre-loaded Health Reimbursement Arrangement (HRA) to help reduce your deductible and maximum out-of-pocket expenses. With a higher deductible, the employer-funded HRA, and lower co-insurance amounts, a CDHP engages members in their healthcare decisions and makes them more aware of the cost and utilization of healthcare services. Like

a PPO, members in a CDHP have flexibility when choosing healthcare from in-network providers and members must pay more for healthcare from out-of-network providers. Unused dollars in the HRA can accumulate and carryover to the next plan year if a member continues to elect a CDHP. **NOTE:** Beginning in 2018, the carryover amount on an HRA will be capped at \$7,500.

2. What is a Preferred Provider Organization plan (PPO)?

PPOs are a type of insurance plan with which most people are familiar. Usually PPOs have higher premiums, low deductibles and require you to pay co-pays and co-insurance. The insurance plan is responsible for the remainder. In addition, PPOs allow flexibility when choosing healthcare from in-network providers and members must pay more for healthcare from out-of-network providers.

3. What is a deductible?

A deductible is the amount you have to pay out-of-pocket before the plan begins to pay expenses. Deductibles are generally calculated per calendar year and most plans have individual and family deductible amounts.

4. What is co-insurance?

Co-insurance refers to a shared payment between the health plan and you, described in percentages (e.g. 80%/20%).

5. What is out-of-pocket maximum?

This is the most money in a plan year that you can expect to pay for covered medical and pharmacy services.

6. What is a co-pay?

A co-pay is your portion of the cost for a health care service (e.g., you may pay \$25 per office visit or \$10 to get a prescription filled.) Your insurance plan pays the difference.

Health Reimbursement Arrangements and Flexible Spending Accounts

1. What is a Health Reimbursement Arrangement (HRA)?

An HRA is an account that you can use to cover qualified expenses. The KEHP has multiple types of HRAs: 1) an embedded HRA is part of the CDHP plan options and is pre-funded for you to use to help cover your deductible and co-insurance expenses. 2) a Waiver General Purpose HRA and a Waiver Dental/Vision Only HRA are employer-funded and can be selected when you choose to waive your health coverage. HRA funds can carry over to the next plan year, as long as you continue to elect the same type of HRA. **NOTE:** Beginning in 2018, the carryover amount on an HRA will be capped at \$7,500.

Funds in the LivingWell CDHP HRA, Standard CDHP HRA, and the Waiver General Purpose HRA can be used to pay for:

- Medical and prescription deductibles, co-payments, and co-insurance
- Certain dental fees such as cleanings, fillings, and crowns
- Orthodontic treatment
- Vision fees including contacts, eyeglasses, and laser vision correction
- Medical supplies such as wheelchairs, crutches, and walkers

NOTE: If you use your CDHP HRA funds for dental and vision expenses, these funds will not apply to your deductible and out-of-pocket maximum.

Funds in the Waiver Dental/Vision Only HRA can be used to pay for:

- Certain dental fees such as cleanings, fillings, and crowns
- Orthodontic treatment
- Vision fees including contacts, eyeglasses, and laser vision correction

NOTES: a. Retirees are not eligible for either Waiver HRA or the Dental/Vision Only HRA. b. If you or your spouse or dependent is contributing funds to a Health Savings Account (HSA), you should consult a tax advisor prior to establishing an HRA or FSA. c. Employees of employers that do not participate in KEHP's HRA program are not eligible for the Waiver HRA options.

2. What is a Healthcare Flexible Spending Account (FSA)?

A Healthcare FSA is an account funded by you to pay for healthcare services such as prescription co-payments, deductibles, and doctor's office co-payments with pre-tax money. The amount you contribute will be payroll deducted. You can use your FSA for family members who are considered a tax dependent. The 2017 limit for contributions to a Healthcare FSA is a minimum of \$120 to a maximum of \$2,500 per employee, per year. There is virtually no risk in losing your FSA money if you don't spend it all because you may carry over a minimum of \$50, up to a maximum of \$500 per plan year. FSA funds can be used to pay for:

- Medical and prescription co-payments and co-insurance
- Certain dental fees such as cleanings, fillings, and crowns
- Orthodontic treatment
- Vision fees including contacts, eyeglasses, and laser vision correction
- Medical supplies such as wheelchairs, crutches, and walkers

3. What is a Dependent Care Flexible Spending Account (FSA)?

A Dependent Care FSA allows you to pay for dependent care expenses such as daycare or after-school programs for dependents up to age 13. The Dependent Care FSA may also be used to pay for adult day care services for adult dependents. The maximum that you can contribute to a Dependent Care FSA per year is based on your tax filing status: \$5,000 for married, filing a joint return; \$5,000 filing as head-of-household; or \$2,500 married, filing separate returns. Make sure to set aside only as much as you will use. You can use the money only for eligible expenses paid for during the current plan year. There is no carry over of unused Dependent Care FSA funds.

4. How do I receive reimbursement for my HRA or FSA account?

WageWorks offers a variety of methods to pay for and verify your eligible expenses.

- **Swipe and Go:** Use your WageWorks Healthcare Card, a convenient payment method tied to WageWorks Healthcare FSA and HRAs to make healthcare purchases at the doctor's office, pharmacy, optician, dentist, and other healthcare providers easy. You cannot use the WageWorks Healthcare Card for Dependent Care FSA reimbursement.
- **Online:** Reimbursement forms are readily available online. You can upload your receipt directly to your account. When accessing your account online, you can also setup the Pay My Provider service to pay many of your eligible healthcare and dependent care expenses directly from your spending account (similar to online banking). Go to WageWorks.com/KEHP.

- **Mobile App:** WageWorks offers a mobile app that allows you to take a picture of your claim receipt or Explanation of Benefits (EOB) and send it to your WageWorks online account. They will use the receipt to validate any receipts needing verification. The mobile app enables you to log in to your account and check your balances, submit claims, snap photos of receipts, get alerts by text or email — all on the go!
- **Fax/Mail:** You can also print the needed forms from the WageWorks website and submit via fax or mail to: Claims Administrator P.O. Box 14053, Lexington, KY 40512 Fax 877-353-9236.

5. What is substantiation?

Substantiation is required by the IRS to verify that an HRA or FSA claim is an eligible expense. If you have a health insurance plan with KEHP, as well as a Healthcare FSA, then most of your HRA or FSA expenses paid with WageWorks Healthcare Card will be verified through Anthem’s medical claims system. If you choose a Waiver HRA, your primary health insurance plan is not through KEHP. You will need to keep your receipts in the event WageWorks needs to verify the expense, even if you use your WageWorks Healthcare Card. You can submit receipts and verify expenses online or use the EZ Receipts Mobile App.

6. Who is eligible for an FSA?

Employees of state agencies, schools boards, and certain quasi-agencies are eligible. Contact your Insurance Coordinator or HR department for details.

7. Can I have an HRA and a Healthcare FSA?

Yes, you can elect both. Because HRAs are employer-funded and FSAs are employee-funded, you could choose to have both to cover your out-of-pocket expenses. For example, you elect the LivingWell CDHP, family coverage level, and have \$1,000 in an employer-funded HRA that can be used toward your deductible. You could also elect to have \$1,500 of your money added to a Healthcare FSA and use those pre-tax dollars to help meet your deductible or to pay for vision and dental expenses. If you have both, your Healthcare FSA funds will be spent first before your HRA funds.

8. How long do I have to spend FSA and/or HRA money?

FSA and/or HRA funds may only be used to pay for eligible expenses incurred during the coverage plan year. However, you have until March 31, 2018 to submit reimbursement requests for HRA expenses incurred during your 2017 coverage period.

Waiving Health Insurance Coverage

1. Who is eligible for the Waiver General Purpose HRA?

Only persons who have other group health plan coverage that provides minimum value and who declare, in writing that they have such other coverage. Otherwise, any active employee of a state agency, school board, or certain quasi-governmental agency who:

- a. is eligible for state-sponsored health insurance coverage;
- b. whose employer participates in the KEHP’s HRA/FSA program;
- c. who has other group health plan coverage that provides minimum value; and
- d. who declares, in writing, that they have such other group health plan coverage.

2. Who is not eligible for the Waiver HRA?

If you are a member of an agency that does not participate in KEHP's HRA/FSA program, a retiree, or a retiree under age 65 who has gone back to work and elected coverage under the retirement system, then you are not eligible for the Waiver HRA.

NOTE: If you or your spouse or dependent is contributing funds to a Health Savings Account (HSA), you should consult a tax advisor prior to establishing an HRA.

3. What is "other group health plan" coverage?

"Group health plan coverage" means coverage under a plan (including a self-insured plan) maintained by an employer (including a self-employed person) or labor union to provide health care for current or former employees or their families. Group health plan coverage does not include Medicaid, KCHIP, TRICARE, Medicare, Veteran's Benefits, Peace Corp coverage, any other governmental insurance plan, student policies, state high risk pool coverage, or individual market coverage, including individual coverage purchased through the Marketplace.

4. What is "minimum value"?

A group health plan provides "minimum value" if the plan pays at least 60% of the total allowed cost of covered benefits/services and participants or members in the plan are required to pay no more than 40% of the total allowed cost of covered benefits/services.

5. How do I know if my other group health plan coverage provides minimum value?

The employer or the sponsor of the other group health plan coverage can tell you if the group health plan provides minimum value.

6. Who must be covered under the other group health plan coverage for me to be eligible for the Waiver General Purpose HRA?

If eligible to elect a Waiver General Purpose HRA, the federal guidelines related to HRAs allow you to use the Waiver General Purpose HRA to pay for qualified medical expenses for you, your spouse, and your dependents as long as you can attest that all persons covered under the Waiver General Purpose HRA have other group health insurance coverage.

7. What happens if I lose my other group health plan coverage during the year?

If an employee elects a Waiver General Purpose HRA and ceases to be covered under another group health plan that provides minimum value, the employee must notify KEHP within 35 days after the date that the other group health plan coverage ends. In this event, coverage under the Waiver General Purpose HRA will be terminated and the employee may elect a KEHP health insurance plan option or the Waiver Dental/Vision ONLY HRA. Any funds remaining in the Waiver General Purpose HRA after termination may be used to reimburse the employee for eligible expenses incurred prior to termination of the Waiver General Purpose HRA. The employee is permitted to permanently opt out of and waive future reimbursements from the Waiver HRA at least annually at open enrollment.

8. What happens if I choose a Waiver General Purpose HRA but do not have other group health plan coverage that provides minimum value?

You are not eligible for coverage under a Waiver General Purpose HRA unless you declare, in writing, that you and your spouse and dependents, if applicable, have other group health plan coverage that provides minimum value. If KEHP determines that you have made a false certification, your coverage under the Waiver General Purpose HRA will be revoked.

9. Why must the Waiver General Purpose HRA be integrated with other “group health plan” coverage?

The rules regarding the Waiver General Purpose HRA are established by the federal government. The Waiver General Purpose HRA is considered a “group health plan” but it does not comply with certain federal law requirements for group health plans. For instance, the Waiver General Purpose HRA does not provide preventive care at zero cost sharing for members. Also, the Waiver General Purpose HRA does not comply with the prohibition against annual limits as it is limited to \$2,100 per year. For these reasons, federal law requires the Waiver General Purpose HRA to be coupled, or integrated, with other “group health plan” coverage that meets all the requirements for health plans imposed by the federal government. This ensures that individuals have the necessary coverage to comply with the federal individual health insurance mandate.

10. Why isn't TRICARE considered other “group health plan” coverage?

On September 13, 2013, the US Department of Labor, the US Department of Treasury, and the US Department of Health and Humana Services collectively issued guidance regarding HRAs. As indicated by the guidance, an HRA, like the Commonwealth's Waiver General Purpose HRA, must be integrated with other group health plan coverage and that coverage must provide minimum value. In order to elect the Waiver General Purpose HRA, the employee must be “actually enrolled in a group health plan that provides minimum value.” The term “group health plan” is specifically defined by federal law. With respect to a “group health plan,” the following definition applies: 26 USC 5000(b)(1) - The term “group health plan” means a plan (including a self-insured plan) of, or contributed to by, an employer (including a self-employed person) or employee organization to provide health care (directly or otherwise) to the employees, former employees, the employer, others associated or formerly associated with the employer in a business relationship, or their families. TRICARE is a government-sponsored plan and is not an employer-sponsored or employee organization (e.g. union) – sponsored plan. As such, persons with TRICARE are not able to attest or declare that they are enrolled in a “group health plan” that provides minimum value.

11. What is the difference between a Waiver (general purpose) HRA and a Waiver Dental/Vision Only HRA?

A Waiver General Purpose HRA will reimburse the employee or the employee's dependents for certain medical expenses such as medical and prescription drug deductibles, co-payments and co-insurance, certain dental and vision services, and medical supplies. The Waiver Dental/Vision ONLY HRA will reimburse the employee or the employee's dependents only for expenses related to vision and dental services.

12. Can I choose a Waiver Dental/Vision ONLY HRA if I do not have other group health plan coverage that provides minimum value?

Yes. You may waive KEHP health insurance coverage and choose a Waiver Dental/Vision ONLY HRA even if you do not have other group health plan coverage that provides minimum value. You are not required to sign a written declaration if you waive KEHP health insurance coverage and choose a Waiver Dental/Vision ONLY HRA. You should bear in mind, however, that you might owe a tax penalty if you do not maintain minimum essential health coverage.

13. Who is eligible for the Waiver Dental/Vision Only HRA?

Any active employee of a state agency, school board or certain quasi-governmental agency who is eligible for state-sponsored health insurance coverage may waive health insurance and enroll in the Waiver Dental/Vision Only HRA. Retirees who have returned to work and who are over age 65 may also waive health insurance and enroll in the Waiver Dental/Vision Only HRA.

14. Who is not eligible for the Waiver Dental/Vision Only HRA?

If you are a member of an agency that does not participate in KEHP's HRA/FSA program, a retiree, or a retiree under age 65 who has gone back to work and elected coverage under the retirement system, then you are not eligible for the Waiver Dental/Vision Only HRA.

Tobacco Use

1. What is the non-tobacco user discount?

The Commonwealth of Kentucky is committed to fostering and promoting wellness and health in the workforce. As part of the KEHP wellness program, incentives are available for members who do not use tobacco products, including monthly premium discounts for non-tobacco users. You, the primary planholder, are eligible for the monthly non-tobacco user rates if you certify that neither you nor any other person to be covered under your plan has regularly used tobacco within the past six months. Certification of tobacco use or non-use is accomplished by reviewing the rules governing the Tobacco Use Declaration found in your Benefits Selection Guide or online at kehk.ky.gov and checking the appropriate boxes on your application for health insurance coverage through KEHP. Specifically, the questions on the Tobacco Use Declaration ask:

- a. "Within the past six months, have you used tobacco regularly?"
- b. "Has your spouse, if covered under this plan, used tobacco regularly within the past 6 months?"
- c. Have any children covered under this plan, age 18 or older, used tobacco regularly within the past 6 months?

2. What does "used tobacco regularly" mean?

"Regularly" means you (or a spouse or dependent 18 years of age or older) has used tobacco four or more times per week on average excluding religious or ceremonial uses.

3. What is considered tobacco?

"Tobacco" means all tobacco products including, but not limited to, cigarettes, pipes, chewing tobacco, snuff, dip, and any other tobacco products regardless of the frequency or method of use. Electronic cigarettes are not considered a form of tobacco.

4. Who is considered a dependent for the Tobacco Use Declaration?

“Dependent” means, for the purpose of the Tobacco Use Declaration, only those dependents who are 18 years of age or older and covered under your plan.

5. When can I qualify for the monthly employee insurance premium contribution discounts for non-tobacco users?

All KEHP members or prospective KEHP members have the opportunity to qualify for the monthly employee insurance premium contribution discounts for non-tobacco users upon application (new hires) for insurance coverage through KEHP and once each year at open enrollment (ongoing employees).

6. Can I change the tobacco use status during the plan year if I stop smoking?

Yes, provided all persons covered under your plan are non-tobacco users. KEHP Planholders certifying that there is a tobacco user covered under the Planholder’s insurance plan will be eligible for discounted premium contribution rates provided all persons covered under the plan stop using tobacco products regularly (four or more times per week on average) during the plan year. In order to qualify for the discounted premium contribution rates, the Planholder must sign a Tobacco Use Change Form certifying that neither the Planholder nor the Planholder’s spouse/dependent(s) regularly used tobacco products during the 6 months prior to completion of the Tobacco Use Change Form.

To the extent available, proof of completion of a tobacco cessation program or other proof of non-tobacco use will be required (i.e. proof of successful completion of the Cooper-Clayton program). The monthly discounted premium contribution rates will be applicable on the first of the month following the signature date on the Tobacco Use Change Form.

7. Do I continue to get the monthly discounted premium contribution rates for non-tobacco users if I or a spouse/dependent covered under my insurance plan begin using tobacco during the plan year?

During the plan year, KEHP Planholders must complete a Tobacco Use Change Form if the Planholder experiences any changes in the Planholder’s tobacco use or that of a spouse or dependent covered under the Planholder’s insurance plan. KEHP Planholders who certify that there are no regular tobacco users covered under the Planholder’s insurance plan are eligible for the monthly discounted premium contribution rates and are required to notify KEHP if either the Planholder or the Planholder’s spouse/dependent(s) become regular tobacco users.

8. What is the Tobacco Use Change Form?

The Tobacco Use Change Form is a form used to advise KEHP of any changes in Members’ tobacco use status that occur during the plan year. A Member refers to each person covered under a KEHP insurance plan including employees and retirees and their spouses and dependents.

9. What happens if I do not accurately declare the tobacco use for persons covered under my KEHP plan?

KEHP Planholders who do not accurately declare the tobacco use for persons covered under the Planholder’s insurance plan will be required to pay the difference between the tobacco-user and the non-tobacco-user premium contribution rates on a retroactive basis for the period during which the

Planholder falsely certified eligibility for the non-tobacco-user monthly discounted premium contribution rates.

10. How can I get help to quit using tobacco?

KEHP has programs available to help you quit using tobacco such as the Kentucky Tobacco Quit line. Through these programs, KEHP Members can get over-the-counter Nicotine Replacement Therapy, without any cost for the life of the program. After the program is complete, KEHP Members can continue to receive over-the-counter Nicotine Replacement Therapy without any cost if prescribed by a physician. KEHP also offers a coaching program that will assist the Member with designing a personal plan to decrease dependency on tobacco products and manage withdrawal and cravings that accompany tobacco use cessation.

11. What are the alternative standards available for those who are unable to meet the non-tobacco use standard?

Members who request a reasonable alternative standard must complete the Go365® Health Assessment and enroll in a Coaching program. Through Coaching, the Member is assigned a “coach” that will assist the Member with designing a personal plan to decrease dependency on tobacco products and manage withdrawal and cravings that accompany tobacco use cessation. The coach will support the Member as they go through the steps of ceasing to use tobacco. When the Member completes their Go365® Health Assessment, the Member will be given a goal and will have access to the Coaching program.

Members who are unable to satisfy or have completed the Health Assessment and Health Coaching alternative standard will be required to enroll in either the Cooper-Clayton smoking cessation program or the Kentucky Tobacco Quit Line program.

Members who are unable to satisfy the Freedom From Smoking or Kentucky’s Tobacco Quit Line alternatives must contact DEI for other reasonable alternatives such as the assignment of a personal nurse for support, advice, and information regarding smoking cessation.

To the extent feasible and to the extent the Member’s physician has joined in the request for a reasonable alternative standard, KEHP will provide the Member an opportunity to comply with the recommendations of the Member’s personal physician as a reasonable alternative standard to meeting the non-tobacco use standard. In any event, each Member seeking a reasonable alternative standard must complete the Go365® Health Assessment. KEHP will work with you (and, if you wish, with your doctor) to find a wellness program with the same monthly reward that is right for you in light of your health status.

KHRIS ESS – Online Enrollment/Employee Self-Service

1. How do I enroll through KHRIS ESS?

If you are an active employee, a TRS retiree, or a KCTCS retiree, you can go to openenrollment.ky.gov to login and enroll for benefits.

2. What is my KHRIS User ID?

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Your KHRIS User ID is a six-character identification provided to you in the KEHP Open Enrollment packet you should receive in late September. If you do not know your KHRIS ID, you can retrieve it by clicking “Forgot KHRIS User ID?” on the KHRIS login page.

3. How do I find my password?

You can go to khris.ky.gov and follow these steps:

- Click the “Forgot/Reset Password or New User” link.
- Enter your KHRIS User ID and click “Validate.” For security purposes, you must provide the following information: Last Name, Zip Code, Date of Birth, and Social Security Number. Click “Authenticate.” If your information has been validated, a temporary password displays. Write this down or copy it.
- Click “Exit.” Back at the main page khris.ky.gov, type your KHRIS User ID and temporary password.
- Click “Log On.” You will now be prompted to change the temporary password. Type your temporary password created above, create a new password, and confirm your new password by typing it again. Click “Change.”

4. I’m having trouble with KHRIS ESS after I have logged into the site, what do I need to do?

You can review the KHRIS Technical Requirements and make any necessary changes. Keep in mind these tips for accessing the Open Enrollment portion of KHRIS ESS:

- Best viewed with Microsoft Internet Explorer version 7+
- Not recommended for MAC systems or mobile devices (iPads, tablets, etc.)
- Disable all pop-up blockers
- Screen resolution below 1280x960 may cause some items to not fit on the screen
- Install the most recent version of Adobe Reader to correctly view/display forms

KEHP Health and Wellness Programs

1. What is KEHP’s health and wellness program?

LivingWell is KEHP’s voluntary wellness program available to all KEHP members. The program is administered according to federal rules permitting employer-sponsored wellness programs that seek to improve employee health or prevent disease. Those federal rules include the Americans with Disabilities Act of 1990, the Genetic Information Nondiscrimination Act of 2008, and the Health Insurance Portability and Accountability Act, as applicable, among others. If you choose to participate in the wellness program you will be asked to complete a voluntary health assessment or “HA” that asks a series of questions about your health-related activities and behaviors and whether you have or had certain medical conditions (e.g., cancer, diabetes, or heart disease). In lieu of completing an HA, you may complete a biometric screening, which will include a blood test to check your cholesterol and blood glucose levels. You are not required to complete the HA or to participate in the biometric screening or any other medical examination. However, employees who choose to participate in the LivingWell wellness program will receive an incentive in the form of a discounted employee premium contributions for their health insurance coverage. Although you are not required to complete the HA or participate in the biometric screening, only employees who do so will receive the discounted health insurance premiums.

Additional incentives in the form of gift cards, consumer goods, and other prizes may be available for employees who participate in certain health-related activities such as participating in walking challenges or quitting smoking. In addition, KEHP offers discounted monthly employee premium contribution rates to non-tobacco users. Each KEHP member has at least one opportunity per Plan Year to qualify for the monthly premium contribution discount.

KEHP is committed to helping you achieve your best health. Incentives for participating in KEHP's LivingWell wellness program are available to all employees and KEHP members. If you are unable to participate in any of the health-related activities or you think you might be unable to meet a standard to earn an incentive under the LivingWell wellness program, you may request a reasonable accommodation or an alternative standard. Contact the Department of Employee Insurance, Member Services Branch at (888) 581-8834 or (502) 564-6534 and we will work with you (and, if you wish, with your doctor) to find a wellness program with the same incentive that is right for you in light of your health status.

2. How is the information gathered through the wellness program used?

The KEHP is required by law to maintain the privacy and security of your personally identifiable health information. The KEHP does not collect or retain personal health or medical information through its LivingWell wellness program; however, the KEHP may receive and use aggregate information that does not identify any individual in order to design programs based on identified health risks in the workplace and that are aimed at improving the health of KEHP members. The KEHP will never disclose any of your personal information either publicly or to your employer, except as necessary to respond to a request from you for a reasonable accommodation needed to participate in the wellness program, or as expressly permitted by law. Medical information that personally identifies you that is provided in connection with the wellness program will not be provided to your supervisors or managers and may never be used to make decisions regarding your employment.

Your health information will not be sold, exchanged, transferred, or otherwise disclosed except to the extent permitted by law to carry out specific activities related to the wellness program, and you will not be asked or required to waive the confidentiality of your health information as a condition of participating in the wellness program or receiving an incentive. Anyone who receives your information for purposes of providing you services as part of the wellness program will abide by the same confidentiality requirements. The only individuals who may receive your personally identifiable health information are persons employed by Go365 (KEHP's wellness administrator) and Anthem (KEHP's third-party medical administrator). This may include nurses in Anthem's disease management program and health coaches in Go365's health coaching program. Disclosure of your personally identifiable health information to these persons is necessary in order to provide you with services under the wellness program.

In addition, all medical information obtained through the wellness program will be maintained separate from your personnel records, information stored electronically will be encrypted, and no information you provide as part of the wellness program will be used in making any employment decision. Appropriate precautions will be taken to avoid any data breach, and in the event a data breach occurs involving information you provide in connection with the wellness program, we will notify you immediately upon discovery of the breach.

You may not be discriminated against in employment because of the medical information you provide as part of participating in the LivingWell wellness program, nor may you be subjected to retaliation if you choose not to participate.

3. What is HumanaVitality®

Go365® is KEHP’s incentivized wellness program that allows you to earn points for rewards such as movie tickets, hotel stays, sports equipment and other items. Go to LivingWell.ky.gov for more details.

Affordable Care Act, Preventive Care and Other Questions

1. What is the “Marketplace”?

In an effort to give individuals access to affordable, comprehensive health insurance coverage, the ACA established the Health Benefit Exchange or the “Marketplace.” The Marketplace offers one-stop-shopping for health insurance coverage. Through the Marketplace, individuals can shop, compare, and apply for coverage. They can also apply for premium tax credits that can be used to reduce the cost of coverage.

2. How can I find out more information about the Marketplace?

You can learn more about the Marketplace by reviewing the Marketplace notice at kehp.ky.gov under “Legal Notices.” You can also Healthcare.gov for more information.

3. Will employees eligible for coverage through KEHP be eligible for premium tax credits through the Marketplace?

No. If an employee has an offer of health coverage from their employer that meets certain affordability and minimum value standards, the employee will not be eligible for a tax credit through the Marketplace. KEHP will ensure that plan(s) available for participating groups will meet the affordability and the minimum value tests. It is likely that not all plans offered through KEHP will meet the test for every employee, but at least one plan that meets both tests will be available for every employee. No employer action is required to ensure the coverage offered through KEHP meets the affordability and minimum value tests, provided the employer does not make any changes to the employer or employee contributions established by KEHP. If an employer group participating in KEHP offers employer or employee contributions different than those established by KEHP, the employer will need to conduct its own analysis to determine if the minimum essential coverage is affordable.

4. Can I waive health insurance and buy coverage from the Marketplace?

Yes. However, if an employee has an offer of health coverage through KEHP from their employer, the employee will not be eligible for a tax credit through the Marketplace. Also, the employer premium contribution as well as the employee’s premium contribution is excluded from income for Federal and State income tax purposes. Payments for coverage through the Marketplace are made on an after-tax basis.

5. What is preventive care and what is covered under the preventive care benefits?

Preventive care helps you stay healthy - it includes annual exams for children and adults, immunizations, and screenings such as mammograms and colonoscopies. In 2015, all four KEHP health plan options will provide members with extensive preventive care benefits.

Coverage for children's preventive health services will include autism screening, blood pressure screening, developmental screening, hearing and vision screening, immunization vaccines, and many other tests and screenings. For women, preventive services will include contraception, breastfeeding supplies and counseling, well-woman visits, breast cancer mammography screening, and many other tests, counseling, and screening services. For adults, preventive services include cholesterol screening, diabetes screening, depression screening, immunizations, obesity screening, diet counseling, and many other tests and preventive services. For a full listing of preventive services covered under the KEHP plans in 2017, please go to kehpcy.gov.

6. Will I have to pay a co-payment, co-insurance, or deductible for preventive care?

No, in 2017, preventive care will be paid for under all four KEHP health plan options without any member cost sharing. That means KEHP members will be able to get preventive care without paying a co-payment, co-insurance, or a deductible for those services. To take advantage of the preventive care without cost-sharing, in-network providers must provide the preventive services.