

**Commonwealth of Kentucky**  
**Personnel Cabinet**  
**Department of Employee Insurance**

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**Administration Manual**  
**Revised January 2016**

*This Administration Manual will be updated quarterly as needed.*

*Refer to the* KHRIS [Benefits Administration User Guide](#) and the KHRIS [Benefits Accounting User Guide](#) for assistance in KHRIS.

**Personnel Cabinet  
Department of Employee Insurance (DEI)  
Kentucky Employees' Health Plan (KEHP)  
501 High Street, 2<sup>nd</sup> Floor  
Frankfort, KY 40601  
kehp.ky.gov**

**COMMISSIONER'S OFFICE**

(502) 564-0358  
(502) 564-5278 (Fax)



**KEHP's Wellness Program**

Access a variety of wellness services through the  
Living Well Website at [LivingWell.ky.gov](http://LivingWell.ky.gov)

**DIVISION OF INSURANCE ADMINISTRATION**

**Enrollment Information Branch**

(888) 581-8834 (option 2)  
(502) 564-1205  
(502) 564-1085 Fax

**Member Services Branch**

(888) 581-8834 (option 1)  
(502) 564-6534  
(502) 564-5278 Fax

**DIVISION OF FINANCIAL AND DATA SERVICES**

**Data Analysis Branch**

(502) 564-7101  
(502) 564-0715 Fax

**Financial Management Branch**

(502) 564-9097  
(502) 564-0715 Fax

**Premium Billing Branch**

(502) 564-9097  
(502) 564-0364 Fax

*The Department of Employee Insurance does not administer Life Insurance benefits; however, the Kentucky Human Resource Information System (KHRIS) combines Life Insurance and Health Insurance information; therefore, the contact information for the Life Insurance Branch is listed below:*

Personnel Cabinet

Office of Employee Relations, Life Insurance Branch - (502) 564-4774 or (800) 267-8352

*Any person who knowingly and with intent to defraud any insurance company or other person who files an application for insurance containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime. This includes adding a Dependent to the Plan who does not meet KEHP eligibility rules forging a signature, or using an incorrect signature date.*

# INTRODUCTION to the KENTUCKY EMPLOYEES' HEALTH PLAN (KEHP)

KEHP, a self-insured plan with benefits designed in-house, partners with multiple vendors to provide benefit administration and customer service.

## KEHP Vendors

- **Medical:** Anthem Blue Cross Blue Shield (Anthem) has operated in Kentucky for more than 75 years and is the largest insurance carrier in the Commonwealth. We are excited to work with this new partner, who will offer an even bigger network of providers, excellent service and technology, and opportunities to help hold down costs.



844-402-KEHP (5347)

- **Pharmacy:** The CVS caremark network includes more than 67,000 pharmacies nationwide, including chain pharmacies and 20,000 independent pharmacies. It is important to know that you do not have to use a CVS pharmacy and may continue to use your existing retail, grocery store, independent pharmacy, etc.



866-601-6934

- **FSA/HRA/COBRA:** WageWorks is a leader in administering Flexible Spending Accounts (FSA) and Health Reimbursement Arrangements (HRAs). WageWorks is solely dedicated to administering pre-tax spending accounts which empower employees to save money on taxes. They also provide COBRA administration services. WageWorks cares about people and wants to empower everyone—employers, employees, and their families—to lead healthier, happier, and more productive lives. They make benefits programs easier to understand and use so that everyone can take advantage of pre-tax savings and focus on what matters most. They currently work with more than 29,000 employers to help more than 3.2 million people save money.



877-430-5519

- **Vitals SmartShopper** (formerly Compass SmartShopper) is KEHP's transparency vendor. It's an innovative program that uses financial incentives to motivate and redirect members to lower-cost, high-quality provider locations.



855-869-2133

- **Humana Vitality<sup>SM</sup>** is a rewards-based wellness program designed to empower Members of KEHP to live healthier lives.



855-478-1623

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# CHAPTER 1:

# ELIGIBILITY

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## 1. Eligible Participants

For the purposes of this manual, the term “Employee” includes regularly employed Employees, classified or certified school Employees, elected member of a local board of education, and employees determined by an active employer to be eligible for coverage under the Affordable Care Act. This manual also includes information regarding Retirees and/or their beneficiaries as well as COBRA qualified beneficiaries who participate or are eligible to participate in KEHP. Employees, Retirees and COBRA participants and/or their Dependents may only be covered under one state-sponsored plan.

**A. Regularly Employed Employees:** Employees of the following agencies who contribute to one of the state-sponsored retirement systems, or who are otherwise defined in **KRS 18A.225**, are eligible to participate:

- State Agencies
- Boards of Education
- Health Departments
- Quasi Agencies

**B. Elected School Board Employees:** Participate on a post-tax basis; the elected official is not eligible for the employer contribution and is responsible for the total premium.

**C. Retirees:** Under the age of 65, or 65 or older and not eligible for Medicare, who draw a monthly retirement check from any of the following systems, are eligible to participate according to Plan guidelines:

- Judicial Retirement Plan (JRP)
- Legislators Retirement Plan (LRP)
- Kentucky Community and Technical College Retirement System (KCTCS)
- Kentucky Teachers’ Retirement System (KTRS)
- Kentucky Retirement Systems (KRS) which include:
  - County Employees Retirement System (CERS)
  - Kentucky Employees Retirement System (KERS)
  - State Police Retirement System (SPRS)

**NOTE:** Retirees who are Medicare eligible and **actively** employed with a KEHP participating employer must contact their retirement system.

**D. COBRA Qualified Beneficiaries:** Employees and/or eligible Dependents who elect COBRA coverage through KEHP.

**E. Dependents:** The following Dependents are eligible for participation through KEHP:

- An Employee or Retiree’s Spouse
- An Employee or Retiree’s child under the age of 26

**NOTE:** When adding dependents to KEHP, Social Security numbers must be provided to fulfill state and federal reporting requirements.

**F. Disabled Dependents:** 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 26<sup>th</sup> 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 26<sup>th</sup> 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.

**G. Members with End Stage Renal Disease (ESRD):** KEHP Members who are diagnosed with ESRD remain eligible for KEHP coverage but should apply for and enroll in Medicare. KEHP coverage will be primary for the first 30 months after the member becomes entitled to Medicare due to ESRD. After the first 30 months, KEHP coverage may continue but Medicare will pay primary. This rule applies whether or not the Member has reached age 65.

**H. Spouses of Active Employees Who Later Gain Planholder Eligibility:** Spouses of active Employees who are covered under KEHP, who later gain eligibility to become a Planholder may:

- remain covered under their Spouse's plan (couple or family); waive Health Insurance and elect either the Waiver General Purpose HRA or the Waiver Dental/Vision ONLY HRA through the active employer with KEHP; or
- begin a Cross-Reference Payment Option with their Spouse, if they have Dependent coverage; or
- drop Health Insurance under their Spouse's KEHP and elect Health Insurance coverage of their own with KEHP.

**I. Superintendent with Working Spouse:**

Superintendents whose contract specifies that the school district is paying 100% of KEHP premiums (employer and employee contributions), and whose working Spouse becomes eligible to participate in KEHP with an active employer, may continue to cover their working Spouse as a Dependent in KEHP. The Spouse may waive Health Insurance with his/her active employer and elect to receive either the Waiver General Purpose HRA or the Waiver Dental/Vision ONLY HRA through the active employer with KEHP.

**J. Active Employees and Dependent Spouses Age 65 or Older:**

- An **active Employee** age 65 or older and eligible for Medicare is eligible for coverage with KEHP through the active employer.

- A **Dependent Spouse** age 65 or older and eligible for Medicare is eligible for coverage with KEHP through the active employer.

NOTE: For more information on Return to work retirees from a Kentucky state sponsored retirement system, review Section 3 of this Chapter.

A Medicare eligible active Employee is treated like any other regularly employed Employee and may elect coverage or elect the Waiver General Purpose HRA, provided an attestation is received, in writing, that he/she has other group health plan coverage. Medicare is not considered other health plan coverage. The Medicare eligible active Employee may elect the Waiver Dental/Vision ONLY HRA with KEHP without an attestation as to other group health plan coverage. **NOTE:** The Insurance Coordinator for the active employer must give an active Employee nearing the age of 65 or an Employee age 65 or older, the notice of KEHP options, upon becoming eligible for Medicare by sending the Employee a copy of the Notice to Active Employees 65 or Older (Appendix A).

#### **K. Employees Eligible for Coverage under the Affordable Care Act:**

The Affordable Care Act requires all active employers with more than 50 full-time employees to offer insurance coverage to its full-time employees and, at a minimum, to the Employee's child dependents. A full-time employee, for the purposes of determining eligibility for health coverage under the ACA only, is an employee who is employed on average at least 30 hours of service per week. Each active employer is responsible for determining if an Employee is eligible for coverage under the ACA. If so, the active employer is responsible for offering such coverage to the Employee. The Employer must notify KEHP of an employee's effective date of starting and terminating health insurance coverage.

Dependent Eligibility Chart - **Dependent eligibility rules and verification requirements are contained in the following chart. Dependent verification for Qualifying Events must be submitted with the Qualifying Event documents. Qualifying Event documents must be signed within the event timeframe.**

NOTE: When adding dependents to KEHP, Social Security numbers must be provided to fulfill state and federal reporting requirements.

## 2. Dependent Eligibility Chart

Definition of Eligible Dependent(s)	Documentation
<p><b><u>Spouse</u></b> A person who is legally married to an Employee or Retiree.</p>	<p>A legible photocopy of the marriage certificate or a legible photocopy of the top half of the front page of the Employee/Retiree's most recent federal tax return (Form 1040)</p>
<p><b><u>Common Law Spouse</u></b> A person with whom you have established a common law union in a state which recognizes common law marriage (Kentucky does not recognize common law marriage).</p>	<p>A legible photocopy of the certificate or affidavit of common law marriage from a state that does recognize common law marriage.</p>
<p><b><u>Child Age 0 to 25</u></b> In the case of a child who has not yet attained his/her 26<sup>th</sup> birthday, "child" means an individual who is –</p> <ul style="list-style-type: none"> <li>• A son, daughter, stepson, or stepdaughter of the Employee/Retiree, or</li> <li>• An eligible foster child of the Employee/Retiree (eligible foster child means an individual who is placed with the Employee/Retiree by an authorized placement agency or by judgment, decree, or other order of any court of competent jurisdiction and includes court awards of guardianship or custody), or</li> <li>• An adopted child of the Employee/Retiree (a legally adopted individual of the Employee/Retiree, or an individual who is lawfully placed with the Employee/Retiree for legal adoption by the Employee/Retiree).</li> </ul>	<p><b><u>Natural Child:</u></b> A legible photocopy of the child's birth certificate showing the name of the Employee/Retiree as a parent, or a copy of the footprint certificate from the hospital indicating baby and parent's name.</p> <p><b><u>Step Child:</u></b> A legible photocopy of the child's birth certificate showing the name of the Employee/Retiree's Spouse as a parent; and a legible copy of the marriage certificate showing the names of the Employee/Retiree and the Spouse.</p> <p><b><u>Legal Guardian, Adoption, or Foster Child(ren):</u></b> Legible photocopies of court orders, guardianship documents, or affidavits of dependency, with the presiding judge's signature and filed status; or legible adoption or legal placement decrees with the presiding judge's signature.</p>
<p><b><u>Disabled Dependent</u></b> 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 26<sup>th</sup> 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.</p> <p>A Dependent child who is not already covered by KEHP at the time of his/her 26<sup>th</sup> 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.</p>	<p>Anthem certifies all disabled dependents based on medical necessity and member's financial responsibility for the dependent. Contact the Enrollment Information Branch at 502-564-1205 for more information. Dependent under age 26 will be enrolled by EIB as a disabled dependent and Anthem will initiate disabled dependent certification process. Dependent over age 26, EIB receives request from member based on loss of other insurance coverage and requests Anthem to initiate disabled dependent certification process.</p>

### 3. Retirees

When Retirees reach age 65, they should receive a letter stating whether or not they are Medicare eligible.

Retirees who have not returned to active employment, and who become eligible for Medicare are no longer eligible participants in KEHP (See KRS 18A.225), EXCEPT in cases of End Stage Renal Disease (See paragraph 1.G). The retirement system must send a termination notice to KEHP terminating the Retiree due to Medicare eligibility. If the Medicare letter states that the Retiree does not qualify for Medicare, the retirement system must submit the letter to KEHP to show that the Retiree is still qualified to remain on the Plan.

Insurance Coordinators should refer each “return-to-work” Retiree who is Medicare-eligible and participating in a KRS, KTRS or Judicial/Legislative Retirement system to the appropriate retirement system.

#### A. Retirees Who Return-to-Work (RTW)

##### 1. General Rules for RTW Retirees:

For the purposes of this section of the Administration Manual:

- A “retiree” is a present recipient of a retirement allowance from one of the retirement plans administered by the Kentucky Retirement Systems (KRS) or the Kentucky Teachers’ Retirement System (KTRS).
- A “RTW Retiree” is a retiree who resumes active employment with an employer participating in the KEHP.

All RTW Retirees are entitled to KEHP health insurance coverage through their active employer. An employer may not deny a RTW Retiree KEHP coverage.

All RTW Retirees are required to contact their retirement system before they begin active employment.

##### 2. Health Insurance Coverage Options for RTW Retirees:

- In some situations, a RTW Retiree is **required** to take KEHP health insurance coverage rather than benefits offered through the retiree’s retirement system.
- In some situations, a RTW Retiree **may have a choice** to receive KEHP health insurance coverage through the active employer or through the retirement system.
- The **age** of the RTW Retiree is an important factor in determining health insurance coverage options available to the RTW Retiree. (i.e. Medicare eligibility at age 65).
- KRS and KTRS sometimes have different rules and requirements regarding health insurance coverage for RTW Retirees.

##### 3. KTRS RTW Retirees:

- KTRS RTW Retiree health insurance coverage rules:
  - apply to all retirees at any age (over and under age 65);
  - apply if the RTW Retiree is “regularly employed” and eligible for health insurance with the active employer; and
  - apply whether the retiree is covered by KEHP or by a KTRS plan that supplements Medicare coverage.
- General Rules for KTRS RTW Retirees:
  - If you are a RTW Retiree who is employed by an agency that participates in the KEHP and you are eligible for health insurance, you must terminate coverage through KTRS;
  - If you are a RTW Retiree who is employed by an agency that does not participate in the KEHP, but you are eligible for health insurance through that employment, you must

terminate KTRS coverage unless that coverage is not as good as KTRS coverage. The RTW Retiree may be asked to certify this information;

- Once a RTW Retiree terminates employment or loses eligibility for insurance through the active employer, the retiree must contact KTRS within the qualifying event period (usually 30 days) to re-enroll and provide the required documentation; and
- A RTW Retiree is not eligible for a contribution for health insurance from the active employer and a contribution from the retirement system. [See, KRS 18A.225(12)].
- KTRS Health Insurance Coverage Options:
  - The RTW Retiree must waive coverage through KTRS (either KEHP coverage or coverage that supplements Medicare) if the RTW Retiree is eligible for the KEHP coverage through the active employer.
  - The RTW Retiree may enroll in the KEHP through the active employer.
  - The RTW Retiree may elect to participate in a Healthcare or Dependent Care FSA through the active employer.
  - If the RTW Retiree does not want KEHP health insurance coverage through the active employer because they have other health insurance coverage (i.e. through a spouse's employer):
    - The RTW Retiree may waive coverage through the active employer and enroll in the Waiver General Purpose HRA if the RTW Retiree provides an attestation that he/she has other group health insurance coverage. The other group health insurance coverage cannot be Medicare.
    - The RTW Retiree may waive coverage through the active employer and enroll in the Waiver Dental/Vision Only HRA or no HRA.
    - Note: The active employer must participate in the employer-funded waiver HRA program for the RTW Retiree to choose either the Waiver General Purpose HRA or the Waiver Dental/Vision Only HRA.

#### **4. KRS RTW Retirees:**

- KRS RTW Retiree health insurance coverage rules:
  - are different depending on whether the RTW Retiree is over or under age 65 or Medicare-eligible or not Medicare eligible;
  - apply if the RTW Retiree is “regularly employed” and eligible for health insurance with the active employer; and
  - apply whether the retiree is covered by KEHP or by a KRS plan that supplements Medicare coverage.
- KRS RTW Retiree Under Age 65 and/or not Medicare Eligible:
  - is not eligible for a contribution for health insurance from the active employer and a contribution from the retirement system. [See, KRS 18A.225(12)];
  - may remain in KEHP through KRS and waive KEHP coverage through the active employer without an HRA if the RTW Retiree has a KRS participation date before September 1, 2008;
  - is not eligible to elect KEHP coverage through KRS and must enroll in KEHP coverage through the active employer if the RTW Retiree has a KRS participation date on or after September 1, 2008.

- Note: If the RTW Retiree selects KEHP coverage through KRS, the active employer must reimburse KRS for the contribution made for single coverage health insurance for the RTW Retiree. [KRS 61.637(17)(d)4];
- may elect to participate in a Healthcare or Dependent Care FSA through the active employer.
- If the RTW Retiree does not want KEHP health insurance coverage through KRS or the active employer because they have other health insurance coverage (i.e. through a spouse's employer):
  - The RTW Retiree may waive KEHP coverage through the active employer and enroll in the Waiver General Purpose HRA if the RTW Retiree provides an attestation that he/she has other "group" health insurance coverage. The other group health insurance coverage cannot be Medicare.
  - The RTW Retiree may waive KEHP coverage through the active employer and enroll in the Waiver Dental/Vision Only HRA or no HRA.
  - Note: The active employer must participate in the employer-funded waiver HRA program for the RTW Retiree to choose either the Waiver General Purpose HRA or the Waiver Dental/Vision Only HRA)
- KRS RTW Retiree Over Age 65 and/or Medicare Eligible:
  - is not eligible to participate in coverage provided by KRS that supplements the employee's Medicare coverage.
  - must terminate enrollment in the KRS supplemental Medicare plan. In some rare situations where the active employer has fewer than 20 employees, a RTW Retiree who is Medicare eligible may be able to retain their supplemental coverage through KRS rather than enrolling in KEHP. The RTW Retiree should ask KRS for more information about this exception.
  - may enroll in KEHP health insurance coverage through the active employer.
  - may elect to participate in a Healthcare or Dependent Care FSA through the active employer.
  - If the RTW Retiree does not want KEHP health insurance coverage through the active employer because they have other health insurance coverage (i.e. through a spouse's employer):
    - The RTW Retiree may waive KEHP coverage through the active employer and enroll in the Waiver General Purpose HRA if the RTW Retiree provides an attestation that he/she has other "group" health insurance coverage. The other group health insurance coverage cannot be Medicare.
    - The RTW Retiree may waive KEHP coverage through the active employer and enroll in the Waiver Dental/Vision Only HRA or no HRA.
    - Note: The active employer must participate in the employer-funded waiver HRA program for the RTW Retiree to choose either the Waiver General Purpose HRA or the Waiver Dental/Vision Only HRA)

**B. Deceased and Medicare Eligible Retiree's Beneficiary** The individual designated by the Retiree as his or her Retiree health beneficiary, and filed with the retirement system:

- may apply to enroll in KEHP when experiencing a Qualifying Event that allows the beneficiary to enroll (such as loss of other coverage) or during Open Enrollment.

- may “take over” the plan, and become the Planholder, if the Retiree’s beneficiary is a Dependent/Spouse on the plan. Coverage must be elected within 35 days of the loss of coverage. (KTRS does not permit Dependent children to “take over” the Plan).
- must contact the retirement system within 35 days of the death of the Retiree. (If a Retiree’s beneficiary is not a current Spouse or Dependent on the plan, the retirement system will determine eligibility dates). In this case, the death of the Retiree by itself may not be a Qualifying Event that would allow the beneficiary to enroll in the plan.

**NOTE:** Eligibility determinations for Retirees and their families are made by the respective Retirement System.

### C. Spouses of Retirees

A Spouse of a Hazardous Duty Retiree who is covered under the Retiree’s plan AND who is actively employed is not eligible to waive Health Insurance coverage and receive the employer contribution into a Waiver HRA (commonly referred to as double-dipping) due to KRS 18A.225 (12) which reads:

*Any Employee who is eligible for and elects to participate in the state Health Insurance program as a Retiree, or the Spouse or beneficiary of a Retiree, under any one (1) of the state-sponsored retirement systems shall not be eligible to receive the state Health Insurance contribution toward health care coverage as a result of any other employment for which there is a public employer contribution. This does not preclude a Retiree and an active Employee Spouse from using both contributions to the extent needed for purchase of one (1) state sponsored Health Insurance policy for that Plan Year. (Emphasis added).*

**NOTE:** The Kentucky Retirement System (KRS) does not pay for dependent coverage, except for hazardous duty retirees. Therefore, the spouse can elect the Waiver General Purpose HRA provided an attestation is received, in writing, that he/she has other group health insurance.

## 5. Eligibility for the Employer Contribution

### A. Agencies Covered Under KRS 18A and Technical Schools

- After the initial new hire waiting period, Employees are eligible for the employer contribution for the current Semi-Monthly Billing Period if during the previous Semi-Monthly Billing Period, they:
  - worked any part of the prior Semi-Monthly Billing Period;
  - were on paid leave, other than holiday or educational leave ; and/or
  - used Family Medical Leave.
- Employees returning from leave without pay (LWOP) must work at least one day in the previous Semi-Monthly Billing Period to qualify for the employer contribution for the current Semi-Monthly Billing Period.
- Coverage for Employees who do not meet the requirements to receive an employer contribution must be terminated and the Employee must be offered COBRA continuation coverage. The COBRA notice will be triggered via file based on termination date in KHRIS.

**NOTE:** Semi-Monthly Billing Period is defined as follows – first day of the month through the fifteenth day of the month and the sixteenth through the last day of the month, regardless of the Employee’s pay and/or work schedule.

## **B. Agencies NOT Covered Under KRS 18A**

- After the initial new hire waiting period, Employees are eligible for the employer contribution for the current Semi-Monthly Billing Period if during that Semi-Monthly Billing Period, they:
  - worked any part of the Semi-Monthly Billing Period;
  - were on paid leave; and/or
  - used Family Medical Leave.
- Employees returning from leave without pay (LWOP) must work at least one day in the Semi-Monthly Billing Period to qualify for the employer contribution for that Semi-Monthly Billing Period.
- Coverage for Employees who do not meet the requirements to receive an employer contribution must be terminated and the Employee must be offered COBRA continuation coverage. The COBRA notice will be triggered via file based on termination date in KHRIS.

**NOTE:** Semi-Monthly Billing Period is defined as follows – first day of the month through the fifteenth day of the month and the sixteenth through the last day of the month, regardless of the employee’s pay and/or work schedule.

## **C. Quasi-Governmental Agencies**

Insurance Coordinators for quasi-governmental agencies should refer to their administrative regulations or internal policies for the definition of a regularly employed Employee entitled to employer contributions.

## **D. Dual Employment**

An Employee who is considered regularly employed for two participating employers (and meets the eligibility requirements for each employer) is eligible for the employer contribution from each employer. However, an Employee is only eligible to participate in one KEHP Health Insurance plan. Therefore, a dual Employee may enroll in a KEHP Health Insurance plan through one employer and waive KEHP coverage through the other employer and enroll in a Waiver HRA with both. In this case, the Employee must provide an attestation, in writing that the employee has other group health plan coverage to enroll in the Waiver General Purpose HRA.

## **6. Eligibility for Participation in the LivingWell CDHP or the LivingWell PPO Plan Option**

The LivingWell CDHP and the LivingWell PPO plan options require planholder(s) to agree to the LivingWell Promise in order to be eligible to elect either LivingWell plan options. The LivingWell Promise requirements may change each plan year. For plan year 2016, the LivingWell Promise is an agreement to take the HumanaVitality® Health Assessment **or** to complete a Vitality Check (biometric screening). In a Cross-Reference Payment Option, both Planholders must agree to the LivingWell Promise and fulfill the Promise. Each Planholder may choose either the Health Assessment or a biometric screening to fulfill the Promise.

### **A. Open Enrollment Election**

- The Planholder(s) must take the HumanaVitality® Health Assessment from January 1 through May 1, 2016; **or**
- The Planholder(s) must complete a Vitality Check (biometric screening) from January 1 through May 1, 2016.

### **B. Newly-Hired Employees**

- Newly-hired employees who are hired between January 1 and June 1, 2016 must take the HumanaVitality® Health Assessment or complete a Vitality Check within 90 days of their coverage effective date.
- Newly-hired employees who are hired on June 2, 2016 or later are encouraged but are not required to take the Health Assessment or complete a Vitality Check.

## **7. Eligibility for Waiver General Purpose HRA and Waiver Dental/Vision only HRA.**

Employees are only eligible for the Waiver General Purpose HRA if they 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 kynect or governmental plans such as TRICARE, Medicare, Medicaid, or VA healthcare benefits.

If an Employee elects the Waiver General Purpose HRA and they cease to remain covered under another group health plan they must notify KEHP within 35 days of the date that the other group health plan coverage ceased. In this event, coverage under the Waiver General Purpose HRA will be terminated and they may elect a KEHP health insurance plan option or the Waiver Dental/Vision Only HRA. Any funds remaining in a Waiver General Purpose HRA, or the Waiver Dental/Vision only HRA, after termination may be used to reimburse the employee for eligible expenses incurred prior to termination of the Waiver HRA. Upon termination of employment, the remaining amounts in a Waiver HRA are forfeited.



# CHAPTER 2:

# ENROLLMENT

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## 1. Initial Enrollment

### A. Regularly Employed Employees:

For new regularly employed Employees who are eligible for health insurance benefits at the time they are hired, coverage will begin on the first day of the second calendar month following the Employee's hire date. Example: if employment begins anytime in August, the Employee is eligible for coverage October 1.

New Employees may make their elections online in KHRIS ESS or they may complete an Enrollment Application within the first 35 calendar days of employment.

Employees who fail to make their Health Insurance elections or waive their coverage within the designated time frame will not be allowed to enroll until the next Open Enrollment period, unless an appropriate Qualifying Event occurs. **Employees who fail to enroll will automatically be enrolled in the Single Coverage Level of the Standard CDHP.**

**NOTE:** During the month of the Annual Open Enrollment period, Employees have 35 days from their date of hire to complete the new hire application to elect coverage for the current plan year and must also complete an Open Enrollment application for the next plan year.

### B. ACA Eligible Employees:

Federal law requires all large employers to offer minimum essential coverage to all of the employer's full-time employees and their dependents or be subject to penalties. A "large" employer is an employer that employs at least 50 full-time employees. A "full-time" employee is an employee who is employed on average at least 30 hours of service per week (or 130 hours of service per month). "Hours of service" includes: (1) each hour for which an employee is paid, or entitled to payment, for the performance of duties for the employer; and (2) each hour for which an employee is paid, or entitled to payment by the employer on account of a period of time during which no duties are performed due to vacation, holiday, illness, incapacity, layoff, jury duty, military duty, or leave of absence.

Employers are required to determine whether, based on federal law, there are employees who are otherwise non-eligible for benefits that would be eligible for benefits because they are full-time employees. Note, KRS 18A requires an employee to be "regularly employed" and contributing in a state-sponsored retirement system. The ACA full-time employee eligibility rule supersedes KRS 18A such that ACA Eligible Employees can receive health insurance benefits without having to contribute in a state-sponsored retirement system.

The ACA eligible Employee must be provided the opportunity to enroll in Health Insurance coverage. An ACA Eligible Employee who fails to enroll or waive coverage will be automatically enrolled in the Single Coverage Level of the Standard CDHP. The ACA Eligible Employee may also waive coverage with no benefits or, if the active employer participates, waive coverage and elect one of the Waiver HRAs. The ACA Eligible Employee must meet the eligibility requirements for the Waiver General Purpose HRA (See 2.A. below) to enroll in that HRA. The ACA Eligible Employee may also elect to participate in an FSA on a pretax basis (if the active employer participates).

ACA Eligible Employees should complete and submit a paper Enrollment Application to enroll in or waive Health Insurance coverage.

## 2. Waiving Health Insurance Benefits

Employees who do not wish to enroll in a Health Insurance plan with KEHP may be eligible to waive their Health Insurance benefits. KEHP offers the Waiver General Purpose HRA and the Waiver Dental/Vision ONLY HRA.

Both HRAs are funded with an employer contribution of \$175 per month, up to \$2100 per calendar year. Employees will receive funds into either HRA in two installments: January 1 with \$1,050 and July 1 with \$1,050. All remaining unspent HRA funds, at the end of the calendar year, will carry over to the next calendar year provided the Employee continues to waive Health Insurance coverage and enroll in the same Waiver HRA. Waiver General Purpose HRA funds will only carry over to a Waiver General Purpose HRA, and Waiver Dental/Vision ONLY HRA funds will only carry over to a Waiver Dental/Vision ONLY HRA.

Not all Employees are eligible to receive the HRA when coverage is waived. Refer to Chapter 7 and the applicable Summary Plan Description for more details. Employees may elect to waive Health Insurance coverage online in KHRIS ESS, or they may elect to waive Health Insurance on the Enrollment Application. Waiving coverage must be completed within the timeframe in “Initial Enrollment” above.

**A. Waiving Health Insurance and receiving the Waiver General Purpose HRA is only permitted**

- during the annual Open Enrollment period;
- for new Employees or ACA Eligible Employees;
- for Employees with an 11 or more working day break in service (in employment);
- for Employees who have other group health plan coverage that provides minimum value; and who attest, in writing, that they have other group health plan coverage;
- for Employees who experience a different Open Enrollment that occurs between KEHP’s Open Enrollment and December 31 (i.e. between mid-October and December 31)

**B. Waiving Health Insurance and receiving the Waiver Dental/Vision ONLY HRA is only permitted**

- during the annual Open Enrollment period;
- for new Employees or ACA Eligible Employees;
- for Employees with an 11 or more working day break in service (in employment);
- for Employees who experience a different Open Enrollment that occurs between KEHP’s Open Enrollment and December 31 (i.e. between mid-October and December 31);
- for Employees returning from Military Leave who are remaining on TRICARE; or

**C. Waiving Health Insurance – Employee Does Nothing**

Employees who fail to waive Health Insurance online in KHRIS ESS, or who fail to complete an Enrollment Application electing to waive Health Insurance (the Employee does nothing) will be defaulted automatically into a the Standard CDHP Plan Option with a Single Coverage Level. *Pay special attention to Open Enrollment materials, as this requirement may change from year to year.*

**D. Redirection of the Employer Contribution**

Redirection of the employer contribution is the ability to stop employer funds from being directed into either the Waiver General Purpose HRA or the Waiver Dental/Vision ONLY HRA, in order to start receiving an employer contribution toward a Health Insurance plan. **NOTE:** If an Employee experiences a Qualifying Event that permits the termination of Health Insurance, he/she may terminate Health Insurance, but may not enroll in the Waiver General Purpose HRA or the Waiver Dental/Vision ONLY HRA. This is merely a Qualifying Event that allows the termination of Health Insurance; no funds will be allocated to either Waiver HRA.

### 3. Open Enrollment

Open Enrollment is a period of time for Employees to make KEHP elections for the upcoming Plan Year, which runs from January 1 to December 31 each year. Open Enrollment requirements may vary during each Open Enrollment period. KEHP will provide specific Open Enrollment guidelines to all Employees during each period.

After Open Enrollment elections have been made, Employees may only change their elections under very specific circumstances. Such changes are regulated by federal law and are referred to as “permitted election changes” or Qualifying Events under the federal regulations. The requested change must always be consistent with the Qualifying Event.

All changes are permitted during Open Enrollment with the following exceptions: 1) Employees cannot drop Dependent children for whom they are required by an administrative order to provide coverage (if the enforcement of the order is directed to the employer), including National Medical Support Orders; 2) Employees cannot add a previously un-covered disabled Dependent (DD) who is over the age limit.

An ACA Eligible Employee who gains eligibility during the Plan Year and is added outside of Open Enrollment should make coverage elections or waive coverage during Open Enrollment for as long as the Employee is eligible to receive Health Insurance benefits.

### 4. Transition from Dependent Child to New Employee

Adult children who are regularly employed and benefits eligible with a participating KEHP employer are eligible to continue benefits under their parent’s KEHP plan up to their 26<sup>th</sup> birthday. Adult children are defined as children who are at least 19 years old, but not yet 26 years old. The newly hired Dependent child may enroll in his/her own plan with health insurance coverage, or he/she may waive health insurance coverage with an HRA and enroll as a Dependent under his/her parent’s plan. DEI will terminate the Dependent from the parent’s plan when an enrollment is received with the Dependent as a planholder. The termination date as a Dependent will be on the day prior to the Effective Date of the child’s coverage as an active Employee (Planholder). A dependent child is only eligible to participate in one KEHP Health Insurance Plan.

### 5. Reinstatement of an Employee

If an agency employer is ordered to “make the employee whole” upon reinstatement of an employee after a period of separation, there are guiding principles for how an agency may make the employee whole with respect to health insurance.

- A. If an employee did not procure other health insurance or incur any medical expenses during the separation period, the employee will be made whole by reinstating health insurance coverage through KEHP on a prospective basis.
- B. If the employee procured other health insurance during the employee’s separation period, the agency must reimburse the employee for any insurance premiums paid (such as premiums paid for COBRA coverage). Health insurance coverage through KEHP will be reinstated on a prospective basis.
- C. If the employee did not procure other health insurance but incurred medical expenses that would have been covered under KEHP, the agency must reimburse the employee for any substantiated medical expenses incurred during the separation period. Insurance through KEHP will be reinstated on a prospective basis.



In some instances, a court's or administrative agency's order may require specific relief upon reinstatement after an employee's period of separation. As each situation is unique, agencies are directed to consult with the Department of Employee Insurance regarding health insurance when preparing board order payments.

## **6. Newly-Hired Employees, Transfers, Rehires and Return-to-Work Retirees to a KEHP Participating Company**

New Employees are Employees newly hired by a company. They may or may not have worked for another KEHP participating company as of the business day prior to their hire date with your company. In order to determine the Effective Date of coverage with your company and whether or not newly-hired Employees are allowed to make changes to their KEHP elections, review the scenarios below.

### **A. Newly-Hired Employees With No Prior Employment with a KEHP Participating Company**

- The Effective Date of KEHP elections will be the first day of the second calendar month following the hire date. *Example:* if employment begins anytime in August, Employees are eligible for coverage October 1.
- The newly-hired Employee may enroll in KEHP or waive Health Insurance coverage and enroll in the Waiver General Purpose HRA, provided an attestation is received, in writing, that he/she has other group health plan coverage, or the Waiver Dental/Vision ONLY HRA, if eligible.

### **B. Newly-Hired Employees Who Are Transferring From Another KEHP Participating Company - WITHOUT a Break in Employment**

- The newly-hired transferring Employee will have a "clean" transfer.
- The Effective Date of KEHP elections is the first day of the Semi-Monthly Billing Period of the hire date with the new company. This will require your company to begin providing the employer contribution for the Semi-Monthly Billing Period in which the Employee was hired.

*Example:* Employment begins on August 1 and the Employee's last Working Day with the previous employer was July 31; the new company must provide coverage and the employer contribution for the month of August.

- Newly-hired transferring Employees who do not have a break in employment are NOT permitted to make new KEHP elections. The Insurance Coordinator must "hire-in" Employees in KHRIS with the transfer reason code, or submit an Update Form with the transfer information. In some instances, the newly-hired transferring Employee may terminate employment at one company at the end of a week (before a weekend) and begin employment with the new company at the beginning of the next work week (usually Monday), or during a holiday. Employees in this situation will not have a break in employment because weekends and/or holidays are not regularly scheduled Working Days.
- If the newly-hired transferring Employee transfers from an agency that does not participate in the KEHP FSA/HRA program, the newly-hired transferring Employee may elect to participate in an FSA/HRA with the new agency for the remainder of the calendar year. Employee contributions will begin in the next semi-monthly billing period in which the employee was transferred into the new agency.

**NOTE:** A Working Day is any period of time, on any given day that an Employee is required by his/her employer to work. A Working Day also includes any day the employee does not work, yet is eligible for paid leave such as holiday, compensatory, annual, and sick leave.

Employees whose “weekends” fall in the middle of the week rather than Saturday and Sunday will have their regularly scheduled days count as a weekend, and will not count as a break in employment. Please notify KEHP if this occurs, for appropriate adjustments.

**C. Newly Hired Employees Who Are Transferring From Another KEHP Participating Company – WITH a Break in Employment**

**1. Break in service of 1 to 10 working days:**

- A small break transfer.
- May experience a half month break in KEHP coverage elections.
  - If the 1 to 10 day break occurs in the same Semi-Monthly Billing Period there is no break in coverage.
  - If the 1 to 10 day break occurs within different Semi-Monthly Billing Period, there is a ½ month break in coverage.
- If the newly-hired transferring Employee transfers from an agency that does not participate in the KEHP FSA/HRA program, the newly-hired transferring Employee may elect to participate in an FSA/HRA with the new agency for the remainder of the calendar year. Employee contributions will begin in the next semi-monthly billing period in which the employee was transferred into the new agency.
- Employees with a small break transfer are not allowed to make new KEHP coverage elections. These Employees will be allowed to make new coverage elections only if they experienced a Qualifying Event (all Qualifying Event guidelines apply) or if an Open Enrollment period coincides with the break in employment. If this is the case, the Employees must follow Open Enrollment guidelines and submit an Enrollment Application.

*Example 1:* No Break in Coverage: Employee stops working at old company 7/19, Health Insurance stops on 7/31. The Employee is hired by a new company on 7/24, with Health Insurance beginning on 8/1. This Employee does not experience a break in coverage.

*Example 2:* Half Month Break in Coverage: Employee stops working at old company 8/10, Health Insurance stops on 8/15. The Employee is hired by a new company on 8/18, with Health Insurance beginning on 9/1. This Employee will have a ½ month break in coverage (from 8/15 to 8/31).

**2. Break in employment of 11 or more working days:**

- Considered new Employees and are treated as such for enrollment and eligibility.
- The Effective Date of their Health Insurance elections is the first day of the second calendar month following their hire date. *Example:* If employment begins anytime in August, the Employees are eligible for coverage October 1.
- As new Employees they are allowed to enroll in any available Plan Option, waive Health Insurance coverage and enroll in the Waiver General Purpose HRA Waiver General Purpose HRA, provided an attestation is received, in writing, that they have other group health plan coverage,

or the Waiver Dental/Vision ONLY HRA, if eligible, make changes to tobacco status if needed (all enrollment procedures, deadlines and restrictions apply).

*Example:* Employee stops working at old company 2/10, Health Insurance stops on 2/15. The Employee is hired by a new company on 2/22, with Health Insurance beginning on 4/1. The Employee will have a 1 ½ month break in coverage. However, with the new company, the Employee is allowed to make new KEHP elections as well as change his/her tobacco status, if needed.

**NOTE: When there is a break in the Employee's employment of 11 or more working days, the Employee is treated as a new Employee. As a new Employee, if the Employee fails to waive Health Insurance online in KHRIS ESS, or fails to complete an Enrollment Application electing to waive Health Insurance (the Employee does nothing) the Employee will be defaulted automatically into a the Standard CDHP Plan Option with a Single Coverage Level**

#### **D. Return to Work Retirees**

- Under age 65:
  - The return-to-work retiree will be treated similar to an Employee transferring to a new agency (See B above) except with a coverage effective date of the first day of the month following re-employment. Also see Chapter 1, Section 3 for eligibility information related to return to work retirees.
- Over Age 65:
  - The return-to-work retiree who is over 65 and therefore not on the KEHP plan, will be treated as a newly hired employee with no prior employment with a KEHP participating employer (see 5A above). The Effective Date of KEHP elections will be the first day of the second calendar month following the hire date. *Example:* if employment begins anytime in August, Employees are eligible for coverage October 1. Also see Chapter 1, Section 3 for eligibility information related to return to work retirees.

#### **E. ACA Eligible Employees**

- If an ACA Eligible Employee changes employers, moving from one participating employer's Tax ID Number (TIN) to another participating employer's TIN, to a position which is normally eligible for all benefits per 18A rules, the ACA Eligible Employee becomes a Regular Eligible Employee and may qualify as a transfer in terms of KEHP's transfer rules. The Regular Eligible may be processed using normal transfer rules (0 day break, small break and 11+ day break) as outlined above.
- If the ACA Eligible Employee changes employers, moving from one participating employer's Tax ID Number (TIN) to another participating employer's TIN, to a new position under the new employer where eligibility has not been determined based on federal law, the new employer must determine eligibility for coverage. Coverage under the old employer will stop and will not begin under the new employer until the new employer determines eligibility.
- If the ACA Eligible Employee transfers to another part-time position within the same employer (same TIN), the employer is not required to restart the eligibility determination period. Health coverage will continue for the ACA Eligible Employee until such time as the employee loses eligibility.

# **CHAPTER 3: COVERAGE LEVELS & CROSS-REFERENCE PAYMENT OPTION**

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## 1. Coverage Levels

KEHP offers four Coverage Levels to choose from when making Health Insurance elections.

- A. **Single Coverage Level:** Covers the Employee.
- B. **Parent Plus Coverage Level:** Covers the Employee and one or more eligible children.
- C. **Couple Coverage Level:** Covers the Employee and the Employee's Spouse.
- D. **Family Coverage Level:** Covers the Employee, Spouse and one or more eligible children.

## 2. Cross-Reference Payment Option

Spouses who are both eligible to participate in the state health insurance plan may be covered under one family health benefit plan with lower Employee premiums. This is known as the Cross-Reference Payment Option. Employee premiums are deducted from both Employees' paychecks. Employees must satisfy all requirements below to elect the Cross-Reference Payment Option.

### A. Requirements

- The Employees must be legally married spouses 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; and
- The Employees must both complete an Enrollment Application complete with signatures from both Employees and Insurance Coordinators.

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.*

### B. Electing the Cross-Reference Payment Option

1. **Experiencing a Qualifying Event:** When two Employees experience a Qualifying Event, which will allow their plans to merge into one Cross-Reference Payment Option, one Employee may change his/her Plan Option to begin a Cross-Reference Payment Option. This is not a Qualifying Event that allows both Planholders to elect a new Plan Option (i.e. if they have two different Plan Options, they must select which plan they desire). The Employee with the oldest hire date in KHRIS will become the primary Planholder.
2. **At the Time of Hire with a Participating Group:** The newly-hired Employee must elect coverage to match the existing Employee/Retiree's elections and the Employee with the oldest hire date in KHRIS will become the primary Planholder.

If the existing Employee has waived Health Insurance, or has KEHP Health Insurance, the existing Employee must sign and date the Enrollment Application requesting to begin a Cross-Reference Payment Option within 35 calendar days of the loss. Depending on how the dates fall, the existing Employee may have to pay full family premium for the first month.

*Example:* Jane Doe works for a board of education. She waives her Health Insurance coverage and receives the Waiver General Purpose HRA. Her Spouse, John, is hired by the local health department, losing his

Health Insurance with his former company. John elects to start a Cross-Reference Payment Option with Jane, effective June 1. The first step Jane must take is to establish herself as a Planholder with a Health Insurance plan. She must submit a Loss of Coverage Qualifying Event (loss of coverage from her Spouse's former employer). If her Qualifying Event is effective before June 1, she must start her insurance without the cross-reference payment option, and then June 1, she may switch to the Cross-Reference Payment Option with her Spouse John.

3. **During Open Enrollment:** Employee with the oldest hire date in KHRIS will be the primary Planholder.
4. **At Retirement:** Retirees who are newly retired and with a participating retirement system can elect the Cross-Reference Payment Option, if applicable. The new Retiree must elect coverage to match the existing Employee/Retiree's elections and the member with the oldest hire date in KHRIS becomes the primary Planholder.

### C. Ending the Cross-Reference Payment Option

1. **Termination of Employment or Loss of Employer Paid Benefit Eligibility:** If either Employee loses employment/eligibility for any reason (Qualifying Event), the Cross-Reference Payment Option terminates since eligibility to participate in the Cross-Reference Payment Option has ceased.
  - The remaining Planholder will automatically default to a Parent Plus Coverage Level. If desired, the remaining Planholder may change Coverage Level to a Single Coverage Level. A Dependent Drop Form must be received within 35 calendar days after the date of the Qualifying Event.
  - If the Dependent Drop Form does not indicate the Coverage Level or is not received within 35 calendar days, the default Coverage Level will remain in effect until the next Open Enrollment period, or a permitted Qualifying Event occurs.
  - If the remaining Planholder wishes to add the former Employee to the Plan, the Planholder **MUST** request the change to their Coverage Level (Parent Plus) within 35 days of the loss of Planholder status in order to have a Family Coverage Level, and because the planholder is adding a spouse, the plan option can be changed.
  - The remaining Planholder may request to change Plan Options.
2. **New Retirement:** Newly retired Retirees of a participating retirement system may elect to cancel their Cross-Reference Payment Option. The Spouse of the new Retiree will be enrolled in a Coverage Level that corresponds to the new Retiree's Coverage Level. No Plan Option changes will be allowed for the active Employee.
3. **Either Participant Loses Eligibility for Coverage Due to LWOP**
4. **Qualifying Event:**
  - If the Employee experiences a Qualifying Event that allows the Spouse to be dropped from the Plan. Changes in Plan Options will **NOT** be allowed.
  - If the Employee experiences a Qualifying Event that allows the only Dependent child to be dropped from the Plan. The covered Employees will be assigned to two Single Coverage Level Plans. Changes in Plan Options will **NOT** be allowed.

# CHAPTER 4:

## TERMINATION of COVERAGE

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## 1. Health Insurance Coverage Termination

If Employees terminate employment between the 1<sup>st</sup> and the 15<sup>th</sup> of the month, their Health Insurance coverage will terminate on the 15<sup>th</sup> of the same month.

If Employees terminate employment between the 16<sup>th</sup> and the end of the month, their Health Insurance coverage will terminate on the last day of the same month.

*Example:* An Employee terminates employment on March 5; Health Insurance coverage terminates on March 15. If an Employee terminates employment on March 25; Health Insurance coverage terminates on March 31.

The Employee's premium will be deducted automatically from the Employee's check for state agencies and boards of education. In the event there is not enough money in the last paycheck to cover the premiums due, employers should collect from the individual or deduct the remainder from the payout of vacation or compensatory pay.

The Insurance Coordinator must terminate the Employee in KHRIS or submit an Update Form listing the Employee's last day of employment.

<b>NOTE: Terminations must be entered within 10 days of the occurrence.</b>
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### A. Loss of Dependent Eligibility

Dependent children and/or Spouses who become ineligible for coverage under the Plan (other than for attaining the limiting age) will be terminated at the end of the month they cease to meet the dependency requirements, whether the 35-day requirement notification has been met or not.

Dependent children who become ineligible under the plan due to attaining the limiting age will be terminated at the end of the calendar month in which the 26<sup>th</sup> birthday occurs.

### B. Retirees

Retirees who are Medicare eligible and not actively employed will be terminated at the end of the month before becoming Medicare eligible.

1. **If Dependents are currently enrolled in the Plan**, they may apply to become the Planholder. If the Spouse or Dependent chooses to become the Planholder, and later dies leaving Dependents remaining on the Plan, Health Insurance coverage will terminate at the end of the month following the date of death. In both cases above, the Retiree is not deceased.

2. **If there are no Dependents currently enrolled in the Plan**, coverage terminates at the end of the month before becoming Medicare eligible.

### C. Death of an Employee or Dependent

In administering the Qualifying Event of death, the amount to be billed for premiums may not correlate to the actual date of death. See Appendix I for examples of administering the Qualifying Event of Death.

## 2. Retroactive Termination

Based on processing timelines with multiple agencies, KEHP's normal business flow requires up to 90 days to process terminations. Retroactive terminations greater than 90 days must be reviewed to ensure KEHP adheres to federal laws related to rescission. If you have a retroactive termination greater than 90 days, you must contact the Benefits Branch Manager in the Enrollment Information Branch for guidance in processing.

## 3. Leaves of Absence

**Health Insurance ONLY – Refer to Chapter 7 for Flexible Benefits**

### A. Leave Without Pay (LWOP)

The following LWOP guidelines apply to eligibility for KEHP and are not meant to replace any LWOP guidelines established by a company. While an Employee is on LWOP the following could occur:

#### 1. New Employees Beginning LWOP Before Health Insurance Coverage Begins:

In some instances a new Employee may go on LWOP before the Effective Date of Health Insurance coverage; in this case, the following rules will apply if the Enrollment Application has been completed and signed within the required 35 day period after the hire date.

Health Insurance coverage will be effective on the later of the following two dates:

- The 1<sup>st</sup> day of the second month following the date of hire or
- The 1<sup>st</sup> day of the Semi-Monthly Billing Period following the Semi-Monthly Billing Period in which the employee returns from LWOP.

However, if the paycheck an Employee receives is not sufficient to cover his/her portion of the premium, the Employee must submit a personal check for the amount due.

#### 2. Beginning LWOP

- **KRS Chapter 18A Agencies and Technical Schools (780 KAR 6:062):**  
An Employee can be on intermittent LWOP and continue to be eligible for the employer contribution for Health Insurance as long as the Employee has worked any part of the previous Semi-Monthly Billing Period. Employees on approved LWOP (except educational LWOP) must have worked any part of **the previous Semi-Monthly Billing Period** (the first through the 15<sup>th</sup> or the 16<sup>th</sup> through the end of the month) to be eligible for the Commonwealth employer contribution for Health Insurance for the next Semi-Monthly Billing Period.
- **Non KRS Chapter 18A Agencies:**  
Employees on approved LWOP must work **at least one day during the Semi-Monthly Billing Period** (the first through the 15<sup>th</sup> or the 16<sup>th</sup> through the end of the month) to be eligible for the Commonwealth employer contribution for Health Insurance for that current **Semi-Monthly Billing Period**. An Employee can be on intermittent LWOP and continue to be eligible for the employer contribution for Health Insurance as long as the Employee works at least one day during each Semi-Monthly Billing Period. However, if the Employees pay is not

sufficient to cover their portion of the premium, a personal check for the amount due must be submitted.

- **HRA Employer Contribution**

Employees on LWOP must work any part of each Semi-Monthly Billing Period to be eligible to receive the HRA employer contribution.

Example: If the Employee waives coverage and has the Waiver HRA, and the Employee works one day from the 1st through the 15th, the Employee will be eligible to receive ½ of the employer contribution (\$87.50) for that Semi-Monthly Billing Period.

If the Employee works any time from the 16th to the end of the month, the Employee will receive ½ of the employer contribution (\$87.50) for that Semi-Monthly Billing Period.

Non-Commonwealth Paid contributions are due on the 15th and Commonwealth Paid contributions are due on the 5th of the month in which leave begins.

The Insurance Coordinator must collect the check for the contributions (payable to the Kentucky State Treasurer) and forward it to:

Financial Management Branch  
Department of Employee Insurance  
Personnel Cabinet  
501 High Street, 2<sup>nd</sup> Floor  
Frankfort, Kentucky 40601

If an Employee is on approved LWOP, an HRA will terminate the end of the semi-monthly billing period. Refer to the [Benefits Administration User Guide](#) for KHRIS processing steps. Employees who lose the employer contribution for the Waiver HRA because they did not work at least one day during a Semi-Monthly Billing Period are eligible for COBRA. Dependent Care FSA is not eligible for COBRA.

### 3. **Extended LWOP**

If an Employee is on approved LWOP and does not work:

- **KRS 18A Agencies and 780 KAR Agencies:** any part of a Semi-Monthly Billing Period (the first through the 15<sup>th</sup> or the 16<sup>th</sup> through the end of the month) the Employee will not be eligible for the employer contribution for Health Insurance for the next Semi-Monthly Billing Period.
- **Non-KRS 18A Agencies:** one day during each Semi-Monthly Billing Period (the first through the 15<sup>th</sup> or the 16<sup>th</sup> through the end of the month) the Employee will not be eligible for the employer contribution for Health Insurance for that Semi-Monthly Billing Period.

The Insurance Coordinator must either enter the LWOP action in KHRIS or submit an Update Form to KEHP providing the Employee's approved LWOP begin date and the Health Insurance termination date (end of the Semi-Monthly Billing Period). *Examples:* These examples apply to KRS 18A Agencies and KAR 780 Agencies:

- Employee on approved LWOP and works any part of the Semi-Monthly Billing Period of the 1<sup>st</sup> through the 15<sup>th</sup>

- Health Insurance ends the last day of the month.
- Employee works any part of the Semi-Monthly Billing Period between the 16<sup>th</sup> and the end of the month.
  - Health Insurance ends on the 15<sup>th</sup> of the following month.
- If the paycheck an Employee receives is not sufficient to cover his/her portion of the premium, the Employee must submit a personal check for the amount due.

*Examples:* These examples apply to Non-18A Agencies:

- Employee on approved LWOP and works during the Semi-Monthly Billing Period of the 1<sup>st</sup> through the 15<sup>th</sup>.
  - Health Insurance ends on the 15<sup>th</sup> of the same month.
- Employee works between the 16<sup>th</sup> and the end of the month.
  - Health Insurance ends on the last day of the same month.
- If the paycheck an Employee receives is not sufficient to cover his/her portion of the premium, the Employee must submit a personal check for the amount due.

#### **4. LWOP and the Cross-Reference Payment Option**

If an Employee is on LWOP and loses coverage, the Cross-Reference Payment Option must be broken. KEHP will notify the remaining Spouse's Insurance Coordinator that one of the Employees is on LWOP and the remaining Employee will be defaulted from a Cross-Reference Payment Option to a Parent Plus Coverage Level.

If the remaining Planholder wishes to elect a Single Coverage Level, a Couple Coverage Level or a Family Coverage Level to include the Employee on LWOP, they MUST complete an Enrollment Application to change Coverage Levels within 35 days of the loss of Planholder status. The remaining Planholder would then be responsible for the total Employee contribution for the plan. If LWOP results in a loss of coverage

#### **5. Returning from LWOP-Eligibility for the Employer Contribution**

##### **KRS Chapter 18A Agencies and Technical Schools (780 KAR 6:602)**

Employees who return from approved LWOP must work in the PREVIOUS Semi-Monthly Billing Period to be eligible to receive the employer contribution for the current Semi-Monthly Billing Period.

*Example:* Employee returns from approved extended LWOP.

Employee works between the 1<sup>st</sup> and the 15<sup>th</sup> of the month

- Health Insurance starts on the 16<sup>th</sup> of the current month
- Employee works between the 16<sup>th</sup> and the end of the current month
- Health Insurance starts on the 1<sup>st</sup> of the next month

However, if the pay an Employee receives is not sufficient to cover his/her portion of the premium, the Employee must submit a personal check for the amount due.

## **Non-18A Agencies or KAR 780 Agencies**

Employees who return from approved LWOP must work in the CURRENT Semi-Monthly Billing Period to be eligible to receive the employer contribution for the current Semi-Monthly Billing Period.

Employee works between the 1<sup>st</sup> and the 15<sup>th</sup> of the current month

- Health Insurance starts on the 1<sup>st</sup> of the current month

Employee works between the 16<sup>th</sup> and the end of the current month

- Health Insurance starts on the 16<sup>th</sup> of the current month

However, if the pay an Employee receives is not sufficient to cover his/her portion of the premium, the Employee must submit a personal check for the amount due.

### **6. Returning from LWOP-Eligibility for Coverage Level Changes**

Employees who return to work after being on approved LWOP will automatically be reinstated to the elections they had prior to LWOP status, unless the previous plan is no longer offered.

Employees who return to work after being on approved LWOP will not be eligible to make any changes to their insurance coverage unless they:

- experience a Qualifying Event and apply for an appropriate Coverage Level change no later than 35 days from their return to work date.
- return in a new Plan Year and they were on approved LWOP during the Open Enrollment period. They must apply for a Plan Option and/or Coverage Level change no later than 35 days after the return.

### **7. When Employees are on LWOP the following may occur:**

#### **An Open Enrollment Period**

- Employees who are on LWOP during the Open Enrollment period will not receive an Open Enrollment packet.
- Employees who elected COBRA will receive Open Enrollment packets from the COBRA administrator.
- Upon returning to work, the Employees are entitled to receive the Open Enrollment information from the Insurance Coordinator. Employees will have 35 days from the date they return to work to make their Open Enrollment elections.

#### **The Employees Experience a Qualifying Event**

- Employees on LWOP who experience a Qualifying Event must follow the same Qualifying Event rules as other Employees. However, they must request the mid-year election change within 35 days from the return to work date.

The same rules as defined in the Returning from LWOP section will be applied to determine the Effective Date of coverage.

### **8. Additional LWOP Information**

- When there is a loss of coverage, the Insurance Coordinator must submit an Update Form to the Department of Employee Insurance indicating the Employee is on LWOP or suspended. The

Insurance Coordinator must also submit an Update Form to **reinstate** the Employee's Health Insurance when the Employee regains eligibility.

- The Commonwealth of Kentucky's regulations which address LWOP for Employees of executive branch agencies are set forth in 101 KAR 2:102, Section 2 (2)(c) (Classified leave administrative regulations); and 101 KAR 3:015, Section 2 (2)(c) (Leave administrative regulations for the unclassified service). According to the amended regulations (July 15, 2009):

An employee who is eligible for state contributions for health benefits pursuant to the provisions of KRS Chapter 18A shall have worked or been paid leave, other than holiday or education leave, during any part of the previous pay period.

- If an Employee fails to submit appropriate premium payments due within the specified deadline (at 90 days members will be terminated for non-payment), the ENTIRE Health Insurance plan will be cancelled. If this occurs, the Insurance Coordinator should request a refund of any employer contribution amount paid.
- When an Employee is granted approved extended LWOP, the Insurance Coordinator must send the Guidelines for Benefits While on Approved LWOP memo.
- Workers' Compensation – being on Workers' Compensation or being hurt on the job has no effect on LWOP or an Employee's Health Insurance coverage. However, if an Employee goes on extended LWOP the Employee loses eligibility for Health Insurance coverage.
- As an employer, agencies who participate in KEHP may have different guidelines for administering LWOP programs; this guidance is established for Health Insurance and FSA coverage only.

## **B. Family and Medical Leave Act (FMLA)**

The Family and Medical Leave Act of 1993 (FMLA) requires employers to provide up to 12 weeks of job-protected leave for certain family and medical reasons. Employees are eligible for FMLA leave if they have completed 12 months of service and worked or been on paid leave at least 1,250 hours in the 12 months preceding the first day of FMLA leave. This leave is available annually.

The Employees may choose to:

- use paid (annual, sick or compensatory) leave concurrently with FMLA leave (101 KAR 2:102);
- use unpaid leave during the FMLA leave; or
- reserve ten days of accumulated sick leave prior to being placed on FMLA leave.

When Employees are granted FMLA leave, the Insurance Coordinator should send the Guidelines for Benefits While on Approved Family Leave memo (Appendix E). While Employees are on unpaid FMLA, they may choose to keep their Health Insurance and Flexible Spending Account(s) active. Refer to the Qualifying Event Charts in Chapter 5 for the specific payment options.

Employees on unpaid FMLA and enrolled in a Healthcare FSA may elect COBRA.

Employees on unpaid FMLA and enrolled in a Dependent Care FSA are NOT eligible for COBRA benefits for the Dependent Care FSA. However, if IRS regulations are met, the Employee on unpaid FMLA may continue to file Dependent care claims for the remaining funds in their account until the end of the Plan Year.

**NOTE:** Being on Workers' Compensation or being hurt on the job has no effect on FMLA or Health Insurance.

**1. Starting FMLA leave**

Starting FMLA leave is not a Qualifying Event to change KEHP elections. When Employees begin FMLA leave, the employer contribution for Health Insurance must continue through the leave period. Employees are responsible for the Employee's share of the Health Insurance contributions. Employees may choose to:

- Cease contributions (terminate entire plan);
- Prepay the coverage contributions for the FMLA leave period;
- Choose the pay-as-you-go method. If Employees choose this method of payment the Employee's premiums are due at the same time premiums would be due if made by payroll deduction.

Non-Commonwealth Paid premiums are due on the 15<sup>th</sup> and Commonwealth Paid premiums are due on the 5<sup>th</sup> of the month in which leave begins. The Insurance Coordinator must collect the premium check (payable to the Kentucky State Treasurer) and forward it to the Financial Management Branch, Department of Employee Insurance, Personnel Cabinet, 501 High Street, 2<sup>nd</sup> floor, Frankfort, Kentucky 40601.

**2. During FMLA**

When an Employee is on FMLA, the following may occur:

**An Open Enrollment Period**

- Employees who are on FMLA during Open Enrollment and are still covered through KEHP will receive an Open Enrollment packet from their Insurance Coordinator.
- Employees who choose to cease contributions, which stop coverage, are not eligible for Health Insurance under the Kentucky Employees' Health Plan (KEHP) until they return to work. If the Employee returns to work, they will have 35 days to make Open Enrollment elections.

**Employees experience a Qualifying Event**

- Employees on FMLA who experience a Qualifying Event will have 35 days from their return to work date to request a status change.

**3. Returning from FMLA leave**

- Employees returning from FMLA leave, where coverage was stopped during the leave must be reinstated to the prior elections unless there has been an intervening status change, in which case, the Employees will have 35 days from their return to work date to request a status change.
- If Employees choose to suspend Health Insurance coverage during FMLA leave, they may be reinstated to the prior elections on the day they return to active status.
  - If the Employee is reinstated between the 1<sup>st</sup> and the 15<sup>th</sup> of a month, the Employees will be responsible for payment of premiums for the entire month at the new Coverage Level, if applicable.

- If the Employee is reinstated between the 16th and the end of a month, the Employees will be responsible for payment of premiums for the one half month of reinstatement at the new Coverage Level, if applicable.
- If coverage was cancelled due to non-payment of premiums, the Employees are to be reinstated to the prior elections upon payment of all past-due premiums.
- If Employees choose suspension of coverage or fail to pay past-due premiums, the company is to request a refund of the employer contribution for the applicable months.

#### **4. Not returning from FMLA leave**

When Employees have exhausted FMLA leave, but do not return to work (begin LWOP), the Insurance Coordinator must notify the Employees of their COBRA rights (if eligible), regardless of their insurance status during the FMLA leave.

For purposes of COBRA, the date of this COBRA Qualifying Event is the date the FMLA leave ends. Employees are eligible for 18 months of COBRA coverage.

**NOTE:** September 9, 2013 Personnel Memo 13-22 clarified 101 KAR 2:102 simplified Sick Leave requirements for 18A employees. It stated: "Specifically, the regulation is amended to clarify that unpaid sick leave by personnel action shall commence after the employee has been on unpaid sick leave for thirty (30) calendar days." This clarification does not change any of the above procedures. Health insurance, Waiver HRAs, Waiver Dental/Vision Only HRAs, and FSAs will end based on the last day payment for coverage is received.

**Example:** Member is on unpaid sick leave (LWOP) starting July 10. The personnel action (PAN) to terminate is effective August 10 (31 day after LWOP begins). Once the 31 days have elapsed and the Pan action is completed, KEHP coverage would then be terminated as of July 31 based on last payment received for coverage.

### **C. Military Leave**

Employees called to active military duty are eligible for health benefits through the United States government. The Employee's Dependents may also be eligible for military Health Insurance.

#### **1. Beginning Military Leave**

Employees may stop their Health Insurance coverage on the last day of the Semi-Monthly Billing Period in which they are activated with the Armed Services.

Employees may elect to maintain their current level of Health Insurance coverage, as well as maintain military health care coverage. They must ensure that the applicable premiums are available via payroll deduction or are received by their Insurance Coordinator no later than the 15<sup>th</sup> day of the month of the coverage month for Non-Commonwealth Paid Employees, and the 5<sup>th</sup> day of the month of the coverage month for Commonwealth Paid Employees. All premiums due upon return from active duty will be determined by the date of return to active employment.

#### **2. During military leave**

If Employees elect to maintain their Health Insurance while on leave, they must ensure that the applicable premiums are available via payroll deduction or are received by their Insurance

Coordinator no later than the 15<sup>th</sup> day of the month of the coverage month for Non-Commonwealth Paid Employees, and the 5<sup>th</sup> day of the month of the coverage month for Commonwealth Paid Employees. The premium would include the total monthly premium (Employee and employer cost) if the Employee does not have paid leave status.

**3. Returning from military leave**

Employees returning from military leave will have all benefits (Health Insurance and Flexible Spending Accounts) reinstated the date they return, (first day of the second month rule does not apply) without any waiting period.

Employees returning from military leave have the option to delay the reinstatement of their prior elections until military coverage ends. During that time, Employees may waive coverage and enroll in a Waiver HRA until TRICARE ends. Employees electing this option MUST present supporting documentation of the military coverage end date and coverage will be reinstated the first day of the month following the date of the loss of coverage through TRICARE.

Employees returning between the 1<sup>st</sup> and the 15<sup>th</sup> of the month will need to pay the Employee portion (Family, Couple, Parent Plus or Single Coverage Level, if applicable) of the insurance premium for the month of return. Employees returning on the 16<sup>th</sup> of the month or later will be responsible for one-half month premium.

# CHAPTER 5:

# QUALIFYING EVENTS

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## 1. Qualifying Events

KEHP is provided through a Section 125 plan per the Internal Revenue Code. This allows Employees to pay for their Health Insurance premiums with pre-tax dollars. Section 125 plans are federally regulated, and the guidelines state that if an Employees' Health Insurance or Flexible Spending Account is offered through a Section 125 plan, they cannot make a change to their Health Insurance or Flexible Spending Account options outside of the annual Open Enrollment period, unless they experience a permitted election change (referred to as Qualifying Events).

### A. To Enroll in KEHP Outside of the Annual Open Enrollment Period the Individual:

#### 1. Must Lose Coverage From:

- An employer-sponsored group health plan;
- An individual Health Insurance plan (**must lose eligibility – failure to pay premiums is not a loss of eligibility**) ;
- A short-term, limited-duration insurance policy also known as “gap” insurance;
- A student Health Insurance policy; or
- A government coverage (TRICARE, Medicare, Medicaid, KCHIP)

*Losing coverage from one of the following **does not allow** the individual to enroll outside of the annual Open Enrollment period:*

- Coverage only for accident or disability income insurance;
- Coverage issued as a supplement to liability insurance;
- Liability insurance;
- Workers' compensation or similar insurance;
- Automobile medical payment insurance;
- Credit-only insurance;
- VA Benefits;
- Coverage for on-site medical clinics; or
- Other similar insurance coverage under which benefits for medical care are secondary or incidental to other insurance benefits.

#### 2. Must Lose Coverage Due To:

- A maximum benefits level being reached;
- An insurance agency canceling the policy (other than for non-payment);
- Coverage being provided under COBRA and COBRA has expired;
- Coverage was non-COBRA and the coverage terminated due to loss of eligibility for coverage (including but not limited to: legal separation, divorce, end of Dependent status, death of an Employee, termination of employment, reduction in hours) or employer contributions for coverage were terminated; or
- The plan no longer offers benefits for a group of individuals.

*Not Due To:*

- Non-payment of insurance premiums – choosing to stop payment of a plan for any reason;
- Non-renewal – choosing to stop renewal of a plan for any reason;
- Cancellation of coverage by policyholder for policyholder or for a Dependent;
- Increase in cost of coverage (unless for Dependent Care FSA); or
- Reduction of contributions or level of benefits.

## B. General Guidelines

### 1. Event Date

The Event date is the date the event occurs. It is not the date the Employee or Dependent is notified of the event. The **only exceptions** to this are entitlement to:

- CHAMPVA
- TRICARE
- Medicare
- Medicaid

In the instances above, the Qualifying Event date can be the date the Employee or Dependent is notified.

### 2. Signature Date

The Signature Date is the date the Employee's signature is on the applicable documentation. Most Qualifying Events have a signature deadline of 35 calendar days from the Event Date. However, some have a signature deadline of 60 calendar days from the Event Date. It is important to know the deadlines for the Signature Date for all Qualifying Events.

To calculate the number of calendar days, begin counting on the day after the Qualifying Event.

*Example:* If the Employee gets married on March 5, the Employee must sign the applicable forms within 35 calendar days from the event (marriage). Day one would be March 6, and day 35 would be April 9. The Employee's signature must be on the applicable forms no later than April 9.

#### Pre-Signing

Applicable forms may not be signed prior to the event date, except for the following:

- Loss of other health coverage;
- Gaining other health coverage;
- Entitlement to Medicare; and
- Spouse's different Open Enrollment period.

The timing of the signature date is critical. Employees must complete the Enrollment forms and sign the applicable forms before the signature date deadline. The Employee does not need to wait for any supporting documentation to arrive before the form is signed.

### 3. Effective Date

The Effective Date is the date the coverage takes effect. Most Effective Dates are the first day of the month following the signature date. Coverage can NEVER be effective prior to the Event Date. Always consider the following:

- If the Qualifying Event date is the first of the month, the Employee may pre-sign during the previous month.

*Example:* If "loss of coverage" occurs on April 1, the Employee may sign the applicable documentation during the month of March. The Effective Date of the change will be April 1.

- If the Qualifying Event date is any other day of the month, the Employee may pre-sign during that month only.

*Example:* If “loss of coverage” occurs on April 18, the Employee may sign the applicable documentation during the month of April. The Effective Date of the change will be May 1. The Employee is not permitted to sign in March since that would make the Effective Date April 1, which is effective prior to the event of April 18.

#### **4. Qualifying Event Charts**

The next several pages are the Qualifying Event charts. Use the charts as your guide in knowing what mid-year election changes are permitted, and what documentation is required. Healthcare and Dependent Care FSA elections may be increased, decreased or terminated during specific Qualifying Events; decreasing an election means to lower the election amount, terminating an election means to terminate the entire FSA.

# Qualifying Event – MARRIAGE OF PLANHOLDER

## PERMITTED CHANGES

<b>Health Insurance</b>
Add Employee, Spouse and/or Dependent(s), including Tag-Alongs
Make Coverage Level or Plan Option change if adding Dependent(s)
Drop Dependent(s) if Employee gains coverage under Spouse's plan
Make Plan Option change if dropping Dependent(s)
<b>Waiver General Purpose HRA or Waiver Dental/Vision ONLY HRA</b>
Terminate election and redirect the state contribution to Health Insurance

<b>Healthcare FSA</b>
Enroll in or increase election
Decrease election if Employee and/or family member(s) become covered under Spouse's plan
<b>Dependent Care FSA</b>
Enroll or increase election if marriage increases Dependent Care expenses
Decrease election if family member becomes covered under Spouse's plan or marriage decreases Dependent Care FSA expenses

<b>EVENT DATE</b>	
Adding Spouse and/or Dependent(s)	Date of marriage
Dropping Dependent(s) – if other coverage gained	Date Dependent gained other group Health Insurance coverage under the Spouse's plan

<b>Signature Deadline</b>	35 calendar days from the event date
<b>Effective Date</b>	<i>Cannot be effective before the event date</i>
Adding Dependent	First of the month following the Employee's signature date.
Dropping Dependent	End of the month of the Employee's signature date.
Enrolling/increasing FSA	First day of the month following Employee's signature date.
Terminating/decreasing FSA	End of the month of the Employee's signature date.
<b>Document(s) Required</b>	
Adding Spouse	See Dependent Eligibility Chart – Chapter 1, Page 3
Adding Dependent(s)	See Dependent Eligibility Chart – Chapter 1, Page 3
Dropping Employee/Dependent(s) due to gaining other group Health Insurance	Notification from employer, on employer's letterhead or via electronically, identifying the coverage Effective Date and the person(s) covered by the policy; or a copy of the new Health Insurance ID card(s) for each covered person, stating the coverage Effective Date
<b>Forms to Use</b>	
Enrolling	Active Employee Health Insurance Enrollment Application
Adding Dependent(s)	Add/Drop Form
Adding Dependent(s) with Plan Option or Coverage Level change	Active Employee Health Insurance Enrollment Application
Dropping Dependent(s)	Add/Drop Form
Changing FSA	FSA Enrollment/Change Application

# Qualifying Event – DIVORCE, LEGAL SEPARATION OR ANNULMENT

## PERMITTED CHANGES

Health Insurance
Add Employee and Dependent(s) if losing coverage under Spouse's plan
Drop Spouse
Drop Dependent child who cease to meet eligibility requirement under KEHP
Change Plan Option if adding or dropping Dependent(s)

Waiver General Purpose HRA or Waiver Dental/Vision ONLY HRA
Terminate election and redirect the state contribution to Health Insurance (if event causes loss of coverage under

Spouse's Plan)
Healthcare FSA
Enroll in or increase election
Decrease election if family member(s) become covered under Spouse's plan

Dependent Care FSA
Enroll in or increase election if event increases Dependent Care FSA expenses or causes loss of coverage under Spouse's plan
Terminate or decrease election if event decreases Dependent Care FSA expenses

Event Date	
Adding Employee/Dependent(s)	Date of loss of coverage under former Spouse's plan or the date the divorce decree is entered by the court.
Dropping Spouse/Dependents	If Dependent ceases to meet eligibility requirements under KEHP, the event date is the date of the divorce decree, annulment or legal separation as entered by the court.
Signature Deadline	35 calendar days from the event date. Former Spouse must be dropped at the end of the month of ineligibility. <i>Cannot be effective before the event date</i>
Adding Dependent/Employee	First of the month following the Employee's signature date.
Dropping Spouse or Dependent(s)	End of the month in which the divorce, legal separation or annulment occurred.
Dropping Dependent(s) added to other group plan	When added to former Spouse's plan, the end of the month following Employee's signature date.
Enrolling in or increasing FSA	First day of the month following Employee's signature date
Terminating or decreasing FSA	End of the month of the Employee's signature date
Document(s) Required	
Adding	Notification from employer on letterhead or electronically, that includes person(s) covered and coverage termination date; letter from insurance company with type of coverage, reason for termination, date of termination, and person(s) covered; or termination letter from governmental agency providing previous coverage.
Dropping	Divorce decree signed by judge and date stamped "filed" or "entered"; or legal separation papers signed by judge and date stamped "filed" or "entered"; or annulment papers signed by judge and date stamped "filed" or "entered"; or a court order resulting from a divorce or separation that indicates a Spouse and/or a Dependent should be dropped.
Forms to Use	
Enrolling	Active Employee Health Insurance Enrollment Application
Adding Dependents	Add/Drop Form
Adding Dependent(s) with Plan Option or Coverage Level change	Active Employee Health Insurance Enrollment Application
Dropping Dependents	Add/ Drop Form
Changing FSA	FSA Enrollment/Change Application

# Qualifying Event – SPOUSE’S DEATH

## PERMITTED CHANGES

Health Insurance	
Add Employee and/or Dependent children, including Tag-Alongs, if coverage is lost due to Spouse’s death.	
Drop deceased Spouse from plan	
Change Plan Option if adding Dependent(s) or if dropping Spouse and/or Dependent(s)	
Waiver General Purpose HRA or Waiver Dental/Vision ONLY HRA	
Terminate election and redirect the state contribution to Health Insurance (if event causes loss of coverage under Spouse’s plan)	

  

Healthcare FSA	
Enroll in or increase election if death caused a loss of coverage under Spouse’s health plan	
Terminate or decrease election	

  

Dependent Care FSA	
Enroll in or increase election if event increases Dependent Care FSA expenses or causes loss of coverage under Spouse’s plan	
Terminate or decrease election if event decreases Dependent Care FSA expenses	

  

Event Date	
Adding Employee/Dependent(s)/Tag-Alongs	Date of loss of coverage under deceased Spouse’s plan.
Dropping Deceased Spouse	Date of death.

  

<b>Signature Deadline</b>	35 calendar days from the event date
<b>Effective Date</b>	<i>Cannot be effective before the event date</i>
Adding Dependent	First of the month following the Employee’s signature on the Enrollment Application, Add/Drop Form or FSA Enrollment/Change Application.
Dropping Spouse or Dependent(s)	End of the month of the Spouse’s death. The new plan, if applicable, will be effective the first day of the following month, regardless of whether the 35 day deadline is met.
Enrolling in or increasing FSA	First day of the month following Employee’s signature date
Terminating or decreasing FSA	End of the month of the Employee’s signature date. <b>Possible refund of FSA:</b> Refund only if Member paid for complete month and death occurred before the 15 <sup>th</sup> of the month.
<b>Document(s) Required</b>	<i>If Adding, must also submit eligibility verification documents</i>
Adding	Notification from Employer on letterhead or electronically, that includes person(s) covered and coverage termination date; Letter from insurance company with type of coverage, reason for termination, date of termination, and person(s) covered; or Termination letter from governmental agency providing previous coverage.
Dropping	If dropping deceased Spouse – none.
<b>Forms to Use</b>	
Enrolling	Active Employee Health Insurance Enrollment Application
Adding Dependents	Add/Drop Form
Adding Dependent(s) with Plan Option or Coverage Level change	Active Employee Health Insurance Enrollment Application
Drop Dependents	Add/ Drop Form
Drop Deceased Spouse	Add/Drop Form
Changing FSA	FSA Enrollment/Change Application

# Qualifying Event – BIRTH, ADOPTION, PLACEMENT FOR ADOPTION

## PERMITTED CHANGES

Health Insurance
Add new child, Employee, Spouse or other Dependent children, including Tag-Alongs
Change Plan Option when adding Dependent(s) or Spouse

Healthcare FSA
Enroll in or increase election

Waiver General Purpose HRA or Waiver Dental/Vision ONLY HRA
Terminate election and redirect the state contribution to Health Insurance

Dependent Care FSA
Enroll in or increase election if event increases Dependent Care FSA expenses.

Event Date	
Adding Employee/Dependent(s)	Birth – Date of Birth Adoption – Date of Adoption; Foreign Adoption- Date Visa stamped Placement – Child’s Placement Date
Signature Deadline	
Adding <b>ONLY</b> a newborn, adopted or placed child	60 calendar days from the event date
Adding newborn, adopted or placed child <b>PLUS Tag-Alongs</b> (such as spouse and/or other children)	35 Calendar days from the event date

Effective Date	<i>Cannot be effective before the event date</i>
Adding	Birth – Date of Birth Adoption – Date of Adoption; Foreign Adoption – Date Visa stamped Placement – Child’s Placement Date
Adding which results in a Coverage Level Change	If the birth, creates a Coverage Level change, no increase in costs until the 32 day from date of <b>birth</b> If the birth, adoption, or placement for adoption plus <b>Tag-Alongs</b> creates a Coverage Level change <ul style="list-style-type: none"> <li>• between the 1<sup>st</sup> and the 15<sup>th</sup> day of the month, the Member must pay the new premium for the entire month</li> <li>• between the 16<sup>th</sup> and the end of the month, the Member must pay the new premium for one-half of the month.</li> </ul>
Enrolling in or increasing FSA	First day of the month following Employee’s signature date

Document(s) Required	<i>If Adding, must also submit eligibility verification documents</i>
Adding	See Dependent Eligibility Chart – Chapter 1, Page 3
Forms to Use	
Enrolling	Active Employee Health Insurance Enrollment Application
Adding Dependent(s)	Add/Drop Form
Adding Dependent(s) with Plan Option or Coverage Level change	Active Employee Health Insurance Enrollment Application
Enroll in/changing FSA	FSA Enrollment/Change Application
Note(s)	When a newborn baby is added to KEHP, no premiums will be charged for the first 31 days, unless Tag-Alongs are added at the time of the newborn’s birth. See Appendices I and J.

## Qualifying Event – LOSS OF GROUP OR EMPLOYER-SPONSORED GROUP HEALTH INSURANCE

Health Insurance
Employee may enroll or increase election for employee, spouse, or dependents who lose eligibility under spouse's or dependent's employer's plan. (Loss of Coverage).
Change Plan Option when adding Dependent(s) or Spouse
Tag-along may be added

Waiver General Purpose HRA or Waiver Dental/Vision ONLY HRA
Employee may terminate election and redirect the state contribution to health insurance if event causes loss of coverage (not required for special enrollment) under spouse's/dependent's plan.
Healthcare FSA
Employee may enroll or increase election to reflect loss of eligibility for health coverage. (Loss of Coverage).
Dependent Care FSA
Employee may enroll or increase election if spouse or dependent loses eligibility for Dependent Care FSA. Employee may decrease or cease election to reflect loss of eligibility for coverage (i.e. if spouse stops working) or decrease in dependent care expenses.

Event Date	
Adding Employee/Dependent(s)	Date of loss of coverage under the other employer-sponsored group health plan

Signature Deadline	
	35 calendar days from the Qualifying Event date.

Effective Date	
Adding Employee, Spouse or Dependent(s)	<i>Cannot be effective before the event date</i> The first day of the month following the Employee's signature date on the Active Employee Health Insurance Enrollment Application or Add/Drop Form. Either <b>may be signed by the Employee prior to the loss of coverage.</b>
Enrolling in or increasing FSA	First day of the month following Employee's signature date
Terminating or decreasing FSA	End of the month of the Employee's signature date
Document(s) Required	
Adding Spouse or Dependent(s)	Notification from Employer on letterhead or electronically, that includes person covered and coverage termination date; Letter from insurance company with type of coverage, reason for termination, date of termination, and person(s) covered; or Termination letter from governmental agency providing previous coverage.

Forms to Use	
Enrolling	Active Employee Health Insurance Enrollment Application
Adding Dependent(s)	Add/Drop Form
Adding Dependent(s) with Plan Option or Coverage Level change	Active Employee Health Insurance Enrollment Application
Changing FSA	FSA Enrollment/Change Application

Note(s)	
	Some employers may offer a few months of COBRA to terminated Employees as a part of a severance package. It is important to know that the end of employer-paid COBRA coverage is NOT a Qualifying Event to allow enrollment in KEHP, since the COBRA continuation coverage period has not been exhausted. Only expiration of COBRA is considered loss of other coverage.

# Qualifying Event – EMPLOYEE, SPOUSE OR DEPENDENT GAINS EMPLOYER-SPONSORED GROUP HEALTH COVERAGE

(due to starting employment, returning to work after a strike or lockout, returning from unpaid leave, gaining eligibility under an employer’s plan).

## PERMITTED CHANGES

Health Insurance
Drop Employee, Spouse and/or Dependent(s) who become covered under an employer-sponsored group health plan
Change Plan Option when dropping Dependent(s) or Spouse
Terminate Health Insurance and elect to Waive with no HRA

Healthcare FSA
Decrease or terminate election, if person becomes covered under an employer-sponsored group health plan

Dependent Care FSA
Enroll or increase election, if event increases Dependent Care FSA expenses.
Terminate or decrease election, if person becomes covered under a Dependent Care FSA

Event Date	
Dropping Employee, Spouse or Dependent(s)	The date the person being dropped gained coverage under the Spouse’s or Dependent’s employer sponsored group health plan.

Signature Deadline	
	35 calendar days from the Qualifying Event date.

Effective Date	
	<i>Cannot be effective before the event date</i>
Dropping Employee, Spouse or Dependents	The end of the month in which the Employee signed the Add/Drop Form or Active Employee Health Insurance Enrollment Application. Either may be signed by the Employee prior to gaining coverage.
Enrolling in or increasing FSA	First day of the month following Employee’s signature date
Terminating or decreasing FSA	End of the month of the Employee’s signature date

Document(s) Required	
Dropping Employee, Spouse or Dependent(s)	Notification from employer, on employer’s letterhead, or electronically, identifying the coverage Effective Date and the person(s) covered by the policy; or Copy of new Health Insurance ID cards(s) for each covered person, reflecting the coverage Effective Date.

Forms to Use	
Dropping Employee/Dependents	Add/Drop Form
Terminating Plan	Add/Drop Form
Changing Plans	Add/Drop Form
FSA Change	FSA Enrollment/Change Application

Note(s)	
	Paperwork may be signed by the Employee prior to gaining coverage

# Qualifying Event – DEPENDENT RE-ESTABLISHES PLAN ELIGIBILITY

## PERMITTED CHANGES

<b>Health Insurance</b>	Enroll in or increase election
Add Dependent(s) who satisfies plan eligibility requirement	
Change Plan Option or Coverage Level if adding a Spouse or Dependent(s)	
<b>Healthcare FSA</b>	
	<b>Dependent Care FSA</b>
	Enroll in or increase election

<b>Event Date</b>	
Adding Spouse/Dependent(s)	Date Dependent re-establishes eligibility

<b>Signature Deadline</b>	35 calendar days from the Qualifying Event date.
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<b>Effective Date</b>	<i>Cannot be effective before the event date</i>
Adding Spouse or Dependent(s)	First day of the month following the Employee's signature date on the appropriate paperwork.
Enrolling or increasing FSA	First day of the month following Employee's signature date

<b>Document(s) Required</b>	
Adding Dependent(s)	The Employee must provide the reason the Dependent is re-establishing eligibility under the guidelines of KEHP.

<b>Forms to Use</b>	
Adding Dependent(s)	Add/Drop Form
Adding Dependent(s) with Plan Option or Coverage Level change	Active Employee Health Insurance Enrollment Application
FSA Change	FSA Enrollment/Change Application

## Qualifying Event – CHANGE IN RESIDENCE

### PERMITTED CHANGES

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Dependent Care FSA
Increase or decrease election if child care provider change is due to change in residence.

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Event Date
Date residence is re-established.

Signature Deadline
35 calendar days from the Qualifying Event date.

Effective Date	
Dependent Care FSA Increase	First day of the month following Employee's signature date
Dependent Care FSA Decrease	End of the month of the Employee's signature date

*Cannot be effective before the event date*

Document(s) Required
Proof of change in residence.

Forms to Use
FSA Enrollment/Change Application

# Qualifying Event – JUDGMENT, DECREE, NATIONAL MEDICAL SUPPORT ORDER, OR ADMINISTRATIVE ORDER RELATING TO HEALTH COVERAGE FOR A CHILD

## PERMITTED CHANGES

Health Insurance	Waiver General Purpose HRA or Waiver Dental/Vision ONLY HRA
Add Dependent(s) to existing plan if required by a court order, placement papers from Cabinet for Health and Family Services or if legal guardianship has been awarded	Terminate election and redirect the state contribution to Health Insurance ( <b>ONLY if a National Medical Support Notice or other employer directed order is received</b> )
Add children if legal guardianship (including a limited guardianship) or custody (permanent or temporary) has been awarded by judgment, decree, or other court order.	Healthcare FSA
Add Employee who previously waived coverage if the court order stipulates to add children to Employee’s plan offered through the employer. Upon receipt of an administrative order, the Employee is responsible for full premiums due.	Enroll or increase election if order requires Employee to provide child’s health coverage
Drop child if order stipulates that coverage is to be provided by the other parent	Dependent Care FSA
Change Plan Option if adding Dependents	Enroll or increase election if child care expenses increase

Event Date	<i>Date order or guardianship documents signed by the judge</i>
Signature Deadline	35 calendar days from the Qualifying Event date National Medical Support Notice (NMSN) directing employer to enroll in Employee’s child in plan, MAY be processed even if the 35 day deadline not met

Effective Date	<i>Cannot be effective before the event date</i>
Adding Dependent at Employee’s request	First day of the month following Employee’s signature date
Adding Dependent due to NMSN (Employee’s consent not needed)	First day of the month following the date of the administrative order or notice
Dropping Dependent due to a new order releasing Employee	Last day of the month in which the child ceases to meet eligibility requirements If dropping a child on NMSN you must have a NMSN rescinding the previous NMSN
Dropping Dependent due to the expiration of an order	Last day of the month in which the child ceases to meet eligibility requirements
Increasing FSA	First day of the month following Employee’s signature date

Document(s) Required	
Adding Spouse or Dependent(s)	See Dependent Eligibility Chart – Chapter 1, Page 3

Forms to Use	
Enrolling	Active Employee Health Insurance Enrollment Application
Adding Dependents	Add/Drop Form
Adding Dependent(s) with Plan Option or Coverage Level change	Active Employee Health Insurance Enrollment Application
Enrolling in or increasing FSA	FSA Enrollment/Change Application
Note(s)	
	Ineligible Dependents are dropped from the plan at the end of the month of ineligibility

**Qualifying Event – EMPLOYEE, SPOUSE OR DEPENDENT ENROLLED IN KEHP  
BECOMES ENTITLED TO MEDICARE (parts A, B or D) or MEDICAID**  
(gaining KCHIP is not a valid QE)

**PERMITTED CHANGES**

<b>Health Insurance</b>
Drop Employee, Spouse and/or Dependent(s), if person becomes eligible and enrolled in Medicare or Medicaid
Change Plan Option if dropping Spouse or Dependent

<b>Waiver General Purpose HRA</b>
Drop Waiver General Purpose HRA and enroll in Waiver/Dental Vision HRA if Medicare eligible due to age.

<b>Healthcare FSA</b>
Decrease election.

<b>Event Date</b>	
	Date the Employee, Spouse or Dependent becomes entitled to Medicare or Medicaid; Medicare and Medicaid may also use the notification date.

<b>Signature Deadline</b>	
	35 calendar days from event date 60 days from event date for Medicaid

<b>Effective Date</b>	
	<i>Cannot be effective before the event date</i>
Dropping Employee, Spouse and/or Dependent(s)	Last day of the month in which the QE document was signed
Decreasing FSA	End of the month of the Employee’s signature date

<b>Document(s) Required</b>	
Medicare	Copy of Medicare card (showing Effective Date) or Initial eligibility letter from Medicare Office
Medicaid	Medicaid Eligibility/Termination Form signed by the Division of Medicaid Services

<b>Forms to Use</b>	
Dropping Employee	Active Employee Health Insurance Enrollment Application reflecting a Waiver with NO HRA
Dropping Dependent(s)	Add/Drop Form. Form may be signed by the Employee prior to the event date; however, the requested change will not be effective prior to the Qualifying Event date
Plan Option change	Active Employee Health Insurance Enrollment Application
Decreasing FSA	FSA Enrollment/Change Application
<b>Note(s)</b>	
	Gaining KCHIP is not a valid qualifying event. No change is allowed
	KCHIP Premium Assistance is a Qualifying Event to add

# Qualifying Event – PLAN OPTION HAS SIGNIFICANT INCREASE OR DECREASE IN COST

## PERMITTED CHANGES

<b>Dependent Care FSA</b>
Make corresponding change (increase or decrease) for a day care provider who is not a relative of the Employee.

<b>Event Date</b>	Date of rate change
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<b>Signature Deadline</b>	35 calendar days from the Qualifying Event date.
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<b>Effective Date</b>	<i>Cannot be effective before the event date</i>
Dependent Care FSA Increase	First day of the month following Employee's signature date
Dependent Care FSA Decrease	End of the month of the Employee's signature date

<b>Document(s) Required</b>	
	Proof of change in rates

<b>Forms to Use</b>	
Dependent Care FSA	FSA Enrollment/Change Application

**Qualifying Event – EMPLOYEE, RETIREE OR SPOUSE HAS A DIFFERENT OPEN ENROLLMENT PERIOD** (includes military insurance coverage, except for Veteran’s Administration benefits)

<b>PERMITTED CHANGES Health Insurance</b>
Add Employee, Spouse or Dependent(s) if Employee, Spouse or Retiree dropped coverage during the Open Enrollment period
Drop Employee, Spouse or Dependent(s) if Employee, Spouse or Retiree enrolled family during the Open Enrollment period

<b>Waiver General Purpose HRA or Waiver Dental/Vision ONLY HRA</b>
After KEHP Open Enrollment and before January 1, Employee may make corresponding change and redirection is permitted.

<b>Healthcare FSA</b>
After KEHP Open Enrollment and before January 1, Employees may make change corresponding to change made under other employer’s plan or military plan.
<b>Dependent Care FSA</b>
Make a corresponding change (increase or decrease). Increasing the election for a day care provider increasing rates mid-year is only permitted if the provider is not a relative of the Employee.

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<b>Event Date</b>	Last day of the Employee’s, Retiree’s or Spouse’s Open Enrollment Period
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<b>Signature Deadline</b>	35 calendar days from the Qualifying Event date.
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<b>Effective Date</b>	<i>Cannot be effective before the event date</i>
Adding or dropping Employee and/or Dependent(s)	Same as the Effective Date of the Employee, Retiree’s or Spouse’s plan

<b>Document(s) Required</b>	If Adding, must also submit eligibility verification documents
	Notification from employer on employer’s letterhead or electronically, identifying <ul style="list-style-type: none"> <li>• Open Enrollment period and deadline</li> <li>• Effective Date of plan</li> <li>• Persons being added or dropped from the policy</li> </ul>

<b>Forms to Use</b>	
Enrolling/Dropping Employee	Active Employee Health Insurance Enrollment Application
Adding Dependents	Add/Drop Form
Dropping Dependents	Add/Drop Form
FSA Change	FSA Enrollment/Change Form

## Mid-Year Scenarios with a CDHP embedded HRA – funding availability

Scenario	Action	Funding	Explanation
1.CDHP Single to Family	Member will receive the additional HRA funds.	Increase available full plan year	HRA increases due to plan change. Member will have access to the larger balance of funds for family coverage for the full year.
2.CDHP Family to Single	Member will not receive any additional HRA funds. Member's HRA funds will not be reduced.	Same amount available full plan year	Two separate elections with one continuous period. If the \$1,000 was totally spent during the first election period, there would not be any additional funds given for the second period, just a different election noted in WW system.
3.LW CDHP to Standard CDHP	Member's HRA funds will not be reduced.	Same amount available full plan year	Two separate elections with one continuous period. No additional money and no money taken back - only different periods that the money is available.
4.LW CDHP single coverage to Standard CDHP parent plus.	No change in HRA funds.	Same amount available full plan year	Member will have the same amount of funds. LW CDHP single coverage/ \$500 HRA and Standard CDHP parent plus coverage/ \$500 HRA which is no change in HRA money.
5.Standard CDHP to LW CDHP	Member will receive additional HRA funds	Increase available full plan year	HRA increases due to plan change – Member will have access to the larger balance of funds for the full year.
6.Standard CDHP family coverage to LW CDHP Single	No change in HRA funds.	Same amount available full plan year	HRA is \$500 for both scenarios.
7.Non-CDHP to CDHP	Member will receive HRA funds	Funds available beginning date of QE	No pro-rating of funds.
8.CDHP to Non-CDHP	Member will receive HRA funds with CDHP.	Funds only available until date of QE	HRA claims can be submitted through run-out period for dates of CDHP coverage. No pro-rating.
9.CDHP planholder whose spouse is newly employed and eligible to elect the cross-reference payment option.	<p>a. Existing planholder has, <i>couple, parent-plus or family, coverage level and will now have cross-reference payment option. Member will not receive additional HRA funds.</i></p> <p>b. Existing planholder has <i>single coverage level and will now have the cross-reference payment option. Member will receive additional HRA funds.</i></p>	Same amount available full plan year	<p>a. No more than the maximum HRA amount per coverage level and plan option will be received. Couple, Parent-plus, family and cross reference payment option have the same HRA amount.</p> <p>b. No more than the maximum HRA amount per coverage level and plan option will be received. Single coverage level receives less funds than the family cross-reference payment option; therefore, member will receive additional HRA funds and funds will be available for the entire year, regardless of the QE date.</p>
10.Non-CDHP planholder whose spouse is newly employed and eligible to elect the cross-reference payment option.	Newly employed spouse must remain on the primary planholder's plan option.	No funds involved	Not a QE – no change in plan option permitted. No funds involved.
11.Begin new cross-reference payment option due to birth, adoption or other QEs.	When electing the cross-reference payment option and changing coverage level from single to cross reference, member receives additional HRA funds; electing a different plan option is permitted.	Funds available full plan year	Amount of the full HRA will be received – no prorating, and funds will be able to be used for the full year.

# CHAPTER 5A

# AUTOMATIC LOSS OF COVERAGE

## **1. Automatic Loss of Coverage**

Certain incidents may result in an Automatic Loss of Coverage, with or without the occurrence of a corresponding Qualifying Event. When an Automatic Loss of Coverage takes place, the occurrence of a Qualifying Event is not necessary to justify the cessation of coverage. The Employee's initial election for coverage already encompassed the concept of automatic revocation, so a mid-year "change" in election is not needed.

### **A. Examples of Incidents Resulting in Automatic Loss of Coverage**

- An incident such as death, loss of employment status, or loss of Dependent status which causes an Employee, Retiree, Dependent or Health Beneficiary to lose eligibility under the Eligibility Requirements of Kentucky Revised Statute 18A.225
- An incident such as death, divorce, loss of employment status, or loss of Dependent status which causes an Employee, Retiree or Beneficiary to lose eligibility for the Cross-Reference Payment Option (refer to Chapter 3 for more information on the Cross-Reference Payment Option)
- Incarceration (notice of incarceration must be provided to the Enrollment Information Branch)
- Moving to Another Country (coverage while out of the country is specifically excluded except for emergencies)

### **B. Termination of Coverage due to an Automatic Loss of Coverage**

If an incident triggers an Automatic Loss of Coverage, Health Insurance will be terminated as follows if the automatic loss of coverage is:

- between the 1<sup>st</sup>-and the 15<sup>th</sup> of the month, coverage will terminate on the 15<sup>th</sup> of the month;
- between the 16<sup>th</sup> and the end of the month, coverage will terminate on the last day of the month.

If the incident is discovered after-the-fact and coverage is retroactively terminated, any refunds (maximum of 90 days) of Employee contribution(s) should be made on an after-tax basis. KHRIS will automatically refund Commonwealth Paid employees on a pre-tax basis.

### **C. Re-gaining Eligibility for Coverage**

In the event of a change in the circumstances which resulted in an Automatic Loss of Coverage, the Planholder or former Planholder may re-apply for coverage via the normal application procedures.

# CHAPTER 6:

# BOARDS OF EDUCATION

Boards of Education Termination of Coverage	Page 1
Summer Transfers	Page 2
“Year Round” Employees (All Other Boards of Education Staff)	Page 2

## 1. Boards of Education Termination of Coverage

School district Employees who work under a contract will be allowed to retain KEHP coverage through the summer months (July and August) provided the

- terms of their contract are fulfilled (this is not the same as working until the last day of school) and
- premiums for the summer KEHP coverage are deducted from the last paycheck(s).

At the end of the contract, if the Employee is non-renewed or the district has issued a “pink slip” with the intention of re-hiring the Employee in the fall, the same coverage extension rules apply. The process for summer extensions will be defined in an annual memorandum.

The employment end date (not the last day of school) will be the contract end date; and the insurance termination date will be the last day in which payment for coverage has been received.

If July and/or August premiums are not deducted from the last paycheck(s) but the Employees have fulfilled the terms of their contract, coverage will end on the last day of the Semi-Monthly Billing Period for which premiums were paid in full. On the Update Form, the employment end date will be the contract end date and the insurance termination date will be the last day of the Semi-Monthly Billing Period for which premiums were paid in full.

Reminder: first - terminate the employee in MUNIS; then send the terminated employee on the weekly term file. The employee termination will be sent to the Kentucky Department of Education (KDE) and will then be sent to KEHP.

### A. Retirements

Employees who retire at the end of their contract, coverage will end on June 30 and all premiums for June are due from the district. Retirement will pick up coverage according to their rules which generally means an Effective Date of July 1. However, final determination of when retirement coverage begins is subject to the rules of that retirement system. The retirement system, like all other agencies, is responsible for processing this in a timely manner to ensure proper coverage. On the Update Form, please indicate a 6/30 end date for both employment and coverage and write “Retirement” on the form.

### B. Terminations Before Contract Ends

Employees who stop working before the last contract day; or, who fail to fulfill the terms of their employment contract; should be terminated from coverage following the regular employment termination rules indicated below. This information should be communicated to KEHP on an Update Form.

*Employment stops between 1<sup>st</sup> and 15<sup>th</sup>:*

- Health Insurance ends on the 15<sup>th</sup> of same month
- FSA/Waiver HRA ends on the 15<sup>th</sup> of the same month

*Employment stops between 16<sup>th</sup> and 31<sup>st</sup>:*

- Health Insurance ends on the last day of same month
- FSA/Waiver HRA end on the last day of the same month

These rules above apply to the following plans:

- Health Insurance
- Flexible Spending Accounts (FSAs)
- Waiver Health Reimbursement Arrangements (HRAs)

Employees whose Health Insurance premiums or HRA contributions are fully paid by the Employer and who qualify for the extended summer coverage will be allowed to retain their coverage.

## 2. Summer Transfers

School district Employees who work the last day of their contract under the old school district and the 1<sup>st</sup> of their contract under the new school district are classified as “Summer Transfers.” Coverage will be extended through the summer if the Employee worked the last day of the contract and premiums are paid. If both Summer Transfer contract date rules are fulfilled and summer premiums have been received, the Employee will not experience a break in coverage. Coverage under the old district will stop on August 31 and coverage under the new district will begin on September 1. When notifying KEHP of a summer transfer, please write “Summer Transfer” on the Update Form or the Enrollment Application.

If coverage was extended until the end of August and an Employee begins working at a new Board of Education during the month of August, this is considered a “Summer Transfer”. Enrollment and contributions should begin with the new agency on September 1.

Employees who should have been classified as a “Summer Transfer” but for whom premiums were not deducted for the summer months will likely experience a break-in-coverage. If this occurs, Employees have two options. The same options also apply to Employees whose new school district did not realize they were a summer transfer and as a result, the Employees experience a break in coverage when the new hire “1<sup>st</sup> day of the 2<sup>nd</sup> month” waiting period was applied.

Employees may choose:

- to back up coverage as early as their hire date under the new school district and pay the arrears either by personal check or through their first paycheck; or
- to leave the summer months without KEHP coverage due to lack of medical or pharmacy claims, and begin coverage either on August 1 or September 1.

“Summer Transfers” do not permit an Employee to change Coverage Levels or Plan Options. When notifying KEHP of an Employee who should have been classified as a summer transfer instead of a new hire, please write “CORRECTION: Summer Transfer” on the Update Form or the Enrollment Application and indicate the Effective Date of their coverage based on the options above. The three Effective Date possibilities are

- the hire date
- August 1 or
- September 1

**If the contract employment date rules were not fulfilled, the Employee is not considered a “Summer Transfer” and must enroll as a new Employee in the fall, subject to all new employment rules and deadlines.**

“Summer Transfer” and coverage terminations must be submitted within 10 Days of the occurrence.
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Employees whose Health Insurance premiums or Waiver HRA contributions are fully paid by the Employer and who qualify for the extended summer coverage will be allowed to retain their coverage.

**NOTE: A “Summer Transfer” may result in an 11 or more day break. If so, Employee is treated as a new Employee. Employees who fail to waive Health Insurance online in KHRIS ESS, or who fail to complete an Enrollment Application electing to waive Health Insurance (the Employee does nothing) will be defaulted automatically into a the Standard CDHP Plan Option with a Single Coverage Level**

## 3. “Year Round” Employees (all other Board of Education staff)

Year Round Employees will be processed in the same manner as a 12-month Employee transferring during any other time of the year.

# **CHAPTER 7:**

## **FLEXIBLE BENEFITS**

### **(FSAs and HRAs)**

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Claims Payment	Page 6
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Termination for Non-Payment of FSA and HRA Contributions	Page 8

## Flexible Benefits

The KEHP Flexible Benefits program is provided through a Section 125 Cafeteria Plan and allows participating Employees to pay for eligible Healthcare and Dependent Care expenses with pre-tax dollars. KEHP offers a Healthcare Flexible Spending Account, a Dependent Care Flexible Spending account, and Waiver HRAs to Eligible Employees whose agencies participate in KEHP's Flexible Benefits program.

Section 125 plans are federally regulated and changes are not permitted outside of the annual Open Enrollment period unless Employees experience an appropriate Qualifying Event as outlined in Chapter 5.

Eligible Employees who wish to participate in a Healthcare or Dependent Care Flexible Spending Account (FSA) MUST enroll online in KHRIS ESS or complete a paper Enrollment Application EVERY YEAR during the annual Open Enrollment period. Enrollment is NOT automatic. Healthcare FSAs funds remaining in the Employees account at the end of the Calendar Year will carryover a maximum of \$500.00 to the next Calendar Year. Dependent Care FSAs do not have any carryover provisions.

Eligible Employees who choose to waive Health Insurance may be able to elect the Waiver General Purpose Health Reimbursement Arrangement (HRA) or the Waiver Dental/Vision ONLY HRA. Certain restrictions apply. Eligible Employees who wish to participate in the Waiver General Purpose HRA or the Waiver Dental/Vision ONLY HRA may have to enroll every year in KHRIS ESS or complete a paper Enrollment Application. Check the annual Open Enrollment information each year to see if Employees are required to re-enroll.

Employees who are eligible for the state-sponsored Health Insurance coverage and who elect to enroll in the LivingWell CDHP or the Standard CDHP plan options are eligible for the HRA that is embedded in the Health Insurance plan. The HRA employer contribution amount will be determined each year.

### 1. Eligibility Requirements

Active Employees who are eligible for the state sponsored Health Insurance coverage may enroll in a Healthcare FSA or a Dependent Care FSA at time of hire, during Open Enrollment, or as a result of an applicable Qualifying Event.

Employees may enroll in either FSA program within 35 days of their employment date. The Effective Date will be the first day of the second month from the date of hire (i.e. Employee hire date is February 25; Employee's Effective Date would be April 1).

Employees who are eligible for state-sponsored Health Insurance coverage but elect to waive coverage, and are eligible to waive coverage, will be eligible for the Waiver General Purpose HRA or the Waiver Dental/Vision ONLY HRA, with an employer contribution up to a maximum of \$2,100 per Plan Year. The Employee does not contribute money to this account.

**NOTES:** Employees who currently have a Health Savings Account (HSA) with their Spouse's employer should consult a tax advisor prior to establishing an FSA or an HRA.

Active Employees who are covered as a Spouse on a hazardous duty Retiree's plan through KEHP, will not be eligible to direct the state contribution into a Waiver HRA.

Retirees who return to work are eligible to participate in the FSA programs.

## 2. Redirection of the Employer Contribution

Redirection of the employer contribution is the ability to stop employer funds from being directed into either the Waiver General Purpose HRA or the Waiver Dental/Vision ONLY HRA, in order to start receiving an employer contribution toward a Health Insurance plan.

**NOTE:** If an Employee experiences a Qualifying Event that permits the termination of Health Insurance, he/she may terminate Health Insurance, but may not enroll in the Waiver General Purpose HRA or the Waiver Dental/Vision ONLY HRA. This is merely a Qualifying Event that allows the termination of Health Insurance; no funds will be allocated to either Waiver HRA.

## 3. Contribution Amounts

### A. Healthcare FSA

The maximum allowable yearly contribution for Plan Year 2016 is \$2,500. However, up to a maximum of \$500 of any unused amounts remaining at the end of the calendar year may be carried over for use in the next calendar year. Any amounts over \$500 at the end of the calendar year will be forfeited or lost.

### B. Dependent Care FSA

The maximum yearly contribution amount depends on the Employee's tax filing status as listed below:

- married filing separately \$2,500
- single and head of household \$5,000
- married and filing jointly \$5,000

Remaining funds at the end of the calendar, will NOT carryover to the next Calendar year. All funds will be lost.

### C. Waiver General Purpose HRA and Waiver Dental/Vision ONLY HRA

Employees who waive their Health Insurance coverage, if eligible, receive up to \$2,100 annually from their employer into either a Waiver General Purpose HRA or a Waiver Dental/Vision ONLY HRA. The maximum annual employer contribution is \$2,100 and is received in two installments: January 1 - \$1,050 and July 1 - \$1,050. The Waiver General Purpose HRA is for reimbursement of various qualified expenses as explained in the Benefits Selection Guide and the Summary Plan Description. The Waiver Dental/Vision ONLY HRA is only for reimbursement of qualified dental and/or vision expenses.

If Employees terminate coverage any time during the Plan Year and are rehired during the same Plan Year, the employee continues to remain eligible to receive the monthly \$175 per month contribution to use on claims, provided the contribution amount was not spent on claims prior to terminating. The company continues to remain responsible for submitting the monthly contribution to KEHP.

*Example:* An Employee waives coverage January 1 and terminates coverage (and Waiver HRA) on May 31. The Employee would have access to the first installment of \$1,050 for any expenses incurred between January 1 and May 31. The Employee is later re-hired in August for an October 1 Effective Date. The Employee will have access to an additional \$525 (\$175 for October, November and December). The

Employee is eligible to submit claims during the coverage period of January 1 through May 31, and October 1 through December 31.

#### 4. Termination of Flexible Benefits

Healthcare and Dependent Care Flexible Spending Accounts (FSAs) and Health Reimbursement Arrangements (HRAs) terminate on the last day of the semi-monthly pay period worked.

*Example:* An Employee terminates employment on March 5. Eligibility for FSA and HRA funds terminates on March 15. The Employee can request reimbursement for Healthcare or Dependent care funds spent up to March 15, but cannot incur new claims after March 15.

#### 5. Semi-Monthly Billing Period and Payment Due Reference Chart

Effective Date	Semi-Monthly Billing Period		Payment Due
January 1	1/1	1/15	1/15
	1/16	1/31	1/30
February 1	2/1	2/15	2/15
	2/16	2/28	2/28
March 1	3/1	3/15	3/15
	3/16	3/31	3/30
April 1	4/1	4/15	4/15
	4/16	4/30	4/30
May 1	5/1	5/15	5/15
	5/16	5/31	5/30
June 1	6/1	6/15	6/15
	6/16	6/30	6/30
July 1	7/1	7/15	7/15
	7/16	7/31	7/30
August 1	8/1	8/15	8/15
	8/16	8/31	8/30
September 1	9/1	9/15	9/15
	9/16	9/30	9/30
October 1	10/1	10/15	10/15
	10/16	10/30	10/30
November 1	11/1	11/15	11/15
	11/16	11/30	11/30
December 1	12/1	12/15	12/15
	12/16	12/31	12/31

#### 6. Time Limit for Refund Requests for FSA/HRA Contributions

A refund of FSA/HRA contributions will only be given for up to 90 days, after the receipt of an Enrollment Notification, except in the event of the death of a Member. Note that any mid-year election change resulting in the termination of a Member will be effective on the date as designated under the terms of KEHP. Therefore, if KEHP receives notification of a termination more than 90 days after the event causing the termination, the contribution will be refunded as shown in Appendix M.

## 7. Leaves of Absence

### A. Leave Without Pay (LWOP)

#### 1. Beginning LWOP

If an Employee is on approved LWOP, Healthcare FSA and a Dependent Care FSA will terminate the last day of the semi-monthly pay period in which the employee worked. Refer to the [Benefits Administration User Guide](#) for processing steps. Employees who lose a Healthcare FSA are eligible for COBRA. Employees with a Dependent Care FSA are not eligible for COBRA.

#### 2. Returning from LWOP

Employees who return to work after being on approved LWOP will become effective either the 1<sup>st</sup> or the 16<sup>th</sup> of the month. Employees who return to work after being on LWOP will be reinstated to the same elections they had prior to LWOP status, unless they have experienced a Qualifying Event that would allow a change.

*Examples:* If the Employee returns from approved LWOP between the 1<sup>st</sup> and the 15<sup>th</sup> of the month, the FSA is reinstated on the 16<sup>th</sup> day of the same month and KEHP expects one ½ month payment.

Employee returns from approved LWOP between 16<sup>th</sup> and the last day of the month, FSA is reinstated on the first of the following month and KEHP expects a full month payment for that month.

This only applies to FSAs. The Waiver General Purpose HRA, Waiver Dental/Vision ONLY HRA, the LivingWell CDHP and the Standard CDHP embedded HRA may be processed differently since the HRA is employer money and subject to the employer's LWOP rules.

### B. Family Medical Leave Act (FMLA)

When Employees are granted FMLA leave, the Insurance Coordinator should send the Guidelines for Benefits While on Approved Family Leave letter in Appendix E.

#### 1. Beginning FMLA

FMLA leave does not constitute a Qualifying Event for the purposes of continuing coverage under COBRA. A Qualifying Event will occur, if an Employee does not return to employment at the end of the FMLA leave and all other COBRA continuation coverage conditions are present. If a Qualifying Event does occur, it occurs on the last day of FMLA leave and the applicable maximum coverage period is measured from this date (unless coverage is lost at a later date and the Plan provides for the extension of the required periods, in which case the maximum coverage date is measured from the date when the coverage is lost.). Note that the covered Employee and family members will be entitled to COBRA continuation coverage even if they failed to pay the employee portion of premiums for coverage under the Plan during the FMLA leave.

*Waiver General Purpose HRA and Waiver Dental/Vision ONLY HRA* - When Employees begin paid or unpaid FMLA, the employer contribution for the HRA will continue until FMLA expires.

*Healthcare FSA* - The Employees may choose to:

- Terminate the existing election;

- Change the existing election;
- Keep the existing election and prepay the total contribution for the FMLA leave period;
- Choose the pay-as-you-go method. If the Employees choose this method of payment the Employee's contributions are due at the same time the contribution would be made by payroll deduction.

When Employees are on FMLA, the Insurance Coordinator should collect the FSA check (payable to the Kentucky State Treasurer) and forward contribution checks to:

Personnel Cabinet  
 Department of Employee Insurance  
 Premium Billing Branch  
 501 High Street, 2nd Floor  
 Frankfort, Kentucky 40601

**2. Returning from FMLA Leave**

If elections continued during FMLA, the elections continue with no change when the Employee returns from FMLA.

Employees may choose one of the following when returning from FMLA leave:

- Proration: Employees may elect to continue the same monthly contribution as prior to the FMLA leave and the annual amount is reduced by the contributions missed.
- Resume the election.

**3. Not returning from FMLA Leave**

When Employees have exhausted their FMLA leave, and do not return to work (begin LWOP), the Employees will receive notice of their COBRA rights from WageWorks, regardless of the Employee's FSA status during the FMLA. For purposes of COBRA, the date of the COBRA Qualifying Event is the date the FMLA leave ends. Employees are eligible for COBRA through the end of the Plan Year

**C. Military leave**

Employees may discontinue their contributions to the Flexible Spending Account Program when they are activated with the Armed Services. This option will allow the Employees to be reinstated when returning to employment from military leave.

Employees may elect to continue at the same monthly contribution prior to military leave and the annual amount is reduced by the contributions missed.

Employees returning between the 1<sup>st</sup> and the 15<sup>th</sup> of the month will be effective on their date of return BUT will have to pay the entire monthly contribution for FSA. The employer will be required to pay HRA contributions for the whole month in which the Employee returns.

Employees returning on or after the 16<sup>th</sup> of the month will be effective on their date of return BUT will only need to pay ½ of the monthly contribution for FSA. The employer will be required to pay the employer's portion of the contribution for HRA for the Semi-Monthly Billing Period in which the Employees return.

## 8. Claims Payment

### A. Paper Claims

KEHP reserves the right to initiate the following correction procedures to recoup money from Members for claims that are improperly paid from the Healthcare FSA or HRA.

- Deny Access to the WageWorks Healthcare Card to ensure that no further violations occur. The WageWorks Healthcare Card will be deactivated until the amount of the improper claim payment is recovered.
- Require Repayment. The employer may “demand” that the Employee repay the improper payment. A letter to the Member will be sent identifying the amount, the reasons for requiring repayment, and the timeframe in which the repayment must be made.
- Withhold From Pay. If the demand for repayment is unsuccessful, then an amount equal to the improper payment must be withheld from the participant’s pay or other compensation, to the full extent permitted under applicable law.
- Offset. If the improper payment is still outstanding and amounts are not available to be withheld, then the employer is to apply a substitution or offset approach against subsequent valid claims, up to the amount of the improper payment.
- Treat Payment as Other Business Indebtedness. If the above correction efforts prove unsuccessful, then the Employee remains indebted to the employer for the amount of the improper payment. In that event, and consistent with its business practices, the employer may treat the payment as it would treat any other business indebtedness.

## 9. Timely Filing of Claims

All claims must be submitted by March 31 of the following Plan Year. Services will not be covered unless the Employees are eligible for benefits on the date services are rendered. *Example:* Employees who have coverage from 1/1 - 5/31, may submit claims for reimbursement up to 3/31 of the next calendar year, provided the dates of service of such claims are between 1/1 - 5/31.

## 10. Termination for Non-Payment of FSA and HRA Contributions

The Financial Management Branch/Premium Billing Branch will terminate Flexible Spending Accounts and Health Reimbursement Arrangements of members whose employee/employer portion is 90 days past due. ICs will be notified by letter of members who are 30 or 60 days in arrears and 90 days in arrears who are subject to termination for nonpayment. Members will be notified by letter when their premiums are 60 days in arrears and 90 days in arrears and are subject to termination for nonpayment.

A list of members who are termed for nonpayment will be sent to the Enrollment Information Branch so those members can be set up as Waiver/No HRA for the remainder of the plan year. Members who are termed for nonpayment will only be reinstated upon FMB/PBB receiving payment in full within 30 days. Employees will be responsible for refunding any claims that Anthem has processed with a date of service that is past the termination date.

See Chapter 12 for more details.

# CHAPTER 8:

## GRIEVANCES AND APPEALS

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## **1. Grievance Process for Eligibility and Enrollment Issues**

Employees who are dissatisfied with a decision regarding enrollment or disenrollment (Qualifying Events) in the Plan may file a grievance to the KEHP Grievance Committee. The grievance must be filed no later than thirty (30) calendar days from the event or notice of the decision being protested. Grievances must be filed in writing by completing the Grievance Form. The form can be found at [kehpcy.gov](http://kehpcy.gov), and should be mailed to:

Personnel Cabinet  
Department of Employee Insurance  
Attention: Grievance Committee  
501 High Street, Second Floor  
Frankfort, KY 40601

A grievance must include ALL of the following: 1) name, social security number and company where employed; 2) a description of the issue(s) disputed; 3) a statement of the resolution requested; 4) all other relevant information; and all supporting documentation. Any grievance that does not include all necessary information will be returned. A written response will be mailed to the Employee and the Insurance Coordinator stating the decision of the Committee. The Committee will review a second request only if additional relevant facts are provided.

## **2. Appeals to Anthem (Third Party Administrator)**

Anthem has an internal appeals process relating to medical claims. Refer to the relevant Health Insurance benefit booklet at [kehpcy.gov](http://kehpcy.gov) for details.

## **3. Appeals to CVS/caremark (Pharmacy Benefit Manager)**

CVS/caremark has an internal appeals process for pharmacy claims. Refer to the relevant pharmacy Summary Plan Description for details.

## **4. External Review for Appeals to Anthem and CVS/caremark**

If an Employee has exhausted all levels of internal appeals with Anthem and/or CVS/caremark and desires to appeal further, he/she may request an external review through the Kentucky Department of Insurance. Refer to the relevant medical or pharmacy Summary Plan Description for details.

## **5. Prescription Formulary Appeals**

Employees who are dissatisfied with a change in the prescription formulary may file an appeal with CVS/caremark. An appeal may be filed by the member, an authorized representative, or the member's provider acting on the member's behalf and with the member's permission. CVS/caremark must receive the request for a review within 60 calendar days from the date of the notice of the formulary change. The request should include a doctor's statement regarding the need to receive the drug at the copayment/coinsurance as before the formulary change. A decision will be issued within 30 calendar days of CVS/caremark's receipt of the request. Please send written appeals to the following address or the member can ask the member's doctor to call CVS/caremark at 866-443-118/Fax 866-443-1172. CVS/caremark, MC 109, PO Box 52084, Phoenix, AZ 85072-2084.

# CHAPTER 9:

# HIPAA

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## **HIPAA**

The Health Insurance Portability and Accountability Act was passed by Congress in 1996. This law helps to protect an Employee's right to health coverage during events such as changing or losing jobs, pregnancy, moving or divorce. It also provides rights and protections for employers when obtaining and renewing health coverage for their Employees.

The HIPAA's Privacy Rules became effective April 14, 2003. These were issued to provide protection against the unauthorized use and disclosure of an individual's Protected Health Information (PHI). KEHP is adhering to these rules in order to protect the confidentiality of our Members. PHI is defined as information that can be identified as belonging to a specific individual. This information can be transmitted or maintained in many ways such as, but not limited to, mail, fax, copier, telephone, email or paper mediums. Disclosure of PHI to anyone other than the Member is prohibited without the Member's specific authorization to disclose.

KEHP benefits information may be disclosed to the Member's Spouse, Dependent, or the Member's legal counsel/representative if that Member has completed an Authorization for Disclosure form for the Plan Year and it has been received by KEHP. If the Member obtains legal counsel, the Member will need to complete the Authorization for Disclosure form and also provide a copy of the Letter of Representation authorizing KEHP to correspond with the legal counsel. If the correct information is not provided to KEHP, there will be no disclosure of information to anyone except the Member. The KEHP only maintains demographic information on Members. KEHP will only provide information pertaining to eligibility, enrollment, disenrollment and Qualifying Events.

Authorization for Disclosure forms are maintained by KEHP for the Plan Year or until revoked by the Member, whichever is shorter. KEHP's HIPAA Privacy Notice and Authorization form are located online at [kehp.ky.gov](http://kehp.ky.gov) under legal documents.

### **1. KEHP and HIPAA**

Due to compliance requirements, KEHP implemented several changes designed to protect personal health information used in electronic mail. These changes are applicable to all programs. When a Member's information is being transmitted via electronic mail there are two competing interests: (1) the Planholder has an expectation that the use of PHI is limited to the minimum necessary to carry out the purpose of the communication; and (2) the Employees involved in the communication have an interest in sharing the maximum amount of information permissible to ensure the purpose/needs of the communication is/are met. KEHP does not maintain information regarding Employee's specific medical or health conditions but does maintain demographic PHI and other information that is necessary for determining eligibility and enrollment in KEHP.

In addition to those concerns, electronic mail is considered a public document and is subject to open records requests. One of KEHP's concerns is that PHI transmitted via electronic mail may be inadvertently disclosed to the public through an open records request. Based on these concerns, KEHP implemented the following procedures for transmitting Employee information (PHI or personally identifiable information) to our vendors/third-party administrators (TPAs), Insurance Coordinators, Enrollment Specialists, Business Associates, and Billing Specialists within KEHP via electronic mail: Use encrypted email (ENTRUST or a similar encryption product) to transmit any and all PHI. In the subject line of the encrypted email use the word "Confidential."

DO NOT send any PHI information via email if you do not have encryption software. When KEHP faxes information to an Insurance Coordinator they will first call to verify the Insurance Coordinator is available to receive the fax. After receiving the fax the Insurance Coordinator must call KEHP to acknowledge receipt of the fax.

Members will need to contact the applicable KEHP vendors (Anthem, WageWorks, CVS/caremark) for information relating to payment of claims and benefits are covered under their health plan. If the Member needs to have information disclosed from any vendor to someone other than themselves, the vendor may require them to complete an Authorization for Disclosure form. KEHP's Authorization for Disclosure Form will not be accepted by the vendor. The Member will be required to abide by the vendor's policies and procedures concerning release of their PHI.

## 2. ENTRUST Software

ENTRUST is available to all Insurance Coordinators and Billing Liaisons, within KEHP **free of charge**. There are two different appliances that may be installed depending upon whether your email domain is managed by COT (Commonwealth Office of Technology).

If your e-mail is managed by COT, you can get ENTRUST installed on your computer. This will be integrated directly into your Outlook and will allow you to send and receive encrypted e-mails directly from Outlook. All requests for ENTRUST installation are to go through your IT support department, who in turn, will coordinate the necessary processes with the COT Support Desk. Once installed, this will allow you to send and receive encrypted e-mails. There is no charge for this additional service.

If your e-mail is not managed by COT, you can get ENTRUST installed on your computer. This will allow you to send and receive encrypted e-mails through a web interface and receive alerts in Outlook when you have messages waiting for you. This web appliance is free.

*If you already have ENTRUST but do not remember your password, please contact COT Support Desk at 502-564-7576 to have your password reset. If you do not have ENTRUST, you may register directly at <https://securemail.ky.gov/webmail/do/Start>.*

## 3. HIPAA Training

HIPAA training is required, on an annual basis, by the Department of Employee Insurance for Insurance Coordinators, Billing Liaisons and Human Resource Generalists who have access to members' PHI. This annual training is now being handled by Bridgefront. You will receive emails from Bridgefront with instructions to create an account and take the KEHP HIPAA training. HIPAA Forms and Contact Information

KEHP's Notice of HIPAA Privacy Practices, Authorization Form, and other related HIPAA forms are located on our website at [kehp.ky.gov](http://kehp.ky.gov).

Contact Information:

HIPAA Privacy Officer: Sharron Burton, (502) 564-5506

HIPAA Security Officer: Cindy Stivers, (502) 564-6730

# CHAPTER 10:

## COBRA

### Consolidated Omnibus Budget Reconciliation Act

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## COBRA Continuation of Benefits

On April 7, 1986, the Consolidated Omnibus Budget Reconciliation Act (COBRA) was signed into law. This federal law applies to employers with 20 or more Employees. The law requires that employers offer Employees and/or their Dependents continuation of medical coverage at group rates in certain instances where there is a loss of group insurance coverage.

### 1. Eligibility

A Qualified Beneficiary under COBRA law means an Employee, Employee's Spouse or Dependent child covered by the Plan on the day before a Qualifying Event. A Qualified Beneficiary under COBRA law also includes a child born to the Employee during the coverage period or a child placed for adoption with the Employee during the coverage period.

Employees covered by KEHP have the right to elect COBRA continuation coverage if coverage is lost due to one of the following Qualifying Events:

- Termination (for reasons other than gross misconduct) of the Employee's employment or reduction in the hours of Employee's employment; or
- Termination of Retiree coverage when the former employer discontinues Retiree coverage within one year before or one year after filing for Chapter 11 bankruptcy.

**NOTE: This includes transferring out of an agency, retirement, and LWOP.**

Spouses covered by KEHP have the right to elect continuation coverage if the group coverage is lost due to one of the following Qualifying Events:

- The death of the Employee;
- Termination of the Employee's employment (for reasons other than gross misconduct) or reduction of the Employee's hours of employment with the employer;
- Divorce or legal separation from the Employee;
- The Employee becomes entitled to Medicare benefits; or
- Termination of a Retiree Spouse's coverage when the former employer discontinues Retiree coverage within one year before or one year after filing for Chapter 11 bankruptcy.

Dependent Children covered by KEHP have the right to continuation coverage if group coverage is lost due to one of the following Qualifying Events:

- The death of the Employee-parent;
- The termination of the Employee-parent's employment (for reasons other than gross misconduct) or reduction in the Employee-parent's hours of employment with the employer;
- The Employee-parent's divorce or legal separation;
- Ceasing to be a "Dependent child" under the Plan;
- The Employee-parent becomes entitled to Medicare benefits; or
- Termination of the Retiree-parent's coverage when the former employer discontinues Retiree coverage within one year before or one year after filing for Chapter 11 bankruptcy.

## **2. Loss of Coverage**

A loss of coverage is when coverage is lost in connection with the above Qualifying Events, when a covered Employee, Spouse or Dependent child ceases to be covered under KEHP's terms and conditions as in effect immediately before the Qualifying Event, such as an increase in the premium or contribution which must be paid for Employee, Spouse or Dependent child coverage.

If coverage is reduced or eliminated in anticipation of an event (example: an employer eliminating an Employee's coverage in anticipation of the termination of the Employee's employment, or an Employee eliminating the coverage of the Employee's Spouse in anticipation of a divorce or legal separation), the reduction or elimination is disregarded in determining whether the event causes a loss of coverage.

A loss of coverage need not occur immediately after the event, so long as it occurs before the end of the Maximum Coverage Period.

## **3. Maximum Coverage Period**

COBRA continuation coverage may continue up to:

- 18 months for termination of Employee's employment or reduction in hours of employment;
- 36 months for a Spouse whose coverage ended due to the death of the Employee or Retiree, divorce, or the Employee becoming entitled to Medicare at the time of the initial qualifying event;
- 36 months for a Dependent child whose coverage ended due to the divorce of the Employee parent, the Employee becoming entitled to Medicare at the time of the initial qualifying event, the death of the Employee, or the child ceasing to be a Dependent under the Plan;
- For the Retiree, until the date of death of the Retiree who is on continuation due to loss of coverage within one year before or one year after the employer filed Chapter 11 bankruptcy.

## **4. Disability**

An 11-month extension of coverage may be available if any of the qualified beneficiaries are determined by the Social Security Administration (SSA) to be disabled. The disability has to have started at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the 18 month period of continuation coverage. The Qualified Beneficiary must provide notice of such determination prior to the end of the initial 18 month continuation period to be entitled to the additional 11-months of coverage. Each Qualified Beneficiary who has elected continuation coverage will be entitled to the 11-month disability extension if one of them qualifies. If a Qualified Beneficiary is determined by SSA to no longer be disabled, he/she must notify the Plan of that fact within 30 days after SSA's determination.

## **5. Second Qualifying Event**

An 18-month extension of coverage will be available to Spouses and Dependent children who elect continuation coverage if a second Qualifying Event occurs during the first 18 months of continuation coverage. The maximum amount of continuation coverage available when a second occurs is 36 months. Such second Qualifying Event may include the death of a covered Employee, divorce or separation from the covered Employee, the covered Employee's becoming entitled to Medicare benefits (under Part A, Part B, or both), or a Dependent child's ceasing to be eligible for coverage as a Dependent under the Plan. These events can be a second only if they would have caused the Qualified Beneficiary to lose coverage under the Plan if the first Qualifying Event had not occurred. The

Employees must notify the Plan within 60 days after the second Qualifying Event occurs if they want to extend your continuation coverage.

## 6. COBRA Administrator

KEHP's COBRA Administrator is WageWorks. KEHP sends files to WageWorks. It is extremely important that you, as the Insurance Coordinator, submit your Employee's COBRA Qualifying Event information via KHRIS, MUNIS or by submitting the appropriate documents to the Enrollment Information Branch, within 30 days of the event, or within 30 days of you receiving notification from the Employee. WageWorks is responsible for COBRA notification letters, enrollment, premium collection, and other COBRA related services.

## 7. Notification of COBRA Rights – Initial Notice/General Notice

COBRA regulations provide that a group health plan is required to provide written notice of COBRA rights to all covered Employees and their Spouses, if any, when coverage under the plan first commences. The regulations require that group health plans furnish written notice of COBRA rights no later than 90 days after their coverage begins. This written notice may be referred to as either the Initial Notice or the General Notice. This Initial Notice or General Notice will be mailed to Employees by WageWorks immediately after receiving the enrollment information from the KEHP files. It is extremely important that you, as the Insurance Coordinator, ensure all new hires are in KHRIS in a timely manner.

## 8. Notification of a Qualifying Event

The employer cannot detect the occurrence of some Qualifying Events, because information concerning such events is uniquely within the control of the Qualified Beneficiary. If the event results in a loss of coverage under the group plan then the COBRA regulations require that the covered Employee or other Qualified Beneficiary notify the Insurance Coordinator or the COBRA Administrator of the following events:

- Divorce or legal separation;
- Dependent children ceasing to qualify as Dependents under the terms of the plan. KEHP will notify WageWorks directly of this event;
- The occurrence of a second Qualifying Event after the Qualified Beneficiary becomes entitled to COBRA continuation coverage with the maximum duration of 18 or 29; and

A determination by the Social Security Administration (SSA) that a covered Employee or other Qualified Beneficiary is disabled or a subsequent determination by the SSA that the individual is no longer disabled.

The Employees or their qualified beneficiaries are required to notify you no later than 60 days after the Qualifying Event. Failure to notify you in a timely manner will result in unavailability of COBRA continuation coverage for the affected individuals. The employer must notify the Employees of some Qualifying Events. If the event results in a loss of coverage under the group health plan, the Insurance Coordinator must enter into KHRIS and WageWorks will notify the Qualified Beneficiary of the following events:

- Death of the covered Employee;
- Termination of employment (other than for gross misconduct);
- Reduction in the Employee's hours of employment;
- The Employee's entitlement to Medicare (under Parts A or B, or both);
- The employer's bankruptcy; and

- Break in coverage due to a transfer between agencies within KEHP.

**When Employees experience any of the above Qualifying Events, the Insurance Coordinator must submit all information in a timely manner via KHRIS ESS, MUNIS or by submitting paperwork to the Enrollment Information Branch. WageWorks will then mail all necessary notifications and forms within the required timeframes.**

## **9. COBRA Rates**

COBRA regulations do not require employers to pay for continuation coverage. Instead, employers are expressly permitted to charge Employees 100 percent of the cost of the group health coverage, plus an additional two percent, for a total premium of 102 percent. The COBRA rates are included in this manual (refer to Appendix G) and the KEHP website. The additional two percent covers the added cost for administering COBRA continuation coverage.

# CHAPTER 11:

## NEW EMPLOYEE ORIENTATION

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## **New Employee Orientation**

This Chapter has been designed to assist Insurance Coordinators with the enrollment of new Employees. All new Employees should receive the following information:

### **1. Memorandum Regarding Notice About Special Enrollment Rights and Notice About Women’s Health and Cancer Rights Act**

Federal law requires that all Employees receive notification of the Notice of Special Enrollment Rights and Notice about Women’s Health and Cancer Rights Act. A copy of this notice is provided for your assistance in Appendix B.

### **2. KEHP Checklist**

New Employees should be given the KEHP checklist for review and they should check each item as explained to them by the Insurance Coordinator. This checklist ensures that Employees have received the required information and protects the Insurance Coordinator in the event of a discrepancy. A KEHP checklist is included in Appendix C and should be made a part of the employee’s personnel files as acknowledgement of receipt of information.

### **3. Additional Resources**

Employees should visit the KEHP website at [kehp.ky.gov](http://kehp.ky.gov) to locate the Benefits Selection Guide, Summary Plan Descriptions, benefit booklets, and Summary of Benefits and Coverage. Both documents will provide necessary information in making their benefit selections. Non-Commonwealth Paid Insurance Coordinators can also access the [Benefits Administration User Guide](#) and the [Benefits Accounting User Guide](#)

# **CHAPTER 12:**

## **BENEFITS ACCOUNTING**

### **COLLECTIONS & DISBURSEMENTS**

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*Throughout Chapter 12 there is reference to Health Insurance, Life Insurance, FSA and HRA bills. Life Insurance is being addressed because benefits are billed on one bill. If you have questions regarding the Life Insurance portion of the bill you must contact Group Life Insurance at:*

**Personnel Cabinet  
Office of Employee Relations, Life Insurance Branch  
(502) 564-4774 or (800) 267-8352**

## **1. Collections and Disbursements (CD)**

The Collections and Disbursements (CD) module in KHRIS is used to facilitate the reconciliation and management of Health Insurance, FSA/HRA and Life Insurance enrollment data, premiums owed and contributions. By managing all premiums and contributions, the CD module supports the Commonwealth's self-funded insurance model. The CD system allows for:

- Creation of Health Insurance, Life Insurance, FSA/HRA and administration fee bills using KHRIS Web-billing (Broker Report);
- Reconciliation of Health Insurance, Life Insurance and FSA/HRA coverage with all agencies and administrators;
- Posting of all premiums, contributions and adjustments; and
- Reporting and resolution of discrepancies.

## **2. Billing Statements**

### **A. State government agencies**

State government agencies do not receive bill statements. KEHP receives a file extract from the state payroll system. Health Insurance, Life Insurance, FSA/HRA contributions, premiums and administration fees are posted into the CD system automatically from this extract.

Once the extract has been loaded into CD, KEHP will review the results and notify each state agency's Insurance Coordinator of any discrepancies by running an "arrears report" after each payroll has been run.

### **B. Boards of Education**

#### **1. Employee Portion of Premiums/Contributions**

Boards of Education will have a monthly bill statement (semi-monthly for FSA/HRA) generated by CD for the Employee portion of Health Insurance, FSA, Optional and Dependent Life insurance premiums and contributions only. The bill statements will be posted in KHRIS Web Billing (broker report) located at [khris.ky.gov](http://khris.ky.gov).

Insurance Coordinators and/or Billing Liaisons are responsible for reconciling the monthly and semi-monthly bills posted on KHRIS Web Billing (broker report) to enrollment records for the Employees and to deductions made from the board of education payroll system and adjusting the web bill if necessary. It is important to note that the premiums received must match the monthly or semi-monthly KHRIS web billing broker report.

## 2. **Employer Portion of Health Insurance, Basic Life Insurance or HRA**

KDE pays the employer portion of Health Insurance, HRA and basic Life Insurance premiums/contributions and the administration fees. Insurance Coordinators or payroll officers with questions related to MUNIS must contact the Kentucky Department of Education (KDE) at (502)564-3846.

## C. **Health Departments and Quasi-Governmental Agencies**

Currently, health departments do not participate in KEHP's Flexible Spending Account Program and there are only a limited number of quasi-governmental agencies participating.

The CD (collections and disbursement) module of KHRIS generates monthly (semi-monthly for FSA/HRA) broker reports for health departments and quasi-governmental agencies Insurance Coordinators are responsible for reviewing the monthly (semi-monthly for FSA/HRA) KHRIS broker reports for accuracy and must make any necessary changes.

For billing questions refer to the [Benefits Accounting User Guide](#).

## 3. **Payment Information**

Everyone is encouraged to use the Web Billing function called TPE to **pay via ACH at no cost**. The ACH process now provides the ability to pay using multiple funding accounts. One payment may be submitted for Health Insurance, FSA, Life Insurance and administration fees. If you pay by paper check, make the check payable to the Kentucky State Treasurer and mail to:

Personnel Cabinet  
Department of Employee Insurance  
Premium Billing Branch  
501 High Street, 2nd Floor  
Frankfort, Kentucky 40601

If you have questions refer to the [Benefits Accounting User Guide](#) or contact KEHP Premium Billing Branch at 502.564.9097.

## 4. **Arrears Process for Non-Commonwealth Paid Agencies/Members**

Monthly after the broker bills are generated, 30 and 60-day arrears letters and 90-day termination letters are run. The 60 and 90-day letters are sent to all members who owe arrears and all agencies that KHRIS shows have members in arrears.

### A. **IC/BL Letters**

ICs/BLs receive letters that notify them of members whose health insurance premiums and/or FSA/HRA contributions are 30 or 60 days in arrears and members who are 90 days in arrears who will be termed for nonpayment. Agencies that work the bill but do not submit payment are also considered delinquent accounts and the same arrears rules apply.

## **B. Member Letters**

Members receive letters that notify them that their health insurance premiums and/or FSA/HRA contributions are 60 days in arrears and at 90 days in arrears they are subject to termination for nonpayment.

The members are given 30 days from the date of the 60-day arrears letter to pay the arrears and avoid termination for nonpayment. If payment is not received, at the end of 30 days, the member's coverage is termed for nonpayment and they will receive the 90-day letter notifying them of the termination. A list of members who are termed for nonpayment will be sent to the Enrollment Information Branch so those members can be set up as Waiver/No HRA for the remainder of the plan year. Members will only be eligible to reinstate coverage during the next Open Enrollment for the next plan year. (Some exclusions apply – ex. LWOP).

## **5. Arrears Process for Commonwealth Paid Agencies/Members**

### **A. IC Notification**

ICs receive notification (semi-monthly discrepancy reports) of members whose health insurance premiums and/or FSA/HRA contributions are 30 or 60 days in arrears and members who are 90 days in arrears who will be termed for nonpayment.

### **B. Member Letters**

Members receive letters that notify them that their health insurance premiums and/or FSA/HRA contributions are 60 days in arrears and at 90 days in arrears they are subject to termination for nonpayment.

The members are given 30 days from the date of the 60-day termination letter to pay the arrears and avoid termination for nonpayment. If payment is not received, at the end of 30 days, the member's coverage is termed for nonpayment and they will receive the 90-day letter notifying them of the termination. A list of members who are termed for nonpayment will be sent to the Enrollment Information Branch so those members can be set up as Waiver/No HRA for the remainder of the plan year. Members will only be eligible to reinstate coverage during the next Open Enrollment for the next plan year. (Some exclusions apply – ex. LWOP).

## **6. 90-Day Revenue Forfeitures**

All billing issues must be resolved within 90 days of the discrepancy. Any overpayment (credit) made by a member or an agency that has not been requested or taken as a credit on agency billing will be forfeited at 90 days. The 90-day credits will be written-off as revenue forfeitures and will not be refunded to the member or agency.

**CHAPTER 13:**  
**GLOSSARY OF TERMS**

# Glossary of Terms

**COBRA** – The Consolidated Omnibus Budget Reconciliation Acts of 1986, as amended, including parallel provisions as outlined in Title XXII of the Public Health Service Act. COBRA allows Employees to continue their group Health Insurance coverage for a period of time.

**Commonwealth Paid** – Employees whose paychecks are generated by KHRIS.

**Couple Coverage Level** – Coverage for Employee or Retiree and their eligible covered Spouse.

**Coverage Level** – Single, parent plus, couple or family coverage.

**Cross-Reference Payment Option** – A married couple who, as Eligible Employees or Retirees of KEHP, may elect to have both state paid contributions applied to one Family Coverage Level (which includes an eligible Dependent).

**Default Plan Option** - Single Coverage Level of the Standard CDHP.

**Dependent** – A Spouse or Dependent child covered under the Plan.

**Dependent Care FSA** – A benefit provided through a Section 125 Cafeteria Plan that allows employees to pay for Dependent Care expenses with pre-tax dollars.

**Dual Employment** – Employees who are regularly employed with different agencies (i.e. school board and state company) and who meet the benefit eligibility requirements for both employers.

**Effective Date** – The date on which coverage for a covered person begins.

**Eligible Employee** – A person who meets the eligibility requirements of KEHP and his/her employer.

**Employee** – A person who is employed by a company participating with KEHP and eligible to apply for coverage under KEHP.

**Enrollment Application** – The form which is used upon hire or during Open Enrollment for an Employee to elect a Plan Option.

**Enrollment Notification** – The notification received by the Department of Employee Insurance whether via the KHRIS file; enrollment/change application; add/drop form; or IC entry in KHRIS.

**Family Coverage Level** – Coverage for the Employee, the Employee's Spouse under a legal marriage and one or more Dependent children.

**Flexible Spending Account** – A tax free account governed by a Section 125 Cafeteria Plan that allows employees to pay for certain Healthcare or Dependent Care (child or adult day care services) expenses with pre-tax money that you set aside through payroll deductions.

**Group Health Plan Coverage** – Coverage under a plan (including a self-insured plan) maintained by an employer (including a self-employed person) or labor union to provide healthcare for current employees or their families. Group Health Plan Coverage does not include Medicaid, KCHIP, TRICARE, Medicare, veteran's health coverage, 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 Kentucky Health Benefit Exchange (kynect).

**Healthcare FSA** – A benefit provided through a Section 125 Cafeteria Plan that allows employees to pay for eligible healthcare benefits with pre-tax dollars.

**Health Insurance** – A health benefit that provides reimbursement for covered eligible expenses due to sickness, injury and certain preventive care treatment after a specified premium has been paid.

**Insurance Coordinator** – The Human Resources representative within a company who is responsible for advising Employees of any benefits available through KEHP and the governing Cafeteria 125 rules.

**Kentucky Employees' Health Plan (KEHP)** – The group, which is composed of Eligible Employees of state agencies, boards of education, health departments and quasi agencies. Also Retirees of KCTCS, Retirees of the Kentucky Retirement Systems, Teachers' Retirement System, the Legislators Retirement Plan and the Judicial Retirement Plan who are under age 65, and their eligible Dependents.

**Kentucky Human Resource Information System (KHRIS)** – A software system that manages human resource data , including KEHP benefits for the Commonwealth.

**Late Enrollee** – An Eligible Employee who requests enrollment in a plan after the initial open enrollment period. An individual shall not be considered a Late Enrollee if:

- The person enrolls during their initial enrollment period;
- The person enrolls during any annual open enrollment period; or
- The person enrolls during a Special Enrollment Period.

**LivingWell Promise** – A promise from planholder(s) who elect the LivingWell CDHP or the LivingWell PPO to take the HumanaVitality health assessment or receive a biometric screening during the time period allotted.

**Member** – Any Employee, Retiree, COBRA participant or Dependents that are covered by one of the health plans offered by KEHP.

**Non-Commonwealth Paid** – Employees who receive life or health benefits from the Commonwealth but are not on the state payroll.

**Open Enrollment** – A defined period of time, prior to the beginning of a Coverage Period, during which an Employee shall be entitled to elect Plan Options for the subsequent Plan Year.

**Parent Plus Coverage Level** – Coverage for the Employee and one or more eligible Dependent children.

**Planholder** – The Employee who has coverage in KEHP. For the Cross-Reference Payment Option, one Employee will be designated as the Planholder.

**Plan Option** – An option such as LivingWell CDHP, LivingWell PPO, Standard PPO and the Standard CDHP.

**Plan Year** – Each successive twelve-month period starting on January 1 and ending on December 31.

**Premium Due Date** – The date on which a premium is due to maintain coverage under KEHP.

**Qualified Beneficiary** – Any individual who, on the day before a COBRA Qualifying Event, is covered under the Plan by virtue of being a covered person on that day, or any child who is born or placed for adoption with an Employee during a period of COBRA continuation coverage.

**Qualifying Event** – A specific situation or occurrence that enables an Eligible Employee to enroll or terminate coverage outside the designated enrollment period for self and/or eligible Dependents, as a result of that person becoming eligible for or losing eligibility for coverage under this Plan or another plan.

**Redirection** - is the ability to stop employer funds from being directed into either the Waiver General Purpose HRA or the Waiver Dental/Vision ONLY HRA, in order to start receiving an employer contribution toward a Health Insurance plan.

**Retiree** – A Retiree of a retirement plan administered by the Kentucky Retirement Systems, Kentucky Teachers' Retirement System, Legislators Retirement Plan, Judicial Retirement Plan or any other state retirement system, who is under age 65.

**Semi-Monthly Billing Period** – For purposes of Health Insurance the semi-monthly billing period is the 1<sup>st</sup> through the 15<sup>th</sup> of the month and the 16<sup>th</sup> through the last day of the month.

**Single Coverage Level** – Coverage for the Employee/Retiree only.

**Special Enrollment Period** – A period of time during which an Eligible Employee or Dependent who loses other Health Insurance coverage or incurs a change in status may enroll in the plan without being considered a Late Enrollee.

**Spouse** – A person who is legally married to an Employee or Retiree.

**Tag-Alongs** – Eligible individuals who can be added to the plan, when a spouse or dependent gains eligibility as a result of a change in status event or a HIPAA special enrollment event.

**Waiver** – Employees who do not elect one of the Health Insurance plan options in KEHP.

**Waiver Dental/Vision ONLY HRA** – A Health Reimbursement Arrangement for Employees who are eligible to waive Health Insurance coverage and who are eligible to receive HRA funds of \$175 per month up to \$2,100 per year in two installments: January 1 - \$1,050 and July 1 - \$1,050. This Waiver Dental/Vision ONLY HRA is a limited purpose HRA and will only reimburse for qualified dental and vision expenses.

**Waiver General Purpose HRA** – A Health Reimbursement Arrangement for Employees who are eligible to waive Health Insurance coverage and who are eligible to receive HRA funds of \$175 per month up to \$2,100 per year in two installments: January 1 - \$1,050 and July 1 - \$1,050.

**Working Day** – Any period of time, on any given day that an Employee is required by his/her employer to work. A “working day” also includes any day the employee does not work, yet is eligible for paid leave such as compensatory, annual, and sick leave.

# CHAPTER 14:

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## SAMPLE

### USE YOUR COMPANY LETTERHEAD

## MEMORANDUM

TO: *(Employee)*

FROM: *(Insurance Coordinator or Human Resource Generalist)s*

DATE: *(Insert)*

SUBJECT: **Notice to Active Employees Age 65 or Older**

Employer records indicate that you are an active employee nearing age 65 or who has already turned age 65. This letter is to inform you of your health insurance options upon becoming eligible for Medicare. Medicare is a federal government health insurance program for people age 65 or older.

Any individual age 65 or older who has current employment status is entitled to the same benefits under the employer's group health plan as other employees who are under the age of 65. Further, an employee's spouse who is over the age of 65 is also entitled to benefits under the employer's group health plan as a dependent of the employee.

See below for more information regarding enrolling in Medicare and your health insurance choices. If you have Medicare and employer-sponsored group health insurance, the Medicare Secondary Payer rules specify who pays first. Generally, employer-sponsored group health insurance offered to current employees, regardless of the employee's Medicare status, pays what it owes on your medical bills first for individuals covered through their own or a Spouse's *current* employer. The rules also provide that employers may not offer individuals entitled to Medicare financial or other incentives to opt out of employer-provided group health coverage, and they prohibit certain actions that "take into account" an individual's Medicare entitlement.

## MEDICARE

**You will receive information regarding Medicare enrollment approximately three months prior to your 65<sup>th</sup> birthday.** Medicare is divided into two main parts, which differ in terms of benefits, eligibility, and administration. Part A is the hospital insurance program, and Part B is the supplementary medical insurance program, covering physicians' services and other health care expenses. In addition, individuals who are entitled to these Parts of Medicare may also be eligible for the Medicare Advantage program (Part C) or for certain prescription drug benefits (Part D).

If you are eligible for Medicare Part A, the coverage will generally be free and enrollment will be automatic. Medicare Part B is **not** free and enrollment is **not** automatic. You are encouraged to contact your local Social Security office to determine your eligibility for these programs.

### **KENTUCKY EMPLOYEES' HEALTH PLAN (KEHP)**

Your Medicare eligibility or enrollment does not affect your eligibility to continue coverage with KEHP as long as you continue to meet the eligibility requirements as an employee. However, your eligibility to participate in the Kentucky Retirement System(s) Medicare Supplement (KERS/CERS, KTRS, Judicial or Legislators' Retirement) plan may be affected.

Under the Medicare Secondary Payer ("MSP") statute, employer group health plans, like KEHP, must pay primary to Medicare for employees who are eligible for the employer's group health plan ("GHP") coverage by reason of their "current employment status." See 42 U.S.C. § 1395y (b); 42 C.F.R. § 411.100(a)(1)(i). If an employee retires and then returns to work, and the Retiree works enough hours to qualify for coverage (avg. 100 hours/month) under the employer's group health plan for active employees, federal regulations require the employer to treat the Retiree as an active employee for purposes of the MSP rules:

A reemployed Retiree or annuitant who is covered by a GHP and who performs sufficient services to qualify for coverage on that basis (that is, other employees in the same category are provided health benefits) is considered covered "by reason of current employment status" even if: (1) The employer provides the same GHP coverage to Retirees; or (2) The premiums for the plan are paid from a retirement or pension fund. See 42 C.F.R. § 411.172(d).

### **EMPLOYEE OPTIONS**

**NOTE:** These are the same KEHP options available to active employees as a result of employment and KEHP eligibility.

**A. Health Insurance:** Since you will be eligible to participate in Medicare and KEHP, you should compare the cost and benefits of each, and make your decisions based upon your needs.

You may choose Medicare Parts A & B as your only source of coverage and be eligible to waive your employer-sponsored health insurance. There is a monthly premium for Medicare Part B.

You may choose not to enroll in Medicare Part B and continue in KEHP. You may delay enrollment in Medicare Part B until a later date, however, you will need to contact your local Social Security office regarding the Special Enrollment requirements, including dates. Contact your local Social Security office or check the Centers for Medicare/Medicaid Services website to obtain all the information necessary to make your decisions.

**B. Waiver General Purpose HRA:** You may elect to waive KEHP health insurance coverage and enroll in a Waiver General Purpose HRA. However, this option is only available for employees that have other group health plan coverage that provides minimum value. "Group health plan coverage" that provides "minimum value" is coverage offered by an employer or an employer organization (such as a union) that pays at least 60% of the

total allowed costs of covered benefits under the plan. Employees choosing to waive KEHP health insurance coverage and choose a Waiver General Purpose HRA must attest, in writing, that they have group health plan coverage that provides minimum value. **Medicare is not considered “group health plan coverage.”**

The Waiver General Purpose HRA provides you up to \$2,100 per year in a Health Reimbursement Arrangement (HRA). If you are eligible and you elect the Waiver General Purpose HRA, the HRA funds will be primary to Medicare and will pay first, together with your other group health plan coverage.

- C. Waiver Dental/Vision ONLY HRA:** You may elect to waive KEHP health insurance coverage and enroll in a Waiver Dental/Vision ONLY HRA. The Waiver Dental/Vision ONLY HRA benefit provides you up to \$2,100 per year in a Waiver Dental/Vision ONLY Health Reimbursement Arrangement (HRA). If an employee elects the Waiver Dental/Vision ONLY HRA, the HRA funds will be *secondary* to Medicare and will pay last.
  
- D. Waiver No HRA:** You may an elect to waive KEHP health insurance coverage without a Health Reimbursement Arrangement (HRA).

If you have questions, contact your (*Insurance Coordinator, Human Resource Generalists*) or the Enrollment Information Branch at 502-564-1205

## MEMORANDUM

TO: New Employees or Prospective Enrollees

FROM: (Name of State Agency, Board of Education, Local Health Department, KCTCS, etc.)

DATE:

### NOTICE ABOUT SPECIAL ENROLLMENT RIGHTS

Under the Health Insurance Portability and Accountability Act (HIPAA), you have “special enrollment” rights if you have a loss of other coverage or you gain a new dependent. In addition, you may qualify for a special enrollment in the Kentucky Employees’ Health Plan (KEHP) under the Children’s Health Insurance Program Reauthorization Act of 2009 (CHIPRA).

#### 1. HIPAA Special Enrollment Provision - Loss of Other Coverage.

If you decline enrollment for yourself or your eligible dependent(s) (including your spouse) because of other health insurance or group health plan coverage, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing toward your or your dependents’ other coverage). However, you must request enrollment within 35 days after your or your dependents’ other coverage ends (or after the employer stops contributing toward the other coverage).

#### 2. HIPAA Special Enrollment Provision - New Dependent as a Result of Marriage, Birth, Adoption, or Placement for Adoption.

If you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your new dependent(s). However, you must request enrollment within 35 days after the marriage and within 60 days after birth, adoption, or placement for adoption.

#### 3. CHIPRA Special Enrollment Provision – Premium Assistance Eligibility.

If you or your children are eligible for Medicaid or the Children’s Health Insurance Program (CHIP) and you’re eligible for health coverage from your employer, Kentucky may have a premium assistance program that can help pay for coverage using funds from the state’s Medicaid or CHIP programs. If you or your dependent(s) are eligible for premium assistance under Medicaid or CHIP, as well as eligible for health insurance coverage through KEHP, your employer must allow you to enroll in KEHP if you aren’t already enrolled. This is called a “special enrollment” opportunity, and you **must request coverage within 60 days of being determined eligible for premium assistance**. In addition, you may enroll in KEHP if you or your dependent’s Medicaid or CHIP coverage is terminated as a result of loss of eligibility. An employee must request this special enrollment within 60 days of the loss of coverage. More information and the required CHIP Notice may be found at [kehpc.ky.gov](http://kehpc.ky.gov).

## **NOTICE ABOUT WOMEN'S HEALTH AND CANCER RIGHTS ACT**

If you have had or are going to have a mastectomy, you may be entitled to certain benefits under the Women's Health and Cancer Rights Act of 1998 (WHCRA). For individuals receiving mastectomy-related benefits, coverage will be provided in a manner determined in consultation with the attending physician and the patient, for:

- All stages of reconstruction of the breast on which the mastectomy was performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance;
- Prostheses; and
- Treatment of physical complications of the mastectomy, including lymphedema.

These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under the 2016 plans offered through the Kentucky Employees' Health Plan. For further details, please refer to your Medical Benefit Booklet or go to [kehp.ky.gov](http://kehp.ky.gov), Legal Notices.

## **NOTICE ABOUT COBRA**

COBRA continuation coverage is a continuation of KEHP coverage when it would otherwise end because of a life event. This is also called a "qualifying event." After a qualifying event, COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." Qualified beneficiaries may elect to continue their coverage under the plan for a prescribed period of time on a self-pay basis. **Each qualified beneficiary has 60 days to choose whether or not to elect COBRA coverage, beginning from the later of the date the election notice is provided, or the date on which the qualified beneficiary would otherwise lose coverage under KEHP due to a qualifying event.** As a new employee, KEHP's third-party COBRA administrator will send to you additional information about your COBRA rights. You may also learn more about COBRA and your rights under COBRA at [kehp.ky.gov](http://kehp.ky.gov), Legal Notices.

## **NOTICE ABOUT NEWBORNS' AND MOTHERS' HEALTH PROTECTION ACT OF 1996**

Group health plans generally may not, under Federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, Federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 (or 96, as applicable) hours. In any case, plans may not, under Federal law, require that a provider obtain authorization from the plan or the insurance issuer for prescribing a length of stay not in excess of 48 (or 96) hours.

## **WELLNESS PROGRAM DISCLOSURE**

KEHP offers a variety of wellness opportunities and rewards through its LivingWell wellness program. In particular, 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. Rewards for participating in a wellness program are available to all employees. If you think you might be unable to meet a standard for a reward under this wellness program, you might qualify for an opportunity to earn the same reward by different means. Contact the Department of Employee Insurance at (888) 581-8834 or (502) 564-6534 and KEHP will work with you (and, if you wish, with your doctor) to find a wellness program with the same reward that is right for you in light of your health status. KEHP does not collect or retain personal health or medical information through its wellness program; however, KEHP may receive aggregate information that does not identify any individual in order to design and offer health programs aimed at improving the health of KEHP members.

## **HIPAA PRIVACY NOTICE**

KEHP gathers and collects demographic information about its members such as name, address, and social security numbers. This information is referred to as individually identifiable health information and is protected by HIPAA and related regulations regarding the privacy and security of such information. HIPAA requires KEHP to maintain the privacy of your protected health information (PHI) and notify you following a breach of unsecured PHI. In addition, KEHP is required to provide to its members a copy of its Notice of Privacy Practices (NPP) outlining how KEHP may use and disclose your PHI to carry out treatment, payment, or health care operations, or for any other purposes that are permitted or required by law. The NPP also informs members about their rights regarding their PHI and how to file a complaint if a member believes their rights have been violated. KEHP's Notice of Privacy Practices and associated forms may be obtained by visiting [kehpk.ky.gov](http://kehpk.ky.gov).

#### **PLAN YEAR 2016 KEHP PRESCRIPTION DRUG COVERAGE AND MEDICARE-NOTICE OF CREDITABLE COVERAGE**

KEHP has determined that KEHP's prescription drug coverage is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

#### **NOTICE OF AVAILABILITY OF SUMMARY OF BENEFITS AND COVERAGE (SBC)**

As an employee or retiree, the health benefits available to you represent a significant component of your compensation package. They also provide important protection for you and your family in the case of illness or injury. KEHP offers a series of health coverage options. Choosing a health coverage option is an important decision. To help you make an informed choice, KEHP makes available a Summary of Benefits and Coverage (SBC), which summarizes important information about your health coverage options in a standard format, to help you compare across options. The SBCs are only a summary. You should consult KEHP's Summary Plan Descriptions and/or Medical Benefit Booklet to determine the governing contractual provisions of the coverage. KEHP's SBCs are available on KEHP's website at [kehpk.ky.gov](http://kehpk.ky.gov). A paper copy is also available, free of charge, by contacting the Department of Employee Insurance, Member Services Branch at (888) 581-8834 or (502) 564-6534.

#### **UNIFORMED SERVICES EMPLOYMENT AND REEMPLOYMENT RIGHTS ACT NOTICE**

The Uniformed Services Employment and Reemployment Right Act (USERRA) protects the job rights of individuals who voluntarily or involuntarily leave employment positions to undertake military service or certain types of service in the National Disaster Medical System. USERRA also prohibits employers from discriminating against past and present members of the uniformed services, and applicants to the uniformed services.

##### Health Insurance Protection

- If you leave your job to perform military service, you have the right to elect to continue your existing employer-based health plan coverage for you and your dependents for up to 24 months while in the military.
- Even if you don't elect to continue coverage during your military service, you have the right to be reinstated in your employer's health plan when you are reemployed, generally without any waiting periods or exclusions (e.g., pre-existing condition exclusions) except for service-connected illnesses or injuries.

USERRA affords other rights and protections including reemployment rights and the right to be free from discrimination and retaliation. To view the complete notice of your rights under USERRA, go to [http://www.dol.gov/vets/programs/userra/USERRA\\_Private.pdf](http://www.dol.gov/vets/programs/userra/USERRA_Private.pdf).

**Keep this information for your records.**

**Kentucky Employees' Health Plan  
INSURANCE AND FLEXIBLE SPENDING ACCOUNT CHECKLIST FOR NEW EMPLOYEES**

<b>Name:</b>	<b>Hire Date:</b>
<b>Company Name:</b>	<b>Company #:</b>

The following is a list of your rights and responsibilities regarding enrollment in the Kentucky Employees' Health Plan (KEHP). Read this form carefully and make sure you understand each item. You may direct your questions to your Human Resource Office/Insurance Coordinator at \_\_\_\_\_ or you may contact KEHP at 888-581-8834.

As a new Employee, I understand that:

- I have 35 calendar days from my date of hire to make my coverage elections with KEHP, which includes enrolling in a Health Insurance plan, Flexible Spending Account and/or waiving Health Insurance coverage.**
  - I must enroll by: \_\_\_\_\_ ( 35 days are counted beginning with the day after my hire date).
  - My Effective Date of coverage is \_\_\_\_\_ (first day of the second month after my hire date).
  
- I must make my health insurance elections online in KHRIS ESS – OR I must complete an Enrollment Application and submit to my Insurance Coordinator.
  - I have been directed to the Summary Plan Descriptions, the Summary of Benefits and Coverage and the Benefits Selection Guide, on KEHP's website at [kehp.ky.gov](http://kehp.ky.gov), where I can find all relevant information pertaining to my KEHP coverage.
    - Health Insurance coverage options for Plan Year 2016 include:
      - LivingWell CDHP
      - LivingWell PPO
      - Standard PPO
      - Standard CDHP
      - Waiver (General Purpose) HRA – with \$2,100
      - Waiver Dental/Vision HRA – with \$2,100
      - Waiver without HRA – no funds
  - If I fail to enroll within the specified deadline, I will be automatically enrolled in the single coverage level of the Standard CDHP (Consumer Driven Health Plan) which has an employee contribution.
  
- I may enroll in a Flexible Spending Account (FSA) program (if my agency participates) online in KHRIS ESS – OR I can complete an FSA Enrollment Application and submit to my Insurance Coordinator.
  - I have been directed to the appropriate Healthcare and/or Dependent Care FSA Summary Plan Descriptions and the Benefits Selection Guides on KEHP's website at [kehp.ky.gov](http://kehp.ky.gov).
  
- If my spouse is also an eligible KEHP employee or retiree and we have at least one dependent, we can elect a Cross-Reference Payment Option.
  - If later, one of us terminates employment, the remaining Employee/Retiree will default to a Parent Plus plan.
  
- Once I make my elections, I cannot change those elections during the Plan Year unless I experience a valid Qualifying Event or during the next Open Enrollment Period.
  - A list of Qualifying Events is available from your Insurance Coordinator or KEHP's website at [kehp.ky.gov](http://kehp.ky.gov), under the Enrolling or Changing Coverage link.

- Retirees who return to work – please read this information carefully:
  - If I am 65 or older, I have the same opportunity to enroll in KEHP as any other active Employee.
  - If I am a KRS/KTRS/Judicial return to work Retiree age 65 or older and/or Medicare eligible I am not eligible to continue a Medicare supplement plan offered by one of Kentucky’s retirement systems. I must call my retirement system to notify them that I have returned to work.
  - If I have Medicare, I am not eligible to waive KEHP coverage and elect the Waiver (General Purpose) HRA unless I have other group health plan coverage (sponsored by an employer or an employer organization) that provides minimum value. I may choose a KEHP health insurance plan or waive coverage and elect a Waiver Dental/Vision ONLY HRA.
  
- KEHP operates as a Section 125 Cafeteria Plan that allows me to pay my portion of the Health Insurance premium with pre-tax dollars. I understand that I will automatically be enrolled in the program by virtue of enrolling in Health Insurance, unless I sign the Post-Tax Form.
  
- If I experience a COBRA Qualifying Event, such as, but not limited to, termination of employment, I have the right to continue my Health Insurance at my own expense under COBRA.

Have you worked for any other company participating in the Kentucky Employees’ Health Plan within the last 11 days?

Yes  No  If yes, please give name of company and date terminated or transferred.

Company Name: \_\_\_\_\_ Date terminated or transferred: \_\_\_\_\_

Are you retired from a state-sponsored retirement system?

Yes  No  If yes, please specify which retirement system: \_\_\_\_\_

I acknowledge that I have received copies of the following:

- Enrollment Application or KHRIS ESS online enrollment instructions
- Flexible Spending Account Information, if applicable, and online enrollment instructions or application
- Memorandum regarding Notice of Special Enrollment Rights and Women’s Health and Cancer Right Act
- Other \_\_\_\_\_

I certify that I have had my Health Insurance and Flexible Spending Account benefits explained and that I understand the benefits and my responsibilities.

\_\_\_\_\_  
Employee Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Company/Agency Representative

\_\_\_\_\_  
Date

**SAMPLE**

**USE YOUR COMPANY LETTERHEAD**

**MEMORANDUM**

TO: *(Employee on LWOP)*

FROM: *(Insurance Coordinator or Human Resource Generalists)*

DATE:

SUBJECT: Guidelines for Benefits While on Approved LWOP

As an Employee on Leave Without Pay (LWOP), you are eligible to continue your Health Insurance, Health Reimbursement Arrangement and Healthcare Flexible Spending Account at your own expense through COBRA. You must contact *(Insurance Coordinator/Human Resource Generalists)* to make arrangements to continue your benefits.

**Health Insurance**

To continue your group Health Insurance coverage you must pay the premiums or you may elect COBRA.

- A. If you are on LWOP and you have a pay-check during the semi-monthly period the leave starts, please check with *Insurance Coordinator/Human Resource Generalist* for information as to when your Health Insurance, Waiver General Purpose HRA, Waiver Dental/Vision ONLY HRA or FSA will terminate. If your pay for the semi-monthly period is not sufficient to cover the Employee's portion of the premium, you will need to submit a check for the amount due.

Any portion of a premium due by you must be submitted to *Insurance Coordinator/Human Resource Generalist* by the 20<sup>th</sup> of the month. The check must be payable to the Kentucky State Treasurer with your Social Security Number listed on the check. *Insurance Coordinator/Human Resource Generalist* will forward your payment to KEHP.

**NOTE:** If you fail to submit appropriate premium payments due within the specified deadline, your Plan(s) will be terminated.

- B. If you will be on LWOP and lose eligibility under the Plan, you may continue your coverage through COBRA. You will need to complete the COBRA election form and submit it, with your payment, to WageWorks. Follow the instructions provided with your COBRA materials.

## **Healthcare Flexible Spending Account**

If you are eligible and you decide to continue your participation in the Healthcare FSA, you must submit a check to Insurance Coordinator/Human Resource Generalist, in the amount of \$\_\_\_\_\_ made payable to the Kentucky State Treasurer.

When you return to work after being on LWOP, please check with Insurance Coordinator/Human Resource Generalist to see when your coverage will become effective.

When you return from LWOP, your length of absence may affect your Health Insurance.

When you return to work after being on LWOP you will not be eligible to make any changes to the Health Insurance coverage in which you were enrolled prior to the LWOP unless one of the following has occurred:

- You experience a Qualifying Event and you apply for an appropriate change within 35 days of returning to work, except when adding a child ONLY due to birth, adoption, or placement for adoption, which would require you to apply within 60 days.
- You return in a new Plan Year or after missing the Open Enrollment period and you apply for a coverage change no later than 35 days after your return.
- The coverage in which you were enrolled prior to the beginning of the LWOP is not available upon your return. You will have no more than 35 days after your return to apply for an appropriate change.

Insurance Coordinator/Human Resource Generalist must provide the necessary applications upon return. Should you have any questions, you may contact me at \_\_\_\_\_.

**SAMPLE**

**USE YOUR COMPANY LETTERHEAD**

**MEMORANDUM**

TO: *(Employee on Family Leave)*

FROM: *(Insurance Coordinator/Human Resource Generalist)*

DATE:

SUBJECT: Guidelines for Benefits While on Approved Family Medical Leave (FML)

This letter is to inform you of your health insurance responsibilities as an employee on Family Medical Leave (FMLA). As an employee on FMLA, your employer will continue to make the employer contributions for your health insurance or Health Reimbursement Arrangement (HRA), if applicable. It is your responsibility to make timely payments of any employee contributions that had been previously deducted from your check for health insurance and/or Flexible Spending Accounts (FSAs).

**Health Insurance**

While on FMLA, two conditions must be met in order to qualify for the health insurance employer contribution. First you must maintain the plan option and the coverage level that was in effect before going on leave. Secondly, you must pay the employee contribution, if applicable. To continue your health insurance you must submit a check made payable to the Kentucky State Treasurer, in the amount of \$\_\_\_\_\_ (employee contribution). Your check must be received by me before \_\_\_\_\_(insert date).

**Flexible Spending Account *(if applicable)***

If you are enrolled in KEHP's Flexible Benefits program, you may submit a check in the amount of \$\_\_\_\_\_ made payable to the Kentucky State Treasurer. Your check must be received by me before \_\_\_\_\_(insert date). If you choose to not continue participating in the Flexible Benefits program, your annual election amount will be reduced by the per semi-monthly contribution amounts not deducted during the FMLA period. If you wish to resume your employee contribution when you return from FMLA, you must complete an FSA Enrollment Change Application.

The payments for Health Insurance and Flexible Spending Accounts should be submitted to the following address by the \_\_\_\_\_(insert date) of each month. Please include your Social Security number on each check.

\_\_\_\_\_  
\_\_\_\_\_

If you exhaust your FMLA time before you are able to return to work, you will be placed on Leave Without Pay (LWOP) and may be eligible for COBRA. If eligible, you will be sent a COBRA notification letter, which allows you to continue your health insurance, Health Reimbursement Arrangement (HRA) and Healthcare FSA totally at your own expense. Should you opt not to continue under COBRA, you will be restored to your previous benefits on the 1<sup>st</sup> or the 16<sup>th</sup> of the month upon your return to work.

If you have any questions, please feel free to contact me at \_\_\_\_\_.

# 2016 Monthly Premiums and Contributions

Non-Tobacco User Rates All employee contributions are per employee, per month.

## LivingWell CDHP

	Total Premium	Employer Contribution	Employee Contribution
Single	\$702.10	\$654.12	\$47.98
Parent Plus	\$967.18	\$844.20	\$122.98
Couple	\$1,302.74	\$1,014.76	\$287.98
Family	\$1,453.94	\$1,115.96	\$337.98
Family Cross-Reference	\$810.00	\$732.02	\$77.98

## LivingWell PPO

	Total Premium	Employer Contribution	Employee Contribution
Single	\$721.14	\$641.16	\$79.98
Parent Plus	\$1,023.04	\$795.06	\$227.98
Couple	\$1,564.20	\$1,051.22	\$512.98
Family	\$1,738.40	\$1,095.42	\$642.98
Family Cross-Reference	\$865.64	\$712.66	\$152.98

## Standard PPO

	Total Premium	Employer Contribution	Employee Contribution
Single	\$677.74	\$629.74	\$47.98
Parent Plus	\$963.36	\$840.38	\$122.98
Couple	\$1,474.84	\$1,186.86	\$287.98
Family	\$1,640.84	\$1,302.86	\$337.98
Family Cross-Reference	\$814.72	\$736.74	\$77.98

## Standard CDHP

	Total Premium	Employer Contribution	Employee Contribution
Single	\$663.68	\$650.70	\$12.98
Parent Plus	\$930.34	\$870.36	\$59.98
Couple	\$1,429.26	\$1,179.28	\$249.98
Family	\$1,591.52	\$1,291.54	\$299.98
Family Cross-Reference	\$792.90	\$764.92	\$27.98

# 2016 Monthly Premiums and Contributions

Tobacco User Rates All employee contributions are per employee, per month.

## LivingWell CDHP

	Total Premium	Employer Contribution	Employee Contribution
<b>Single</b>	\$702.10	\$614.12	\$87.98
<b>Parent Plus</b>	\$967.18	\$764.20	\$202.98
<b>Couple</b>	\$1,302.74	\$934.76	\$367.98
<b>Family</b>	\$1,453.94	\$1,035.96	\$417.98
<b>Family Cross-Reference</b>	\$810.00	\$692.02	\$117.98

## LivingWell PPO

	Total Premium	Employer Contribution	Employee Contribution
<b>Single</b>	\$721.14	\$601.16	\$119.98
<b>Parent Plus</b>	\$1,023.04	\$715.06	\$307.98
<b>Couple</b>	\$1,564.20	\$971.22	\$592.98
<b>Family</b>	\$1,738.40	\$1,015.42	\$722.98
<b>Family Cross-Reference</b>	\$865.64	\$672.66	\$192.98

## Standard PPO

	Total Premium	Employer Contribution	Employee Contribution
<b>Single</b>	\$677.74	\$589.76	\$87.98
<b>Parent Plus</b>	\$963.36	\$760.38	\$202.98
<b>Couple</b>	\$1,474.84	\$1,106.86	\$367.98
<b>Family</b>	\$1,640.84	\$1,222.86	\$417.98
<b>Family Cross-Reference</b>	\$814.72	\$696.74	\$117.98

## Standard CDHP

	Total Premium	Employer Contribution	Employee Contribution
<b>Single</b>	\$663.68	\$610.70	\$52.98
<b>Parent Plus</b>	\$930.34	\$790.36	\$139.98
<b>Couple</b>	\$1,429.26	\$1,099.28	\$329.98
<b>Family</b>	\$1,591.52	\$1,211.54	\$379.98
<b>Family Cross-Reference</b>	\$792.90	\$724.92	\$67.98

## 2016 COBRA Rates

	Single	Parent Plus	Couple	Family
LivingWell CDHP	\$716.14	\$986.52	\$1328.79	\$1483.02
LivingWell PPO	\$735.56	\$1043.50	\$1595.48	\$1773.17
Standard PPO	\$691.29	\$982.63	\$1504.34	\$1673.66
Standard CDHP	\$676.95	\$948.95	\$1457.85	\$1623.35
Waiver HRA	\$169.58			

## 2016 COBRA Calendar

Qualifying Event Date	18 Months	36 Months
12/15	06/30/17	12/31/18
01/16	07/31/17	01/31/19
02/16	08/31/17	02/28/19
03/16	09/30/17	03/31/19
04/16	10/31/17	04/30/19
05/16	11/30/17	05/31/19
06/16	12/31/17	06/30/19
07/16	01/31/18	07/31/19
08/16	02/28/18	08/31/19
09/16	03/31/18	09/30/19
10/16	04/30/18	10/31/19
11/16	05/31/18	11/30/19
12/16	06/30/18	12/31/19

## Chart to Assist in Administering the Qualifying Event of Death

### Health Insurance Coverage

Coverage Level	Death of:	Date of Death	Coverage Ends	Premiums
<b>Single</b>	Member	1 <sup>st</sup> – 15 <sup>th</sup> of the month	Date of Death	No premium due
	Member	16 <sup>th</sup> – end of the month	Date of Death	Full month due
<b>Couple</b>	Member	1 <sup>st</sup> – 15 <sup>th</sup> of the month	End of Current Month	Full month due
	Member	16 <sup>th</sup> – end of the month	End of Current Month	Full month due
	Dependent	1 <sup>st</sup> – 15 <sup>th</sup> of the month	End of Current Month	Full month due
	Dependent	16 <sup>th</sup> – end of the month	End of Current Month	Full month due
<b>Parent Plus</b>	Member	1 <sup>st</sup> – 15 <sup>th</sup> of the month	End of Current Month	Full month due
	Member	16 <sup>th</sup> – end of the month	End of Current Month	Full month due
	Dependent	1 <sup>st</sup> – 15 <sup>th</sup> of the month	End of Current Month	Full month due
	Dependent	16 <sup>th</sup> – end of the month	End of Current Month	Full month due
<b>Family</b>	Member	1 <sup>st</sup> – 15 <sup>th</sup> of the month	End of Current Month	Full month due
	Member	16 <sup>th</sup> – end of the month	End of Current Month	Full month due
	Dependent	1 <sup>st</sup> – 15 <sup>th</sup> of the month	End of Current Month	Full month due
	Dependent	16 <sup>th</sup> – end of the month	End of Current Month	Full month due
<b>Family Cross-Reference</b>	Member/ Spouse	1 <sup>st</sup> – 15 <sup>th</sup> of the month	End of Current Month	Full month due
	Member/ Spouse	16 <sup>th</sup> – end of the month	End of Current Month	Full month due
<b>Family Cross-Reference</b>	Dependent	1 <sup>st</sup> – 15 <sup>th</sup> of the month	End of Current Month	Full month due
	Dependent	16 <sup>th</sup> – end of the month	End of Current Month	Full month due

### Flexible Spending Accounts and Waiver Health Reimbursement Arrangement

	Death of:	Date of Death	Coverage Ends	Contributions
<b>FSA &amp; HRA</b>	Member	1 <sup>st</sup> – 15 <sup>th</sup> of the month	Date of Death	½ of the monthly contribution
	Member	16 <sup>th</sup> – end of the month	Date of Death	Full monthly contribution

## Chart to Assist in Administering the Qualifying Event of Birth

Pursuant to KRS 304.17A-139, when a newly born child is added to KEHP, no additional premiums can be charged for the newborn for the first 31 days (for purposes of this statute, newborn does not include adopted child). Newly born children must be enrolled within 60 days from the date of birth; however, if Tag-Alongs are being enrolled with the newborn, the newly born child and the Tag-Alongs must be enrolled within 35 days from the birth and additional premiums can be charged. A spouse or other children who are already covered on the plan are not considered Tag-Alongs. For the chart below, the newly born child is born on October 6 and the 32<sup>nd</sup> day of coverage is on November 7. The enrollment and billing information is segregated by semi-monthly periods to show how an Employee could potentially be enrolled in a specific Coverage Level while being billed for a different Coverage Level.

	September 1 <sup>st</sup> -15 <sup>th</sup>	September 16 <sup>th</sup> -31 <sup>st</sup>	October 1 <sup>st</sup> -15 <sup>th</sup> (Newborn born on 10/6)		October 16 <sup>th</sup> -31 <sup>st</sup>	November 1 <sup>st</sup> -15 <sup>th</sup>	November 16 <sup>th</sup> -31 <sup>st</sup>
<b>Coverage Level:</b> Single to Parent Plus <u>with no</u> Tag-Alongs	Single Coverage Level	Single Coverage Level	Single Coverage Level	Parent Plus Coverage Level as of 10/6	Parent Plus Coverage Level	Parent Plus Coverage Level	Parent Plus Coverage Level
<b>Bill for:</b>	Single Contribution	Single Contribution	Single Contribution		Single Contribution	Single Contribution	Parent Plus Contribution
	September 1 <sup>st</sup> -15 <sup>th</sup>	September 16 <sup>th</sup> -31 <sup>st</sup>	October 1 <sup>st</sup> -15 <sup>th</sup> (Newborn born on 10/6)		October 16 <sup>th</sup> -31 <sup>st</sup>	November 1 <sup>st</sup> -15 <sup>th</sup>	November 16 <sup>th</sup> -31 <sup>st</sup>
<b>Coverage Level:</b> Single to Parent Plus <u>with</u> Tag-Along	Single Coverage Level	Single Coverage Level	Single Coverage Level	Parent Plus Coverage Level as of 10/6	Parent Plus Coverage Level	Parent Plus Coverage Level	Parent Plus Coverage Level
<b>Bill for:</b>	Single Contribution	Single Contribution	Parent Plus Contribution		Parent Plus Contribution	Parent Plus Contribution	Parent Plus Contribution
	September 1 <sup>st</sup> -15 <sup>th</sup>	September 16 <sup>th</sup> -31 <sup>st</sup>	October 1 <sup>st</sup> -15 <sup>th</sup> (Newborn born on 10/6)		October 16 <sup>th</sup> -31 <sup>st</sup>	November 1 <sup>st</sup> -15 <sup>th</sup>	November 16 <sup>th</sup> -31 <sup>st</sup>
<b>Coverage Level:</b> Single to Family <u>with</u> Tag-Alongs	Single Coverage Level	Single Coverage Level	Single Coverage Level	Family Coverage Level	Family Coverage Level	Family Coverage Level	Family Coverage Level
<b>Bill for:</b>	Single Coverage Level	Single Coverage Level	Family Coverage Level		Family Coverage Level	Family Coverage Level	Family Coverage Level
	September 1 <sup>st</sup> -15 <sup>th</sup>	September 16 <sup>th</sup> -31 <sup>st</sup>	October 1 <sup>st</sup> -15 <sup>th</sup> (Newborn born on 10/6)		October 16 <sup>th</sup> -31 <sup>st</sup>	November 1 <sup>st</sup> -15 <sup>th</sup>	November 16 <sup>th</sup> -31 <sup>st</sup>
<b>Coverage Level:</b> Family to Family with or without Tag-Along	Family Coverage Level	Family Coverage Level	Family Coverage Level	Family Coverage Level as of 10/6 with new Dependent	Family Coverage Level	Family Coverage Level	Family Coverage Level
<b>Bill for:</b>	Family Contribution	Family Contribution	Family Contribution		Family Contribution	Family Contribution	Family Contribution
	September 1 <sup>st</sup> -15 <sup>th</sup>	September 16 <sup>th</sup> -31 <sup>st</sup>	October 1 <sup>st</sup> -15 <sup>th</sup> (Newborn born on 10/6)		October 16 <sup>th</sup> -31 <sup>st</sup>	November 1 <sup>st</sup> -15 <sup>th</sup>	November 16 <sup>th</sup> -31 <sup>st</sup>
<b>Coverage Level:</b> Parent Plus to Parent Plus with or without Tag-Along	Parent Plus Coverage Level	Parent Plus Coverage Level	Parent Plus Coverage Level	Parent Plus Level as of 10/6 with new Dependent	Parent Plus Coverage Level	Parent Plus Coverage Level	Parent Plus Coverage Level
<b>Bill for:</b>	Parent Plus Contribution	Parent Plus Contribution	Parent Plus Contribution		Parent Plus Contribution	Parent Plus Contribution	Parent Plus Contribution

	September 1 <sup>st</sup> -15 <sup>th</sup>	September 16 <sup>th</sup> -31 <sup>st</sup>	October 1 <sup>st</sup> -15 <sup>th</sup> (Newborn born on 10/6)		October 16 <sup>th</sup> -31 <sup>st</sup>	November 1 <sup>st</sup> -15 <sup>th</sup>	November 16 <sup>th</sup> -31 <sup>st</sup>
<b>Coverage Level:</b> Parent Plus to Family with Tag-Along	Parent Plus Coverage Level	Parent Plus Coverage Level	Parent Plus Coverage Level	Family Coverage Level as of 10/6	Family Coverage Level	Family Coverage Level	Family Coverage Level
<b>Bill for:</b>	Parent Plus Contribution	Parent Plus Contribution	Family Contribution		Family Contribution	Family Contribution	Family Contribution
	September 1 <sup>st</sup> -15 <sup>th</sup>	September 16 <sup>th</sup> -31 <sup>st</sup>	October 1 <sup>st</sup> -15 <sup>th</sup> (Newborn born on 10/6)		October 16 <sup>th</sup> -31 <sup>st</sup>	November 1 <sup>st</sup> -15 <sup>th</sup>	November 16 <sup>th</sup> -31 <sup>st</sup>
<b>Coverage Level:</b> Two Single to a Family Cross-Reference Payment Option without Tag-Alongs	Two Single Coverage Levels	Two Single Coverage Levels	Two Single Coverage Levels	Family Cross-Reference Payment Option as of 10/6	Family Cross-Reference Payment Option	Family Cross-Reference Payment Option	Family Cross-Reference Payment Option
<b>Bill for:</b>	Two Single Contributions	Two Single Contributions	Two Single Contributions		Two Single Contributions	Two Single Contributions	Two Family Cross-Reference Contributions
	September 1 <sup>st</sup> -15 <sup>th</sup>	September 16 <sup>th</sup> -31 <sup>st</sup>	October 1 <sup>st</sup> -15 <sup>th</sup> (Newborn born on 10/6)		October 16 <sup>th</sup> -31 <sup>st</sup>	November 1 <sup>st</sup> -15 <sup>th</sup>	November 16 <sup>th</sup> -31 <sup>st</sup>
<b>Coverage Level:</b> One Single and one Parent Plus to Family Cross-Reference Payment Option without Tag-Alongs	One Single Coverage Level and One Parent Plus Coverage Level	One Single Coverage Level and One Parent Plus Coverage Level	One Single Coverage Level and One Parent Plus Coverage Level	Family Cross-Reference Payment Option as of 10/6	Family Cross-Reference Payment Option	Family Cross-Reference Payment Option	Family Cross-Reference Payment Option
<b>Bill for:</b>	One Single Contribution and One Parent Plus Contribution	One Single Contribution and One Parent Plus Contribution	One Single Contribution and One Parent Plus Contribution		One Single Contribution and one Parent Plus Contribution	One Single Contribution and one Parent Plus Contribution	Two Family Cross-Reference Contributions
	September 1 <sup>st</sup> -15 <sup>th</sup>	September 16 <sup>th</sup> -31 <sup>st</sup>	October 1 <sup>st</sup> -15 <sup>th</sup> (Newborn born on 10/6)		October 16 <sup>th</sup> -31 <sup>st</sup>	November 1 <sup>st</sup> -15 <sup>th</sup>	November 16 <sup>th</sup> -31 <sup>st</sup>
<b>Coverage Level:</b> Waiver HRA to Parent Plus (Employee is Tag-Along)	Waiver HRA	Waiver HRA	Waiver HRA	Parent Plus Coverage Level as of 10/6	Parent Plus Coverage Level	Parent Plus Coverage Level	Parent Plus Coverage Level
<b>Bill for:</b>	Waiver HRA	Waiver HRA	Single Contribution		Single Contribution	Single Contribution	Parent Plus Contribution
	September 1 <sup>st</sup> -15 <sup>th</sup>	September 16 <sup>th</sup> -31 <sup>st</sup>	October 1 <sup>st</sup> -15 <sup>th</sup> (Newborn born on 10/6)		October 16 <sup>th</sup> -31 <sup>st</sup>	November 1 <sup>st</sup> -15 <sup>th</sup>	November 16 <sup>th</sup> -31 <sup>st</sup>
<b>Coverage Level:</b> Waiver HRA to Family (Employee, Spouse and Children as Tag-Alongs)	Waiver HRA	Waiver HRA	Waiver HRA	Family Coverage Level as of 10/6	Family Coverage Level	Family Coverage Level	Family Coverage Level
<b>Bill for:</b>	Waiver HRA	Waiver HRA	Couple Contribution		Couple Contribution	Couple Contribution	Family Contribution

### Newborn Calculator for Higher Premium

Date of Birth	Higher Premium Becomes Effective
01/01/2016	02/16/2016
01/02/2016	02/16/2016
01/03/2016	02/16/2016
01/04/2016	02/16/2016
01/05/2016	02/16/2016
01/06/2016	02/16/2016
01/07/2016	02/16/2016
01/08/2016	02/16/2016
01/09/2016	02/16/2016
01/10/2016	02/16/2016
01/11/2016	02/16/2016
01/12/2016	02/16/2016
01/13/2016	02/16/2016
01/14/2016	02/16/2016
01/15/2016	02/16/2016
01/16/2016	03/01/2016
01/17/2016	03/01/2016
01/18/2016	03/01/2016
01/19/2016	03/01/2016
01/20/2016	03/01/2016
01/21/2016	03/01/2016
01/22/2016	03/01/2016
01/23/2016	03/01/2016
01/24/2016	03/01/2016
01/25/2016	03/01/2016
01/26/2016	03/01/2016
01/27/2016	03/01/2016
01/28/2016	03/01/2016
01/29/2016	03/01/2016

Date of Birth	Higher Premium Becomes Effective
01/30/2016	03/16/2016
01/31/2016	03/16/2016
02/01/2016	03/16/2016
02/02/2016	03/16/2016
02/03/2016	03/16/2016
02/04/2016	03/16/2016
02/05/2016	03/16/2016
02/06/2016	03/16/2016
02/07/2016	03/16/2016
02/08/2016	03/16/2016
02/09/2016	03/16/2016
02/10/2016	03/16/2016
02/11/2016	03/16/2016
02/12/2016	03/16/2016
02/13/2016	03/16/2016
02/14/2016	04/01/2016
02/15/2016	04/01/2016
02/16/2016	04/01/2016
02/17/2016	04/01/2016
02/18/2016	04/01/2016
02/19/2016	04/01/2016
02/20/2016	04/01/2016
02/21/2016	04/01/2016
02/22/2016	04/01/2016
02/23/2016	04/01/2016
02/24/2016	04/01/2016
02/25/2016	04/01/2016
02/26/2016	04/01/2016
02/27/2016	04/01/2016

Date of Birth	Higher Premium Becomes Effective
02/28/2016	04/01/2016
02/29/2016	04/01/2016
03/01/2016	04/16/2016
03/02/2016	04/16/2016
03/03/2016	04/16/2016
03/04/2016	04/16/2016
03/05/2016	04/16/2016
03/06/2016	04/16/2016
03/07/2016	04/16/2016
03/08/2016	04/16/2016
03/09/2016	04/16/2016
03/10/2016	04/16/2016
03/11/2016	04/16/2016
03/12/2016	04/16/2016
03/13/2016	04/16/2016
03/14/2016	04/16/2016
03/15/2016	04/16/2016
03/16/2016	05/01/2016
03/17/2016	05/01/2016
03/18/2016	05/01/2016
03/19/2016	05/01/2016
03/20/2016	05/01/2016
03/21/2016	05/01/2016
03/22/2016	05/01/2016
03/23/2016	05/01/2016
03/24/2016	05/01/2016
03/25/2016	05/01/2016
03/26/2016	05/01/2016
03/27/2016	05/01/2016

Date of Birth	Higher Premium Becomes Effective
03/28/2016	05/01/2016
03/29/2016	05/01/2016
03/30/2016	05/01/2016
03/31/2016	05/16/2016
04/01/2016	05/16/2016
04/02/2016	05/16/2016
04/03/2016	05/16/2016
04/04/2016	05/16/2016
04/05/2016	05/16/2016
04/06/2016	05/16/2016
04/07/2016	05/16/2016
04/08/2016	05/16/2016
04/09/2016	05/16/2016
04/10/2016	05/16/2016
04/11/2016	05/16/2016
04/12/2016	05/16/2016
04/13/2016	05/16/2016
04/14/2016	05/16/2016
04/15/2016	06/01/2016
04/16/2016	06/01/2016
04/17/2016	06/01/2016
04/18/2016	06/01/2016
04/19/2016	06/01/2016
04/20/2016	06/01/2016
04/21/2016	06/01/2016
04/22/2016	06/01/2016
04/23/2016	06/01/2016
04/24/2016	06/01/2016
04/25/2016	06/01/2016
04/26/2016	06/01/2016

Date of Birth	Higher Premium Becomes Effective
04/27/2016	06/01/2016
04/28/2016	06/01/2016
04/29/2016	06/01/2016
04/30/2016	06/01/2016
05/01/2016	06/16/2016
05/02/2016	06/16/2016
05/03/2016	06/16/2016
05/04/2016	06/16/2016
05/05/2016	06/16/2016
05/06/2016	06/16/2016
05/07/2016	06/16/2016
05/08/2016	06/16/2016
05/09/2016	06/16/2016
05/10/2016	06/16/2016
05/11/2016	06/16/2016
05/12/2016	06/16/2016
05/13/2016	06/16/2016
05/14/2016	06/16/2016
05/15/2016	06/16/2016
05/16/2016	07/01/2016
05/17/2016	07/01/2016
05/18/2016	07/01/2016
05/19/2016	07/01/2016
05/20/2016	07/01/2016
05/21/2016	07/01/2016
05/22/2016	07/01/2016
05/23/2016	07/01/2016
05/24/2016	07/01/2016
05/25/2016	07/01/2016
05/26/2016	07/01/2016

Date of Birth	Higher Premium Becomes Effective
05/27/2016	07/01/2016
05/28/2016	07/01/2016
05/29/2016	07/01/2016
05/30/2016	07/01/2016
05/31/2016	07/16/2016
06/01/2016	07/16/2016
06/02/2016	07/16/2016
06/03/2016	07/16/2016
06/04/2016	07/16/2016
06/05/2016	07/16/2016
06/06/2016	07/16/2016
06/07/2016	07/16/2016
06/08/2016	07/16/2016
06/09/2016	07/16/2016
06/10/2016	07/16/2016
06/11/2016	07/16/2016
06/12/2016	07/16/2016
06/13/2016	07/16/2016
06/14/2016	07/16/2016
06/15/2016	08/01/2016
06/16/2016	08/01/2016
06/17/2016	08/01/2016
06/18/2016	08/01/2016
06/19/2016	08/01/2016
06/20/2016	08/01/2016
06/21/2016	08/01/2016
06/22/2016	08/01/2016
06/23/2016	08/01/2016
06/24/2016	08/01/2016
06/25/2016	08/01/2016

Date of Birth	Higher Premium Becomes Effective
06/26/2016	08/01/2016
06/27/2016	08/01/2016
06/28/2016	08/01/2016
06/29/2016	08/01/2016
06/30/2016	08/01/2016
07/01/2016	08/16/2016
07/02/2016	08/16/2016
07/03/2016	08/16/2016
07/04/2016	08/16/2016
07/05/2016	08/16/2016
07/06/2016	08/16/2016
07/07/2016	08/16/2016
07/08/2016	08/16/2016
07/09/2016	08/16/2016
07/10/2016	08/16/2016
07/11/2016	08/16/2016
07/12/2016	08/16/2016
07/13/2016	08/16/2016
07/14/2016	08/16/2016
07/15/2016	08/16/2016
07/16/2016	09/01/2016
07/17/2016	09/01/2016
07/18/2016	09/01/2016
07/19/2016	09/01/2016
07/20/2016	09/01/2016
07/21/2016	09/01/2016
07/22/2016	09/01/2016
07/23/2016	09/01/2016
07/24/2016	09/01/2016

Date of Birth	Higher Premium Becomes Effective
07/25/2016	09/01/2016
07/26/2016	09/01/2016
07/27/2016	09/01/2016
07/28/2016	09/01/2016
07/29/2016	09/01/2016
07/30/2016	09/01/2016
07/31/2016	09/01/2016
08/01/2016	09/16/2016
08/02/2016	09/16/2016
08/03/2016	09/16/2016
08/04/2016	09/16/2016
08/05/2016	09/16/2016
08/06/2016	09/16/2016
08/07/2016	09/16/2016
08/08/2016	09/16/2016
08/09/2016	09/16/2016
08/10/2016	09/16/2016
08/11/2016	09/16/2016
08/12/2016	09/16/2016
08/13/2016	09/16/2016
08/14/2016	09/16/2016
08/15/2016	09/16/2016
08/16/2016	10/01/2016
08/17/2016	10/01/2016
08/18/2016	10/01/2016
08/19/2016	10/01/2016
08/20/2016	10/01/2016
08/21/2016	10/01/2016
08/22/2016	10/01/2016

Date of Birth	Higher Premium Becomes Effective
08/23/2016	10/01/2016
08/24/2016	10/01/2016
08/25/2016	10/01/2016
08/26/2016	10/01/2016
08/27/2016	10/01/2016
08/28/2016	10/01/2016
08/29/2016	10/01/2016
08/30/2016	10/01/2016
08/31/2016	10/16/2016
09/01/2016	10/16/2016
09/02/2016	10/16/2016
09/03/2016	10/16/2016
09/04/2016	10/16/2016
09/05/2016	10/16/2016
09/06/2016	10/16/2016
09/07/2016	10/16/2016
09/08/2016	10/16/2016
09/09/2016	10/16/2016
09/10/2016	10/16/2016
09/11/2016	10/16/2016
09/12/2016	10/16/2016
09/13/2016	10/16/2016
09/14/2016	10/16/2016
09/15/2016	11/01/2016
09/16/2016	11/01/2016
09/17/2016	11/01/2016
09/18/2016	11/01/2016
09/19/2016	11/01/2016
09/20/2016	11/01/2016

Date of Birth	Higher Premium Becomes Effective
09/21/2016	11/01/2016
09/22/2016	11/01/2016
09/23/2016	11/01/2016
09/24/2016	11/01/2016
09/25/2016	11/01/2016
09/26/2016	11/01/2016
09/27/2016	11/01/2016
09/28/2016	11/01/2016
09/29/2016	11/01/2016
09/30/2016	11/01/2016
10/01/2016	11/16/2016
10/02/2016	11/16/2016
10/03/2016	11/16/2016
10/04/2016	11/16/2016
10/05/2016	11/16/2016
10/06/2016	11/16/2016
10/07/2016	11/16/2016
10/08/2016	11/16/2016
10/09/2016	11/16/2016
10/10/2016	11/16/2016
10/11/2016	11/16/2016
10/12/2016	11/16/2016
10/13/2016	11/16/2016
10/14/2016	11/16/2016
10/15/2016	11/16/2016
10/16/2016	12/01/2016
10/17/2016	12/01/2016
10/18/2016	12/01/2016
10/19/2016	12/01/2016
10/20/2016	12/01/2016

Date of Birth	Higher Premium Becomes Effective
10/21/2016	12/01/2016
10/22/2016	12/01/2016
10/23/2016	12/01/2016
10/24/2016	12/01/2016
10/25/2016	12/01/2016
10/26/2016	12/01/2016
10/27/2016	12/01/2016
10/28/2016	12/01/2016
10/29/2016	12/01/2016
10/30/2016	12/01/2016
10/31/2016	12/16/2016
11/01/2016	12/16/2016
11/02/2016	12/16/2016
11/03/2016	12/16/2016
11/04/2016	12/16/2016
11/05/2016	12/16/2016
11/06/2016	12/16/2016
11/07/2016	12/16/2016
11/08/2016	12/16/2016
11/09/2016	12/16/2016
11/10/2016	12/16/2016
11/11/2016	12/16/2016
11/12/2016	12/16/2016
11/13/2016	12/16/2016
11/14/2016	12/16/2016
11/15/2016	01/01/2017
11/16/2016	01/01/2017
11/17/2016	01/01/2017
11/18/2016	01/01/2017
11/19/2016	01/01/2017

Date of Birth	Higher Premium Becomes Effective
11/20/2016	01/01/2017
11/21/2016	01/01/2017
11/22/2016	01/01/2017
11/23/2016	01/01/2017
11/24/2016	01/01/2017
11/25/2016	01/01/2017
11/26/2016	01/01/2017
11/27/2016	01/01/2017
11/28/2016	01/01/2017
11/29/2016	01/01/2017
11/30/2016	01/01/2017
12/01/2016	01/16/2017
12/02/2016	01/16/2017
12/03/2016	01/16/2017
12/04/2016	01/16/2017
12/05/2016	01/16/2017
12/06/2016	01/16/2017
12/07/2016	01/16/2017
12/08/2016	01/16/2017
12/09/2016	01/16/2017
12/10/2016	01/16/2017
12/11/2016	01/16/2017
12/12/2016	01/16/2017
12/13/2016	01/16/2017
12/14/2016	01/16/2017
12/15/2016	01/16/2017
12/16/2016	02/01/2017
12/17/2016	02/01/2017
12/18/2016	02/01/2017
12/19/2016	02/01/2017

<b>Date of Birth</b>	<b>Higher Premium Becomes Effective</b>
12/20/2016	02/01/2017
12/21/2016	02/01/2017
12/22/2016	02/01/2017
12/23/2016	02/01/2017
12/24/2016	02/01/2017
12/25/2016	02/01/2017
12/26/2016	02/01/2017
12/27/2016	02/01/2017
12/28/2016	02/01/2017
12/29/2016	02/01/2017
12/30/2016	02/01/2017

### Chart to Assist in Determining the Effective Date of Coverage

Coverage for new Employees will begin on the first day of the second calendar month following the Employee's hire date. Example: if employment begins anytime in August, the Employee is eligible for coverage October 1.

<b>Employees Hired During the Month of:</b>	<b>Will Have Coverage Effective</b>
January	March 1
February	April 1
March	May 1
April	June 1
May	July 1
June	August 1
July	September 1
August	October 1
September	November 1
October	December 1
November	January 1
December	February 1

**Chart to Assist in Determining the County Code needed for Enrollment**

COUNTY	CODE	CITIES
Adair	001	Columbia
Allen	002	Scottsville
Anderson	003	Lawrenceburg
Ballard	004	Barlow, Kevil, LaCenter, Wickliffe
Barren	005	Cave City, Glasgow, Park City
Bath	006	Owingsville, Salt Lick, Sharpsburg
Bell	007	Pineville, Middlesborough
Boone	008	Burlington, Florence, Union, Walton
Bourbon	009	Millersburg, North Middletown, Paris
Boyd	010	Ashland, Catlettsburg
Boyle	011	Danville, Junction City, Perryville
Bracken	012	Augusta, Brooksville, Germantown
Breathitt	013	Jackson
Breckinridge	014	Cloverport, Hardinsburg, Irvington
Bullitt	015	Fox Chase, Hebron Estates, Hillview, Hunters Hollow, Lebanon Junction, Mount Washington, Pioneer Village, Shepherdsville
Butler	016	Morgantown, Rochester, Woodbury
Caldwell	017	Dawson Springs, Fredonia, Princeton
Calloway	018	Hazel, Murray
Campbell	019	Alexandria, Bellevue, California, Cold Spring, Crestview, Dayton, Fort Thomas, Highland Heights, Melbourne, Mentor, Newport, Silver Grove, Southgate, Wilder, Woodlawn
Carlisle	020	Arlington, Bardwell
Carroll	021	Carrollton, Ghent, Prestonville, Sanders, Worthville
Carter	022	Grayson, Olive Hill
Casey	023	Liberty,
Christian	024	Crofton, Hopkinsville, LaFayette, Oak Grove, Pembroke
Clark	025	Winchester
Clay	026	Manchester
Clinton	027	Albany
Crittenden	028	Marion
Cumberland	029	Burkesville
Daviess	030	Owensboro, Whitesville
Edmonson	031	Brownsville
Elliott	032	Sandy Hook
Estill	033	Irvine, Ravenna
Fayette	034	Lexington
Fleming	035	Ewing, Flemingsburg
Floyd	036	Allen, Martin, Prestonsburg, Wayland, Wheelwright
Franklin	037	Frankfort
Fulton	038	Fulton, Hickman
Gallatin	039	Glencoe, Sparta, Warsaw
Garrard	040	Lancaster
Grant	041	Corinth, Crittenden, Dry Ridge, Williamstown
Graves	042	Mayfield, Water Valley, Wingo
Grayson	043	Caneyville, Clarkson, Leitchfield
Green	044	Greensburg

COUNTY	CODE	CITIES
Greenup	045	Bellefonte, Flatwoods, Greenup, Raceland, Russell, South Shore, Worthington, Wurtland
Hancock	046	Hawesville, Lewisport
Hardin	047	Elizabethtown, Radcliff, Sonora, Upton, Vine Grove, West Point
Harlan	048	Benham, Cumberland, Evarts, Harlan, Loyall, Lynch, Wallins Creek
Harrison	049	Berry, Cynthiana
Hart	050	Bonnieville, Horse Cave, Munfordville
Henderson	051	Corydon, Henderson, Robards
Henry	052	Campbellsburg, Eminence, New Castle, Pleasureville, Smithfield
Hickman	053	Clinton, Columbus
Hopkins	054	Dawson Springs, Earlington, Hanson, Madisonville, Mortons Gap, Nebo, Nortonville, Saint Charles, White Plains
Jackson	055	McKee
Jefferson	056	Anchorage, Audubon Park, Bancroft, Barbourmeade, Beechwood Village, Bellemeade, Bellewood, Blue Ridge Manor, Briarwood, Broeck Pointe, Brownsboro Farm, Brownsboro Village, Cambridge, Coldstream, Creekside, Crossgate, Douglass Hills, Druid Hills, Fincastle, Forest Hills, Glenview, Glenview Hills, Glenview Manor, Goose Creek, Graymoor-Devondale, Green Spring, Hickory Hill, Hills and Dales, Hollow Creek, Hollyvilla, Houston Acres, Hurstbourne, Hurstbourne Acres, Indian Hills, Jeffersontown, Kingsley, Langdon Place, Lincolnshire, Louisville, Lyndon, Lynnview, Manor Creek, Maryhill Estates, Meadow Vale, Meadowbrook Farm, Meadowview Estates, Middletown, Mockingbird Valley, Moorland, Murray Hill, Norbourne Estates, Northfield, Norwood, Old Brownsboro Place, Parkway Village, Plantation, Poplar Hills, Prospect, Richlawn, Riverwood, Rolling Fields, Rolling Hills, Saint Matthews, Saint Regis Park, Seneca Gardens, Shively, South Park View, Spring Mill, Spring Valley, Strathmoor Manor, Strathmoor Village, Sycamore, Ten Broeck, Thornhill, Watterson Park, Wellington, West Buechel, Westwood, Wildwood, Windy Hills, Woodland Hills, Woodlawn Park, Worthington Hills
Jessamine	057	Nicholasville, Wilmore
Johnson	058	Paintsville
Kenton	059	Bromley, Crestview Hills, Crescent Springs, Covington, Edgewood, Elsmere, Erlanger, Fairview, Fort Mitchell, Fort Wright, Independence, Kenton, Lakeside Park, Ludlow, Park Hills, Ryland Heights, Ryland Hills, Taylor Mill, Villa Hills, Vale, Walton
Knott	060	Hindman, Pippa Passes
Knox	061	Barbourville, Corbin
Larue	062	Hodgenville, Upton
Laurel	063	London
Lawrence	064	Blaine, Louisa
Lee	065	Beattyville
Leslie	066	Hyden
Letcher	067	Jenkins, Fleming-Neon, Blackey, Whitesburg
Lewis	068	Concord, Vanceburg
Lincoln	069	Hustonville, Crab Orchard, Eubank, Stanford
Livingston	070	Grand Rivers, Carrsville, Smithland, Salem
Logan	071	Adairville, Auburn, Lewisburg, Rossellville
Lyon	072	Kuttawa, Eddyville
Madison	076	Berea, Richmond
Magoffin	077	Salyersville
Marion	078	Bradfordsville, Raywick, Loretto, Lebanon
Marshall	079	Hardin, Benton, Calvert City,
Martin	080	Inez, Warfield, Dover, Maysville, Sardis
Mason	081	Dover, Germantown, Maysville, Sardis ,

COUNTY	CODE	CITIES
McCracken	073	Lone Oak, Paducah
McCreary	074	Whitley City
McLean	075	Island, Calhoun, Livermore, Sacramento
Meade	082	Ekron, Brandenburg, Muldraugh,
Menifee	083	Frenchburg
Mercer	084	Harrodsburg, Burgin
Metcalfe	085	Edmonton
Monroe	086	Gamaliel, Fountain Run, Tompkinsville
Montgomery	087	Jeffersonville, Camargo, Mount Sterling
Morgan	088	West Liberty
Muhlenburg	089	Greenville, Bremen, Central City, Drakesboro, Powderly, South Carrollton
Nelson	090	Fairfield, Bloomfield, Bardstown, New Haven
Nicholas	091	Carlisle
Ohio	092	Hartford, Fordsville, Beaver Dam, Centertown, McHenry, Rockport
Oldham	093	Prospect, LaGrange, Goshen, Crestwood, Pewee Valley, Orchard Grass Hills, River Bluff
Owen	094	Sparta, Gratz, Owenton, Monterey
Owsley	095	Booneville
Pendleton	096	Butler, Falmouth, Williamstown
Perry	097	Hazard, Buckhorn, Vicco,
Pike	098	Elkhorn City, Coal Run Village, Pikeville
Powell	099	Stanton
Pulaski	100	Ferguson, Burnside, Somerset, Science Hill, Eubank
Robertson	101	Sardis, Mount Olivet
Rockcastle	102	Brodhead, Mount Vernon, Livingston
Rowan	103	Lakeview Heights, Morehead
Russell	104	Jamestown, Russell Springs
Scott	105	Georgetown, Stamping Ground, Sadieville
Shelby	106	Pleasureville, Shelbyville
Simpson	107	Franklin
Spencer	108	Taylorsville
Taylor	109	Campbellsville
Todd	110	Guthrie, Elkton, Trenton,
Trigg	111	Cadiz
Trimble	112	Bedford, Milton
Union	113	Morganfield, Sturgis, Waverly, Uniontown
Warren	114	Bowling Green, Plum Springs, Oakland, Smiths Grove, Woodburn
Washington	115	Springfield, Willisburg, Monticello
Wayne	116	Monticello
Webster	117	Clay, Dixon, Providence, Slaughters, Sebree, Wheatcroft
Whitley	118	Williamsburg, Corbin,
Wolfe	119	Campton
Woodford	120	Midway, Versailles

### Chart to Assist in Refunding Premiums

Notification Received:	90 days prior	Period for which premium is to be refunded:	
01/01/2016	10/03/2015	10/01/2015	01/31/2016
01/02/2016	10/04/2015	10/01/2015	01/31/2016
01/03/2016	10/05/2015	10/01/2015	01/31/2016
01/04/2016	10/06/2015	10/01/2015	01/31/2016
01/05/2016	10/07/2015	10/01/2015	01/31/2016
01/06/2016	10/08/2015	10/01/2015	01/31/2016
01/07/2016	10/09/2015	10/01/2015	01/31/2016
01/08/2016	10/10/2015	10/01/2015	01/31/2016
01/09/2016	10/11/2015	10/01/2015	01/31/2016
01/10/2016	10/12/2015	10/01/2015	01/31/2016
01/11/2016	10/13/2015	10/01/2015	01/31/2016
01/12/2016	10/14/2015	10/01/2015	01/31/2016
01/13/2016	10/15/2015	10/01/2015	01/31/2016
01/14/2016	10/16/2015	10/16/2015	01/31/2016
01/15/2016	10/17/2015	10/16/2015	01/31/2016
01/16/2016	10/18/2015	10/16/2015	01/31/2016
01/17/2016	10/19/2015	10/16/2015	01/31/2016
01/18/2016	10/20/2015	10/16/2015	01/31/2016
01/19/2016	10/21/2015	10/16/2015	01/31/2016
01/20/2016	10/22/2015	10/16/2015	01/31/2016
01/21/2016	10/23/2015	10/16/2015	01/31/2016
01/22/2016	10/24/2015	10/16/2015	01/31/2016
01/23/2016	10/25/2015	10/16/2015	01/31/2016
01/24/2016	10/26/2015	10/16/2015	01/31/2016
01/25/2016	10/27/2015	10/16/2015	01/31/2016
01/26/2016	10/28/2015	10/16/2015	01/31/2016
01/27/2016	10/29/2015	10/16/2015	01/31/2016
01/28/2016	10/30/2015	10/16/2015	01/31/2016
01/29/2016	10/31/2015	10/16/2015	01/31/2016
01/30/2016	11/01/2015	11/01/2015	01/31/2016
01/31/2016	11/02/2015	11/01/2015	01/31/2016
02/01/2016	11/03/2015	11/01/2015	02/29/2016
02/02/2016	11/04/2015	11/01/2015	02/29/2016
02/03/2016	11/05/2015	11/01/2015	02/29/2016
02/04/2016	11/06/2015	11/01/2015	02/29/2016
02/05/2016	11/07/2015	11/01/2015	02/29/2016
02/06/2016	11/08/2015	11/01/2015	02/29/2016
02/07/2016	11/09/2015	11/01/2015	02/29/2016
02/08/2016	11/10/2015	11/01/2015	02/29/2016
02/09/2016	11/11/2015	11/01/2015	02/29/2016
02/10/2016	11/12/2015	11/01/2015	02/29/2016
02/11/2016	11/13/2015	11/01/2015	02/29/2016
02/12/2016	11/14/2015	11/01/2015	02/29/2016
02/13/2016	11/15/2015	11/01/2015	02/29/2016
02/14/2016	11/16/2015	11/16/2015	02/29/2016

Notification Received:	90 days prior	Period for which premium is to be refunded:	
02/15/2016	11/17/2015	11/16/2015	02/29/2016
02/16/2016	11/18/2015	11/16/2015	02/29/2016
02/17/2016	11/19/2015	11/16/2015	02/29/2016
02/18/2016	11/20/2015	11/16/2015	02/29/2016
02/19/2016	11/21/2015	11/16/2015	02/29/2016
02/20/2016	11/22/2015	11/16/2015	02/29/2016
02/21/2016	11/23/2015	11/16/2015	02/29/2016
02/22/2016	11/24/2015	11/16/2015	02/29/2016
02/23/2016	11/25/2015	11/16/2015	02/29/2016
02/24/2016	11/26/2015	11/16/2015	02/29/2016
02/25/2016	11/27/2015	11/16/2015	02/29/2016
02/26/2016	11/28/2015	11/16/2015	02/29/2016
02/27/2016	11/29/2015	11/16/2015	02/29/2016
02/28/2016	11/30/2015	11/16/2015	02/29/2016
02/29/2016	12/01/2015	12/01/2015	02/29/2016
03/01/2016	12/02/2015	12/01/2015	03/31/2016
03/02/2016	12/03/2015	12/01/2015	03/31/2016
03/03/2016	12/04/2015	12/01/2015	03/31/2016
03/04/2016	12/05/2015	12/01/2015	03/31/2016
03/05/2016	12/06/2015	12/01/2015	03/31/2016
03/06/2016	12/07/2015	12/01/2015	03/31/2016
03/07/2016	12/08/2015	12/01/2015	03/31/2016
03/08/2016	12/09/2015	12/01/2015	03/31/2016
03/09/2016	12/10/2015	12/01/2015	03/31/2016
03/10/2016	12/11/2015	12/01/2015	03/31/2016
03/11/2016	12/12/2015	12/01/2015	03/31/2016
03/12/2016	12/13/2015	12/01/2015	03/31/2016
03/13/2016	12/14/2015	12/01/2015	03/31/2016
03/14/2016	12/15/2015	12/01/2015	03/31/2016
03/15/2016	12/16/2015	12/16/2015	03/31/2016
03/16/2016	12/17/2015	12/16/2015	03/31/2016
03/17/2016	12/18/2015	12/16/2015	03/31/2016
03/18/2016	12/19/2015	12/16/2015	03/31/2016
03/19/2016	12/20/2015	12/16/2015	03/31/2016
03/20/2016	12/21/2015	12/16/2015	03/31/2016
03/21/2016	12/22/2015	12/16/2015	03/31/2016
03/22/2016	12/23/2015	12/16/2015	03/31/2016
03/23/2016	12/24/2015	12/16/2015	03/31/2016
03/24/2016	12/25/2015	12/16/2015	03/31/2016
03/25/2016	12/26/2015	12/16/2015	03/31/2016
03/26/2016	12/27/2015	12/16/2015	03/31/2016
03/27/2016	12/28/2015	12/16/2015	03/31/2016
03/28/2016	12/29/2015	12/16/2015	03/31/2016
03/29/2016	12/30/2015	12/16/2015	03/31/2016
03/30/2016	12/31/2015	12/16/2015	03/31/2016

Notification Received:	90 days prior	Period for which premium is to be refunded:	
03/31/2016	01/01/2016	01/01/2016	03/31/2016
04/01/2016	01/02/2016	01/01/2016	04/30/2016
04/02/2016	01/03/2016	01/01/2016	04/30/2016
04/03/2016	01/04/2016	01/01/2016	04/30/2016
04/04/2016	01/05/2016	01/01/2016	04/30/2016
04/05/2016	01/06/2016	01/01/2016	04/30/2016
04/06/2016	01/07/2016	01/01/2016	04/30/2016
04/07/2016	01/08/2016	01/01/2016	04/30/2016
04/08/2016	01/09/2016	01/01/2016	04/30/2016
04/09/2016	01/10/2016	01/01/2016	04/30/2016
04/10/2016	01/11/2016	01/01/2016	04/30/2016
04/11/2016	01/12/2016	01/01/2016	04/30/2016
04/12/2016	01/13/2016	01/01/2016	04/30/2016
04/13/2016	01/14/2016	01/01/2016	04/30/2016
04/14/2016	01/15/2016	01/01/2016	04/30/2016
04/15/2016	01/16/2016	01/16/2016	04/30/2016
04/16/2016	01/17/2016	01/16/2016	04/30/2016
04/17/2016	01/18/2016	01/16/2016	04/30/2016
04/18/2016	01/19/2016	01/16/2016	04/30/2016
04/19/2016	01/20/2016	01/16/2016	04/30/2016
04/20/2016	01/21/2016	01/16/2016	04/30/2016
04/21/2016	01/22/2016	01/16/2016	04/30/2016
04/22/2016	01/23/2016	01/16/2016	04/30/2016
04/23/2016	01/24/2016	01/16/2016	04/30/2016
04/24/2016	01/25/2016	01/16/2016	04/30/2016
04/25/2016	01/26/2016	01/16/2016	04/30/2016
04/26/2016	01/27/2016	01/16/2016	04/30/2016
04/27/2016	01/28/2016	01/16/2016	04/30/2016
04/28/2016	01/29/2016	01/16/2016	04/30/2016
04/29/2016	01/30/2016	01/16/2016	04/30/2016
04/30/2016	01/31/2016	01/16/2016	04/30/2016
05/01/2016	02/01/2016	02/01/2016	05/31/2016
05/02/2016	02/02/2016	02/01/2016	05/31/2016
05/03/2016	02/03/2016	02/01/2016	05/31/2016
05/04/2016	02/04/2016	02/01/2016	05/31/2016
05/05/2016	02/05/2016	02/01/2016	05/31/2016
05/06/2016	02/06/2016	02/01/2016	05/31/2016
05/07/2016	02/07/2016	02/01/2016	05/31/2016
05/08/2016	02/08/2016	02/01/2016	05/31/2016
05/09/2016	02/09/2016	02/01/2016	05/31/2016
05/10/2016	02/10/2016	02/01/2016	05/31/2016
05/11/2016	02/11/2016	02/01/2016	05/31/2016
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05/13/2016	02/13/2016	02/01/2016	05/31/2016
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05/16/2016	02/16/2016	02/16/2016	05/31/2016
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05/31/2016	03/02/2016	03/01/2016	05/31/2016
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## Sample Past Due Premium Notification Letters

The following sample letters are for arrears in health insurance premiums. Similar letters will also be used for arrears in Flexible Spending Account payments.

### 30/60-Day Past Due Letter to IC

Date

Agency

IC

Street Address

City State Zip

RE: Health Insurance 30/60 Days Past Due Notice

Dear IC,

During a recent review of health insurance benefits for your organization, our records indicate that health insurance premium payments for the following bills are 30 and/or 60 days past due for one or more of your members. Each member past 60 days has been sent a delinquent premium letter.

**Failure to pay past due amounts will result in termination of the member's health insurance and they will not be eligible to re-enroll in a health plan until the Open Enrollment period for the next calendar year.** In order to prevent lapse or termination of the member's health insurance, we must receive payment within 30 days from the date of this letter for items 60 days past due or benefits will be terminated. The attached list includes the name of each member who is more than 30 and/or 60 days in arrears. Members who are 60 days past due will have an asterisk.

**Please ensure that your invoices are "worked" and paid promptly and that the monthly bill amount(s) match the payment and coupon amount(s).** Bills worked in KHRIS with no payment submitted will still be considered delinquent and subject to termination of benefits.

For faster payment posting and more accurate service, you may sign up for free ACH (Automated Clearing House) payment. ACH payments are processed using a customer's bank account(s) and routing information to make payments. You would save on postal cost, time delays or wire fees.

Or you can send the coupon with your check(s) payable to the Kentucky State Treasurer to:  
Personnel Cabinet, Department of Employee Insurance  
Premium Billing Branch  
State Office Bldg  
501 High St. 2nd Floor  
Frankfort, KY 40601

If you have any questions please feel free to contact your Premium Billing Branch (PBB) Representative at (502) 564-9097.

Sincerely,  
Premium Billing Branch  
Department of Employee Insurance

cc: PBB Representative, Enrollment Information Branch

60-Day Member Past Due Letter with Copy to IC

May 16, 2015

Smith, Jane  
Po Box 100,  
Anytown, KY 40000

RE: 60 Day Past Due Health Premium Notice

Dear Ms. Smith,

During a recent review of your health insurance premiums, our records indicate that your premiums are 60 days past due for one or more months. A listing of your arrears appears on the attached page.

If payment is not received by (xx/xx/xxxx), your coverage will be termed effective (xx/xx/xxxx).

To avoid an interruption of coverage, please submit payment in full promptly to your insurance coordinator listed below. Please make your payment payable to the Kentucky State Treasurer.

**If payment is not received and benefits are terminated, you will only be eligible to file claims for expenses incurred prior to the termination date.** Medical claims paid after the termination date will be recovered by Anthem from the provider and you become responsible for incurred cost(s) to the provider(s). You will not be eligible to enroll in health insurance until the next benefit Open Enrollment period.

If you have any questions please contact your Insurance Coordinator to help ensure this matter is resolved immediately.

IC Name: XXXXX XXXXXXXX  
Agency  
Address  
Anytown Kentucky 40000-0000

IC Phone: (000) 546-0000

Sincerely,

Premium Billing Branch  
Financial and Data Services Division  
Department of Employee Insurance  
Commonwealth of Kentucky Personnel Cabinet

Cc: FMB Representative

Broker 800000007

90-Day Termination Letter to IC

Date

Agency  
IC  
Street Address  
City State Zip

RE: Member(s) Termed for Non-Payment of Health Premium(s)

Dear IC,

You recently received correspondence from our office indicating that members within your agency had a premium deficiency greater than 60 days. The members were notified and given 30 days to contact your office and make payment in full to avoid termination of benefits.

Our records indicate that these accounts are still in arrears and their health insurance has been terminated effective the date(s) indicated on the attached listing. **These members are no longer eligible to enroll in a health plan until the next benefit Open Enrollment period. The member will only be eligible to file claims for expenses incurred prior to the termination date of the health plan.**

If you have questions or concerns, please contact your Premium Billing Branch (PBB) representative at (502) 564-9097, between the hours of 8:00 am and 4:30 pm EST.

PBB Representative: Name

Sincerely,  
Premium Billing Branch  
Financial and Data Services Division  
Department of Employee Insurance  
Commonwealth of Kentucky Personnel Cabinet

Broker #

cc: Enrollment Information Branch

90-Day Termination Letter to Member

May 15, 2015

Member Name  
Member Address Line 1  
Member Address Line 2  
City, State, Zip

RE: Term for Non-Payment of Health Premiums

Dear "member name"

You were recently sent correspondence from our office indicating that your health insurance premiums were in arrears for more than 60 days. You were given 30 days to bring your account to a current status.

Our records indicate your account is still in arrears therefore your health insurance was terminated effective on the date indicated below.

Coverage Termination Date: \_\_\_\_\_

- You are not eligible to enroll in health insurance until the next benefit Open Enrollment period.
- You will only be eligible to file claims for expenses incurred prior to the termination date of your health insurance.
- In addition, Anthem will recover any medical claims paid after the health insurance termination date and you will be responsible for paying the providers.

If you have any questions please contact your Insurance Coordinator listed below.

IC Name:

IC Phone:

Sincerely,

Premium Billing Branch  
Financial and Data Service Division  
Department of Employee Insurance  
Commonwealth of Kentucky Personnel Cabinet