# DEPARTMENT OF EMPLOYEE INSURANCE ADMINISTRATION MANUAL

## KENTUCKY EMPLOYEES' HEALTH PLAN AND OPTIONAL INSURANCE BENEFITS

PERSONNEL CABINET
DEPARTMENT OF EMPLOYEE INSURANCE (DEI)
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KEHP.KY.GOV

Refer to the KHRIS Benefits Administration User Guide & the KHRIS Benefits Accounting User Guide for processing guidelines.

08/26/2026 Revision

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*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.*

NOTE: ALL GUIDELINES OUTLINED IN THIS ADMINISTRATION MANUAL PERTAIN TO HEALTH, DENTAL, AND VISION UNLESS HEALTH IS ADDRESSED SPECIFICALLY.

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# CHAPTER 1: ELIGIBILITY


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| Eligible Participants |
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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 members 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 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-Governmental 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 and administration fee. The district must notify the Department of Employee Insurance's (DEI) Premium Billing Branch (PBB) when an elected school board employee has selected KEHP coverage. PBB will enter adjustments which reflect rules indicated in Ch. 12, Section 6, B.

**NOTE: Elected School** Board members shall be eligible to participate in any group medical, FSA, dental or vision insurance plan provided to employees of the district pursuant to KRS 161.158. Participating board members shall pay the full cost of any premium required for their participation in the plan. Premiums are paid post-tax. *Elected School Board* members are not eligible for waiver plans or life insurance.

**C. Retirees:** Under the age of 65, or 65 and 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 Form Retirement System (JFRS) which includes:
  - Judicial Retirement Plan (JRP)
  - Legislative Retirement Plan (LRP)
- Kentucky Community and Technical College Retirement System (KCTCRS)
- Teachers' Retirement System (TRS)
- Kentucky Public Pensions Authority (KPPA) which includes:
  - County Employees Retirement System (CERS)
  - Kentucky Employees Retirement System (KERS)
  - State Police Retirement System (SPRS)

**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

The following Dependents are eligible for participation in Optional Insurance benefits through DEI:

- An Employee's Spouse
- An Employee's child, including natural child, stepchild, adopted, and foster 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:** Dependent children who are totally and permanently disabled may be covered by KEHP beyond the end of the month in which they turn 26, provided the disability (a) started before their 26th birthday and (b) is medically certified in writing by a physician. Dependent children will be considered totally and permanently disabled if, in the judgment of KEHP's medical Third Party Administrator, the written certification adequately demonstrates that the 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.

Dependent children who are not already covered by KEHP at the time of their 26th birthday may not later be enrolled in KEHP on grounds of total and permanent disability unless and until they sustain a loss of other insurance coverage. In such a case, a request to enroll Dependent children in KEHP on grounds of total and permanent disability must be made no later than 30 calendar days following the loss of other insurance coverage.

Anthem will make all Dependent children 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 Limited Purpose HRA through the active employer with KEHP; or
- drop Health Insurance under their Spouse's KEHP coverage 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 Limited Purpose HRA through the active employer with KEHP.

**J. Active Employees and Dependent Spouses <u>Age 65 or Older:</u>**

- 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.

Medicare-eligible active Employees are treated like any other regularly employed Employees and may elect coverage or elect the Waiver General Purpose HRA, provided an attestation is received, in writing, that they have other Group Health Plan Coverage. *Medicare is not considered other Group Health Plan Coverage.*

Medicare eligible active Employees may elect the Waiver Limited Purpose 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 a new 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:

General Rule: The Affordable Care Act (ACA) requires all active employers with 50 or more full-time Employees (applicable large employer) to offer Health 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 the Employee is deemed eligible, the active employer is responsible for offering such coverage to the Employee. *The Employer must notify KEHP of both an Employee's effective date and termination date of Health Insurance coverage.*

**NOTE**: Employees deemed eligible for KEHP under ACA are not eligible for Optional Insurance Benefits, such as Life, Dental and Vision plans.

- **Breaks in Service – Not an Educational Organization:**
  Except with respect to educational organizations, an Employee whose employment is terminated with an applicable large employer and resumes employment with the same large employer may be treated as a new Employee (with a waiting period) upon the resumption of services only if the Employee's break in service was for a period of at least 13 consecutive weeks immediately preceding the resumption of services. If the Employee's break in service is less than 13 consecutive weeks, the Employee is a continuing Employee and will resume the same Health Insurance coverage as the Employee had immediately prior to the Employee's break in service, without a waiting period.

- **Breaks in Service – Educational Organization:**
  With respect to educational organizations, an Employee whose employment is terminated with an applicable large employer and resumes employment with the same large employer may be treated as a new Employee (with a waiting period) upon the resumption of services only if the Employee's break in service was for a period of at least 26 consecutive weeks immediately preceding the resumption of services. If the Employee's break in service is less than 26 consecutive weeks, the Employee is a continuing Employee and will resume the same Health Insurance coverage as the Employee had immediately prior to the Employee's break in service, without a waiting period.

**NOTE:** The ACA requires large employers to file information returns with the IRS and provide statements to their Employees about Health Insurance coverage the employer offered. This filing requirement applies to Employees and their Spouses and Dependents who had coverage through KEHP during the year. Employers that do not file information returns or do not file correct information returns are subject to a penalty imposed by the IRS. Employers participating in KEHP are responsible for ensuring that KEHP has the correct Taxpayer Identification Number (TIN) regarding covered Employees, Spouses, and Dependents. An Employee, Spouse, or Dependent may be subject to a $50 penalty under the Internal Revenue Code section 6723 for each filing with the IRS that contains an incorrect TIN.

## L. Incarcerated Individuals

- An Employee, Retiree, Spouse, or Dependent is not eligible for coverage through KEHP if they are incarcerated in prison, jail, or a custodial facility after having been convicted of a crime or offense.
- Dependents and Spouses who are released from prison, jail, or a custodial facility regain eligibility for coverage and may be added to the plan.

## 2. Dependent Eligibility Chart

Dependent eligibility rules and documentation requirements are contained in the following chart. Supporting documentation for Qualifying Events must be submitted along with the QE and are listed under the 'Documentation' column. Qualifying Event forms must be signed within the event timeframe. See Appendix I: Qualifying Evens and Mid-Year Scenarios for more information.

| Definition of Eligible Dependent(s) | Documentation |
|---|---|
| **Spouse**<br>A person who is legally married to an Employee or Retiree. | 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). |
| **Common Law Spouse**<br>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). | A legible photocopy of the certificate or affidavit of common law marriage from a state that does recognize common law marriage. |
| **Child Ages 0 to 25**<br>In the case of a child who has not yet attained his/her 26th birthday, "child" means an individual who is –<br>• A son, daughter, stepson, or stepdaughter of the Employee/Retiree, or<br>• 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<br>• 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). | **Natural Child**: 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 the hospital name, baby's name, name of Employee/Retiree as a parent, and signed by the attending physician or a hospital representative; or verification of the birth document from the hospital indicating the name of baby and parent(s). At least one parent must be an Employee/Retiree eligible to participate in KEHP. **Stepchild**: 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 or a photocopy of the top half of the front page of the Employee/Retiree's most recent federal tax return (Form 1040). **Legal Guardian, Adoption, or Foster Child(ren)**: Legible photocopies of court orders, guardianship documents, or affidavits of dependency, with the presiding judge's signature and filed status; or legible adoption papers with the presiding judge's signature; or a petition for adoption; or notarized or official placement papers from an adoption/placement agency (no judge's signature required). See App. I, Pg 23, Judgements, Decrees, or Orders (NMSN) qualifying event for more information regarding acceptable custody and dependency. |

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|---|---|
| **Disabled Dependent**<br>A Dependent child who is totally and permanently disabled may be covered by KEHP beyond the end of the month in which he/she turns 26, provided the disability (a) started before his/her 26th birthday and (b) is medically certified in writing by a physician. A Dependent child will be considered totally and permanently disabled if, in the judgment of KEHP's medical Third Party Administrator (Anthem), the written certification adequately demonstrates that the Dependent child is unable to engage in any substantial gainful activity by reason of medically determinable physical or mental impairment that can be expected to result in death or that has lasted or can be expected to last for a continuous period of not less than 12 months. A Dependent child who is not already covered by KEHP at the time of his/her 26th birthday may not later be enrolled in KEHP on grounds of total and permanent disability unless and until he/she sustains a loss of other insurance coverage. In such a case, a request to enroll a Dependent child in KEHP on grounds of total and permanent disability must be made no later than 30 calendar days following the loss of other insurance coverage. | Dependents under the age 26 will reflect in KHRIS as a Dependent child. The employee must initiate the disabled Dependent certification process before the Dependent turns 26 by calling the Enrollment Information Branch (EIB) at 888-581-8834, option 3. Anthem certifies all disabled Dependents based on medical necessity and Member's financial responsibility for the Dependent. If the request is approved, the dependent will be updated in KHRIS to reflect Disabled Dependent (DD). Dependents over the age of 26, and not covered by the plan when they turn 26, can only be added to the plan if they experience a loss of other insurance. The request must be initiated by the member. |

# 3. Retirees

When Retirees reach age 65, they should receive a letter stating whether 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.

**NOTE**: Retirees who have not returned to active employment are not eligible for Optional Insurance Benefits including Life, Dental and Vision plans.

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




**NOTE:** In general, Retirees 65 and over, eligible for Medicare and actively employed with a KEHP participating employer should consider electing coverage with the employer to avoid penalties from Medicare.

Insurance Coordinators should refer each Return-to-Work Retiree who is Medicare-eligible and participating in a KPPA, TRS or Judicial/Legislative Retirement system to the appropriate retirement system.

## A. Return to Work (RTW) Retirees

### 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 Public Pensions Authority (KPPA), the Teachers' Retirement System (TRS) or the Judicial Form Retirement System (JFRS).
- 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).
- KPPA and TRS sometimes have different rules and requirements regarding Health Insurance coverage for RTW Retirees.

**3. TRS RTW Retirees:**

- TRS 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 TRS plan that supplements Medicare coverage.
- General Rules for TRS RTW Retirees:
  - If returning to work and eligible for health insurance through active employment, the retiree must waive insurance coverage through TRS, regardless of whether they are covered by the KEHP or the Medicare Eligible Health Plan (MEHP).
  - Once a RTW Retiree terminates employment or loses eligibility for insurance through the active employer, the Retiree must contact TRS 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)].
- TRS Health Insurance Coverage Options:
  - The RTW Retiree must waive coverage, with no HRA funds, through TRS (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 Child and Adult Daycare 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 either the Waiver Limited Purpose HRA or the Waiver 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 Limited Purpose HRA.

**4. KPPA RTW Retirees:**

- KPPA 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 KPPA plan that supplements Medicare coverage.

- KPPA RTW Retiree Under Age 65 and 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 KPPA and waive KEHP coverage through the active employer without an HRA if the RTW Retiree has a KPPA participation date before September 1, 2008;
  - is not eligible to elect KEHP coverage through KPPA and must enroll in KEHP coverage through the active employer if the RTW Retiree has a KPPA participation date on or after September 1, 2008.

**NOTE:** If the RTW Retiree selects KEHP coverage through KPPA, the active employer must reimburse KPPA for the contribution made for Single Coverage Level Health Insurance for the RTW Retiree. [KRS 61.637(17)(d)4].

- may elect to participate in a Healthcare or Child and Adult Daycare FSA through the active employer;
- If the RTW Retiree does not want KEHP Health Insurance coverage through KPPA 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, with no HRA funds, 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 Limited Purpose 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 Limited Purpose HRA.

- KPPA RTW Retiree Over Age 65 and/or Medicare Eligible:
  - is not eligible to participate in coverage provided by KPPA that supplements the Employee's Medicare coverage.
  - must terminate enrollment in the KPPA 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 KPPA rather than enrolling in KEHP. The RTW Retiree should ask KPPA 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 Child and Adult Daycare FSA through the active employer.
  - If the RTW Retiree does not want KEHP Health Insurance coverage through KPPA 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 Limited Purpose HRA or no HRA.

**NOTE:** In general, Retirees 65 and over, eligible for Medicare and actively employed with a KEHP participating employer should consider electing coverage with the employer to avoid penalties from Medicare.

**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 Limited Purpose HRA.

**5. JFRS RTW Retirees:**

- JRFS RTW Retirees include members receiving a retirement benefit from the Judicial Retirement Plan and/or the Legislators Retirement Plan.
- JFRS RTW Retiree health insurance coverage availability applies to all Retirees at any age (over and under 65).
- If the JFRS RTW Retiree is employed by an agency that participates in KEHP, the JFRS Retiree can elect to:
    - Retain his/her health insurance through JFRS, in which event the active Employee loses eligibility for insurance through his/her Employer and is not entitled to enroll in the Waiver General Purpose HRA or Waiver Limited Purpose HRA; or
    - Terminate his/her health insurance coverage through JFRS and elect to participate in KEHP though his/her active employer.

## 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 30 days of the loss of coverage. (TRS does not permit Dependent children to "take over" the Plan).
- must contact the retirement system within 30 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 any Waiver with HRA funds (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 Public Pensions Authority (KPPA) does not pay for Dependent coverage, except for hazardous duty Retirees. Therefore, the non-hazardous duty Spouse can elect the Waiver General Purpose HRA provided an attestation is received, in writing, that he/she has other group Health Insurance.

### D. Disabled Retirees Under Age 65, Medicare Eligible

If permitted by the Retiree's retirement system, a Retiree under the age of 65 who is Medicare eligible due to a disability may continue coverage under KEHP. In the event the Retiree has Medicare and KEHP, Medicare will pay primary.

## 4. 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 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/Dual Employees

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 receive either Waiver HRA with funds; or
- enroll in a Waiver HRA with funds with both employers. To elect the Waiver General Purpose HRA, the Employee must provide an attestation, in writing that the Employee has other Group Health Plan Coverage or must enroll in the Waiver Limited Purpose HRA.

**EXAMPLE:** Member is currently employed with KCTCS and is gaining employment with another school board but will remain eligible under ACA with KCTCS. Member wants to pick up coverage with the new school board and waive coverage with KCTCS. If member gains coverage with the new board of education, this is **not** considered a Qualifying Event to waive coverage with KCTCS. Member is not permitted to change plan option or coverage level because she is going to work with another KEHP agency. Member must keep plan with KCTCS and waive coverage with the new school board. Member would only be permitted to change plans if coverage was lost due to ACA.

**EXAMPLE**: Member is currently employed with KCTCS and another school board but will lose coverage with the school board mid-April. The Dual employee who lost coverage mid-month with one agency can pick up coverage as soon as the other coverage ended with the other agency. If the member lost coverage 4/15 and signed a new application 4/28, then coverage with the other agency would begin 4/16.

**EXAMPLE:** Member is currently employed with LRC as a State Legislator and currently a principal with a school board at the time of Annual Open Enrollment Period. Member can elect coverage through either LRC or the school board and elect a Waiver HRA with funds with the other employer for the new Plan year.

**NOTE:** Dual Employees who experience a loss of eligibility or loss of coverage with of one of their agencies must complete an Employee Benefits Enrollment/Change Form. **Coverage with the existing agency shall begin immediately with no break in coverage provided the Employee Benefits Enrollment/Change form is signed within 30 days of loss of coverage from prior agency.**

## 5. Eligibility for the Premium Discount for the Following Year

All KEHP plans require Planholder(s) to agree to fulfill the LivingWell Promise in order to be eligible to receive the monthly premium discount for the entirety of the following year. Failure to fulfil the promise will result in the Planholder losing eligibility for the monthly premium discount for the entire following year. The LivingWell Promise requirements may change each Plan Year. The LivingWell Promise is an agreement to take the Health Assessment. In a Cross-Reference Payment Option, both Planholders must agree to and fulfill the Promise by completing individual Health Assessments.

- **Open Enrollment Election**
  - The Planholder(s) must take the Health Assessment from January 1 through July 1.
- **Newly Hired Employees**
  - Any member with an effective date of January 1 (current year) is required to fulfill the Promise. An employee with an effective date after January 1 (current year) is not required to fulfill the Promise, including an employee that leaves employment and returns to employment during the Promise period.

See specific examples below:

- Example 1: Member 1 is effective January 1 – Completion of the Promise is required.
- Example 2: Member 2 is effective March 1 – Completion of the Promise is not required.
- Example 3: Member 3 is effective January 1, leaves employment, and insurance terminates January 31. Member returns to employment with an effective date of April 1 – Completion of the Promise is not required.

## 6. Eligibility for Waiver General Purpose HRA and Waiver Limited Purpose HRA

Employees are eligible for the Waiver General Purpose HRA only if the Employee, and the Employee's Spouse and Dependents are covered under other Group Health Plan Coverage that provides minimum value. A group health plan refers to coverage provided by an employer, an employer organization, or a union. A group health plan does not include individual policies purchased through the Marketplace or governmental plans such as TRICARE, Medicare, and Medicaid. A participant in a health care sharing ministry does not have "Group Health Plan Coverage" and is not eligible to waive coverage and elect the Waiver General Purpose HRA, but they are eligible to waive coverage and elect the Waiver Limited Purpose HRA.

If an Employee elects the Waiver General Purpose HRA and terminates coverage under another group health plan, they must notify KEHP within 30 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 Limited Purpose HRA. Any funds remaining in a Waiver General Purpose HRA, or the Waiver Limited Purpose HRA, after termination may be used to reimburse the Employee for eligible expenses incurred prior to termination of either Waiver HRA. Funds are not available upon termination of employment. The funds not used during the eligibility period are forfeited. Active Employees who are covered as a Spouse or Dependent on a hazardous duty Retiree's plan through KEHP, will not be eligible to direct the state contribution into any Waiver with HRA funds.

An employee who has elected a Waiver GP HRA and who becomes entitled to and covered under Medicare, Medicaid, or TRICARE must drop the Waiver GP HRA and may redirect future employer contributions to a Waiver Limited Purpose HRA or choose Waiver no HRA. Funds in the Waiver GP HRA will not rollover or transfer to the Waiver Limited Purpose HRA. A spouse or dependent covered under the Waiver GP HRA who becomes entitled to and covered under Medicare, Medicaid, or TRICARE cannot be covered under the Employee's Waiver GP HRA. No change permitted for an Employee with a Waiver Limited Purpose HRA.

# CHAPTER 2: ENROLLMENT


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|---|
| Initial Enrollment |
| Waiving Health Insurance Benefits |
| Open Enrollment |
| Transition from Dependent Child to New Employee |
| Reinstatement of an Employee |
| Newly hired Employees, Transfers and Rehires to a KEHP Participating Company |

# 1. Initial Enrollment

## A. Regularly Employed Employees:

1. For Commonwealth-Paid Employees, except PVAs and County Fees:

Starting 1/1/2025, for new regularly employed Employees who are eligible for Health Insurance benefits at the time they are hired, health insurance and flexible spending accounts will begin on the Employee's hire date. All optional benefits will begin on the first day of the second calendar month following the Employee's hire date.

**Example**: Appointed August 12. Health insurance and FSA(s) will start August 12, while Life, Dental and Vision Insurances will start October 1.

**NOTE:** It is especially important to note that those in this group can only enroll in Health/FSA once during the 30-day period. Once they select a health plan and FSA amount, they cannot change it, even if the 30-day period has not yet expired. This is known as the "One and Done" rule and only applies to Health/FSA elections.

2. For Non-Commonwealth Paid Employees, PVAs and County Fees:

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.

**NOTE:** School Board Teachers should be treated as new hires at the time of certification. Coverage is not back dated to original hire date as part-time sub. The teacher would still need to go through the waiting period.

All new Employees will be defaulted to a Waiver No HRA plan. They may make their elections online in KHRIS ESS or they may complete an Employee Benefits Enrollment/Change Form within the first 30 calendar days of employment.

Employees who fail to elect benefits within the designated period will not be allowed to enroll until the next Open Enrollment period unless a valid Qualifying Event occurs.

**NOTE:** During the month of the Annual Open Enrollment period, Employees have 30 days from their date of hire to complete both an Employee Benefits Enrollment/Change Form to elect coverage for the current Plan Year and an Employee Benefits Enrollment/Change Form for Open Enrollment to elect coverage for the next Plan Year.

## B. Newly Elected School Board Members:

Newly elected school board members have 30 days from the date they are elected to complete the Health Insurance Enrollment to elect coverage for the current Plan Year. Coverage will begin on the first day of the month of appointment unless it is a mid-month appointment. In this case, coverage begins the first day of the month following the member's election appointment date. Newly elected school board members who fail to timely complete the application will not be eligible for coverage until they experience a valid Qualifying Event.

- Example: Appointed on March 1, insurance effective on March 1
- Example: Appointed on March 16, insurance effective on April 1

## C. ACA Eligible Employees: *(Health Insurance/FSA Only)*

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 considered full-time Employees under the ACA. 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 elect benefits must be enrolled in the Waiver No HRA plan. The ACA Eligible Employee may, 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 pre-tax basis (if the active employer participates). Employer must notify KEHP of an Employee's effective date of starting and terminating Health Insurance coverage.

ACA Eligible Employees should complete and submit a paper Employee Benefits Enrollment/Change Form 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 Limited Purpose HRA. Employees who enroll during Open Enrollment will receive an employer contribution of $175 per month, up to $2,100 per calendar year, and funds will be available in two installments: January 1 with $1,050 and July 1 with $1,050.

Employees who enroll as a newly hired Employee, at a time other than Open Enrollment, will receive a pro-rated employer contribution of $175 per month, up to $2,100 per calendar year. For example: Employee is hired on July 13 with coverage becoming effective on September 1. Employee will receive $175 for September, October, November, and December, for a total of $700.

Unspent HRA funds up to $2,100, 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 Limited Purpose HRA funds will only carry over to a Waiver Limited Purpose HRA.

Employees may elect to waive Health Insurance coverage online in KHRIS ESS, or they may elect to waive Health Insurance on the Employee Benefits Enrollment/Change Form. Waiving coverage must be completed within the timeframe in "Initial Enrollment".

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.

### 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 period that occurs between KEHP's Open Enrollment and December 31 (i.e. between mid-October and December 31)

Group Health Plan Coverage refers to coverage provided by an Employer, an Employer organization, or a union. Group Health Plan Coverage does not include individual policies purchased through the Marketplace or governmental plans such a TRICARE, Medicare, and Medicaid.

**B. Waiving Health Insurance and receiving the Waiver Limited 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 experience a different Open Enrollment period 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

**C. 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 Limited Purpose HRA, in order to start receiving an employer contribution toward a Health Insurance plan. **NOTE:** If Employees experience a Qualifying Event that permits the termination of Health Insurance, they may terminate Health Insurance, but they may not enroll in the Waiver General Purpose HRA or the Waiver Limited Purpose 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 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 referred to as "permitted election changes" or Qualifying Events under the federal regulations. The requested change must always be consistent with the Qualifying Event. See Appendix I – Qualifying Events and Mid-Year Scenarios for more information.

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$^{th}$ birthday. Adult children are defined as children who are at least 19 years old, but not yet 26 years old. Newly hired Dependent children may enroll in their own plan with Health Insurance coverage, or they may waive Health Insurance coverage with an HRA and enroll as a Dependent under their 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 Employee is reinstated after a period of separation, KEHP will reinstate Health Insurance coverage on a prospective basis only. Prospective basis means that Health Insurance coverage will be effective on the first day of the next month following the effective date of any order, determination, or order approving a settlement agreement from the Personnel Board, administrative agency, employer tribunal, or court. KEHP will not reinstate

Health Insurance coverage on a retroactive basis, including the period of time beginning on the date of separation up to the date of any applicable reinstatement order.

In some instances, a reinstatement order may require the employer to "make the Employee whole." A reinstatement order may also require specific relief upon reinstatement after an Employee's period of separation. For instance, if an Employee procured other Health Insurance during the Employee's separation period, the order may require the employer to reimburse the Employee for any increase in insurance premiums paid for equivalent coverage (such as premiums paid for COBRA coverage). Any determination regarding the handling of "make whole" orders or orders requiring specific relief is between the employer and the reinstated Employee.

## 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.

**NOTE:** If a company chooses to cease participation with KPPA pursuant to KRS 61.522, any new employee to that agency, including rehires or a transfer from another KEHP agency, will not be eligible for insurance with the Department of Employee Insurance. This includes health insurance and all optional benefits.

### A. Newly hired Employees With No Prior Employment with a KEHP Participating Company

- Refer to Ch. 2, 1, A "Regularly Employed Employees" for new employee effective date rules.
- Newly hired Employees 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 they have other Group Health Plan Coverage, or the Waiver Limited Purpose HRA, if eligible.

### B. Newly hired Employees Who Are Transferring from Another KEHP Participating Company - <u>WITHOUT</u> a Break in Employment

- Newly hired transferring Employees will have a "clean" transfer based on the number of Working Days between employment.
- 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 the new 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 upload the Employee Benefits Enrollment/Change Form with the transfer information using the DEI upload tool. 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 workweek (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 transferred into the new agency.

**NOTE:** A Working Day, **for purposes of this section**, 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.

**Example**: 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.

## 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:

- Referred to as a small break transfer.
- The employee 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 a different Semi-Monthly Billing Period, there is a ½-month break in coverage.

**NOTE:** Employees transferring from Non-Commonwealth Paid agencies to Commonwealth-Paid agencies may not see a break in coverage depending on the hire date at the CP agency. As of January 1, 2025, Health/FSA coverage is effective on date of hire, so although there may be a break in employment, the employee may or may not experience a small break in coverage. The half-month break may still apply to any Dental, Vision and Life insurances.

**Example for NCP to NCP Transfer**: 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) for Health/FSA. The Member is eligible to elect COBRA during this break and will receive notification from HealthEquity.

**Example for NCP to CP Transfer**: Employee stops working at old company 8/10, Health Insurance stops on 8/15. The Employee is hired by CP agency 8/18, with Health beginning 8/18. The employee will have a 2-day break in coverage (from 8/15 to 8/17). The Member is eligible to elect COBRA during this break and will receive notification from HealthEquity.

- 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 Employee Benefits Enrollment/Change Form.

**NOTE:** When a new hire terms with one agency during the initial waiting period and transfers to another agency (clean or small break) before coverage is effective, all original benefit enrollments (Health/Dental/Vision/FSA/Life) elected as a new hire at the prior agency will be transferred with no changes allowed.

**2. Break in employment of 11 or more Working Days:**

- Considered new Employees and are treated as such for enrollment and eligibility. Refer to Ch. 2, 1. A. "Regularly Employed Employees" for rules.
- Not eligible to start a cross-reference payment option.
- 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, provided an attestation is received, in writing, that they have other Group Health Plan Coverage, or the Waiver Limited Purpose HRA, if eligible, and 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 2/28, 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 Employee Benefits Enrollment/Change Form electing to waive Health Insurance (the Employee does nothing) the Employee will be defaulted to a Waiver No HRA plan.

## D. Return to Work Retirees

- Under age 65: The RTW Retiree will be treated similar to a new employee except with a coverage effective date of the first day of the month following re-employment for health and FSA elections. This will require the new company to begin providing the employer contribution before the expiration of the typical new hire waiting period. **RTW Retirees have the option to make new elections for all coverages including adding/dropping dependents. Coverage effective date for any Optional coverage including Life, Dental and Vision will be the first day of the second month following re-employment.** Also, see Chapter 1, Section 3 for eligibility information related to RTW Retirees.
  Over Age 65: The RTW 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 6A 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 RTW 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 Employee 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 the Employee loses eligibility.

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


| Coverage Levels |
| --- |
| Cross-Reference Payment Option |

# 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 *(Health Insurance Only)*

Spouses who were both hired before 1/1/2025 and remain continuously eligible to participate in KEHP, 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**

- Current retirees and employees hired before 1/1/2025 who remain continuously eligible.
- Current retirees and employees hired before 1/1/2025 who experience a qualifying event.
- 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 one Employee Benefits Enrollment/Change Form 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.*

**NOTE:** Both employees must pay the tobacco user rate if either of the employees uses tobacco or if a dependent child over 18 uses tobacco while covered under 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.

   A loss of outside group coverage could allow a plan change option if the existing Employee waived coverage. If the existing Employee has waived Health Insurance, or has KEHP Health Insurance, the existing Employee must sign and date the Employee Benefits Enrollment/Change Form requesting to begin a Cross-Reference Payment Option within 30 calendar days of the loss of coverage. Depending on how the dates fall, the existing Employee may have to pay full family premium for the first month.

2. **During Open Enrollment:** Employee with the oldest hire date in KHRIS will be the primary Planholder.

3. **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. **Qualifying Events:** Certain Qualifying Events will result in the loss of eligibility for the Cross-Reference Payment Option. These events include, but may not be limited to, the following:
    - **a.** Termination of Employment;
    - **b.** Leave without pay;
    - **c.** Divorce;
    - **d.** Dependent loss of eligibility (i.e. over age 26)

    If one of these Qualifying Events occurs, the Cross-Reference Payment Option terminates.

2. **Administering the Termination of Cross-Reference:**
    - **a. Termination of Employee/Spouse's Employment:**
        - If one Employee's employment is terminated, the remaining Planholder will automatically default to a Parent Plus Coverage Level.
        - The remaining Planholder may change the Coverage Level to Family Coverage by adding the former Employee/Spouse to the Plan. KEHP must receive the Employee Benefits Enrollment/Change Form within 30 days from the former Employee/Spouse's termination date. KEHP will then add the spouse to the Employee's coverage **with no break in service** and change the Coverage Level to Family Coverage for the remaining planholder.
        - The remaining Planholder may also make a Plan Option change.
        - The remaining Planholder may enroll in or increase HCFSA contributions if the termed Spouse had a prior HCFSA.
        - To make a Coverage Level or Plan Option change, the Planholder must submit an Employee Benefits Enrollment/Change Form within 30 calendar days after the date of the Qualifying Event.
        - If the Employee Benefits Enrollment/Change Form does not indicate the Coverage Level or is not received within 30 calendar days of the Qualifying Event, the default Coverage Level will remain in effect until the next Open Enrollment period or a permitted Qualifying Event occurs.
        - The remaining Planholder is not permitted to change the Coverage Level to Single since there has been no Qualifying Event that would result in the Dependent's loss of eligibility.
    - **b. Leave Without Pay:**
        - If one Employee/Spouse goes on leave without pay, the remaining Planholder will automatically default to Parent Plus Coverage Level.
        - The remaining Planholder may change the Coverage Level to Family Coverage by adding the Employee/Spouse on LWOP to the Plan.
        - The remaining Planholder may also make a Plan Option change.
        - To make a Coverage Level or Plan Option change, the Planholder must submit an Employee Benefits Enrollment/Change Form within 30 calendar days after the date of the Qualifying Event.
        - If the Employee Benefits Enrollment/Change Form does not indicate the Coverage Level or is not received within 30 calendar days of the Qualifying Event, the default Coverage Level will remain in effect until the next Open Enrollment period or a permitted Qualifying Event occurs.
        - The remaining Planholder is not permitted to change the Coverage Level to Single since there has been no Qualifying Event that would result in the Dependent's loss of eligibility.

**c. Divorce**

- If two Employees with a Cross-Reference Payment Option divorce, the primary Planholder will automatically default to Parent Plus Coverage Level, and the secondary Planholder will automatically default to Single Coverage Level.
- The Employees may each change their defaulted Coverage Levels but at least one must provide coverage for the Dependents.
- The Employees may also make a Plan Option change.
- To make a Coverage Level or Plan Option change, the Planholder must submit an Employee Benefits Enrollment/Change Form within 30 calendar days after the date of the Qualifying Event.
- If the Qualifying Event Form does not indicate the Coverage Level or is not received within 30 calendar days of the Qualifying Event, the default Coverage Level will remain in effect until the next Open Enrollment period or a permitted Qualifying Event occurs.

**d. Lose Dependent – Loss of Dependent Eligibility:**

- If the final Dependent in a Cross-Reference Payment Option loses eligibility, each Employee will automatically default to Single Coverage Level.
- The Employees may change the Coverage Level to Couple Coverage Level.
- The Employees may also make a Plan Option change.
- To make a Coverage Level or Coverage Option change, the Employees must submit an Employee Benefits Enrollment/Change Form within 30 calendar days after the date of the Qualifying Event.
- If the Employee Benefits Enrollment/Change Form does not indicate the Coverage Level or is not received within 30 calendar days of the Qualifying Event, the default Coverage Level will remain in effect until the next Open Enrollment period or a permitted Qualifying Event occurs.

**3.** **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.

# CHAPTER 4:
# TERMINATION OF COVERAGE


| |
|---|
| Health Insurance Coverage Termination |
| Optional Insurance Coverage Termination |
| Retroactive Termination |
| Leaves of Absence |

# 1. Health Insurance Coverage Termination

If Employees terminate employment between the 1st and the 15th of the month, their Health Insurance coverage will terminate on the 15th of the same month. If Employees terminate employment between the 16th 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.

# 2. Optional Insurance Coverage Termination

If Employees terminate employment, their optional insurance coverage will terminate on the last day of the same month.

*Example*: An Employee terminates employment on March 5; Optional Insurance coverage terminates on March 31. If an Employee terminates employment on March 25, Optional 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 Employee Benefits Enrollment/Change Form listing the Employee's last day of employment.

**NOTE:** Terminations **must be entered within 10 days of the occurrence**.

## 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 30-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 26th 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 D for examples of administering the Qualifying Event of Death.

# 3. 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 120 days must be reviewed to ensure KEHP adheres to federal laws related to rescission. If you have a retroactive termination greater than 120 days, you must contact the Benefits Branch Manager in the Enrollment Information Branch for guidance in processing.

# 4. Leaves of Absence

This section applies to Health, Waiver HRAs, Dental and Vision Insurances ONLY. Refer to Chapter 7 for Flexible Benefits. See Appendix H for assistance with LWOP dates.

**NOTE**: A Working Day, **for purposes of this section**, 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 compensatory, annual, and sick leave.

**NOTE:** During approved LWOP, employees can continue their Basic life and any Optional and/or Dependent life insurance by paying the premiums during the LWOP status. The monthly payment would be $1.00 for the $20,000 Basic policy plus the monthly premium for any Optional/Dependent coverage. Please refer to Appendix M for a sample LWOP template ICs/HRGs should provide to all employees being placed on official LWOP.

## 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 or agency. Agencies and companies shall notify KEHP within 120 days of an Employee going on LWOP.

### 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 Employee Benefits Enrollment/Change Form has been completed and signed within the required 30-day period after the hire date.

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

- The 1st day of the second month following the date of hire or
- The 1st 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 approved LWOP and continue to be eligible for the employer contribution for Health Insurance while still working. This is known as intermittent LWOP. Employees on approved intermittent LWOP (except educational LWOP) must have worked any part of **the previous Semi-Monthly Billing Period** (the first through the 15th or the 16th 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 intermittent LWOP must work **at least one day during the Semi-Monthly Billing Period** (the first through the 15th or the 16th through the end of the month) to be eligible

for the Commonwealth employer contribution for Health Insurance for that current **Semi-Monthly Billing Period**. However, if the Employee's 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 either 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.

  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.

**3. Extended LWOP**

Eligibility for benefits and the employer contribution may end while an employee is on extended Leave Without Pay. 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 15th or the 16th 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 15th or the 16th 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.
- **All Agencies:** In general, an Employee is deemed resigned if the Employee has been on one year of continuous unpaid sick leave. Unless an Employee has worked intermittently during the LWOP period to maintain Health Insurance coverage and the Employer's contribution to that coverage, an Employee who has been on LWOP for more than 1 year and 30 days will not be reinstated upon the Employee's return to work but will be treated as a new hire.

  Both CP and NCP IC/HRGs must submit an Employee Benefits Enrollment/Change Form to KEHP providing the Employee's approved LWOP begin date and the Health Insurance termination date (end of the Semi-Monthly Billing Period). Only the CP HRG can enter the sick leave by PAN action in KHRIS and should submit the Employee Benefits Enrollment/Change Form to KEHP once the action has cleared in KHRIS.

  *Examples*: These examples apply to KRS 18A Agencies and 780 KAR Ch. 6 Agencies:

  - Employee on approved LWOP and works any part of the Semi-Monthly Billing Period of the 1st through the 15th.
    - Health Insurance ends the last day of the month.
  - Employee works any part of the Semi-Monthly Billing Period between the 16th and the end of the month.
    - Health Insurance ends on the 15th 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 1st through the 15th.
  - Health Insurance ends on the 15th of the same month.
- Employee works between the 16th 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. Returning from LWOP - Eligibility for the Employer Contribution**

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

An employee is deemed resigned if the employee has been on one year of continuous LWOP. In this case, the employee will be treated as a new hire and be subject to the applicable waiting period.

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 1st and the 15th of the month
  - Health Insurance starts on the 16th of the current month
- Employee works between the 16th and the end of the current month
  - Health Insurance starts on the 1st 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 780 KAR 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 1st and the 15th of the current month
  - Health Insurance starts on the 1st of the current month
- Employee works between the 16th and the end of the current month
  - Health Insurance starts on the 16th 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.

**5. Returning from LWOP - Eligibility for Coverage Level Changes**

Employees who return to work after being on approved LWOP will be automatically 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 30 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 30 days after the return.

**6. 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 30 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 30 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.

**7. Additional LWOP Information**

- When there is a loss of coverage, the Insurance Coordinator must submit an Employee Benefits Enrollment/Change Form to the Department of Employee Insurance indicating the Employee is on LWOP or suspended. The Insurance Coordinator must also submit an Employee Benefits Enrollment/Change 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.*

- Workers' Compensation – being on Workers' Compensation or being hurt on the job has no effect on LWOP or an Employee's Health Insurance coverage unless FMLA and leave time have been exhausted, and the Employee is no longer drawing a paycheck. Once this occurs, an Employee goes on LWOP and the Employee loses eligibility for Health Insurance coverage. The employee will then be offered COBRA.

- As an employer, agencies who participate in KEHP may have different guidelines for administering LWOP programs.
- This guidance is established for Health/Dental/Vision Insurance and FSA coverages 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.

*Under the federal FMLA rules, paid leave does not count toward the 1250 hours required to be eligible for FML. However, employers of KRS 18A employees are subject to 101 KAR 2:102. The regulation provides that paid leave counts toward the required 1250 hours. The KEHP acknowledges that there are employers participating in the KEHP that are not required to follow 101 KAR 2:102 and do not consider paid leave for FML purposes. The employer may have other rules that apply to FML or, the employer may choose to follow the federal rules regarding FML. In either case, the employer is responsible for compliance with providing FML and informing the KEHP when coverage ceases as a result of the loss of FML.

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 D). Refer to the Qualifying Event Charts in Appendix I 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 Child and Adult Daycare FSA are NOT eligible for COBRA. However, if IRS regulations are met, the Employee on unpaid FMLA may continue to file Child and Adult Daycare 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 LWOP or an Employee's Health Insurance coverage unless FMLA and leave time have been exhausted, and the Employee is no longer drawing a paycheck. Once this occurs, an Employee goes on LWOP, and the Employee loses eligibility for Health Insurance coverage. The employee will then be offered COBRA.

### 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.

**NOTE**: If an Employee fails to submit appropriate premium payments due within the specified deadline (at 60 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 partial contribution amounts paid.

Non-Commonwealth Paid premiums are due on the 15th and Commonwealth Paid premiums are due on the 5th 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:

Premium Billing Branch
Department of Employee Insurance
Personnel Cabinet
501 High Street, 4th 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. Employees who choose to cease contributions, which stops coverage, are not eligible for Health Insurance under KEHP until they return to work. Employees who return to work will have 30 days to make Open Enrollment elections.

**Employees experience a Qualifying Event**

- Employees on FMLA who experience a Qualifying Event will have 30 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 Qualifying Event, in which case, the Employees will have 30 days from their return to work date to request a Qualifying Event. They may resume cross referencing also, if hired prior to 1/1/2025 and they were enrolled in a cross-reference plan prior to beginning Leave.
- 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 1st and the 15th 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 Employee may enroll during the next Open Enrollment period.
- 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 submit the LWOP action by Employee Benefits Enrollment/Change

Form or via KHRIS. Once entered into KHRIS, this will trigger a notification of COBRA rights (if eligible).

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, and Waiver Limited Purpose HRAs 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 federal uniformed service (including National Guard deployments exceeding 30 days) are eligible for health benefits through the United States government. The Employee's Dependents may also be eligible for military Health Insurance. Under USERRA, members must be allowed 30 days to decide whether to elect TRICARE or remain covered under KEHP. During that 30-day period, the member is still eligible for the employer contribution. See **UNIFORMED SERVICES EMPLOYMENT AND REEMPLOYMENT RIGHTS ACT NOTICE** in Appendix B for more information. State employees should refer to their agency HR for more details on the 21-day work credit for military leave.

### 1. Beginning Military Leave

Employees may stop their Health Insurance coverage on the last day of the pay period in which they are activated with the Uniformed Services. Employees may drop their Spouse or Dependent(s) on the last day of the pay period in which the dependent is activated with the Uniformed Services.

All premiums due upon return from active duty will be determined by the date of return to active employment. Employees electing this option MUST present supporting documentation of the military coverage such as enlistment papers showing date Employee or Dependent were called to active military duty.

### 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$^{th}$ day of the month of the coverage month for Non-Commonwealth Paid Employees, and the 5$^{th}$ 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. If hired prior to 1/1/2025, they may resume cross referencing if enrolled in a cross-reference payment option prior to starting Military Leave.
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 Limited Purpose HRA until TRICARE ends. (Note: TRICARE may continue to provide coverage for service-related injuries, even after termination of regular TRICARE coverage and reinstatement to KEHP coverage.) 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 may add coverage for a Spouse or Dependent when the Spouse or Dependent returns from military leave and there is proof that military coverage has ended. Employees electing this option MUST present documentation of the military coverage end date for the Spouse or Dependent. Coverage will be reinstated the first day of the month following the date of the loss of coverage through TRICARE.

Employees returning between the 1st and the 15th 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 16th of the month or later will be responsible for one-half month premium.

# CHAPTER 5:
# AUTOMATIC LOSS OF COVERAGE

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)

**NOTE:** If the incident is discovered after-the-fact and coverage is retroactively terminated, any refunds (maximum of 60 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.

## B. 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


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|---|
| Boards of Education Termination of Coverage |
| Summer Transfers |
| "Year Round" Employees (All Other Boards of Education Staff) |

# 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 monthly premium billing period for which premiums were paid in full. On the Employee Benefits Enrollment/Change Form, the employment end date will be the contract end date and the insurance termination date will be the last day of the 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

For 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 Employee Benefits Enrollment/Change Form, please indicate a 6/30 end date for both employment and coverage and write "Retirement" on the form.

## B. Terminations Before Contract Ends

For 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 Employee Benefits Enrollment/Change Form.

*Employment stops between 1st and 15th:*

- Health Insurance ends on the 15th of same month
- FSA/Waiver HRA ends on the 15th of the same month
- Life, Vision and Dental benefits stop on the last day of the same month

*Employment stops between 16th and 31st:*

- Health Insurance ends on the last day of same month
- FSA/Waiver HRA end on the last day of the same month
- Life, Vision and Dental benefits stop on the last day of the same month

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 first 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 either July 31 or August 31 and coverage under the new district will begin on August 1 or September 1. **When notifying KEHP of a summer transfer, please select "Summer Transfer" on the Employee Benefits Enrollment/Change Form using the DEI online upload tool.**
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. 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 "1st day of the 2nd month" waiting period was applied. If this occurs, Employees have two options.

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 1st day of the 2nd month from hire date.

"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" in the notes section when uploading the Employee Benefits Enrollment/Change Form via the DEI online upload tool and indicate the Effective Date of their coverage based on the options above. The two Effective Date possibilities are:

- 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, the Employee is treated as a new Employee. Refer to Chapter 2 for new employee rules and policies.**

## 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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| Eligibility Requirements |
| Redirection of the Employer Contribution |
| Contribution Amounts |
| Termination of Flexible Benefits |
| Time Limit for Refund Requests for FSA/HRA Contributions |
| Leaves of Absence |
| Claims Payment |
| Timely Filing of Claims |
| Termination for Non-Payment of FSA and HRA Contributions |

# Flexible Benefits

This section applies to Flexible Benefits ONLY. Refer to Chapter 4 for Health, Dental and Vision Insurances.

The KEHP Flexible Benefits program is provided through a Section 125 Cafeteria Plan and allows participating Employees to pay for eligible Healthcare and Child and Adult Daycare expenses with pre-tax payroll deductions. KEHP offers a Healthcare Flexible Spending Account (HC FSA), a Child and Adult Daycare Flexible Spending Account (DC FSA), and two types of Waiver HRAs. Please note the FSAs and the Waiver HRAs are only available to Eligible Employees whose agencies participate in KEHP's Flexible Benefits program, whereas the Embedded HRAs are available to all Eligible Employees and retirees who elect one of the CDHP health plans.

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 Appendix I.

Eligible Employees who wish to participate in a Healthcare or Child and Adult Daycare FSA MUST re-enroll EVERY YEAR during the annual Open Enrollment period. Enrollment is NOT automatic. Healthcare FSA funds remaining in an Employee's account at the end of the Calendar Year will carryover a minimum of $50 and the established annual maximum for use in the next calendar year. Any amounts over the established annual maximum at the end of the Run-Out period will be forfeited or lost. Child and Adult Daycare FSAs do not have any carryover provisions.

Eligible Employees who choose to waive Health Insurance may be able to elect the Waiver General Purpose HRA or the Waiver Limited Purpose HRA. Certain restrictions apply. Eligible Employees who wish to participate in the Waiver General Purpose HRA have to enroll every year in KHRIS ESS or complete an Employee Benefits Enrollment/Change Form. Employees and retirees who are eligible for the state-sponsored Health Insurance coverage and who elect to enroll in the LivingWell CDHP or the LivingWell Basic CDHP plans 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 employed with an agency that participates with the KEHP's Flexible Benefits program may enroll in a Healthcare FSA or a Child and Adult Daycare 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 30 days of their employment date. Please refer to Chapter 2 for effective date information and other new employee rules.

Employees who are eligible for state-sponsored Health Insurance coverage but elect to waive coverage, may be eligible for an employer-funded Waiver General Purpose HRA or Waiver Limited Purpose 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. The KEHP does not offer HSA compliant limited purpose FSAs.

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

Retirees who return to work are eligible to participate in the FSA programs. The effective date will be the first of the month following the hire date for RTW Retirees.

## 2. Redirection of the Waiver HRA 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 Limited Purpose 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 Limited Purpose 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

Active Employees may elect an annual contribution amount during their new employee enrollment period, during annual open enrollment, or during the plan year if they experience a qualifying event. Regardless, the contribution amount entered by the employee will:

a. Be rounded up or down to be evenly divisible by the remaining number of semi-monthly periods in the year; and
b. Be re-calculated every month for benefits billing in the following manner:
    i. Contribution amount, minus deductions paid year to date = remaining contribution.
    ii. Remaining contribution, divided by remaining number of semi-monthly periods in the year.

While not required, it is highly recommended that annual contributions entered towards the end of the calendar year, starting in October, be evaluated by the Insurance Coordinator to ensure total contribution(s) due each month will not exceed the employee's net payable wages each month.

### A. Healthcare FSA

The maximum allowable yearly contribution is established annually per IRS. A minimum of $50 and the established annual maximum of any unused funds remaining at the end of the calendar year may be carried over for use in the next calendar year. Any amounts over the established annual maximum at the end of the Run-Out period will be forfeited or lost.

**NOTE**: The maximum carryover amount is subject to change as authorized by the IRS and adopted by the Plan.

Additionally, a Healthcare FSA with a balance that is carried over for two consecutive Plan Years, including the Run-Out Period of the second year, will be terminated and the balance forfeited; provided there have been no new elections for the Healthcare FSA during those two Plan Years. These are referred to as stale accounts. This forfeiture will occur at the end of the Run-Out Period of the second Plan Year.

### B. Child and Adult Daycare FSA

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

- married filing separately $3,750
- single and head of household $7,500
- married and filing jointly $7,500

Unless authorized by the IRS, remaining funds at the end of the calendar year will NOT carry over to the next calendar year. All unused funds will be forfeited or lost.

### C. Waiver General Purpose HRA and Waiver Limited Purpose HRA with Funds

Active 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 Limited Purpose 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 healthcare expenses as explained in the Benefits Selection Guide and the Summary Plan Description. The Waiver Limited Purpose 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 will receive the $175 per month contribution to use on claims, provided the contribution amount was not spent on claims prior to terminating. The employer continues to remain responsible for submitting the monthly contribution to KEHP.

*Example:* An Employee waives coverage January 1 and terminates coverage (and Waiver HRA with funds) 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 has until March 31st of the following year, to submit claims which occurred during the coverage periods of January 1 through May 31, and October 1 through December 31.

## 4. Termination of Flexible Benefits

Healthcare and Child and Adult Daycare FSAs and Waiver 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 Child and Adult Daycare funds spent up to March 15, but cannot incur new claims after March 15.

Employees must submit all claims that were incurred prior to termination by March 31, of the following Plan Year. If not, they will not be reimbursed for the claims incurred.

*Example: An Employee terminates employment on August 18 and his/her coverage terminates on the last day of the semi-monthly pay period worked, which is August 31. All claims must be submitted for processing by March 31 of the following year. Please refer to the FSA/HRA Summary of Benefits for details on submitting claims for reimbursement.*

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

A refund of FSA/HRA contributions will only be given for up to 60 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.

# 6. Leaves of Absence

## A. Leave Without Pay (LWOP)

The following LWOP guidelines apply to eligibility for KEHP Flexible Benefits. Agencies and companies shall notify KEHP within 120 days of an Employee going on LWOP.

### 1. Beginning LWOP

If an Employee is on approved LWOP, Healthcare FSA and a Child and Adult Daycare FSA will terminate the last day of the semi-monthly pay period in which the Employee worked. Employees with a Healthcare FSA are eligible for COBRA. Employees with a Child and Adult Daycare FSA are not eligible for COBRA.

### 2. Returning from LWOP

Employees who return to work after being on approved LWOP will become effective the first day of the next semi-monthly period. See LWOP chart for school board employees. 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.

- If the Employee returns from approved LWOP between the 1st and the 15th of the month, the FSA is reinstated on the 16th day of the same month and KEHP expects a ½ month payment.
- If the Employee returns from approved LWOP between 16th and the last day of the month, the FSA is reinstated on the first of the following month and KEHP expects a full month payment for that following month.

This only applies to FSAs. The Waiver General Purpose HRA, Waiver Limited Purpose HRA, the LivingWell CDHP and the LivingWell Basic CDHP embedded HRAs 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 C.

### 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 Limited Purpose HRA* - When Employees begin paid or unpaid FMLA, the employer contribution for the HRA will continue until FMLA expires.

*Healthcare FSA* – When an Employee begins FMLA, they 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 Employees' 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, 4th Floor
Frankfort, Kentucky 40601

NCP agencies can also make payments online at Benefit Arrears Payment

**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 HealthEquity, 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 1st and the 15th 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 16th 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 Employee returns.

## 7. 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 HealthEquity Healthcare Card to ensure that no further violations occur. The HealthEquity 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 may 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 KEHP 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 KEHP 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.

## 8. 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 dates 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.

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

The Premium Billing Branch will terminate FSAs and HRAs of Members whose Employee/Employer portion is 60 days past due. Members will be notified by letter when their FSA premiums are 30 days in arrears and 60 days in arrears and are subject to termination for non-payment, and ICs will receive notice via email.

Members who are termed for non-payment will not be allowed to re-enroll until the next open enrollment period. Employees will be responsible for refunding any claims previously paid with a date of service that is past the plan termination date.

See Chapter 12 for more details.

# CHAPTER 8:
# EXCEPTIONS AND APPEALS


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| Exception Process for Eligibility and Enrollment Issues |
| Exception Process for Open Enrollment Issues |
| Appeals to Anthem (Third Party Administrator) |
| Appeals to CVS/Caremark (Pharmacy Benefit Manager) |
| External Review for Appeals to Anthem and CVS/Caremark |
| Prescription Formulary Appeals |

## 1. Exception Process for Eligibility and Enrollment Issues

Employees who are dissatisfied with a decision regarding enrollment or disenrollment (Qualifying Events) in the Plan may file an exception to the KEHP Exception Committee. The exception must be filed no later than thirty (30) calendar days from the event or notice of the decision being protested. Exceptions must be filed in writing by completing the Exception Form. The form can be found at kehp.ky.gov and should be uploaded using the DEI upload portal.

An exception must include ALL 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 exception that does not include all necessary information will be returned. A written response will be emailed 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. Exception Process for Open Enrollment Issues

- Members who do not log on during OE – automatically denied.
- Members in a default plan for current year who do not log on and do not make an active election – automatically denied.
- Hard deadline of December 31st of current year – All exceptions must be in house by December 31st of current year. Any received after the start of the new plan year will be automatically denied.
- Members who did log in and made a good effort to elect will be approved.
- Members who enrolled but inadvertently left off a dependent will be approved.
- Open Enrollment Exceptions with Open Enrollment applications should be uploaded using the DEI upload portal.

## 3. Exceptions for Financial or Other Billing Issues

Please refer to Chapter 12 Premium Billing.

## 4. Appeals to Anthem (Third Party Administrator)

Anthem has an internal appeals process relating to medical claims. Refer to the relevant Health Insurance Medical Benefit Booklet at kehp.ky.gov for details.

## 5. 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 at kehp.ky.gov for details.

## 6. 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 at kehp.ky.gov for details.

## 7. 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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| KEHP and HIPAA |
| Training |
| HIPAA Forms and Contact Information |

# 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 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 to transmit all PHI. DO NOT send any PHI information via email without encryption.**

Members will need to contact the applicable KEHP vendors (Anthem, HealthEquity, CVS/Caremark) for information relating to payment of claims and benefits 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. HIPAA Training

HIPAA Privacy and Security training is due annually for individuals who access KEHP Member data. The training is administered by the Department of Employee Insurance and can be accessed through the MyPurpose training portal. Individuals will receive notification via email on how to complete the course. Please ensure that your email address is current in KHRIS.

Additionally, the HIPAA training is part of the initial training requirements for individuals who are new to roles accessing Member data, prior to receiving KHRIS security access.

KEHP's Notice of HIPAA Privacy Practices, Authorization Form, and other related HIPAA forms are located on our website at kehp.ky.gov.

Contact Information:

HIPAA Privacy Officer**:** Will Adams, (502) 782-4370

HIPAA Security Officer: Judy Baker, (502) 564-3638

# CHAPTER 10:
# COBRA
## Consolidated Omnibus Budget Reconciliation Act


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| Eligibility |
| Maximum Coverage Period |
| Disability |
| Second Qualifying Event |
| COBRA Administrator |
| Notification of COBRA Rights – Initial Notice/General Notice |
| Notification of a Qualifying Event |
| COBRA Rates |

# 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 COBRA 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.

**NOTES: This includes transferring out of an agency, retirement, and LWOP. Loss of coverage due to non-payment of premiums is not a Qualifying Event.**

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. 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.

## 3. 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.

## 4. 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.

## 5. COBRA Administrator

KEHP's COBRA Administrator is HealthEquity. KEHP sends files to HealthEquity. 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. HealthEquity is responsible for COBRA notification letters, enrollment, premium collection, and other COBRA related services.

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

COBRA regulations provide that a group health plan be 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 HealthEquity 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.

## 7. 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 HealthEquity 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. <u>If the event results in a loss of coverage under the group health plan, the Insurance Coordinator must enter the event into KHRIS and HealthEquity will notify the Qualified Beneficiary of the following events</u>:

- 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. HealthEquity will then mail all necessary notifications and forms within the required timeframes.**

## 8. 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 on the KEHP website. The additional two percent covers the added cost for administering COBRA continuation coverage.

# CHAPTER 11:
# NEW EMPLOYEE ORIENTATION

| |
|---|
| Memorandum Regarding Notice About Special Enrollment Rights and Notice About Women's Health and Cancer Rights Act |
| KEHP Checklist |
| Additional Resources |

# 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 on the KEHP website under IC/HRG Resources, Forms and Documents and can be accessed here. It 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 to locate the Benefits Selection Guide, Summary Plan Descriptions, Medical Benefit Booklets and Summary of Benefits and Coverage. These documents will provide necessary information in making their benefit selections.

# CHAPTER 12:
# PREMIUM BILLING


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|---|
| Collections and Disbursements (CD) |
| Billing Statements |
| Payment Information |
| Arrears Process for Non-Commonwealth Paid Agencies/Members |
| Arrears Process for Commonwealth Paid Agencies/Members |
| 60-Day Revenue Forfeitures |
| Special Billing Adjustments |

# 1. Collections and Disbursements (CD)

The Collections and Disbursements (CD) module in KHRIS is used to facilitate the reconciliation and management of Health Insurance, Life Insurance, Dental and Vision Insurance, FSA/HRA enrollment, benefit administration fees, premiums owed and contributions. By managing all premiums, contributions, and fees, the CD system allows for:

- Creation of Health Insurance, Life Insurance, Dental and Vision Insurance, FSA/HRA and administration fee bills using KHRIS Web billing (i.e. Broker Report). The monthly billing cycle produces two bills, with the first one commonly referred to as the semi-monthly bill, and the last as the monthly bill:
  - The 15th bill - full month Dental and Vision, first half-month FSA.
  - The 31st bill - both half-months of Health, full month Life, last half-month FSA, and monthly benefit administration fee.
- Reconciliation of Health Insurance, Life Insurance, Dental and Vision Insurance, FSA/HRA coverage and benefit administration fees with all agencies and administrators;
- Posting of all premiums, contributions, fees, and adjustments; and
- Reporting and resolution of discrepancies.

# 2. Billing Statements

## A. State government agencies

State government agencies do not receive bill statements. The Department of Employee Insurance (DEI) receives files from each state payroll run, which are used to post benefit deductions, contributions and benefit administration fees to accounts.

After files are loaded into CD, DEI reviews results and produces an arrears report to notify agency Insurance Coordinators of any discrepancies.

## 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, Optional Life Insurance, Dental and Vision Insurance premiums and FSA contributions only. The bill statements will be posted in KHRIS Web Billing (broker report) located at 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, MUNIS, 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 after adjustments are complete.

Insurance Coordinators, Billing Liaisons, and payroll officers with questions related to MUNIS must contact the Kentucky Department of Education (KDE) at (502)564-2020.

For KHRIS Web Billing questions refer to the Benefits Accounting User Guide.

2. **Employer Portion of Health Insurance, Basic Life Insurance or HRA, and Fees**
KDE pays the employer portion of Health Insurance, Basic Life Insurance and HRAs and the benefit administration fees.

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

Monthly (semi-monthly for FSA/HRA) broker reports, i.e. web bills, are generated for health departments and quasi-governmental agencies. Insurance Coordinators (ICs) and/or Billing Liaisons (BLs) are responsible for reconciling bills to both enrollment records and to payroll deductions for their Employees, and adjusting the online bill as necessary. It is important to note all premiums paid by the IC/BL must match the monthly or semi-monthly KHRIS web billing broker report after adjustments are complete.

For KHRIS Web Billing questions refer to the Benefits Accounting User Guide.

# 3. Payment Information

All benefits are set up as current pay, meaning premiums and contributions are due in the month, for the month of coverage being billed. Pre-payment for summer months for Boards of Education is not permitted. Each individual month must be worked and paid separately.

DEI's preferred payment method is ACH, and all Non-Commonwealth Paid (NCP) groups, i.e. Boards of Education, Health Departments and Quasi-Governmental Agencies, are encouraged to use the Web Billing function called TPE to pay via ACH at no cost. The ACH process allows payment using multiple funding accounts, or can accept one payment which covers Health, Life, Dental, Vision, HRA, FSA, and benefit administration fees. If you must 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, 4th Floor
Frankfort, Kentucky 40601

NCP members can make online arrears payments for Health, Dental, Vision, and Life Insurances and Flexible Spending Accounts. Members will pay their own premium arrears quickly and conveniently online at: https://secure.kentucky.gov/formservices/Personnel/BenefitArrearsPayment. The online arrears payment program is DEI's preferred method for member arrears payments.

Commonwealth Paid (CP) members must pay arrears by paper check. The check must be payable to the Kentucky State Treasurer and mailed to the address above.

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

# 4. Arrears Processes

## 4.1. Non-Commonwealth Paid Agencies/Members

On a monthly basis, after broker bills are run, notifications are generated for 30-day arrears and 60-day terminations for non-payment of amounts owed. The 30- and 60-day letters are sent to Members who owe arrears and emails are sent to BLs.

### A. IC/BL Notification

Billing Liaisons (BLs) will receive notice via email of Members whose health, life, vision, or dental insurance premiums, and FSA contributions are 30 days in arrears, and for Members 60 days in arrears who will be terminated for non-payment. Please note if the bill has been processed, but payment not submitted, the agency will be considered delinquent. Payment(s) must be submitted to stop terminations for non-payment.

### B. Member Letters

Members will receive a letter notifying them of any premiums or contributions that are 30 days in arrears. They will also receive a letter when amounts are overdue by 60 days, notifying them that benefits have been terminated for non-payment.

Members are given 30 days from the date of the 30-day arrears letter to pay the arrears and avoid termination for non-payment. If payment is not received at the end of 30 days, the Member's coverage is terminated for non-payment, and they receive the 60-day notice.

A list of Members and plans which must be termed for non-payment will be processed by the Premium Billing Branch and supporting documentation sent to the Enrollment Information Branch and the Optional Insurance Branch to be scanned into OnBase. Members whose Health Insurance was not paid in full will be set up with a non-payment forced Waiver/No HRA for the remainder of the Plan Year. Members will only be eligible to re-enroll during the next Open Enrollment period, for the next Plan Year. (Some exclusions apply – ex. The Insurance Coordinator has failed to submit timely payments, but the premiums were collected timely from the Employee's paycheck.)

Please note - Payment plans are not permitted. This does not prohibit the agency from paying on the employee's behalf and setting up a payment plan between the employee and the employer.

## 4.2. Commonwealth Paid Agencies/Members

### A. IC Notification

On a semi-monthly basis, after discrepancy reports are generated, Insurance Coordinators (ICs) will receive notice via email of Members whose health, life, vision, or dental premiums, and FSA contributions are 30 days in arrears, and for Members 60 days in arrears who will be terminated for non-payment.

### B. Member Letters

Members receive letters that notify them that their insurance premiums and/or FSA contributions are 30 days in arrears and at 60 days in arrears they are subject to termination for non-payment.

The Members are given 30 days from the date of the 30-day termination letter to pay the arrears and avoid termination for non-payment. DEI does not allow payment plans. If payment is not received, at the end of 30 days, the Member's coverage is termed for non-payment, and they will receive the 60-day letter notifying them of the termination. A list of Members who are termed for non-payment will be processed by the Premium Billing Branch and supporting documentation sent to the Enrollment Information Branch and the Optional Insurance Branch to be scanned into OnBase. Members whose Health Insurance was not paid in full will be set up with a non-payment forced Waiver/No HRA for the remainder of the Plan Year. Members will only be eligible to reinstate coverage during the next Open Enrollment period, for the next Plan Year. (Some exclusions apply – ex. The Insurance Coordinator

has failed to submit timely payments, but the premiums were collected timely from the Employee's paycheck.).

Please note - Payment plans are not permitted. This does not prohibit the agency from paying on the employee's behalf and setting up a payment plan between the employee and the employer.

## 5. 60 Day Revenue Forfeitures

All billing issues must be resolved within 60 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 the web bill will be forfeited at 60 days from the date of the overpayment. The 60-day credits are revenue forfeitures and will not be refunded to the Member or agency. If the agency takes a credit on the bill passed the 60-day deadline and that has already been written-off, the agency will be responsible for repayment.

Ex: A Member terms employment 8/15, but the BL pays for all of August on the August bill that was worked on 8/31. The overpayment occurred on 8/31, and the BL has until 10/31 to take the credit on subsequent bills or request a refund. The BL does not take the credit or request a refund by 10/31, so the credit is adjusted off the account and not returned to the agency or member.

## 6. Special Billing Adjustments

### A. Newborn Credit

Members will not be charged premiums for adding a newborn only (no Tag-Alongs) to their plan for the first 31 days following the date of birth. Refer to KRS 304.17A-139 (3), and Appendix E *Chart to Assist in Administering the Qualifying Event of Birth for Health Insurance Coverage* for additional information.
Example: Member has a single plan. Member has a baby on 3/5, and the newborn is added to the health plan effective 3/5. The higher parent-plus premium will not go into effect until 4/16, providing additional dependents, i.e. Tag-Alongs, were not added along with the newborn.

### B. Elected School Board Officials

Elected School Board Officials who elect to participate with KEHP are responsible for paying the Employee and Employer premiums as well as the benefit administrative fees for their elected coverage. They do not receive any Employer funding. All payments for the month are due at the end of each month.

KRS 18A.225 (1) (a)

KRS 160.280(4)

KRS 161.158

### C. Hazardous Duty Retiree and the Cross-Reference Payment Option

KEHP Members who select the Cross-Reference Payment Option with a hazardous duty Retiree may require DEI to enter a billing adjustment to reflect additional premiums paid towards the non-retiree's portion by the Kentucky Public Pension Authority (KPPA), per KRS 61.702. DEI cannot enter the billing adjustment until official documentation is received from KPPA showing additional funds that will be paid.

# 7. Exceptions and Appeals

Terminations for non-payment of premiums or contributions are not part of the Exceptions or Appeals process. However, if a Member can provide proof that premiums or contributions were deducted from their paycheck for the arrears period, but payment was not sent in by the agency, the Member can submit payroll records showing the deductions were taken and PBB will review on a case-by-case basis. This request must go to the Premium Billing Branch Manager for review.

State of Emergency for which the Governor's Office has requested additional time be granted for payment of premiums, contributions and fees may be granted on a case-by-case basis. The IC/BL must file the request on the Member's behalf. This request must go to the Premium Billing Branch Manager for review.

# 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. This generally includes employees within the Executive, Judicial and Legislative branches of state government, as well as some larger county governmental offices.

**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, and with at least one eligible Dependent, may elect to have both state paid contributions applied to one Family Coverage Level.

**Default Plan Option –** Waiver No HRA

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

**Child and Adult Daycare FSA –** A benefit provided through a Section 125 Cafeteria Plan that allows Employees to pay for Child and Adult Daycare expenses with pre-tax dollars.

**Dual Employment** – Employees who are concurrently, regularly employed with different agencies (e.g. 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 employed by a company participating with KEHP and eligible to apply for coverage under KEHP.

**Enrollment Notification** – The notification received by the Department of Employee Insurance whether via the KHRIS file; Employee Benefits Enrollment/Change Form or IC entry in KHRIS. The form that is used upon hire, during Open Enrollment, and to make updates.

**Family Coverage Level** – Coverage for the Employee or Retiree, 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 Child and Adult Daycare (child or adult day care services) expenses with pre-tax money that they 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 Marketplace.

**Healthcare FSA** – A benefit provided through a Section 125 Cafeteria Plan that allows Employees to pay for eligible healthcare benefits with pre-tax dollars for employee and family members that are considered tax dependents.

**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 Public Pensions Authority, 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.

**LivingWell Promise** – A promise from Planholder(s) who elect KEHP plans to take the Health Assessment 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 health, HRA, FSA, life, dental and vision benefits, all or in part, 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, Retiree or COBRA participant shall be entitled to elect Plan Options for the subsequent Plan Year.

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

**Planholder** – The Eligible Employee or Retiree, who is eligible and has elected coverage under KEHP. For the Cross-Reference Payment Option, the Employee/Retiree with the oldest hire date in KHRIS will be designated as the Planholder.

**Plan Option** – An option such as LivingWell CDHP, LivingWell PPO, LivingWell Basic CDHP and LivingWell HDHP

**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 a Planholder 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. Events must adhere to Cafeteria 125 rules and HIPAA special enrollment rights.

**Redirection** – is the ability to stop employer funds from being directed into either the Waiver General Purpose HRA or the Waiver Limited Purpose 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 Public Pensions Authority (KPPA), Teachers' Retirement System (TRS), Legislators Retirement Plan (LRP), Judicial Retirement Plan (JRP), Kentucky Community and Technical College Retirement System (KCTCRS), or any other state retirement system, who is under age 65.

**Return to Work Retiree** – A Retiree who resumes active employment with any employer participating in KEHP.

**Semi-Monthly Billing Period** – The 1$^{st}$ through the 15$^{th}$ of the month, and the 16$^{th}$ through the last day of the month.

**Single Coverage Level** – Coverage for the Planholder only.

**Special Enrollment Period** – A period of time during which an Eligible Employee, Retiree 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 a Planholder.

**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** – Planholders who do not elect one of the Health Insurance Plan Options in KEHP.

**Waiver Limited Purpose 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: $1,050 on January 1, and $1,050 on July 1. This Waiver Limited Purpose 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: $1,050 on January 1, and $1,050 on July 1.

**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: APPENDICES


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# MEMORANDUM – APPENDIX A

**SAMPLE USE YOUR COMPANY LETTERHEAD**

TO: *(Employee)*

FROM: (*Insurance Coordinator(s) 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. Also, prescription coverage under your employer's plan is considered Medicare Creditable Coverage, meaning you will not be charged a penalty if you choose the employer's group health plan and later decide to join a Medicare drug plan.

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. In most situations, 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 65th 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.

> *Most people get Medicare automatically, and some have to sign up. You may have to sign up if you're 65 (or almost 65) and not getting Social Security. You should contact Medicare for assistance.

**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

Public Pensions Authority Medicare Supplement (KERS/CERS) Teachers' Retirement System, or Judicial or Legislators' Retirement Medicare Supplement plan may be affected. You should contact your Retirement System.

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 Limited Purpose ONLY HRA:** You may elect to waive KEHP health insurance coverage and enroll in a Waiver Limited Purpose HRA. The Waiver Limited Purpose HRA benefit provides you up to $2,100 per year in a Waiver Limited Purpose ONLY Health Reimbursement Arrangement (HRA). If an Employee elects the Waiver Limited Purpose 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 888-581-8834, Option 3.

# MEMORANDUM – APPENDIX B

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 30 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 30 days after the marriage, 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 are not 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 kehp.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 plans offered through the Kentucky Employees' Health Plan. For further details, please refer to your Medical Benefit Booklet or go to 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 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 you additional information about your COBRA rights. You may also learn more about COBRA and your rights under COBRA at 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 kehp.ky.gov.

**KEHP PRESCRIPTION DRUG COVERAGE AND MEDICARE-<u>NOTICE OF CREDITABLE COVERAGE</u>**

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 <u>Creditable Coverage</u>. 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 kehp.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 do not 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.

**Keep this information for your records.**

# MEMORANDUM – APPENDIX C

**SAMPLE USE YOUR COMPANY LETTERHEAD**

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 (FML). As an employee on FML, 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 have been previously deducted from your check for Health Insurance and/or Healthcare Flexible Spending Account (FSA).




Upon starting an unpaid leave of absence under FML, you may opt to continue all coverages or elect to revoke all coverages. Should you decide to revoke your elections, they may be subject to reinstatement upon your return from leave. You have 30 days from your last paid date prior to unpaid leave to notify your employer of your revocation. Current elections will terminate based on the last day of paid leave.

**Health Insurance**

While on FML, two conditions must be met 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 Healthcare FSA, 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 not to continue participating in the Healthcare FSA, 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 KHRIS User ID or Personnel Number on each check.

If you exhaust your FML time before you can 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 would be restored to your previous benefits on the 1$^{st}$ or the 16$^{th}$ of the month upon your return to work.

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

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

**Health Insurance Coverage only – Reported Deaths over two years must be sent to DEI Executive Management for review.**

**NOTE: Optional Insurance coverage will terminate on the last day of the month of date of death.**

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

### FSAs and Waiver HRAs

| | Death of: | Date of Death | Coverage Ends | Contributions |
|---|---|---|---|---|
| **FSA** | Member | 1st – 15th of the month | Date of Death | ½ of the monthly contribution |
| **FSA** | Member | 16th – end of the month | Date of Death | Full monthly contribution |
| **Waiver HRA** | Member | 1st – 15th of the month | End of Semi-Monthly Period | N/A |
| **Waiver HRA** | Member | 16th – end of the month | End of Semi-Monthly Period | N/A |

# Chart to Assist in Administering the Qualifying Event of Birth for Health Insurance Coverage – APPENDIX E

**NOTE: Optional Insurance coverage is effective the first of the month following signature date of QE application.**

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 30 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 30 days from 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 32nd 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 1st-15th** | **September 16th-31st** | **October 1st-15th (Newborn born on 10/6)** | | **October 16th-31st** | **November 1st-15th** | **November 16th-31st** |
|---|---|---|---|---|---|---|---|
| **Coverage Level:** 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 |
| **Bill for:** | Single Contribution | Single Contribution | Single Contribution | | Single Contribution | Single Contribution | Parent Plus Contribution |
| | **September 1st-15th** | **September 16th-31st** | **October 1st-15th (Newborn born on 10/6)** | | **October 16th-31st** | **November 1st-15th** | **November 16th-31st** |
| **Coverage Level:** 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 |
| **Bill for:** | Single Contribution | Single Contribution | Parent Plus Contribution | | Parent Plus Contribution | Parent Plus Contribution | Parent Plus Contribution |
| | **September 1st-15th** | **September 16th-31st** | **October 1st-15th (Newborn born on 10/6)** | | **October 16th-31st** | **November 1st-15th** | **November 16th-31st** |
| **Coverage Level:** 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 |
| **Bill for:** | Single Contribution | Single Contribution | Family Coverage Level | | Family Contribution | Family Contribution | Family Contribution |
| | **September 1st-15th** | **September 16th-31st** | **October 1st-15th (Newborn born on 10/6)** | | **October 16th-31st** | **November 1st-15th** | **November 16th-31st** |
| **Coverage Level:** 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 |
| **Bill for:** | Family Contribution | Family Contribution | Family Contribution | | Family Contribution | Family Contribution | Family Contribution |
| | **September 1st-15th** | **September 16th-31st** | **October 1st-15th (Newborn born on 10/6)** | | **October 16th-31st** | **November 1st-15th** | **November 16th-31st** |

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| **Coverage Level:** 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 |
| **Bill for:** | Parent Plus Contribution | Parent Plus Contribution | Parent Plus Contribution | | Parent Plus Contribution | Parent Plus Contribution | Parent Plus Contribution |
| | **September 1st-15th** | **September 16th-31st** | **October 1st-15th (Newborn born on 10/6)** | | **October 16th-31st** | **November 1st-15th** | **November 16th-31st** |
| **Coverage Level:** 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 |
| **Bill for:** | Parent Plus Contribution | Parent Plus Contribution | Family Contribution | | Family Contribution | Family Contribution | Family Contribution |
| | **September 1st-15th** | **September 16th-31st** | **October 1st-15th (Newborn born on 10/6)** | | **October 16th-31st** | **November 1st-15th** | **November 16th-31st** |
| **Coverage Level:** 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 |
| **Bill for:** | Two Single Contributions | Two Single Contributions | Two Single Contributions | | Two Single Contributions | Two Single Contributions | Two Family Cross Reference Contributions |
| | **September 1st-15th** | **September 16th-31st** | **October 1st-15th (Newborn born on 10/6)** | | **October 16th-31st** | **November 1st-15th** | **November 16th-31st** |
| **Coverage Level:** Two Single to a Family Cross-Reference Payment Option with 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 |
| **Bill for:** | Two Single Contributions | Two Single Contributions | Two Family Cross Reference Contributions | | Two Family Cross Reference Contributions | Two Family Cross Reference Contributions | Two Family Cross Reference Contributions |
| | **September 1st-15th** | **September 16th-31st** | **October 1st-15th (Newborn born on 10/6)** | | **October 16th-31st** | **November 1st-15th** | **November 16th-31st** |
| **Coverage Level:** 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 |
| **Bill for:** | 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 | Two Family Cross Reference Contributions |
| | **September 1st-15th** | **September 16th-31st** | **October 1st-15th (Newborn born on 10/6)** | | **October 16th-31st** | **November 1st-15th** | **November 16th-31st** |
| **Coverage Level:** | Waiver HRA | Waiver HRA | Waiver HRA | | Parent Plus Coverage | Parent Plus Coverage Level | Parent Plus Coverage Level |

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| Waiver HRA to Parent Plus (Employee is Tag-Along) | | | | | Level as of 10/6 | | |
| **Bill for:** | Waiver HRA | Waiver HRA | Parent Plus Contribution | Parent Plus Contribution | Parent Plus Contribution | Parent Plus Contribution | Parent Plus Contribution |
| | **September 1st-15th** | **September 16th-31st** | **October 1st-15th (Newborn born on 10/6)** | | **October 16th-31st** | **November 1st-15th** | **November 16th-31st** |
| **Coverage Level:** 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 |
| **Bill for:** | Waiver HRA | Waiver HRA | Family Contribution | Family Contribution | Family Contribution | Family Contribution | Family Contribution |

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

Health, HRA and FSA coverage for CP new employees will begin on the date of hire, while Vision, Dental and Life coverage will begin on the first day of the second calendar month following the employee's hire date. Example: Employee hired August 16. Health, HRA and FSA benefits may start on August 16th, while Vision, Dental and Life benefits may start October 1st.

| **Commonwealth Paid Employees** | | |
|---|---|---|
| **Employees Hired During the Month of:** | **Benefits** | **Coverage Effective** |
| January | Health/HRA/FSA | Date of Hire |
| | Life/Vision/Dental | March 1st |
| February | Health/HRA/FSA | Date of Hire |
| | Life/Vision/Dental | April 1st |
| March | Health/HRA/FSA | Date of Hire |
| | Life/Vision/Dental | May 1st |
| April | Health/HRA/FSA | Date of Hire |
| | Life/Vision/Dental | June 1st |
| May | Health/HRA/FSA | Date of Hire |
| | Life/Vision/Dental | July 1st |
| June | Health/HRA/FSA | Date of Hire |
| | Life/Vision/Dental | August 1st |
| July | Health/HRA/FSA | Date of Hire |
| | Life/Vision/Dental | September 1st |
| August | Health/HRA/FSA | Date of Hire |
| | Life/Vision/Dental | October 1st |
| September | Health/HRA/FSA | Date of Hire |
| | Life/Vision/Dental | November 1st |
| October | Health/HRA/FSA | Date of Hire |
| | Life/Vision/Dental | December 1st |
| November | Health/HRA/FSA | Date of Hire |
| | Life/Vision/Dental | January 1st |
| December | Health/HRA/FSA | Date of Hire |
| | Life/Vision/Dental | February 1st |

Coverage for NCP, PVA and County Fee 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.

| **Non-Commonwealth Paid Employees** | |
|---|---|
| **Employees Hired During the Month of:** | **Will Have Coverage Effective** |
| 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 FSA/HRA Semi-Monthly Billing Period and Premium Due Date – APPENDIX G

| 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 |

# Chart to Assisting in Processing LWOP
# APPENDIX H

**Optional insurance and life insurance are effective the first of the month following return from LWOP date unless the return date falls on the first of the month.**




**18A Employees: Per 101 KAR 2:102 § 2(2)(d), an employee has to have had a day of paid work or paid leave in the prior pay period in order to be eligible for health coverage. Because Sick Leave by PAN occurs on the 31st day of consecutive sick leave without pay, the termination of Health insurance, Waiver HRAs, and Waiver Limited Purpose HRAs should be retroactive based on the last day payment for coverage is received. See Chapter 4: Leaves of Absences for more information.**

| Leave Without Pay | | | | |
|---|---|---|---|---|
| **Type** | **Sick Leave by PAN** | **Health Insurance & Waiver Coverage Ends** | **Return from Sick Leave by PAN** | **Coverage Starts** |
| **18A** | 1st-15th | Based on last payment received | 1st-15th | 16th of the same month |
| **18A** | 16th-31st | Based on last payment received | 16th-31st | 1st of the following month |
| **Type** | **Official LWOP Begins** | **Health Insurance & Waiver Coverage Ends** | **Official LWOP Ends** | **Coverage Starts** |
| **Non 18A** | 1st-15th | 15th of the same month | 1st-15th | 1st of the same month (BOE can choose with 1st or 16th of the same month) |
| **Non 18A** | 16th-31st | 31st of the same month | 16th-31st | 16th of the same month<br><br>(BOE can choose either 1st of next month or 16th of the same month) |

# QUALIFYING EVENTS

# &

# MID-YEAR SCENARIOS

# Qualifying Events – APPENDIX I

KEHP is intended to comply with Section 125 of the Internal Revenue Code. This allows Employees to pay for their share of Health/Dental/Vision Insurance premiums with pre-tax payroll deductions. Section 125 plans are federally regulated, and the guidelines state that if an Employees' Health/Dental/Vision Insurance or Flexible Spending Account is offered through a Section 125 plan, they cannot make a change to their Health/Dental/Vision 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)
- **Medicaid Eligibility/Termination (MET) Form signed by the Division of Medicaid Services must show loss of eligibility. Failure to recertify/provide verification timely, non-payment of premiums or dropping coverage voluntarily is not a valid loss of eligibility.**

*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; or the former employer ceased paying COBRA premiums on behalf of the employee after termination.
- 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;

## 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:

- 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. Except for losing and gaining Medicaid which has a signature deadline of 60 days, all Qualifying Events have a signature deadline of 30 calendar days from the Event Date. 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 30 calendar days from the event (marriage). Day one would be March 6, and day 30 would be April 4. The Employee's signature must be on the applicable forms no later than April 4.

### 3. 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.**

**4. 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, except for the Open Enrollment Under Other Employer Plan/Different Year QE.

**5. Supporting Documentation**

Most all QEs must be validated with supporting documentation, such as, but not limited to marriage certificates, divorce agreements, or letters from employers. Before a Dependent can be added to a health insurance plan, verification documents must be provided. See Dependent Eligibility Chart in Chapter 1, page 5. Each Qualifying Event in the chart contains a Document Required section. Other documents, besides those listed, may be acceptable. In all event situations, KEHP must be satisfied that the event has occurred and that the requested change is permitted for that event. Otherwise, the documentation submitted will not be accepted and a plan change will not be permitted.

**6. Qualifying Event Charts**

The Qualifying Event chart is your guide in knowing what mid-year election changes are permitted under a Section 125 plan, and the documentation that is required. This includes Healthcare and Child and Adult Daycare FSA elections as well, and whether they may be increased, decreased, or terminated during specific Qualifying Events. Note: Decreasing an election means to lower the election amount, and terminating an election means to terminate the *entire* FSA.

**7. Child and Adult Daycare FSA**

The types of Qualifying Events that are permitted with a Child and Adult Daycare FSA are quite expansive - much more than for Healthcare FSA. The IRS has indicated that QEs for Child and Adult Daycare FSAs are intended to be more liberally interpreted.

**8. Health FSA and Child and Adult Daycare FSA Election Reduction**

Regardless of the Qualifying Event that permits an FSA election change, under no circumstances is an Employee permitted to reduce their FSA election to a point where the total contributions for the plan year are less that the amount already reimbursed for that plan year. You should check the Employee's FSA expenditures prior to approving a request for an FSA reduction based on a Qualifying Event.

# Qualifying Events for Life Insurance

Commonwealth of Kentucky Group Life Insurance plans allow for fewer Qualifying Events than KEHP does as per the Certificate of Coverage. In addition, life insurance premiums are post-tax payroll deductions. Under the rules of the benefit plan, an employee may enroll in or change the amount of life insurance between open enrollment periods, without evidence of insurability, if there has been a Qualifying Event. The employee has 30 days from the date of that change to make a request and new or increased coverage will take effect on the first day of the month following the signature date on the Life Insurance Enrollment and Change form, if the employee is considered **Actively at Work (not on leave with or without pay** on that date). If employee is not Actively at Work on the date insurance would otherwise take effect, insurance will take effect on the day the employee resumes Active Work. See current Certificate of Coverage for more details. See Appendices L-N for more information on life insurance benefits administration.

**Qualifying Events include**:

- marriage;
- the birth, adoption or placement for adoption of a dependent child;
- divorce, legal separation or annulment;
- the death of a dependent;
- a change in Your or Your dependent's employment status, such as beginning or ending employment, strike, lockout, taking or ending a leave of absence, changes in worksite or work schedule, if it causes You or Your dependent to gain or lose eligibility for group coverage; or
- A dependent's ceasing to qualify as a dependent under this insurance or under other group coverage. If there is a Qualifying Event, the employee will have 30 days from the date of that change to make a request. This request must be consistent with the nature of the Qualifying Event.

**Eligible Dependents include**:

- a natural child, adopted child (including a child from the date of placement with the adopting parents until the legal adoption) or stepchild; or
- an unmarried foster child who resides with and is supported by the employee; or
- a child for whom the employee is the legally appointed guardian who resides with and is supported by the employee;
- and who, in each case, is under age 26.

  **NOTE**: For the purposes of determining who may become covered for insurance, the term also does not include any person who:
  - is on active duty in the military of any country or international authority; however, active duty for this purpose does not include weekend or summer training for the reserve forces of the United States, including the National Guard; or
  - is insured under the Group Policy as an employee.

  **NOTE**: Once You have enrolled one Child for a Dependent insurance benefit, each succeeding Child will automatically be covered for such insurance on the date that Child qualifies as a Dependent.

- Lawful spouse

  **NOTE**: For the purposes of determining who may become covered for insurance, the term does not include any person who:
  - is on active duty in the military of any country or international authority; however, active duty for this purpose does not include weekend or summer training for the reserve forces of the United States, including the National Guard.

# CHANGE IN EMPLOYEE'S LEGAL MARITAL STATUS

## 1. GAIN SPOUSE DUE TO MARRIAGE

| HEALTH/DENTAL/VISION INSURANCE LIFE INSURANCE | FLEXIBLE SPENDING ACCOUNTS | | WAIVER HRA (GP or Limited Purpose) |
|---|---|---|---|
| | Healthcare (HC) | Child and Adult Daycare | |
| **ADD:** Employee may enroll or increase Coverage Level for newly eligible Spouse and Dependent children. Plan Option change may be made. **DROP:** Employee may terminate or decrease Employee's or Dependent's coverage **ONLY** when such coverage becomes effective or is increased under the Spouse's plan (Gain of Other Coverage). **Employee may not drop Health Insurance coverage and choose a Waiver HRA with funds mid-year.** | **ADD:** Employee may enroll or increase election for newly eligible Spouse or Dependents. **DROP:** Employee may decrease election if Employee or Dependents become eligible and covered under new Spouse's health plan. (Gain of Other Coverage). | **ADD:** Employee may enroll or increase to accommodate newly eligible Dependents. **DROP:** Employee may decrease or cease coverage if new Spouse is not employed or makes a Child and Adult Daycare coverage election under Spouse's plan. | Employee may terminate election and redirect the state contribution to Health Insurance. |

**OTHER CONDITIONS/GUIDANCE:**

- Tag-Along rules apply.
- No domestic partnerships; Common law marriage recognized if documented. Need certification/attestation of other coverage.
- Gaining TRICARE as the result of marriage is NOT a valid QE to drop Employee, Spouse, or Dependent Coverage.

## ADMINISTRATION GUIDELINES

| | | |
|---|---|---|
| **Event Date** | Add a Spouse and/or Dependent(s) | Date of marriage |
| | Drop Dependent(s) | Date Dependent gained other group Health Insurance coverage under the new Spouse's plan |
| **Signature Deadline** | 30 calendar days from the event date | |
| **Effective Date** | Add Spouse or Dependent(s) | First of the month following the Employee's signature date |
| | Drop Dependent(s) | End of the month of the Employee's signature date. |
| | Enroll/increase HC or DC FSA | First day of the month following Employee's signature date |
| | Terminate/decrease HC or DC FSA | End of the month of the Employee's signature date |
| **Document(s) Required** | Add Spouse/Dependent(s) | Marriage Certificate; See Dependent Eligibility Chart |
| | Drop Employee or Dependent(s) due to gaining other Group Health Plan Coverage due to marriage | Notification from employer, on employer's letterhead or via electronically, or an email from the employer with HR signature block 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, with coverage Effective Date; or a self-service enrollment confirmation that states the employer's name, effective date and person(s) covered. |
| **Forms to Use** | Health Insurance/Optional Insurance/FSA | Employee Benefits Enrollment/Change Form |
| | Optional/Dependent Life | Life Insurance Enrollment and Change Form |

## 2. LOSE SPOUSE DUE TO DIVORCE, LEGAL SEPARATION, ANNULMENT OR DEATH

| HEALTH/DENTAL/VISION INSURANCE LIFE INSURANCE | FLEXIBLE SPENDING ACCOUNTS | | WAIVER HRA (GP or Limited Purpose) |
|---|---|---|---|
| | Healthcare (HC) | Child and Adult Daycare | |
| **ADD:** May elect coverage for Employee, or Dependents who lose eligibility under Spouse's plan if such individual loses eligibility as a result of the divorce, legal separation, annulment, or death. (Loss of Coverage including the Loss of TRICARE due to divorce).<br>**DROP:** Employee may terminate election for Spouse, and for Dependents who lose eligibility such as a stepchild. Plan option change may be made. | **ADD:** Employee may enroll or increase election where coverage is lost under Spouse's health plan. (Loss of Coverage).<br>**DROP:** Employee may decrease election to reflect loss of Spouse's eligibility. | **ADD:** Employee may enroll or increase to accommodate newly eligible Dependents including increase in Child and Adult Daycare expenses.<br>**DROP:** Employee may cease coverage if eligibility is lost or Child and Adult Daycare expenses decrease (i.e. Dependent now residing with ex-Spouse). | **DROP:** Employee may terminate election and redirect the state contribution to Health Insurance ONLY if event causes a loss of coverage under Spouse's plan. (Loss of Coverage – including loss of TRICARE due to divorce). |

**OTHER CONDITIONS/GUIDANCE:**

- Tag-Along rules apply.
- The effective date of termination of coverage for the ineligible spouse/dependent(s) is the end of the month of the following judge's signature date on the divorce decree or date as entered by the court, but no more than 120 days retroactive from the signature date on the divorce decree.
- In lieu of an employer letter confirming loss of coverage, the following may also be used
    1) Either executed divorce decree or signed divorce papers, AND
    2) Either an old insurance card or explanation of benefits addressed to the person, AND
    3) Either a signed QE Form or signed Exception Form, that includes a statement confirming a loss of prior coverage as a result of divorce.

### ADMINISTRATION GUIDELINES

| | | |
|---|---|---|
| **Event Date** | Add Employee/Dependent(s) | **Divorce, Legal Separation or Annulment:** date of loss of coverage under former Spouse's plan or the date the divorce decree is entered by the court. **Death:** date of loss of coverage under deceased Spouse's plan. |
| | Drop Spouse/Dependent(s) | **Divorce, Legal Separation or Annulment:** 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. **Death:** date of death. |
| **Signature Deadline** | 30 calendar days from the event date. | |
| **Effective Date** | Add Employee/Dependent(s) | **Divorce, Legal Separation or Annulment:** first of the month following the Employee's signature date on the Employee Benefits Enrollment/Change Form. Must also submit eligibility documentation. **Death:** first of the month following the Employee's signature date. |
| | Drop Spouse/Dependent(s) | **Divorce, Legal Separation or Annulment:** End of the month following either judge's signature date or date as entered by the court, whichever is later. **Death:** 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 30-day deadline is met. |
| | Drop Dependent(s) added to other group plan | **Divorce, Legal Separation or Annulment:** When added to former Spouse's plan, the end of the month following Employee's signature date. |
| | Enroll in or increase HC DC FSA | First day of the month following Employee's signature date |

| | | |
|---|---|---|
| | Terminate or decrease HC DC FSA | End of the month of the Employee's signature date. |
| **Document(s) Required** | Add Employee or Dependent(s) | Notification from employer on letterhead or electronically, that includes person(s) covered and coverage termination date; letter from insurance company with type of coverage, date of termination, and person(s) covered; or termination letter from governmental agency providing previous coverage. In the event employee's children lose coverage under ex-spouse's or deceased spouse's plan, provide proof of loss of eligibility due to divorce/death. **Waiver HRA:** Divorce decree, legal separation order, or annulment order and notification from spouse's 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. **See other conditions and guidance for other documentation.** |
| | Drop Spouse/Dependent(s) | **Divorce, Legal Separation or Annulment:** Divorce decree, legal separation orders, or annulment orders 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. **Death**: none. |
| **Forms to Use** | Health Insurance/Optional Insurance/FSA | Employee Benefits Enrollment/Change Form |
| | Optional/Dependent Life | Life Insurance Enrollment and Change Form |

# CHANGE IN NUMBER OF EMPLOYEE'S DEPENDENTS

## 1. GAIN DEPENDENT DUE TO BIRTH, ADOPTION, PLACEMENT FOR ADOPTION

| HEALTH/DENTAL/VISION INSURANCE LIFE INSURANCE | FLEXIBLE SPENDING ACCOUNTS | | WAIVER HRA (GP or Limited Purpose) |
|---|---|---|---|
| | Healthcare (HC) | Child and Adult Daycare | |
| **ADD:** Employee may enroll or increase Coverage Level for self, Spouse and newly eligible Dependent children. Plan option change may be made. **DROP:** Employee may terminate or decrease Employee's or Dependent's coverage if Employee or Dependent becomes eligible under Spouse's plan. | **ADD:** Employee may enroll or increase coverage for newly eligible Dependent children. **DROP:** Employee may terminate or decrease Employee's or Dependent's coverage if Employee or Dependent becomes eligible under Spouse's plan. | **ADD:** Employee may enroll or increase to accommodate newly eligible Dependents. | **DROP:** Employee may terminate election and redirect the state contribution to Health Insurance. |

**OTHER CONDITIONS/GUIDANCE:**

- Tag-Along rules apply.
- 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 same time of the newborn's birth. If the birth, creates a Coverage Level change, no increase in costs until the 32nd day from date of birth. If the birth, adoption, or placement for adoption plus Tag-Alongs creates a Coverage Level change, between the 1st and the 15th day of the month, the Member must pay the new premium for the entire month; if between the 16th and the end of the month, the Member must pay the new premium for one-half of the month. Refer to Appendix E for an example.
- When an Employee's Dependent gives birth, the newborn will be covered under the Employee's (grandparents) plan for the first 31 days. After the first 31 days, the Dependent's newborn is no longer eligible for coverage as a grandchild. At this point, the following actions are permitted:
  - If Dependent gains eligibility through her own employer (either through KEHP or another employer), the Employee may drop the Dependent from coverage. The Dependent's employer should send KEHP a letter advising that the Employer will allow the Dependent to pick up coverage through her Employer. If so, KEHP may drop the Dependent.
  - If Dependent and newborn gain eligibility through the Dependent's Spouse's Employer, KEHP will allow the Employee to drop the Dependent. The Dependent's Spouse's employer needs to provide KEHP a letter advising that the Employer will allow the Dependent and newborn to have coverage through the Employer. If so, KEHP will drop the Dependent.

## ADMINISTRATION GUIDELINES

| | | |
|---|---|---|
| **Event Date** | **Birth:** Date of birth; **Adoption and Placement for Adoption:** Date of Adoption or date of presiding judge's signature or date adoption was entered into court or date of filing of the petition for adoption, whichever comes first; Foreign Adoption- Date Visa stamped; **Placement:** Child's Placement Date. | |
| **Signature Deadline** | Add ONLY a newborn, adopted or placed child with or without Tag-Alongs | 30 Calendar days from the event date |
| | Drop Employee or Dependent(s) | 30 Calendar days from the event date |
| **Effective Date** | Add Employee, Spouse or Dependent(s) | Birth: Date of birth; Adoption: Date of Adoption or date of filing of the petition for adoption; Foreign Adoption- Date Visa stamped; Placement: Child's Placement Date. |

| | | |
|---|---|---|
| | Drop Employee, or Dependent(s) | End of the month of the Employee's signature date. |
| | Enroll/increase HC FSA and DCFSA | First day of the month following Employee's signature date. |
| | Terminate/decrease HC FSA | End of the month of the Employee's signature date. |
| | Add Employee, Spouse or Dependent(s) to Optional Insurance | First day of the month following Employee's signature date. |
| **Document(s) Required** | Add | See Dependent Eligibility Chart. |
| | Drop Employee/Dependent 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, with coverage Effective Date. |
| **Forms to Use** | Health Insurance/Optional Insurance/FSA | Employee Benefits Enrollment/Change Form |
| | Optional/Dependent Life | Life Insurance Enrollment and Change Form |

## 2. LOSE DEPENDENT DUE TO DEATH (child)

| HEALTH/DENTAL/VISION INSURANCE | FLEXIBLE SPENDING ACCOUNTS | | WAIVER HRA (GP or Limited Purpose) |
|---|---|---|---|
| | Healthcare (HC) | Child and Adult Daycare | |
| **DROP:** Employee may drop coverage only for the deceased Dependent. Plan Option changes may be made. | **DROP:** Employee may decrease or cease election for Dependent who loses eligibility. | **DROP:** Employee may decrease election for Dependent who loses eligibility. | No change permitted. |

**OTHER CONDITIONS/GUIDANCE:**

- Tag-Along rule – Not applicable.

## ADMINISTRATION GUIDELINES

| | | |
|---|---|---|
| **Event Date** | Date of death | |
| **Signature Deadline** | 30 calendar days from the event date. | |
| **Effective Date** | Drop Dependent(s) | End of the month of the Dependent's death. |
| **Document(s) Required** | none | |
| **Forms to Use** | Health Insurance/Optional Insurance/FSA | Employee Benefits Enrollment/Change Form |
| | Optional/Dependent Life | Life Insurance Enrollment and Change Form |

# STARTING EMPLOYMENT
## OR OTHER CHANGE OF EMPLOYMENT STATUS BY EMPLOYEE, SPOUSE, OR DEPENDENT THAT TRIGGERS ELIGIBILITY

### 1. STARTING EMPLOYMENT BY EMPLOYEE (New Hire - allowing initial elections outside of Open Enrollment)

| HEALTH/DENTAL/VISION INSURANCE | FLEXIBLE SPENDING ACCOUNTS | | WAIVER HRA (GP or Limited Purpose) |
|---|---|---|---|
| | Healthcare (HC) | Child and Adult Daycare | |
| **ADD:** Provided that eligibility was gained for KEHP coverage, Employee may add coverage for Employee, Spouse, or Dependents. | **ADD:** Provided that eligibility was gained for KEHP coverage, Employee may add coverage. | **ADD:** Provided that eligibility was gained for KEHP coverage, Employee may add coverage. | **ADD:** Provided that eligibility was gained for KEHP coverage, Employee may elect coverage. |

**OTHER CONDITIONS/GUIDANCE:**

- All Dependents may be covered.
- Events that change the employment status of the Employee, the Employee's Spouse, or the Employee's Dependent. Examples: Starting employment, PT to FT.
- Not all Return to Work Retirees can make initial elections via Employee Self-Service. Contact Enrollment Information Branch for more information.

**ADMINISTRATION GUIDELINES**

| | | |
|---|---|---|
| **Event Date** | Date of hire. | |
| **Signature Deadline** | 30 calendar days from the Qualifying Event date. | |
| **Effective Date** | Adding Employee, Spouse or Dependent(s) | CP: Date of Hire for Health/FSA/HRA, and first day of the 2nd month from employee's hire date for Life/Vision/Dental.<br>NCP, PVA, County Fees: The first day of the second month following the Employee's hire date, for all benefits. |
| | Enrolling in FSA | CP: Date of Hire<br>NCP, PVA, County Fees: The first day of the second month following the Employee's hire date. |
| **Document(s) Required** | Adding Spouse or Dependent(s) | See Dependent Eligibility chart. |
| **Forms to Use** | Health Insurance/Optional Insurance/FSA | Employee Benefits Enrollment/Change Form or Employee Self-Service |
| | Optional/Dependent Life | Life Insurance Enrollment and Change Form or Employee Self-Service |

### 2. STARTING EMPLOYMENT BY SPOUSE OR DEPENDENT

| HEALTH/DENTAL/VISION INSURANCE LIFE INSURANCE | FLEXIBLE SPENDING ACCOUNTS | | WAIVER HRA (GP or Limited Purpose) |
|---|---|---|---|
| | Healthcare (HC) | Child and Adult Daycare | |
| **DROP:** Employee may terminate or decrease Coverage Level if Employee, Spouse, or Dependent is added to Spouse's or Dependent's plan. Plan Option changes may be made. | **DROP:** Employee may decrease or cease election if gains eligibility for health coverage under Spouse's or Dependent's plan. | **ADD:** Employee may make or increase election to reflect new eligibility. **DROP:** Employee may terminate election for Dependent's coverage if Dependent is added to Spouse's plan. | No change permitted. |

**ADMINISTRATION GUIDELINES**

| | | |
|---|---|---|
| **Event Date** | The date the person being dropped gained coverage under the Spouse's or Dependent's employer sponsored group health plan. | |
| **Signature Deadline** | 30 calendar days from the Qualifying Event date. | |
| **Effective Date** | Dropping Employee, Spouse or Dependents | The end of the month of the Employee's signature date. |
| | Terminating or decreasing HC FSA | End of the month of the Employee's signature date |
| | Increasing DC FSA | First day of the month following Employee's signature date. |
| **Document(s) Required** | Dropping Employee, Spouse or Dependent(s) | Notification from employer, on employer's letterhead or via electronically, or an email from the employer with HR signature block identifying the coverage Effective Date and the person(s) covered by the policy; or a self-serve enrollment confirmation that states the employer's name, Effective Date, and person(s) covered. |
| **Forms to Use** | Health Insurance/Optional Insurance/FSA | Employee Benefits Enrollment/Change Form |
| | Optional/Dependent Life | Life Insurance Enrollment and Change Form |

# TERMINATION OF EMPLOYMENT

## BY EMPLOYEE, SPOUSE, OR DEPENDENT THAT CAUSES LOSS OF ELIGIBILITY (OR OTHER CHANGE IN EMPLOYMENT STATUS)

### 1. TERMINATION OF EMPLOYEE'S EMPLOYMENT

| HEALTH/DENTAL/VISION INSURANCE<br>LIFE INSURANCE | FLEXIBLE SPENDING ACCOUNTS | | WAIVER HRA<br>(GP or Limited Purpose) |
|---|---|---|---|
| | Healthcare (HC) | Child and Adult Daycare | |
| **DROP:** Employee, Spouse, and Dependent(s) coverage terminates. | Employee's election to participate in the FSA will terminate. No reimbursements for expenses incurred after the end of the day on the last day of the last pay period worked or Employee otherwise ceases to be eligible. COBRA rules may apply. | When a Participant ceases to be a Participant, the Participant's Salary Reductions and election to participate in the Child and Adult Daycare FSA will terminate. The Participant will not be able to receive reimbursements for expenses associated with Child and Adult Daycare incurred after the last day of the last pay period worked or the Participant otherwise ceases to be eligible, with one exception - such Participant (or the Participant's estate) may claim reimbursement for expenses for any Child and Adult Daycare incurred in the month following termination of employment or other cessation of eligibility if such month is in the current Plan Year, provided that the Participant (or the Participant's estate) files a claim for these expenses within 90 days after the date that the Participant's employment terminates or the Participant otherwise ceases to be eligible. COBRA rules do not apply. | **DROP:** Employer ceases employer contributions. COBRA rules may apply. |

### ADMINISTRATION GUIDELINES

| | | |
|---|---|---|
| **Event Date** | Date of termination or event date, whichever is later. | |
| **Signature Deadline** | IC/HRG has 10 days to terminate the Employee in KHRIS or submit an Employee Benefits Enrollment/Change Form. | |
| **Effective Date** | Employee, Spouse or Dependent(s) | If terminated between the 1st and the 15th of the month, coverage will terminate on the 15th of the month. If terminated between the 16th and the end of the month, coverage will terminate on the last day of the same month. |

| | | |
|---|---|---|
| **Document(s) Required** | Notification from employer, on employer's letterhead or via electronically, identifying the coverage termination date and the person(s) covered by the policy; or letter from the insurance company showing the termination date, type of coverage, date of termination and person(s) covered. | |
| **Forms to Use** | Health Insurance/Optional Insurance/FSA | Employee Benefits Enrollment/Change Form |
| | Optional/Dependent Life | Life Insurance Enrollment and Change Form |

## 2. TERMINATION OF SPOUSE'S OR DEPENDENT'S EMPLOYMENT OR OTHER CHANGE IN EMPLOYMENT STATUS RESULTING IN A LOSS OF ELIGIBILITY

| HEALTH/DENTAL/VISION INSURANCE | FLEXIBLE SPENDING ACCOUNTS | | WAIVER HRA (GP or Limited Purpose) |
|---|---|---|---|
| | Healthcare (HC) | Child and Adult Daycare | |
| **ADD:** Employee may enroll or increase Coverage Level for an Employee, Spouse, or Dependent who lost eligibility under Spouse's or Dependent's employer's plan. (Loss of Coverage). Plan Option changes may be made. | **ADD:** Employee may enroll or increase election to reflect loss of eligibility for health coverage. (Loss of Coverage). | **ADD:** Employee may enroll or increase election if Spouse or Dependent loses eligibility for Child and Adult Daycare FSA.<br><br>**DROP:** Employee may decrease or cease election to reflect loss of eligibility for coverage (i.e. if Spouse stops working) or decrease in Child and Adult Daycare expenses. | **DROP:** Employee may terminate election and redirect the state contribution to Health Insurance if event causes loss of coverage under Spouse's/Dependent's plan. Redirection is authorized if either the Spouse, Dependent, Employee or combination of these individuals loses coverage as a result of a Spouse's or Dependent's termination of employment. |

**OTHER CONDITIONS/GUIDANCE:**

- Tag-Along rules apply. Employee can be the Tag-Along.
- Involves any change in employment status resulting in a loss of eligibility under the Spouse's/Dependent's employer's plan. HIPAA special enrollment rights may also apply. Examples: Termination of employment, FT to PT, salaried to hourly, starting unpaid leave, strike, lockout, etc.
- If the Employee is covered under a Waiver HRA, the Employee may terminate the election and redirect the state contribution to Health Insurance provided the loss of a Spouse's or Dependent's employment results in a loss of coverage for at least one person being added to the plan (Employee, Spouse, or Dependent).

## ADMINISTRATION GUIDELINES

| | | |
|---|---|---|
| **Event Date** | Adding Employee, Spouse and/or Dependent(s) | Date of loss of coverage under the other employer-sponsored group health plan. |
| **Signature Deadline** | 30 calendar days from the Qualifying Event date. | |
| **Effective Date** | Adding Employee, Spouse or Dependent(s) | The first day of the month following the Employee's signature date. |
| | Enrolling in or increasing HC 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 Employee, Spouse or Dependent(s) | Notification from employer, on employer's letterhead or via electronically, identifying the coverage termination date and the person(s) covered by the policy; or letter or certificate of creditable coverage from the insurance company showing the termination date, type of coverage, date of termination and person(s) covered. |

| | | |
|---|---|---|
| **Forms to Use** | Health Insurance/Optional Insurance/FSA | Employee Benefits Enrollment/Change Form |
| | Optional/Dependent Life | Life Insurance Enrollment and Change Form |

## 3. CLEAN TRANSFER – FROM ONE PARTICIPATING EMPLOYER TO ANOTHER WITH NO BREAK IN SERVICE

| HEALTH/DENTAL/VISION INSURANCE LIFE INSURANCE | FLEXIBLE SPENDING ACCOUNTS | | WAIVER HRA (GP or Limited Purpose) |
|---|---|---|---|
| | Healthcare (HC) | Child and Adult Daycare | |
| No election changes permitted. Life Insurance Beneficiaries do not transfer to new agency automatically. | No election changes permitted. | No election changes permitted. | No election changes permitted. |

## 4. SMALL BREAK TRANSFER – 1-10 WORKING DAYS

| HEALTH/DENTAL/VISION INSURANCE LIFE INSURANCE | FLEXIBLE SPENDING ACCOUNTS | | WAIVER HRA (GP or Limited Purpose) |
|---|---|---|---|
| | Healthcare | Child and Adult Daycare | |
| No election changes are permitted. Life Insurance Beneficiaries do not transfer to new agency automatically. | No election changes are permitted. | No election changes are permitted. | Reinstate prior elections. No election changes permitted. |

## ADMINISTRATION GUIDELINES

| | | |
|---|---|---|
| **Signature Deadline** | IC/HRG has 10 days to terminate the Employee in KHRIS or submit an Employee Benefits Enrollment/Change Form. | |
| **Effective Date** | If the 1-to-10-day break occurs within the *same* Semi-Monthly Billing Periods, there is no break in coverage. If the 1-to-10-day break occurs within *different* Semi-Monthly Billing Periods, there could be a ½ month break in coverage. *See chapter 2 for more information for 2025 CP changes to Health/FSA effective dates for new hires. | |
| **Forms to Use** | Health Insurance/Optional Insurance/FSA | Employee Benefits Enrollment/Change Form |
| | Optional/Dependent Life | Life Insurance Enrollment and Change Form |

## 5. LARGE BREAK TRANSFER – 11 OR MORE WORKING DAYS

| HEALTH/DENTAL/VISION INSURANCE LIFE INSURANCE | FLEXIBLE SPENDING ACCOUNTS | | WAIVER HRA (GP or Limited Purpose) |
|---|---|---|---|
| | Healthcare (HC) | Child and Adult Daycare | |
| Treat as new Employee. The new hire waiting period applies and Employee may make new elections. | Treat as new Employee. The new hire waiting period applies and Employee may make new elections. | Treat as new Employee. The new hire waiting period applies and Employee may make new elections. | Treat as new Employee. New hire waiting period applies and Employee may make new elections. |

**OTHER CONDITIONS/GUIDANCE:**

- Employee can cover all Dependents with new elections.

| | | |
|---|---|---|
| **Signature Deadline** | IC/HRG has 10 days to terminate the Employee in KHRIS or submit an Employee Benefits Enrollment/Change Form. | |
| **Effective Date** | Employee, Spouse or Dependent | 1st day of the second calendar month following date of hire. |
| **Forms to Use** | Health Insurance/Optional Insurance/FSA | Employee Benefits Enrollment/Change Form |
| | Optional/Dependent Life | Life Insurance Enrollment and Change Form |

# EVENT CAUSING EMPLOYEE'S DEPENDENT TO CEASE TO SATISFY ELIGIBILITY REQUIREMENT

## 1. DEPENDENT CEASES TO SATISFY ELIGIBILITY REQUIREMENTS

| HEALTH/DENTAL/VISION INSURANCE LIFE INSURANCE | FLEXIBLE SPENDING ACCOUNTS | | WAIVER HRA (GP or Limited Purpose) |
|---|---|---|---|
| | Healthcare (HC) | Child and Adult Daycare | |
| **DROP:** Employee may decrease or terminate election only for affected Dependent (or Spouse in the event of incarceration). Plan Option changes may be made. | **DROP:** Employee may decrease or terminate election to take into account ineligibility of expenses of affected Dependent, but only if eligibility is lost. **ADD:** If Dependent remains a tax Dependent and the health FSA provides that the Dependent's expenses remain eligible for reimbursement, then the Employee could increase election. | **DROP:** Employee may decrease or drop election to take into account expenses of affected Dependent. | No change permitted. |

OTHER CONDITIONS/GUIDANCE:

- No tag along change can be made.
- Dependent will automatically be dropped from the KHRIS system at the end of the month in which the Dependent turns 26.
- Aging-out Dependent who is also a KEHP member who has now experienced a loss of coverage.
- Stepchildren who lose eligibility as a result of divorce, annulment or legal separation.
- KPPA Retirees experiencing divorce and signed within 30 days will have ineligible dependents removed the first of the month following either Judge's signature date or date the divorce decree is final and entered into court, whichever is later.
- Incarceration:
  - A Spouse or Dependent who is incarcerated in prison, jail, or a custodial facility after having been convicted of a crime or offense is not eligible for coverage under KEHP.
  - Dependents and Spouses who are released from prison, jail, or a custodial facility regain eligibility for coverage and may be added to the plan.

## ADMINISTRATION GUIDELINES

| | | |
|---|---|---|
| **Event Date** | Dropping Dependent(s) turning 26 years of age | Automatically dropped from KHRIS the last day of the month in which the Dependent turns 26. |
| | Dropping Stepchildren who lost eligibility due to divorce, annulment or legal separation | Date the divorce decree, annulment or legal separation was signed by the Judge or as entered by the court. |
| **Signature Deadline** | 30 calendar days from the event date | |
| **Effective Date** | Dropping Dependent(s) turning 26 years of age | End of the month the Dependent turns 26 years of age. |

| | | |
|---|---|---|
| | Dropping Dependent Stepchildren who lose eligibility as a result of divorce, annulment or legal separation | End of the month following the date of entry of applicable order. |
| | Dropping Dependent or Spouse due to incarceration. | End of the month from date the spouse or dependent begins incarceration in prison, jail, or a custodial facility. |
| **Documents Required** | Divorce decree, legal separation orders, or annulment orders signed by a judge and date stamped "filed" or "entered" or a court order resulting from a divorce or separation that indicates a spouse and/or Dependent should be dropped, and a birth certificate showing the child(ren) are not eligible as a Dependent for the Employee.<br><br>Dropping Step-children: Step-children lose eligibility due to a Divorce, Legal Separation or Annulment: Divorce Decree, legal separation orders, or annulment orders 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 Dependent should be dropped, AND a birth certificate showing the child (ren) are not eligible as a dependent for the Employee.<br><br>Incarceration: Notice of incarceration or conviction.<br>Dropping Dependent turning 26 years of age: none | |
| **Forms to Use** | Health Insurance/Optional Insurance/FSA | Employee Benefits Enrollment/Change Form |
| | Optional/Dependent Life | Life Insurance Enrollment and Change Form |

# CHANGE IN COVERAGE UNDER OTHER EMPLOYER PLAN/MARKETPLACE PLAN

## 1. OTHER EMPLOYER PLAN DECREASES OR CEASES COVERAGE

| HEALTH/DENTAL/VISION INSURANCE | FLEXIBLE SPENDING ACCOUNTS | | WAIVER HRA (GP or Limited Purpose) |
|---|---|---|---|
| | Healthcare (HC) | Child and Adult Daycare | |
| **ADD:** Employee may enroll or increase election for Employee, Spouse, or Dependents if Employee, Spouse or Dependents have elected or received corresponding decreased coverage under other employer plan. | No change permitted. | **ADD:** Employee may enroll or increase election for Employee, Spouse, or Dependents if Employee, Spouse or Dependents have elected or received corresponding decreased coverage under other employer plan. | **DROP:** Employee may terminate election and redirect the state contribution to Health Insurance. |

**OTHER CONDITIONS/GUIDANCE:**
**Examples:** Mandatory change initiated by Spouse's employer; optional change in coverage initiated by Spouse's employer; and change in coverage initiated by Spouse.
**NOTE:** This QE is only related to changes under OTHER EMPLOYER plans. It does not refer to gaining individual coverage through any other source such as through the Marketplace.

### ADMINISTRATION GUIDELINES

| | | |
|---|---|---|
| **Event Date** | Date of coverage change. | |
| **Signature Deadline** | 30 calendar days from the Qualifying Event date | |
| **Effective Date** | Adding Employee, Spouse or Dependent(s) | 1st day of the month following Employee's signature date. |
| | Enrolling or increasing DC FSA | 1st day of the month following Employee's signature date. |
| **Document(s) Required** | Proof of change in other employer coverage. See Dependent Eligibility Chart. | |
| **Forms to Use** | Health Insurance /Optional Insurance/FSA | Employee Benefits Enrollment/Change Form |

## 2. OPEN ENROLLMENT UNDER OTHER EMPLOYER PLAN/DIFFERENT YEAR

| HEALTH/DENTAL/VISION INSURANCE | FLEXIBLE SPENDING ACCOUNTS | | WAIVER HRA (GP or Limited Purpose) |
|---|---|---|---|
| | Healthcare (HC) | Child and Adult Daycare | |
| **ADD:** Employee may enroll or increase election for Employee, Spouse and Dependent(s). Corresponding changes can be made under employer's plan.<br>**DROP:** Employee may drop or decrease election for Employee, Spouse, or Dependent(s) | Corresponding changes can be made under employer's plan. | Corresponding changes can be made under employer's plan | **DROP:** Employee may make corresponding change including terminating coverage and redirecting the state contribution to Health Insurance. |

| ADMINISTRATION GUIDELINES | | |
|---|---|---|
| **Event Date** | Last day of the Employee's, or Spouse's Open Enrollment Period | |
| **Signature Deadline** | 30 calendar days from the Qualifying Event date | |
| **Effective Date** | Adding or dropping Employee and/or Dependent(s) | Same as the Effective Date of the other Employer's Plan. |
| | FSA | Same as the Effective Date of the Employee, or Spouse's plan. |
| **Document(s) Required** | Notification from employer on employer's letterhead or electronically, identifying:<br>1. Open Enrollment period and deadline<br>2. Effective Date of plan | |
| **Forms to Use** | Health Insurance/Optional Insurance/FSA | Employee Benefits Enrollment/Change Form |

## 3. OPEN OR SPECIAL ENROLLMENT AT MARKETPLACE

| HEALTH/DENTAL/VISION INSURANCE | FLEXIBLE SPENDING ACCOUNTS | | WAIVER HRA (GP or Limited Purpose) |
|---|---|---|---|
| | Healthcare (HC) | Child and Adult Daycare | |
| **ADD:** Employee may elect coverage for Employee, Spouse, or Dependent(s) provided OE is after KEHP OE.<br>**DROP:** Employee may revoke election for Self, Spouse, and Dependent(s) provided the revocation corresponds to intended enrollment of Employee/Spouse/Dependent in coverage through the Exchange that is effective no later than the day after the last day of Employer-provided coverage. | No change permitted. | No change permitted | Employee/Spouse/Dependent covered under individual coverage through the Exchange is not eligible for the Waiver GP HRA. Employee taking coverage through the Exchange must **DROP** the Waiver GP HRA and choose the **ADD**: Employee may not redirect state contributions from a health plan to a Waiver HRA and may not choose a |

**OTHER CONDITIONS/GUIDANCE:**

- Coverage through the Exchange must be effective no later than the day after the last day of Employer-provided coverage.
- Marketplace Enrollment Event:

(1) A Participant may revoke an elected Benefit Option if the Participant is eligible for a Special Enrollment Period to enroll in a Qualified Health Plan through a Marketplace or the Participant seeks to enroll in a Qualified Health Plan through a Marketplace during the Marketplace's annual open enrollment period; or

(2) A Participant may revoke an elected Benefit Option if the Participant's Spouse or Dependent is eligible to enroll in a Qualified Health Plan through a Marketplace during a Special Enrollment Period or the Marketplace's annual open enrollment period.

| ADMINISTRATION GUIDELINES | | |
|---|---|---|
| **Event Date** | Last day of the Exchange Special or Open Enrollment | |
| **Signature Deadline** | 30 calendar days from the Qualifying Event date | |
| **Effective Date** | Adding or dropping Employee and/or Dependent(s) | No earlier than the Exchange coverage effective date |
| | FSA | No change permitted |
| **Document(s) Required** | Documentation from Exchange insurer or the Exchange showing the person(s) covered and the effective date of coverage and a confirmation printout or letter from the Exchange showing the coverage was purchased through the Exchange. | |
| **Forms to Use** | Health Insurance/Optional Insurance | Employee Benefits Enrollment/Change Form |

# LOSS OF HEALTH COVERAGE

## 1. LOSS OF ELIGIBILITY FOR HEALTH COVERAGE SPONSORED BY A GOVERNMENTAL OR EDUCATIONAL INSTITUTION (Medicaid, KCHIP, Medicare, TRICARE)

| HEALTH/DENTAL/VISION INSURANCE | FLEXIBLE SPENDING ACCOUNTS | | WAIVER HRA (GP or Limited Purpose) |
|---|---|---|---|
| | Healthcare (HC) | Child and Adult Daycare | |
| **ADD:** Employee may enroll or increase Coverage Level for Employee, Spouse, or Dependent if Employee, Spouse, or Dependent loses health coverage sponsored by governmental or educational institution. Prospective change only. | Employee may enroll or increase election to reflect loss of eligibility for health coverage. | No change permitted. | Employee may terminate election and redirect the state contribution to Health Insurance. |

**OTHER CONDITIONS/GUIDANCE:**

- Tag-Along rules apply.
- Applies only to LOSS (NOT GAIN) of coverage. In the event of a loss of CHIP coverage, HIPAA special enrollment rights may also apply. Government programs include CHIP, a medical care program of an Indian Tribal government, a state health risk pool, a foreign government group health plan.
- Loss of coverage from TRICARE for reservists who were covered on TRICARE would qualify, regardless of whether the member was on active duty or otherwise qualified and was covered, so long as that member was eligible for TRICARE and had TRICARE coverage, and then subsequently lost eligibility.

### ADMINISTRATION GUIDELINES

| | | |
|---|---|---|
| **Event Date** | Date of loss of coverage. | |
| **Signature Deadline** | 30 calendar days from the Qualifying Event date with the exception of Medicaid, which is 60 days from date of loss. | |
| **Effective Date** | Adding Employee, Spouse, Dependent (s) | First day of the month following Employee's signature date. |
| **Document(s) Required** | Medicaid & KCHIP | Medicaid Eligibility/Termination (MET) Form signed by the Division of Medicaid Services. **Failure to recertify/provide verification timely, non-payment of premium or dropping coverage voluntarily is not a valid loss of eligibility.** |
| | Medicare | Notification from Medicare. |
| | TRICARE | Letter from TRICARE showing when Employee, Spouse or Dependent(s) lost coverage through TRICARE. |
| **Forms to Use** | Health Insurance or Waiver/Optional Insurance/HCFSA | Employee Benefits Enrollment/Change Form |

## 2. LOSS OF ELIGIBILITY FOR INDIVIDUAL HEALTH COVERAGE (Marketplace)

| HEALTH/DENTAL/VISION INSURANCE | FLEXIBLE SPENDING ACCOUNTS | | WAIVER HRA (GP or Limited Purpose) |
|---|---|---|---|
| | Healthcare | Child and Adult Daycare | |
| **ADD:** Employee may enroll or increase Coverage Level for Employee, Spouse, or Dependent if Employee, Spouse, or Dependent loses individual health coverage. Prospective change only. | Employee may enroll or increase election to reflect loss of eligibility for health coverage. | No change permitted. | Employee may terminate election and redirect the state contribution to Health Insurance. |

**OTHER CONDITIONS/GUIDANCE:**

- Tag-Along rules apply.
- Applies only to LOSS of (NOT GAIN) coverage.

## ADMINISTRATION GUIDELINES

| | | |
|---|---|---|
| **Event Date** | Loss of eligibility date | |
| **Signature Deadline** | 30 calendar days from the Qualifying Event date | |
| **Effective Date** | Adding Employee, Spouse, or Dependent(s) | First day of the month following signature date. |
| | Enroll or increase FSA | First day of the month following signature date. |
| **Document(s) Required** | Proof of loss of eligibility from Marketplace. See Dependent Eligibility Chart. | |
| **Forms to Use** | Health Insurance, Waiver/Optional Insurance/FSA | Employee Benefits Enrollment/Change Form |

## 3. LOSS OF GROUP HEALTH COVERAGE

| HEALTH/DENTAL/VISION INSURANCE | FLEXIBLE SPENDING ACCOUNTS | | WAIVER HRA (GP or Limited Purpose) |
|---|---|---|---|
| | Healthcare (HC) | Child and Adult Daycare | |
| **ADD:** Employee may elect coverage for Employee, Spouse, or Dependent who has lost other coverage if: (a) The Employee or Dependent was covered under a group health plan or had Health Insurance coverage at the time coverage was previously offered to the Employee or Dependent. | **ADD:** Employee may enroll or increase election to reflect loss of eligibility for health coverage. | No change permitted. | **DROP:** Employee may terminate election and redirect the state contribution to Health Insurance. |

**OTHER CONDITIONS/GUIDANCE:**

- Change Plan Option when adding Dependent(s) or Spouse
- Tag-Along rules apply.
- While other permitted election changes are permissive, health coverage changes are REQUIRED under HIPAA for special enrollment events. Also, certain HIPAA special enrollment events (birth, adoption, or placement for adoption) will allow an election change to pay for retroactive coverage on a pre-tax basis, which cannot be done for other events. Also, HIPAA requires a special enrollment period of a specified minimum duration (30 or 60 days, depending on the event) while other limits for permitted election change events are a matter of plan design.

- If, as an extension of employment benefits, an employer pays COBRA premium on behalf of a terminated employee for a period of time, the loss of COBRA coverage after the expiration of the extension of benefits qualifies as a loss of coverage.

| **ADMINISTRATION GUIDELINES** | | |
|---|---|---|
| **Event Date** | Date of loss of coverage under the other employer-sponsored group health plan. Must also submit eligibility verification document(s). | |
| **Signature Deadline** | 30 calendar days from the Qualifying Event date | |
| **Effective Date** | Adding Employee, Spouse or Dependent(s) | The first day of the month following the Employee's signature date. |
| | Enroll or increase FSA | The first day of the month following the Employee's signature date. |
| **Document(s) Required** | Notification from employer, on employer's letterhead or via electronically, identifying the coverage termination date, the reason for coverage termination, and the person(s) covered by the policy; or a letter or a certificate of creditable coverage from the insurance company showing the termination date, type of coverage, date of termination and person(s) covered. NOTE: Loss of coverage for the failure to pay premium is not a valid QE; however, the loss of coverage because the employer ceased to offer coverage is a valid QE. | |
| **Forms to Use** | Health Insurance, Waiver HRA/Optional Insurance/FSA | Employee Benefits Enrollment/Change Form |

# SPECIAL ENROLLMENT DUE TO ELIGIBILITY FOR STATE PREMIUM ASSISTANCE SUBSIDY FROM MEDICAID OR CHIP

| HEALTH/DENTAL/VISION INSURANCE | FLEXIBLE SPENDING ACCOUNTS | | WAIVER HRA (GP or Limited Purpose) |
|---|---|---|---|
| | Healthcare (HC) | Child and Adult Daycare | |
| **ADD:** Employee may elect coverage for Employee or Dependent who has become eligible for premium assistance subsidy from Medicaid or CHIP. Plan Option change may be made. | Premium assistance subsidy does not apply. No change permitted. | No change permitted. | **DROP:** Employee may terminate election and redirect the state contribution to Health Insurance. |

**OTHER CONDITIONS/GUIDANCE:**

- Tag-Along rules apply.
- 60-day special enrollment period applies for this event. **NOTE: There** is no election change permitted (drop coverage) for persons who gain CHIP coverage. The subsidy subsidizes employer coverage.

## ADMINISTRATION GUIDELINES

| | | |
|---|---|---|
| **Event Date** | The date the Employee gains premium assistance. | |
| **Signature Deadline** | 60 calendar days from the Qualifying Event date. | |
| **Effective Date** | Adding Employee and/or Dependent(s) | The first day of the month following the Employee's signature date. |
| **Document(s) Required** | Medicaid | Medicaid Eligibility Termination (MET) form. See Dependent Eligibility Chart. |
| | KCHIP | Letter from Medicaid or CHIP. See Dependent Eligibility Chart. |
| **Forms to Use** | Health Insurance or Waiver/Optional Insurance | Employee Benefits Enrollment/Change Form |

# JUDGMENTS, DECREES, OR ORDERS (NMSO)

## 1. ORDER REQUIRING COVERAGE FOR CHILD UNDER EMPLOYEE'S PLAN – SIGNED BY A JUDGE

| HEALTH/DENTAL/VISION INSURANCE | FLEXIBLE SPENDING ACCOUNTS | | WAIVER HRA (GP or Limited Purpose) |
|---|---|---|---|
| | Healthcare (HC) | Child and Adult Daycare | |
| **ADD:** Employee may change election to provide coverage for the child. | **ADD:** Employee may change election to provide coverage for the child. | No change permitted. | Employee may terminate election and redirect the state contribution to Health Insurance. |

**OTHER CONDITIONS/GUIDANCE:**

- Tag-Along rules apply.
- While the plan may have to comply with the order regardless of the child's Dependent status, the child must be the Employee's child up to the end of the month in which the child turns 26 or tax Dependent for health coverage purposes in order for the coverage to be paid for on a pre-tax basis.
- Temporary Custody/Guardianship/De Facto Orders – No Enrollment Change Permitted unless the order requires a non-parent to provide health insurance coverage for the dependent.
- A **petition** for guardianship is not sufficient and should not be used to authorize a mid-year election change.
- **NOTE:** Financial responsibility for medical care is different than an order to provide health insurance.

## ADMINISTRATION GUIDELINES

| | | |
|---|---|---|
| **Event Date** | The Qualifying Event Date is the date the Order, Notice or guardianship documents are signed by a judge or authorized individual; or the enter/filed stamp date on the Order. **To the extent the dates are different, the date of entry/filing should control.** For a National Medical Support Notice (NMSN), the Qualifying Event date is the date on the NMSN directing the employer to enroll an Employee's child in a plan. | |
| **Signature Deadline** | 30 calendar days from the Qualifying Event date. NMSN may be processed even if the 30-day deadline is not met. | |
| **Effective Date** | Adding Dependent(s) at Employee's request | First day of the month following Employee's signature date |
| | Adding Dependent(s) due to NMSN (Employee's consent not needed) | First day of the month following the date DEI receives the National Medical Support Notice/Order |
| **Document(s) Required** | Adding Dependent (s) | An Order placing financial responsibility on the Employee or requiring health insurance coverage including:<br>• De Facto Custody Order – An Order changing custody from parent to a non-parent.<br>• Guardianship/Limited Guardianship/Conservator<br>A Temporary Custody/Guardianship/De Facto Custody Order requiring a non-parent to provide health insurance coverage for the dependent<br>Documents that are insufficient proof for the Qualifying Event include:<br>• Powers of Attorney<br>• Authorization to make decisions<br>• Custody Order changing custody from one parent to another<br>• Petitions for Guardians<br>Refer to the Manager of EIB for Orders that do not place a financial responsibility on the Employee or require health insurance coverage. |

| | | |
|---|---|---|
| **Forms to Use** | Health Insurance or Waiver/Optional Insurance/FSA | Employee Benefits Enrollment/Change Form |

## 2. ORDER REQUIRING COVERAGE FOR A DEPENDENT CHILD, DUE TO A NEW ORDER RELEASING THE EMPLOYEE – SIGNED BY A JUDGE

| HEALTH/DENTAL/VISION INSURANCE | FLEXIBLE SPENDING ACCOUNTS | | WAIVER HRA (GP or Limited Purpose) |
|---|---|---|---|
| | **Healthcare (HC)** | **Child and Adult Daycare** | |
| **DROP:** Employee may change election to terminate coverage for the child. | **DROP:** Employee may change election to cancel coverage for the child. Verify other coverage provided before dropping. | No change permitted. | No change permitted. |

**OTHER CONDITIONS/GUIDANCE:**

- Coverage can only be dropped if coverage is actually provided pursuant to the order through another plan. Verify other coverage.

## ADMINISTRATION GUIDELINES

| | | |
|---|---|---|
| **Event Date** | Date of the Order | |
| **Signature Deadline** | 30 calendar days from the event date | |
| **Effective Date** | Dropping Dependent | Last day of the month in which the Employee Benefits Enrollment/Change Form was signed. |
| **Document(s) Required** | Order signed by a judge | |
| **Forms to Use** | Health Insurance/Optional Insurance/HCFSA | Employee Benefits Enrollment/Change Form |

# MEDICARE OR MEDICAID ENTITLEMENT

## 1. EMPLOYEE, SPOUSE, OR DEPENDENT BECOMES ENTITLED TO MEDICARE OR MEDICAID

| HEALTH/DENTAL/VISION INSURANCE | FLEXIBLE SPENDING ACCOUNTS | | WAIVER HRA (GP or Limited Purpose) |
|---|---|---|---|
| | Healthcare (HC) | Child and Adult Daycare | |
| **DROP:** Employee may elect to cancel or reduce coverage for Employee, Spouse, or Dependent as applicable. Optional Insurance coverage can be dropped with gain of Medicaid only. Does not apply to Medicare unless Medicare Advantage plan incorporates Dental and Vision benefits. | **DROP:** Employee may decrease or terminate election under employer plan. | No change permitted. | Member who drops Health Insurance due to entitlement to Medicare or Medicaid cannot elect to redirect employer funds to a Waiver GP HRA or a Waiver Limited Purpose HRA. Employee with a Waiver GP HRA who becomes entitled to and covered under Medicare or Medicaid must drop the Waiver GP HRA and may redirect future employer contributions to a Waiver Limited Purpose HRA Waiver Limited Purpose HRA or choose Waiver no HRA. Funds in the Waiver GP HRA will not rollover or transfer to the Waiver Limited Purpose HRA Waiver Limited Purpose HRA. A spouse or dependent covered under the Waiver GP HRA who becomes entitled to and covered under Medicare or Medicaid cannot be covered under the Employee's Waiver GP HRA. No change permitted for an Employee with a Waiver Limited Purpose HRA. |

**OTHER CONDITIONS/GUIDANCE:**

- A gain of coverage under KCHIP or other state's CHIP program does not permit a drop of coverage under KEHP.
- Entitlement to Medicare or Medicaid refers to coverage other than coverage solely for pediatric vaccines.
- Employee must also show proof of dependent entitlement to Medicaid (listed on MET form) or proof of gaining employer sponsored coverage for Employee to drop coverage for dependent(s) and change to waive with no HRA funds.
- **NOTE**: If a Return-to-work Retiree with KPPA coverage turns 65 and becomes entitled to Medicare while actively employed, they have the option to delay enrolling in Medicare B. They may instead drop KPPA coverage and enroll in their active agency's plan, which helps avoid Medicare late enrollment penalties when they choose to enroll in Medicare at a later time.




## ADMINISTRATION GUIDELINES

| | | |
|---|---|---|
| **Event Date** | Date the Employee, Spouse or Dependent becomes entitled to Medicare or Medicaid; Medicare and Medicaid may also use the notification date. | |
| **Signature Deadline** | 60 calendar days from event date for Medicaid or 30 calendar days from the event date of Medicare. | |
| **Effective Date** | Dropping Employee, Spouse and/or Dependent(s) | Last day of the month in which the Employee Benefits Enrollment/Change Form was signed |
| | Decreasing or terminate FSA | End of the month of the Employee's signature date |
| **Document(s) Required** | Medicare<br>Medicare Advantage (D/V) | Copy of Medicare card (showing Effective Date) or Initial eligibility letter from Medicare Office<br>Supporting documentation must show that dental and/or vision was gained with Medicare Advantage. |
| **Document(s) Required** | Medicaid | Medicaid Eligibility/Termination (MET) Form signed by the Division of Medicaid Services – Cabinet for Health and Family Services |
| **Forms to Use** | Health Insurance/Optional Insurance/FSA | Employee Benefits Enrollment/Change Form |

# MILITARY LEAVE (USERRA)

## 1. EMPLOYEE STARTS MILITARY LEAVE (UNPAID)

| HEALTH/DENTAL/VISION INSURANCE | FLEXIBLE SPENDING ACCOUNTS | | WAIVER HRA (GP or Limited Purpose) |
|---|---|---|---|
| | Healthcare (HC) | Child and Adult Daycare | |
| **Add:** Employee on military leave may either terminate coverage or continue coverage. To continue coverage, the Employee must elect COBRA.<br><br>**Drop**: If the Employee does not continue health plan coverage by electing COBRA while performing military service, coverage will be suspended while the employee is on approved military service leave. Employees returning from military service have the right to have their health benefits reinstated without any re-entry requirements (i.e. waiting period). | Employee on military leave may either terminate coverage or continue coverage. | Employee on military leave may either terminate coverage or continue coverage. | Employer contributions cease.<br>**Waiver GP HRA:** To continue the Waiver GP HRA while on military leave, the Employee must elect COBRA. If the employee does not continue the Waiver GP HRA by electing COBRA, coverage will be suspended while the employee is on approved military service leave. Employees returning from military service have the right to have their Waiver GP HRA reinstated without any re-entry requirements (i.e. waiting period).<br>**Waiver Limited Purpose HRA**: During active military leave, an Employee may not elect COBRA to continue the Waiver Limited Purpose HRA. The Waiver Limited Purpose HRA will be suspended while the Employee is on approved military service leave. Employees returning from military service have the right to have their Waiver Limited Purpose HRA reinstated without any re-entry requirements (i.e. waiting period). |

**OTHER CONDITIONS/GUIDANCE:** None

## ADMINISTRATION GUIDELINES

| | | |
|---|---|---|
| **Event Date** | Date of coverage change. | Beginning military duty – date activated with the Armed Services. |
| **Effective Date** | Dropping Employee, Spouse, or Dependent(s) | Last day of the Semi-Monthly Billing period before activated with the Armed Services. |
| **Document(s) Required** | Enlistment papers/orders showing date Employee was called to active duty **and** a letter from TRICARE showing when the member gained coverage through TRICARE. | |
| **Forms to Use** | Health Insurance/Optional Insurance/FSA | Employee Benefits Enrollment/Change Form |

## 2. EMPLOYEE RETURNS FROM MILITARY LEAVE (UNPAID)

| HEALTH/DENTAL/VISION INSURANCE | FLEXIBLE SPENDING ACCOUNTS | | WAIVER HRA (GP or Limited Purpose) |
|---|---|---|---|
| | Healthcare (HC) | Child and Adult Daycare | |
| Reinstate prior elections unless another event has occurred that allows a change. | Reinstate prior elections unless another event has occurred that allows a change. Reinstate at prior Coverage Level (and make up unpaid premiums) or at a level reduced pro rata for the missed contributions. | Employee may make a new election if coverage terminated while on leave. Same as non-FMLA | Reinstate prior elections unless another event has occurred that allows a change. |

**OTHER CONDITIONS/GUIDANCE:**

- Employees returning from military Leave are eligible for coverage immediately upon return or may delay the effective date until military coverage ends.
- 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 Limited Purpose 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.

## 3. EMPLOYEE'S SPOUSE OR DEPENDENT BEGINS MILITARY DUTY

| HEALTH/DENTAL/VISION INSURANCE | FLEXIBLE SPENDING ACCOUNTS | | WAIVER HRA (GP or Limited Purpose) |
|---|---|---|---|
| | Healthcare (HC) | Child and Adult Daycare | |
| **Drop**: Employee may drop ONLY Spouse or Dependent that begins active military duty upon their gain of TRICARE. | No change permitted | No change permitted | No change permitted |

**OTHER CONDITIONS/GUIDANCE:**
Employee's Gain of TRICARE due to Spouse or Dependent beginning military duty is not a valid QE for Employee to drop Employee coverage.

## ADMINISTRATION GUIDELINES

| | | |
|---|---|---|
| **Event Date** | Date of return from leave | |
| **Signature Date** | 30 Calendar days | |
| **Effective Date** | Adding Employee, Spouse and/or Dependent(s) | Employees returning from military leave will have all benefits (Health Insurance and FSAs) reinstated the date of return, (first day of the second month rule does not apply) without any waiting period. Optional and Life will be reinstated the first of the month following return. |
| **Document(s) Required** | Letter from TRICARE showing when Employee lost coverage through TRICARE. | |
| **Forms to Use** | Health Insurance/Optional Insurance/FSA | Employee Benefits Enrollment/Change Form |

| ADMINISTRATION GUIDELINES | | |
|---|---|---|
| **Event Date** | Date of coverage change | |
| **Signature Date** | 30 calendar days | |
| **Effective Date** | Dropping Spouse or Dependent(s) | Last day of the Semi-Monthly Billing period before activated with the Armed Services. |
| **Document(s) Required** | Enlistment papers/orders showing date Spouse or Dependent(s) was called to duty **and** a letter from TRICARE showing when the Spouse or Dependent(s) gained coverage through TRICARE. | |
| **Forms to use** | Health Insurance/Optional Insurance | Employee Benefits Enrollment/Change Form |

## 4. EMPLOYEE'S SPOUSE OR DEPENDENT RETURNS FROM MILITARY DUTY

| HEALTH/DENTAL/VISION INSURANCE | FLEXIBLE SPENDING ACCOUNTS | | WAIVER HRA (GP or Limited Purpose) |
|---|---|---|---|
| | Healthcare (HC) | Child and Adult Daycare | |
| **Add**: Employee may add Spouse or Dependent that returns from military duty upon their loss of TRICARE. | No change permitted | No change permitted | No change permitted |

**OTHER CONDITIONS/GUIDANCE:** None

| ADMINISTRATION GUIDELINES | | |
|---|---|---|
| **Event Date** | Date of Spouse's or Dependent's Loss of TRICARE | |
| **Signature Date** | 30 calendar days | |
| **Effective Date** | Adding Spouse or Dependent | First day of the month following the date of the loss of coverage through TRICARE. |
| **Document(s) Required** | Proof of the Spouse's or Dependent's loss of coverage through TRICARE. | |
| **Forms to Use** | Health Insurance/Optional Insurance | Employee Benefits Enrollment/Change Form |

# SIGNIFICANT COST CHANGES BY EMPLOYER

## 1. COST CHARGED TO EMPLOYEE/RETIREE FOR A BENEFIT OPTION SIGNIFICANTLY INCREASES

| HEALTH/DENTAL/VISION INSURANCE | FLEXIBLE SPENDING ACCOUNTS | | WAIVER HRA (GP or Limited Purpose) |
|---|---|---|---|
| | Healthcare (HC) | Child and Adult Daycare | |
| **ADD:** Employee may increase election correspondingly.<br>**DROP:** Employee may revoke election and elect coverage under another benefit package option providing similar coverage. See Example below.<br>**KPPA Hazardous Duty Retirees may drop r**emaining dependent children if Retiree is no longer eligible for hazardous duty premium contribution. | No change permitted | **ADD:** Employee may increase election correspondingly**.**<br>**DROP:** Employee may revoke election. No change can be made when the cost change is imposed by a Child and Adult Daycare provider who is a relative of the Employee. | No change permitted. |

**OTHER CONDITIONS/GUIDANCE:**

- Ex: Employee active with KPPA and active agency. EE has plan with KPPA and waived with the active agency. Dependent child on his plan turns 22. KPPA premium increased due to child turning 22. Employee can drop coverage under KPPA when the child turns 22 and now waive with KPPA and pick up active insurance coverage with the active agency.
- Ex: Employee active with KPPA. Dependent child on his plan turns 22. KPPA premium increased due to child turning 22. Employee can drop dependent child who has turned 22 and can remain active with KPPA.
- Ex: KPPA dependent turns 18 and is no longer full-time student or becomes married. KPPA premium increased due to ineligibility for premium contribution. Retiree can drop dependent. Contribution remains unchanged if at least one child meets eligibility criteria.
- **NOTE**: **The significant cost increase must occur during the plan year. This does not apply to cost increases that are announced during open enrollment.**




## ADMINISTRATION GUIDELINES

| | | |
|---|---|---|
| **Event Date** | Date of coverage change. | |
| **Signature Deadline** | 30 calendar days | |
| **Effective Date** | Adding Employee, Spouse or Dependent(s) | First day of the month following the Employee's signature date. |
| | Dropping Employee, Spouse, or Dependent(s) | Last day of the month before the effective date of the new coverage. |
| | Enrolling in or increasing a Child and Adult Daycare FSA | First day of the month following the Employee's signature date. |
| | Decreasing or terminating a Child and Adult Daycare FSA | End of the month of the Employee's signature date. |
| **Document(s) Required** | Proof of change in other employer coverage.<br>**KPPA Retirees**: Proof of change to or loss of Hazardous Duty premium contribution | |
| **Forms to Use** | Health Insurance/Optional Insurance/Child and Adult Daycare FSA | Employee Benefits Enrollment/Change Form |

# HRA Funding - Mid-Year Changes Chart – APPENDIX J

| Mid-Year Scenario | Action | Funding | Explanation |
|---|---|---|---|
| 1. CDHP Single Coverage Level to Family Coverage Level | 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 Coverage Level to Single Coverage Level | 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 will not be any additional funds given for the second election period. |
| 3. LW CDHP to LivingWell Basic 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 Level to LivingWell Basic CDHP Parent Plus Coverage Level | No change in HRA funds. | Same amount available full Plan Year | Member will have the same amount of funds. LW CDHP Single Coverage Level/ $500 HRA and LivingWell Basic CDHP Parent Plus Coverage Level/ $500 HRA |
| 5. LivingWell Basic 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. LivingWell Basic CDHP Family Coverage Level to LW CDHP Single Coverage Level | 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 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. End Cross-Reference Payment Option, the Primary Planholder reverts to Parent Plus Coverage Level. | Member will not receive additional HRA funds. Member's HRA funds will not be reduced. | Same amount available full Plan Year | One continuous election period. No additional money and no money taken back. |
| 10. End Cross-Reference Payment Option, due to termination of the Primary Planholder. The Secondary Planholder becomes the new Planholder with a Family Coverage Level after submitting QE paperwork to add termed spouse. | Member will receive family level HRA funds. | Funds available beginning date of plan change | If Spouse had CDHP HRA prior to the change, his/her unspent CDHP funds may be transferred to the Primary Planholder's CDHP HRA balance. |

| | | | |
|---|---|---|---|
| 11. End Cross-Reference Payment Option, due to termination of the Primary Planholder. The Secondary Planholder becomes the new Planholder with a Parent Plus Coverage Level. | Member will receive family level HRA funds. | Funds available beginning date of plan change | No pro-rating of funds. Unspent CDHP funds under primary's account may be transferred to the secondary's new Parent Plus CDHP HRA account. |
| 12. Retiree becomes ineligible for KEHP due to Medicare. Applicant "takes over" as Planholder in the CDHP plan. | Applicant will receive new CDHP embedded funds. | Funds available beginning of coverage effective date under CDHP plan | Unspent CDHP funds from Retiree's CDHP plan may not be transferred to the Applicant who has become Planholder with CDHP. Retiree has until March of the following year to submit claims for expenses incurred in prior year under CDHP plan with KEHP. |

# Notification Letter Template – Employer Loss of Coverage
# APPENDIX K

**To: Department of Employee Insurance, Kentucky Employees' Health Plan**

From: _____

Date: _____

**Subject: Confirmation of Loss of Coverage**

This letter confirms that the following person, _____ (name), is a current or former employee of our organization whose health coverage ended on _____ (date of coverage termination) due to _____ (reason).

The following persons were covered as either (1) a spouse, or (2) a dependent under the plan:

_____ (name)

_____ (name)

_____ (name)

_____ (name)

_____ (name)

_____ (name)

Should you have any questions, please call _____ (phone number), or email:

_____ (email).

Sincerely,

_____

Signature

_____ _____

Printed Name and Title Date

# Commonwealth of Kentucky – Group Life Benefits Administration
# APPENDIX L

## Policyholder: Commonwealth of Kentucky
## Group Policy Number: 235782-1-G
## Type of Insurance: Term Life & Accidental Death and Dismemberment Insurance
## General Life Insurance Questions for employees of Group 235782

**1. How do new employees enroll in the Optional and/or Dependent Life Insurance**?
A new employee may enroll in Optional and/or Dependent Term Life Insurance within 30 days from their hire date either by enrolling through KHRIS Employee Self-Service (ESS) or by providing a completed life insurance application located here to their IC/HRG who will then upload it using the DEI upload tool to the Optional Insurance Branch.

**2. Who can be covered under the Dependent Term Life Insurance?**
Eligible dependents include a Spouse (to whom the employee is legally married) and dependent children under the age of 26. Dependent children are no longer required to be a full-time student to be eligible for coverage. Dependent children who are also Group Life participants of the Commonwealth as Employees are **not** considered eligible dependents under the Life Insurance certificate of coverage.

**3. When does the Optional and/or Dependent Term Life Insurance start?**
Supplemental Optional and Dependent Term Life Insurance becomes effective on the first day of the second month after your employment date. A Statement of Health is required as Evidence of Insurability if the employee enrolls more than 30 days after the new hire date. If a Statement of Health is required, coverage will be effective on the first day of the month following the date the insurance carrier approves the Statement of Health.

**4. Who is the beneficiary for the Dependent Term Life?**
Benefits will be paid to the employee when a covered eligible dependent dies.

**5. If the employee dies, can the spouse continue his/her coverage?**
In the event of the employee's death, the spouse or dependent can convert their Optional term life insurance to an individual policy. The spouse or dependent has 31 days from the date the employee's coverage ends to convert/port.

**6. If an employee decides they want less coverage, can they decrease their Optional and/or Dependent Life Insurance coverage?**
Yes, simply have them complete an application requesting a change to a plan with less coverage. Remember, if they decide to increase coverage later, they must provide Evidence of Insurability.

**7. If an employee leaves their job, is it possible for them to continue their Life Insurance coverage?**
Yes. Basic, Optional, and Dependent Group Life Insurance coverage will end the last day of the same month in which employment ends. However, in the 31 days following the termination of coverage, they may convert their Basic, Optional, and Dependent Group Life Insurance Coverage to an individual policy without having to furnish Evidence of Insurability. If they die during this 31-day period, this insurance will be paid whether or not they have applied for an individual policy.

**8. When does the Optional Life Insurance end?**
The Optional Life Insurance coverage ends (1) on the last day of the same month in which employment ends, (2) if the plan is discontinued, (3) if the employee stops making contributions, or (4) if they are no longer an eligible employee

**9. When does the Dependent Term Life Insurance end?**
Dependent Term Life Insurance ends (1) on the last day of the same month in which employment ends, (2) if the plan is discontinued, (2) if the employee stops making contributions, (4) if the Dependent dies, (5) if the Dependent is no longer eligible, or (6) if employee is no longer legally married (divorced).

> **NOTE:** The employee must notify the Optional Insurance Branch when a spouse or dependent(s) is no longer eligible for coverage.

**10. Will the plan reimburse for terming coverage on an ineligible spouse or dependent?**
It is the employee's responsibility to notify the Optional Insurance Branch if the employee's spouse or dependent(s) are no longer eligible for coverage. The plan may reimburse the premium paid for an ineligible spouse or dependent a maximum of 90 days back from the date of notification of ineligibility if requested in writing within 90 days of ineligibility. Proof of ineligibility may be required (divorce decree, etc.).

**11. How can an employee change a beneficiary?**
They may obtain a new Beneficiary Designation form from their IC/HRG **OR** use the KHRIS Employee Self Service (ESS) portal. ESS is the preferred method for beneficiary updates. ESS Instructions can be found here. The signed and dated form should be returned to their IC/HRG to process in KHRIS and retain in the employee's record at the agency level.

**12. The employee does not have Dependents now. Can they enroll when they acquire a Dependent?**
Yes. They can enroll in Optional and/or Dependent coverage within 30 days of marriage. They can enroll in Dependent coverage for dependent children under 26 at any time of the year without providing Evidence of Insurability.

**13. Must the employee notify the Optional Insurance Branch if they have a newborn?**
If an employee is already enrolled in a dependent plan covering children, the newborn is automatically covered upon birth. Otherwise, if they want to cover a newborn, they can complete an enrollment application at any time since coverage for dependent children can be added anytime of the year. Coverage for a newborn will be effective on the first day of the month following the employee's signature date on the life application.

**14. How are benefits obtained when there is a claim?**
The beneficiary on the policy should contact the employee's Insurance Coordinator/Human Resources to advise there has been a death. The IC/HR is responsible for uploading the Death Claim notice via the DEI upload tool located here to begin the claim process. Any premiums that have been paid after the coverage is terminated will be refunded to the employee or the employee's estate.

**15. Can the employee keep coverage if they transfer and have no break in service?**
Yes. If they transfer employment to an employer participating in the Group Life Insurance program, their Optional and/or Dependent Term Life Insurance will remain in effect unless they complete a life application requesting a termination of coverage. If they decide to enroll in or increase coverage, they will be required to provide a Statement of Health to the insurance carrier. Coverage begins on the first of the month after the insurance carrier approves the Evidence of Insurability. If there was a loss of life insurance coverage at the prior agency, then proof of loss of coverage must be provided along with a completed and signed life insurance application to enroll or increase in Optional/Dependent coverage offer by the Commonwealth.

**16. Can an employee cancel their Optional and/or Dependent Term Life Insurance at any time?**
Yes. To cancel Optional term life insurance, they must complete an application indicating their intent to terminate coverage. The completed application must be returned to their IC/HRG or the Optional Insurance Branch for them to upload using the DEI upload tool. The request for cancellation must be in writing and include the employee's dated signature.

**17. Is there any Accidental Death and Dismemberment Benefit?**
Yes. If the loss of life is caused by an accident, the Accidental Death Benefit is payable to the designated beneficiary in an amount equal to both the Basic and Optional Life Insurance. Please refer to the Certificate of Coverage for further details.

**18. What are the Exclusions to the Accidental Death & Dismemberment coverage?**
Please refer to the Booklet/Certificate of Coverage online under Group Life Insurance benefits.

**19. Is there an additional cost associated with the Accidental Death & Dismemberment Benefit?**
No. The Accidental Death & Dismemberment Benefit is included as part of the Basic and Optional Life Insurance premium.

**20. Can an employee change their Optional Plan at any time or enroll in any Optional Plan outside of Open Enrollment?**
Yes, however if the employee wishes to increase or enroll in Optional coverage outside of OE, they will be required to furnish satisfactory Evidence of Insurability to the insurance carrier. If approved, the new life insurance coverage amount will become effective the first of the month after the insurance carrier approves your Statement of Health.

**21. Will I receive a certificate explaining my coverage under the Commonwealth Plan?**
A Summary of Coverage, which is an individual certificate showing the selected coverage will be mailed to the home address listed in KHRIS approximately a month after initial elections have been made. Employees will also receive one when rates increase due to entering a new age bracket. The Certificate of Coverage outlining detailed policy information is available online by clicking here.

**22. Will rates for Optional Life Insurance ever change?**
Rates will increase based on the following chart:

| Age Range |
|---|
| 16-29 |
| 30-39 |
| 40-59 |
| 60 and over |

**23. Does Group Term Life Insurance pay for Suicide?**
For all **Optional** insurance issued after January 01, 2022, the benefits payable are limited if the employee or the employee's insured dependent commits suicide, while sane or insane, within two years of the issue date. In such case, liability will be limited to a return of all premiums paid during the policy period. The employer-paid Basic $20K is still payable in the case of suicide.

**24. If I have additional questions, where can I get information?**
Employees can contact their IC/HRG or call the Optional Insurance Branch at (502) 564-4774/ (888) 581-8834 (Option 4). Employees and ICs/HRGs may also visit the Optional Insurance page online for additional information and forms.

**25. Does this Group Life Insurance have any cash value?**
No. This is a term life insurance policy with no cash value.

**26. How long may employees carry Group Life Insurance?**
Coverage will end when employment ends. Employees have the option to convert/port coverage to an individual policy after leaving employment without answering any medical questions. For more information regarding Conversion and Portability, please visit MetLife.com/continuation. Although MetLife will mail a packet to termed employees, a letter is available for ICs/HRGs to use in their exit paperwork in Appendix N or by clicking here.

**27. My spouse and I are both Employees, can we cover each other as a Dependent? Can each of us cover our children?**
Yes. Each of you may enroll in Optional Dependent Group Life Insurance for spouse and children. Any dependent child that is also covered under the same Group Life policy as an employee, however, is not considered an eligible dependent for life insurance purposes.

**28. Can an employee continue their Basic Group Life coverage or any Optional/Dependent Life coverage when they are placed on official Leave Without Pay (LWOP)?**
Yes. The IC/HRG is required to provide the employee with the option to continue coverage while on approved Leave Without Pay due to injury or illness for up to 13 months at the Group rate. The Employee must pay the employer-paid Basic Life premium if they want to continue paying for any Optional or Dependent coverage. Once payment has been submitted to the Premium Billing Branch, the Optional Insurance Branch will be notified to reinstate the Basic Life plan, and if applicable, any Optional or Dependent coverage. A Sample LWOP template (Appendix M) is available online at the State Group Life website or by clicking here.

# State-Sponsored Group Life Insurance LWOP Instructions – Sample LWOP Template – APPENDIX M

(Date of Notice)

(Employee)
(Address)
(City, State, Zip Code)

Re: Group Life Insurance
Dear (Name of Employee):
During your approved leave without pay, you may continue to keep your state-sponsored life insurance benefits active for a period not to exceed 12 months. The state sponsored life insurance is offered by the Commonwealth of Kentucky Personnel Cabinet through MetLife Insurance Company.
You may continue to keep your basic life insurance policy and any optional life insurance active by paying the premium during your leave-without-pay status. The monthly payment would be $1.00 for the $20,000 employee basic policy plus the premium for any optional life insurance you may have elected. The payment can be made directly to your employer or to the Department of Employee Insurance (DEI). Checks sent to DEI should be made payable to the Kentucky State Treasurer. You will not receive a bill from DEI. Rather, it is the employee's responsibility to make sure the premium payments are made in a timely manner, by the first of each month. For example, the premium for January should be made no later than January 1.
If you fail to pay your premium for three (3) months, your coverage may be terminated without notice. If the coverage is terminated due to non-payment, only the basic $20,000 employer-provided life insurance will be reinstated upon return to regular employment.
For questions regarding your leave and the procedures to follow, you may contact your employer or the Optional Insurance Branch:

Department of Employee Insurance
Personnel Cabinet
501 High Street, 4th Floor
Frankfort, Kentucky 40601
(502) 564-4774 or (888) 581-8834, Option 4

Sincerely,

(Your Name)
(Title)

# Commonwealth of Kentucky – Group Life Benefits Administration
# APPENDIX N




Policyholder: Commonwealth of Kentucky
Group Policy Number: 235782-1-G
Type of Insurance: Term Life & Accidental Death and Dismemberment Insurance

## Portability and Conversion: Options and IC/HRG Responsibilities for Group 235782

- **What options do employees have with Life Insurance when they separate employment or retire?**
  There are two options under which employees can continue their coverage — Portability and Conversion. **Neither Option is available on Accidental Death and Dismemberment coverage.**

  **Portability** allows employees and dependents to continue life insurance coverage with MetLife. They have 31 days from the date group life insurance ends to elect portability. Coverage will take effect 32 days after group coverage ends. If applying for portability, preferred portable rates are available for employees and spouses with Evidence of Insurability (EOI).

  **Conversion** allows employees to convert their group life insurance to an individual whole life insurance policy. They have 31 days from the date group coverage ends to elect conversion of coverage. Conversion rates are based on age at the time of conversion.

- **Are there medical questions or a medical exam to be answered?**
  **Portability** – No, not for Non-Preferred Group Life Insurance Term Rates. However, questions must be answered to apply for **Preferred Group Life Insurance Term Rates** (lower premium rates).
  **Conversion** – No.

- **Will the rates be different from the rates paid while working?**
  **Portability** – Rates are based on your current age and differ from the rates you paid while employed. The employee or spouse can apply for Preferred Group Life Insurance Term Rates (lower premium rates) by answering medical questions. If not approved, the employee and spouse can still participate in portable coverage at the Non-Preferred Group Life Insurance Term Rates (higher premium rates).
  **Conversion** – Rates for Conversion are based on your age at the time you convert your coverage and remain level throughout the life of the policy.

- **Where can applications and any additional information regarding Portability and Conversion options for Group Life insurance?**
  MetLife has partnered with Barnum Financial Group to assist members with their life insurance continuation options. MetLife will generate and mail a packet directly to the member's address. Members may also receive a call from a financial professional who can guide them through the application process and answer any questions regarding their options.

Recently separated employees and retirees may also visit MetLife.com/continuation or contact MetLife Transition Solutions at 1-877-275-6387 Monday through Friday, 9:00 a.m. to 6:00 p.m. Eastern, to arrange for a financial professional from Barnum Financial Group to contact them directly.

- **As an Insurance Coordinator or HRG, what is my responsibility at the time an employee separates employment or retires?**
  In most cases, agency ICs/HRGs will no longer need to complete packets at the time of separation. However, the following scenarios will still require agency action, as they are not included in the file:

  - Commonwealth-paid employees moving from full-time (benefits-eligible) status to part-time (PT, Interim, ACA) status and losing life insurance coverage
  - Non-Commonwealth-paid employees moving from full-time (benefits-eligible) status to ACA status and losing life insurance coverage

  *(Note: Non-Commonwealth-paid employees moving to part-time status, non-ACA status should be terminated in KHRIS, which will be reflected in the file.)*

  ICs/HRGs can provide separated and retired employees with a Conversion and Portability Letter outlining this information along with the MetLife Brochure for Portability and Conversion which can be found on the State Group Life Insurance website located here or by going to https://extranet.personnel.ky.gov/Pages/LifeInsurance.aspx.