2018 SPECIAL ENROLLMENT

AUGUST 30 - SEPTEMBER 12, 2018

WHAT IS THE SPECIAL ENROLLMENT FOR?

Per IRS Regulation 26 CFR 1.125-4, the Kenai Peninsula Borough School District is allowing a Special Enrollment period due to a significant increase in the Traditional Plan's monthly contribution rate effective September 1, 2018. ***During this Special Enrollment, ONLY those employees currently enrolled on the Traditional Health Plan may choose to switch to the High Deductible Health Plan, or decline coverage (see section below on page 2) effective September 1, 2018.*** During this Special Enrollment, you may NOT make any other changes to your elections, such as adding a spouse or dependent child. Those changes may be made during the regular annual Open Enrollment Period that will occur from November 15, 2018 through December 15, 2018 with an effective date of January 1, 2019.

- ✓ ENROLLMENT DEADLINE: You MUST submit your Plan changes no later than 4:30 pm on September 12, 2018. All enrollment forms must be turned in to Stacey Cockroft at the District Office by the deadline.
- ✓ NO CHANGES? **No action is required from you; your current enrollment will remain the same.**
- ✓ Enrollment forms are included in this packet and will be available online at http://www.kpbsd.k12.ak.us/employees.aspx?id=5232.
- ✓ All changes made during the Special Enrollment will be effective ***September 1, 2018***.

YOUR MEDICAL OPTIONS

You may ONLY choose to switch from the Traditional Plan to the High Deductible Plan:

MEDICAL BENEFITS	TRADITIONAL PLAN	HIGH DEDUCTIBLE HEALTH PLAN (HDHP)
Annual Medical Deductible Individual Family	 $200 $600	 $1,500 $3,000
Reimbursement Percentage	Plan pays 80% Plan pays 60% (non-PPO facility)	
Out-of-Pocket Maximum (Not including deductible) Individual Family	 $1,000 $3,000	 $2,000 $4,000
Prescription Drug Coverage Generic Copay Preferred Brand Copay Non-Preferred Brand Copay Specialty Copay	 $5 $25 $50 $100 (limited to a 30-day supply)	
Health Reimbursement Arrangement	None	$750/year*
Employee Contribution Monthly (12 month deduction) Monthly Prorated (9 month deduction) Annual	 $550.14** $733.52** $6,601.68**	 $228.00** $304.00** $2,736.00**

**If you newly elect the HDHP, $625 will be credited to your HRA account on September 1st for September 2018 – June 2019. Another $750 will be credited on July 1st for the period July 2019 – June 2020.*

***These rates were set by the Health Care Sub-Committee on 8/29/2018.*

What is a Health Reimbursement Arrangement (HRA)?

An HRA allows KPBSD to set aside funds for you to spend on qualified health care expenses. Money not used in one calendar year can be rolled over from year-to-year. If you newly enroll in the High Deductible Health Plan during this Special Enrollment, KPBSD will contribute $625 to your HRA account on September 1, 2018. If you are enrolled in the HRA on July 1st (the first day of the fiscal year), KPBSD will contribute another $750 to your HRA account.

You may use these funds for you and your dependents who are enrolled in the HDHP. If you terminate KPBSD employment, the funds will be forfeited.

Your HRA funds may be used towards medical, prescription, dental, and vision expenses. The HRA will be administered by Rehn. A claim form is available to submit for HRA reimbursements.

How the HRA works with a Health Care Flexible Spending Account (FSA):

You may have both an HRA and enroll in a Health Care FSA. Expenses are paid from the Health Care FSA first, because that account is "use it or lose it." A Flexible Spending Account is available to employees through American Fidelity. It is not a part of the health plan. For questions relating to the Flexible Spending Account, please contact Darcy Carter at darcy.carter@americanfidelity.com.

IRS rules do not permit changing your current FSA contribution or opening an FSA during this special mid-year enrollment.

YOU MAY BE ABLE TO DECLINE COVERAGE

- You may decline Health Plan coverage ONLY if you are currently enrolled in the Traditional Health Plan and have other health coverage outside of the KPBSD Health Plan that meets the minimum requirements of the Affordable Care Act (ACA). If you decline coverage, you pay no employee contribution. ***Please start this process early to ensure you are able to obtain the necessary Certificate of Coverage and Summary of Benefits and Coverage (SBC) from your current health plan by the September 12, 2018 deadline. Please note the SBC is <u>not</u> the "Summary of Benefits" located in the Plan summary, this document must be specifically requested from the other Plan. Please contact Stacey Cockroft at scockroft@kpbsd.k12.ak.us to request examples of what is required.***

- If you are double covered within the KPBSD health plan because you are both a KPBSD employee and a spouse or dependent of a KPBSD employee and have no coverage outside of KPBSD, you may not decline coverage.

HOW DO I CHANGE MY PLAN SELECTION?

- STEP 1:

  If you decide to switch from the Traditional Plan to the High Deductible Health Plan, please fill out the enrollment form selecting the High Deductible Health Plan. If you would like to decline coverage, please fill out the enrollment form selecting "Declining Coverage" and obtain the necessary documents listed above. If you do not want to change your Plan selection, you do *not* need to submit a form.

- STEP 2:

  Submit the completed enrollment form and applicable documents to Stacey Cockroft at the District Office by the 4:30 pm September 12, 2018 deadline. The enrollment form is included in this packet. Forms are also available online at: http://www.kpbsd.k12.ak.us/employees.aspx?id=5232

FOR MORE INFORMATION:

- Go to our website: http://www.kpbsd.k12.ak.us/employees.aspx?id=5232
  All documents and forms will be posted on the website.
- QUESTIONS? Contact Stacey Cockroft, Employee Benefits Manager, at 907-714-8879 or scockroft@kpbsd.k12.ak.us.

Kenai Peninsula Borough School District Health Care Plan
Participant Enrollment Form

REHN & ASSOCIATES

EMPLOYEE INFORMATION

Name of Employee:			Date of Enrollment or Change:
Social Security Number:		Sex: ❑ M ❑ F	IHS (Indian Health Services)Eligible: ❑ Y ❑ N
Address:			Date of Birth:
City:	State:	Zip:	Marital Status:
Phone:	Email:		Date of Marriage:

TYPE OF ENROLLMENT/LEGAL DOCUMENTATION

Legal documentation is REQUIRED for all new enrollments and any changes made (marriage certificate, birth certificate, etc.):

❑ New Enrollment ❑ Open Enrollment ❑ Change in Status

❑ DECLINING COVERAGE (Note: You may decline only if you have other health coverage outside KPBSD that meets the minimum Affordable Care Act requirements.)

Reason for electing, changing or declining coverage: _____

❑ I wish to DECLINE Dental/Vision coverage (I understand this will NOT reduce/change my contribution amount)

COVERAGE AND DEPENDENT INFORMATION

One plan option must be selected:

❑Traditional Plan ❑HDHPlan *(Note: You may choose to opt-out of HRA reimbursements by contacting the Benefits Manager)*

Add	Drop	Relationship to Employee	Last Name	First Name	Middle Initial	IHS Eligible	Social Security No.	Date of Birth	Employer	Gender
❑	❑	SPOUSE				❑Y ❑N				❑ M❑F
❑	❑					❑Y ❑N				❑ M❑F
❑	❑					❑Y ❑N				❑ M❑F
❑	❑					❑Y ❑N				❑ M❑F
❑	❑					❑Y ❑N				❑ M❑F
❑	❑					❑Y ❑N				❑ M❑F

Is any child over the dependent age limit applying for coverage due to disability? ❑No ❑Yes→*Complete the Request for Certification of Disabled Dependent form.*

Does any dependent have a different mailing address? ❑ No ❑ Yes→ _____
List Dependent name

_____
Write in Dependent mailing address including City, State and ZIP Code

OTHER COVERAGE INFORMATION

Do you, your spouse and/or your covered dependents have other coverage for: If yes, please attach a Certificate of Creditable Coverage from your current carrier(s) – Certificates only apply to newly enrolled Employees & Dependents.

Medical ❑ No ❑ Yes Dental ❑ No ❑ Yes Vision ❑ No ❑ Yes Prescriptions ❑ No ❑ Yes Medicare ❑ No ❑ Yes

COVERAGE #1:

Enrollee's Name:_____ Enrollee's Birth Date: _____ Plan Name_____

ID #:_____ Effective Date: _____ Individuals currently covered under this policy: _____

COVERAGE #2:

Enrollee's Name:_____ Enrollee's Birth Date: _____ Plan Name: _____

ID #:_____ Effective Date: _____ Individuals currently covered under this policy: _____

SIGNATURE

I declare that to the best of my knowledge, all of the information on this form is true and complete, and all of the persons for whom I am requesting enrollment are eligible for coverage. The changes on this form supersede all previous forms submitted. I UNDERSTAND THAT MISSTATEMENT, OMISSION OF MEDICAL INFORMATION OR FAILURE TO DISCLOSE ANY INFORMATION MAY BE USED AS A BASIS FOR RESCISSION OF COVERAGE FOR ME AND FOR MY DEPENDENTS, AND THAT I WILL BE GUILTY OF INSURANCE FRAUD. I authorize deductions, if any, from any earnings toward the cost of the coverage. A copy of this authorization shall be as valid as the original.

Sign Here →

_____	_____	_____
Employee's Signature	*Print Name*	*Date*

THIS SECTION TO BE COMPLETED BY EMPLOYER

Exact date of full-time employment:	Effective Date:	Date Processed:	
Month Day Year	Month Day Year	Month Day Year	Plan Administrator