Health Plan Frequently Asked Questions

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For more detailed Plan information please refer to the Health Care Plan booklet on our website: https://employees.kpbsd.org/wp-content/uploads/health-care-plan/KPBSD-Summary-Plan-Description-FINAL.pdf

1.) **When does my coverage begin?** As long as you have filled out the Rehn & Associates enrollment form and submitted it along with all required legal documents within 31 days from your start date, your coverage becomes effective on the first of the month following or coinciding with your start date.
Due to processing time, your enrollment may not show up in the system immediately.

2.) **When will my coverage end?** Coverage will end on the last day of the month in which the separation occurs. If you have completed your entire work calendar or contract your termination date will be June 30th.

3.) **Do certain employees have the option to opt out of the Health Plan?** Per the Union's Collective Bargaining Agreements (CBA), members who have alternative health insurance coverage meeting the minimum ACA requirements may elect to waive their entitlement to District provided health insurance coverage. Alternative health insurance coverage shall not include District provided coverage which the member is entitled to by reason of his/his status as a spouse or dependent of a District employee who is covered by the District's health insurance plan.

4.) **How much is my health plan coverage co-pay?**

	Tier 1 Employee Only	**Tier 2 Employee + Spouse**	**Tier 3 Employee + Child(ren)**	**Tier 4 Employee + Family**
Employee monthly deduction	$169.58	$373.07	$322.19	$542.64
Times 12 months of coverage	12	12	12	12
Annual employee contribution amount	$2,034.96	$4,476.84	$3,866.28	$6,511.68
Divided by 9 months for payroll deduction (Sept-May)	9	9	9	9
Amount withheld September through May	$226.10	$497.42	$429.59	$723.52

Please note: If you were a new hire during FY24, your deductions may be different than the above. If you have questions, please contact the Payroll department.

5.) **Are deductibles figured for the Calendar Year or the Fiscal Year?** Your deductible will be figured for the Calendar Year (January 1st through December 31st). If you satisfy any portion of your deductible during the last three months of the year, that amount will be carried over to your next Calendar Year deductible.

6.) **How much are my deductibles and prescription drug co-pays?**
Major Medical Deductible, per Calendar Year

HRA Plan:
Individual: $1,500
Family: $3,000

HSA Plan:
Individual: $1,600
Family: *$3,200
**Aggregate Family Deductible applies to any policy with more than one enrollee per IRS regulations – individual deductible will not apply.*

Dental Deductible, per Calendar Year
Individual: $50
Family: $150
$2,500 Calendar Year Maximum Benefit; the calendar year deductible applies to all covered expenses except for Preventative Services.

***Prescription Benefits:**
Generic Drugs: $5 Co-pay
Preferred Brand Name Drugs: $25 Co-pay
Non-Preferred Brand Name Drugs: $50 Co-pay
Specialty Drugs: $100 Co-pay
Maximum 100 day supply per fill

**Major Medical Deductible for the HSA Plan must be met prior to these copays taking effect. $3,000 Aggregate Family Deductible applies to any policy with more than one enrollee per IRS regulations – individual deductible will not apply for a Family Plan.*

For more detailed Plan information please refer to the Health Care Plan booklet on our website: https://employees.kpbsd.org/health-care-plan/

7.) **What if I need to go to the doctor before I receive my insurance ID card?** Please contact Stacey Vinson at SVinson@kpbsd.k12.ak.us to request a paper copy of your ID card.

8.) **How do I access my online Rehn & Associates tools and resources?** You will have access to the Rehn & Associates member website: www.kpbsd.rehnonline.com. Your personalized website offers you access to your claims history and status, Explanation of Benefits, health tools and resources and provider look up features.
To create a new Rehn & Associates online account, go to: www.kpbsd.rehnonline.com. Click on New User; Step One: Enter your Account Number (on your ID card), SSN, and Birth date; click Next. Step Two: Enter the requested personal information where prompted; Click Submit. Once your account is created, your Login and your Password is what you assigned when you created the account.

9.) **What is COBRA?** Consolidated Omnibus Budget Reconciliation Act (COBRA) requires group health plans to offer continuation coverage to covered employees, former employees, spouses, former spouses, and dependent children when group health coverage would otherwise be lost due to certain specific qualifying events. Those events include the death of a covered employee, termination or reduction in the hours of a covered employee's employment for reasons other than gross misconduct, a covered employee's becoming entitled to Medicare, divorce or legal separation of a covered employee and spouse, and a child's loss of dependent status (and therefore coverage) under the plan.

10.) **What is the Preferred Provider (PPO) Hospital in Anchorage?** The preferred provider Facilities in Anchorage are Alaska Regional Hospital, Surgery Center of Anchorage, Alaska Surgery Center, and Alpine Surgery Center for inpatient and outpatient services. You must use these Facilities to avoid a penalty and obtain the best pricing and benefits. This includes, but is not limited to, inpatient hospitalization and outpatient services such as surgery and imaging (CT scans and MRIs for example).

11.) **If I use a facility other than Alaska Regional Hospital, Surgery Center of Anchorage, Alaska Surgery Center, or Alpine Surgery Center when I'm in Anchorage, will I be penalized?** Yes. You will enjoy the best benefits if you use these Facilities when you are in Anchorage. If you use a facility within the Municipality of Anchorage other than the Facilities listed above, the claims will be repriced to the negotiated rate at these Facilities, and then paid at 60% of that allowed amount. Non-emergency services incurred at a non-PPO facility do not apply to your out-of-pocket maximum. *You will not be penalized for emergency services or for services not available at these PPO Facilities*.

12.) **When should I notify the Plan Administrator of any change in status for myself or my dependents?**
You have 31 days to notify the Plan Administrator of these qualifying events:
- Marriage (Certified copy of Marriage Certificate required)
- Birth (Copy of Birth Certificate required)
- Adoption (Copy of adoption documents required)

Coverage will start on the date of the qualifying event. If you fail to make desired changes within the allowed time period, you may do so during Open Enrollment.
Legal documentation (marriage, birth certificates, court orders) must be received within 90 days from the date the dependent becomes eligible.

You have 60 days to notify the Plan Administrator of:
- Divorce (Copy of Divorce Decree required)
- Loss of dependent status (No longer full time student, marriage, attained limiting age)
- Legal separation (Court order required)
- Death

Failure to notify the Plan Administrator of a COBRA qualifying event could constitute a failure of COBRA election rights.

If an employee fails to notify the Plan Administrator within 60 days, the employee may be responsible for reimbursing the Plan for any claims that have been paid on their ineligible dependents.

13.) **How do I add my newborn child to my policy?** You must fill out a new Enrollment Form within 31 days of the birth date; this form must be on file with Human Resources within that 31 day period. You are required to supply a copy of the birth certificate and social security number when you receive them – within 90 days from the date of birth. Coverage will be effective as of the birth date if application is made within the 31 day deadline.
If an Employee fails to enroll themselves or a Dependent within 31 days of eligibility, enrollment can occur only under the conditions specified under the sections entitled "Special Enrollment" or "Open Enrollment."

14.) **When is Open Enrollment?** The period of mid-November to mid-December of each Calendar Year has been designated as an annual open enrollment period during which individuals that are currently eligible for this Plan may add or delete their Dependents to or from coverage. Any such changes will become effective January 1st of the Calendar Plan Year. Legal documentation is required for all enrollments and changes made (Copies of marriage certificate, children's birth certificates, divorce decree, adoption decree, etc.).

15.) **Who do I contact with questions about the Section 125 (FLEX) plan?** Contact Sharon Arteaga with American Fidelity at (503) 718-7040 or email: sharon.arteaga@americanfidelity.com.

16.) **I received a form in the mail from Rehn & Associates. Do I have to fill it out?** Yes, you must fill out and return all forms that Rehn & Associates sends to you as soon as possible. If Rehn & Associates does not receive the form back they will deny all future claims until they receive the requested information. If you do not return the form within 180 days Rehn & Associates will not reprocess the related claims.

17.) **Who do I contact with general Health Plan questions?** You may contact Stacey Vinson, Employee Benefits Manager, with your general Health Plan questions at (907) 714-8879. You may also contact Rehn & Associates directly at (800) 872-8979.

18.) **How do I contact Rehn & Associates?** You may call Rehn & Associates at (800) 872-8979. You may fax claims to (509) 535-7883, email claims to Rehn@rehnonline.com, or mail to: Rehn & Associates, KPBSD Health Plan, PO Box 5433, Spokane, WA 99205-0433. Claim forms are available on the KPBSD Forms page online at https://employees.kpbsd.org/wp-content/uploads/document-library/human-resources/Rehn-Claim-Form.pdf.

19.) **Who does my doctor contact to perform a pre-certification?**
The doctor's office must contact Aetna at: (888) 632-3862

CAUTION: Failure to comply with the Utilization Review pre-certification requirement may reduce your benefit.

20.) **How is the Usual Customary & Reasonable (UCR) allowance determined?** Rehn & Associates purchases UCR allowance data from a third party company. This company collects charge data from physicians under each procedure code or CPT (Common Procedure Terminology) and sorts it by zip code. The UCR allowance for any CPT code is determined by collecting all the charges for the CPT code in the geographic area for a six-month period. The UCR allowance for that CPT code is set at the 90th percentile (90% of all charges collected are equal to or below that cost). If a particular geographical location does not generate enough of a particular procedure (CPT code), to generate a statistically viable sample, charges from a nearby geographical location may be substituted.

There are providers who charge in excess of what is determined to be the UCR allowance. If you receive a claim that has a portion denied due to "above Usual Customary &

Reasonable fee" that means the provider's charge for that service is in excess of that which was charged for 90% of the procedures done during the previous six months.

21.) **What are the Appeal procedures for a denied claim?**

- Check Health Plan language to verify if there is a specific exclusion for the denied service. Health Plan is available online at: http://www.kpbsd.k12.ak.us/employees.aspx?id=5232
- Check with the provider's office to have them review claim for any possible coding or billing errors.
- Contact Shannon Wilkins, Claims Administrative Assistant, at 1-800-872-8979 for further details regarding the claim denial.
- Call Stacey Vinson, KPBSD Employee Benefits Manager, for further assistance at (907) 714-8879.
- If the insured would like to start the First Level Appeal process:
  - Review Appeal guidelines & Requirements in Health Plan (pages 54-57): https://employees.kpbsd.org/wp-content/uploads/health-care-plan/KPBSD-Summary-Plan-Description-FINAL.pdf
  - Insured has 180 days following receipt of the initial denial or adverse benefit determination within which to appeal the determination through the First Level Appeal process.
  - The insured must submit the First Level Appeal to Rehn & Associates, Attn: Appeals, PO Box 5433, Spokane, WA 99205-0433. Appeals are not accepted from providers.
- If the insured receives an adverse decision on the First Level Appeal, they may submit a Second Level Appeal to the Health Plan Administrator at the KPBSD District Office; ATTN: Health Plan Administrator, 148 N Binkley St, Soldotna, AK 99669.
  - Insured has 60 days to submit the Second Level Appeal from receipt of the Plan's adverse decision regarding the First Level Appeal.
  - Insured must fill out HIPAA paperwork prior to the processing of the Second Level Appeal. This paperwork will be provided to the insured.
  - A Second Level Appeal determination letter will be sent to insured.
- External Review Procedure (3rd Level Appeal): For denied claims involving medical judgments or rescission, the Plan has an external review procedure that provides for a review conducted by a qualified Independent Review Organization (IRO). The Covered Person may request a review by an IRO within 4 months after the date of the notice of the Plan's adverse decision regarding the Second Appeal Level. The Plan is entitled to charge a fee of $25 to initiate an External Review, which must be paid when the Covered Person submits the Request for External Review Form to initiate the process.

22.) **How do I file a claim that I paid for out of pocket?**

- **<u>Medical/Dental/Vision claim filing</u>**: Download the "Rehn Claim Form" from the KPBSD website (FORMS tab; Keyword Search "Rehn"): https://employees.kpbsd.org/wp-content/uploads/document-library/human-resources/Rehn-Claim-Form.pdf
  Attach the itemized receipt that the Provider gave you to the Claim Form and mail, fax, or email the claim to Rehn & Associates.

By Mail:
Rehn & Associates
KPBSD Health Plan
PO Box 5433
Spokane, WA 99205-0433

By Fax: 1-509-535-7883

By email: Rehn@rehnonline.com

23.) **Does the Health Plan cover Routine and Preventative Services?**
Preventive care services that are recommended under the Patient Protection and Affordable Care Act (PPACA) will be covered at 100%, with no deductible. These include physical exams (based on age and gender), certain immunizations and some preventive screening. For more information or to see if a particular service is included, please visit: https://www.healthcare.gov/coverage/preventive-care-benefits/ Preventive care services will be subject to all other plan provisions, including Usual, Customary & Reasonable (UCR) limitations.

24.) **Definitions.**
For a complete list of definitions please refer to the Health Care Plan booklet on our website: https://employees.kpbsd.org/wp-content/uploads/health-care-plan/KPBSD-Summary-Plan-Description-FINAL.pdf

Calendar Year

"Calendar Year" shall mean January 1 through December 31 of the same year.

Claims Administrator or Third Party Administrator (TPA)

"Claims Administrator" shall mean Rehn & Associates, PO Box 5433, Spokane, WA 99205-0433.

COBRA

"COBRA" shall mean the Consolidated Omnibus Budget Reconciliation Act of 1985 as amended.

Deductible

"Deductible" shall mean a specified dollar amount of Covered Expenses that must be incurred during a Calendar Year before any other Covered Expenses can be considered for payment at the percentages stated in the Schedule of Benefits of this Plan.

Effective Date

"Effective Date" shall mean the date on which your coverage under this Plan begins. If you reenroll in this Plan after a lapse in coverage, the date that the coverage begins again will be your effective date.

EOB

"EOB" shall mean Explanation of Benefits.

HIPAA

"HIPAA" shall mean the Health Insurance Portability and Accountability Act of 1996, as amended.

Inpatient

"Inpatient" shall mean the classification of a Covered Person when that person is admitted to a Hospital, Hospice or Convalescent Nursing Facility for treatment, and charges are made for Room and Board to the Covered Person as a result of such admission.

Medically Necessary

"Medically Necessary" shall mean any health care treatment, service or supply determined by the Plan Administrator to meet each of these requirements:

1. It is ordered by a Physician for the diagnosis or treatment of a Sickness or Injury;
2. The prevailing opinion within the appropriate specialty of the United States medical profession is that it is safe and effective for its intended use, and that omissions would adversely affect the person's medical condition; and
3. It is furnished by a provider with appropriate training, experience, staff and facilities to furnish that particular service or supply.

The Plan Administrator will determine whether these requirements have been met based upon published reports in authoritative medical and scientific literature; regulations, reports, publications or evaluations issued by government agencies such as the Agency for Health Care Policy and Research, the National Institute of Health, and the Food and Drug Administration (FDA); listings in the following compendia: The American Medical Association Drug Evaluations, The American Hospital Formulary Service Drug Information and The United States Pharmacopoeia Dispensing Information; and other authoritative medical sources to the extent that the Plan Administrator determines them to be necessary.

Outpatient

"Outpatient" shall mean the classification of a Covered Person when that Covered Person receives medical care, treatment, services or supplies at a clinic, a Physician's office at a Hospital, if not a registered bed patient at that Hospital, an outpatient psychiatric facility or an Outpatient Chemical Dependency Treatment Facility.

Plan

"Plan" shall mean the Kenai Peninsula Borough School District.

TPA

"TPA" shall mean Third Party Administrator or Claims Administrator; Rehn & Associates, PO Box 5433, Spokane, WA 99205-0433.

Usual Customary and Reasonable

"Usual Customary and Reasonable" shall mean actual fees for services and supplies that are reasonably necessary for the care and treatment of Sickness or Injury, but only to the

extent that such fees are reasonable. Determination that a fee is reasonable will be made by the Claim Administrator, taking into consideration:

1. The fee which the Provider most frequently charges the majority of patients for the service or supply;

2. The prevailing range of fees charged in the same area by Providers of similar training and experience for the service or supply; and
3. Unusual circumstances or complications requiring additional time, skill and experience in connection with the particular service or supply.

For purposes of this section, "Area" means a metropolitan area, county or such greater area as is necessary to obtain a representative cross-section of Providers rendering such services or furnishing such supplies.