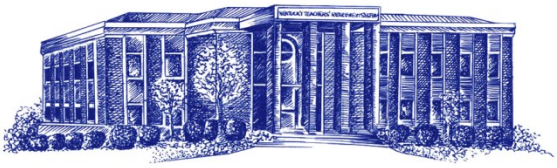
TEACHERS' RETIREMENT SYSTEM OF KENTUCKY

GARY L. HARBIN, CPA
Executive Secretary
(502) 848-8500



SERVING KENTUCKY TEACHERS SINCE 1940

ROBERT B. BARNES, JD
Deputy Executive Secretary
Operations and General Counsel
(502) 848-8500

J. ERIC WAMPLER, JD
Deputy Executive Secretary
Finance and Administration
(502) 848-8500

MEMORANDUM

TO: KTRS Retirees

FROM: KTRS Insurance Department

RE: Adding Dependents

Outside of open enrollment, retirees may be allowed to add a spouse and/or dependents to their plan ***IF a qualifying event (QE) has occurred and the required application/form is signed within 35 days*.**

If a qualifying event has occurred, you should complete the attached "Retiree Health Insurance Add/Drop Form" and return it ***with the required Verification Documentation (see below) and QE documentation (see QE chart)*.**

Person Being Added	Verification Documentation Required
Spouse	A legible photocopy of the Marriage Certificate **OR** a legible photocopy of the top half of the front page of the retiree's most recent federal tax return (Form 1040).
Common Law Spouse	A legible photocopy of the Certificate or Affidavit of Common Law Marriage from a state that recognizes Common Law Marriage (Kentucky does not recognize Common Law Marriage).
Child Age 0 to 25	**Natural Child**: A legible photocopy of the child's birth certificate showing the name of the retiree as a parent. **Step Child**: A legible photocopy of the child's birth certificate showing the name of the retiree's spouse as a parent; **AND** a legible photocopy of the marriage certificate showing the names of the retiree and spouse. **Legal Guardian, Adoption, Grandchild(ren) or Foster Child(ren)**: Legible photocopies of Court Orders, Guardianship Documents, Affidavits of Dependency, with the presiding judge's signature and filed status; **OR** legible Adoption or Legal Placement Decrees with the presiding judge's signature.
Disabled Dependent	Contact the Enrollment Information Branch at 502-564-1205 for the specific documentation needed.

***If documentation is required and not provided, your application cannot be processed*.** Please review the QE chart and sign the application appropriately to avoid double coverage or a lapse in coverage. The application must be signed no later than 35 days from the qualifying event.

NOTE: If your qualifying event allows you to change your Option (LivingWell CDHP, LivingWell PPO, Standard PPO, or Standard CDHP), and you desire to do so, you must download and complete an ***application*** instead of an Add Form.

If you have any questions, please contact our office

QUALIFYING EVENT (QE) CHART WITH DOCUMENTATION REQUIREMENTS TO ADD/ENROLL						Rev 6/2014
Event	**Allowed Changes**	**Event Date**	**Signature Deadline**	**Effective Date**	**FORM REQUIRED**	**DOCUMENTS REQUIRED**
Change in Legal Married Status						
Marriage	- Adding Retiree, Spouse and/or Dependent(s) including Tag-Alongs - Make Coverage Level or Plan Option changes if adding Dependent(s) [9]	Date of the marriage	35 calendar days from the Event Date	First of the month following signature date	Enrollment Application **OR** Add/Drop Form	1 (on pg 2)
Divorce, Legal Separation or Annulment	- Adding Retiree and Dependent(s) if losing coverage under Spouse's plan	Date of loss of coverage under former Spouse's plan	35 calendar days from the Event Date	First of the month following signature date	Enrollment Application **OR** Add/Drop Form	1 **AND** 2, 3, 4 or 5 (on pg 2)
Spouse's Death	- Adding Retiree and/or Dependent(s) including Tag-Alongs; if coverage is lost due to Spouse's death [9]	Date of loss of coverage under deceased Spouse's plan	35 calendar days from the Event Date	First of the month following signature date	Enrollment Application **OR** Add/Drop Form	1 **AND** 2, 3, 4 or 5 (on pg 2)
Change in Number of Dependents						
Birth	- Adding new child, Retiree, Spouse or other Dependent(s) including Tag-Alongs - Changing Plan Option when adding Dependent(s) or Spouse [9]	Date of Birth	60 calendar days (if only adding newborn) 35 calendar days (if adding other dependents)	Date of Birth	Enrollment Application **OR** Add/Drop Form	1 (on pg 2)
Adoption or Placement for Adoption	- Adding new child, Retiree, Spouse or other Dependent(s) including Tag-Alongs - Changing Plan Option when adding Dependent(s) or Spouse [9]	Date of Adoption; Foreign Adoption – Date Visa stamped Placement – child's Placement Date	35 calendar days from the Event Date 60 calendar days (if only adding adopted or placed child)	Date of Adopton; Foreign Adoption – Date Visa stamped Placement – Child's Placement Date	Enrollment Application **OR** Add/Drop Form	1 (on pg 2)
Judgment, decree or administrative order relating to health coverage for child (including grandchildren)	- Adding dependent(s) to existing plan if required by a court order, placement by CHFS or if legal guardianship has been awarded - Enroll Retiree if the court order stipulates to add children to Retiree's plan - Change Plan Option if adding Dependent(s) [9]	Date order or guardianship documents signed by the judge	35 calendar days National Medical Support Notice (NMSN) **may** be processed beyond 35 days	First of the month following signature date	Enrollment Application **OR** Add/Drop Form	1 (on pg 2)
Change in Spouse or Dependent Employment Status (Dependent must continue to meet plan eligibility requirements)						
Spouse or Dependent <u>loses</u> other employer-sponsored health coverage	- Adding Retiree, Spouse and/or Dependent(s), including Tag-Alongs, if event causes loss of coverage under Spouse's or Dependent's health plan - Changing Plan Option when adding Spouse or Dependent(s) [9]	Date of loss of coverage under the employer-sponsored group health plan	35 calendar days from the Event Date	First of the month following signature date. ***This may be signed before the Event Date**	Enrollment Application **OR** Add/Drop Form	1 **AND** 2, 3, 4 or 5 (on pg 2)

Change in Coverage under Employer Plan						
Retiree or Spouse has different Open Enrollment Period	- Adding Retiree, Spouse or Dependent(s) if coverage was dropped during the Open Enrollment period	Last day of the other group's Open Enrollment Period	35 calendar days from the Event Date	Same as the Effective Date of the other group's election	Enrollment Application **OR** Add/Drop Form	1 **AND** 6 (below)
Other Events						
Dependent re-establishes plan eligibility	- Adding Dependent(s) who satisfy plan eligibility requirements - Change Plan Options if adding Dependent(s) [9]	Date Dependent re-establishes eligibility	35 calendar days from the Event Date	First of the month following signature date	Add/Drop Form	1 **AND** 7 (below)
Loss of group health insurance that entitles retiree or family member to enroll under HIPAA Special Enrollment Rights	- Adding Retiree, Spouse and/or Dependent(s) including Tag-Alongs if the event causes a loss of coverage under group, individual, "gap" or student health plan - Change Plan Options if adding Spouse or Dependent(s) [9]	Date of loss of coverage	60 calendar days (if losing Medicaid, KCHIP, KCHIP Premium Supplement, or KHIPP) 35 calendar days for all other losses	First of the month following signature date ***This may be signed before the Event Date**	Enrollment Application **OR** Add/Drop Form	1 **AND** 2, 3, 4 or 5 (below)
Incarceration ends	- Adding Spouse or Dependent who satisfies plan eligibility requirements after incarceration	Date incarceration ends	35 calendar days from the Event Date	First of the month following signature date	Add/Drop Form	1 **AND** 8 (below)

REQUIRED DOCUMENTATION

1. Dependent Eligibility Documentation (see chart on Memorandum – Verification Documentation Required)
2. HIPAA Certificate of Creditable Coverage
3. Letter from Employer on letterhead that includes:
   a. Name(s) of person(s) covered
   b. Coverage termination date
4. Letter from insurance company that includes:
   a. Type of coverage
   b. Reason for termination
   c. Date of termination
   d. Name(s) of person(s) covered
5. Termination letter from governmental agency providing previous coverage
6. Letter from employer on employer's letterhead, identifying:
   a. Open Enrollment period and deadline
   b. Effective Date of plan
   c. Person(s) being dropped from the policy
7. The Retiree must provide the reason the Dependent is re-establishing eligibility under the guidelines of KEHP
8. Documentation from the jail/prison stating name and release date
9. QE permits change in Plan Option (LivingWell CDHP, LivingWell PPO, Standard PPO, or Standard CDHP). Retiree must complete an application instead of Add/Drop Form.

NOTES:

- Military Insurance Coverage is considered "Another Employer Plan," however, Veteran's Administration (VA) benefits are **NOT** considered "Another Employer Plan."
- E-mails, online print-outs, or hand-written letters/forms will not be accepted as Qualifying Event documentation
- All Qualifying Event Forms should be signed within 35 days of the Qualifying Event (unless otherwise stated on the QE chart)
- If coverage terminates mid-month, you cannot sign the Enrollment or Add/Drop Form to begin before the termination (unless otherwise stated on the QE chart)
- The final regulation preamble indicates that dependents who can be added are those who were directly affected by the status change event plus other dependents (the so-called "tag-along" rule). However, the examples in the regulation only explicitly deal with situations where an employee elects family coverage and adds family members at no additional cost. It is not clear, but IRS staff members have informally stated that the "tag-along" rule applies even if the employee must increase an election to add additional dependents. Also, the preamble and examples in the regulation indicate that the "tag-along" rule applies to HIPAA events and situations where a spouse terminates employment; it is not clear what other events might be covered by the "tag-along" rule.

Do Not Staple
Kentucky Employees' Health Plan
Department of Employee Insurance
KEHP.KY.GOV • 1-888-581-8834

2015 KEHP
RETIREE HEALTH INSURANCE ADD/DROP FORM

Section 1: ***To Be Completed by Insurance Coordinator/HR Generalist***					
Retiree's SSN		Retiree Personnel Number		Home County Code	
Company Name	KTRS		Company Number	85000	
Date of Hire:	/ /	Coverage Effective Date		Org. Unit Number	10006418
Reason for Submission:	❑ Qualifying Event		❑ Other		

Section 2: ***Demographic Information***

Name (Last, First, MI) _____ Date of Birth _____

Street Address _____ Home Phone Number _____ Cell Phone Number _____

City, State, ZIP _____ Home Email Address _____

Gender ❑Male ❑Female Married ❑Yes ❑No	Within the past 6 months, have you, or a spouse or dependent(s) age 18 and over, to be covered under your insurance plan, used tobacco regularly? Yes ❑ No ❑	Are you Medicare Eligible due to Social Security Disability? Yes ❑ No ❑

Section 3: ***Change Information***			
Please select one QE Reason		Date of Event:	
Adding Dependents		**Dropping Dependents**	
	Marriage **Copy of Marriage Certificate attached?** Yes ❑ No ❑		Divorce **Copy of Divorce Decree attached?** Yes ❑ No ❑
	Birth/Adoption of Child **Copy of birth certificate or placement documents attached?** Yes ❑ No ❑		Death No documentation required.
	Loss of Other Coverage **Letter from HR or Certificate of Prior Coverage attached?** Yes ❑ No ❑		Gaining Other Coverage **Letter from HR or Certificate of Prior Coverage Attached?** Yes ❑ No ❑
	Loss of KCHIP/Medicaid **MET form attached?** Yes ❑ No ❑		Gaining Medicare/Medicaid **MET form attached?** Yes ❑ No ❑
	Guardianship/Court Order **Copy of Court Order attached?** Yes ❑ No ❑		Other Permitted (explain):

Section 4: ***Plan Election***			
Benefit Option		**Coverage Level**	
	LivingWell CDHP ⟶ I agree to the LivingWell promise ❑		Single (self only)
	LivingWell PPO ⟶ I agree to the LivingWell promise ❑		Parent Plus (self and child(ren))
	Standard PPO		Couple (self and spouse)
	Standard CDHP		Family (self, spouse, and child(ren))
	Waive Health Insurance (No HRA – not eligible)		

Plan Year 2015

			-			-				

Retiree's SSN

Retiree's Name _____

Section 5: ***Dependent Information***				
Spouse's Social Security Number	**Name** (Last, First, Middle Initial)	**Birth Date** MONTH/DAY/YEAR	**Gender**	**Cross Reference Payment Option (LRP, JRP not eligible)** ❑ Yes (Employee, Spouse & child(ren))
		/ /		

Note: If Cross Reference Payment Option Complete This Information on Spouse:				
Spouse's Organizational Unit #: **Spouse's** Company #:	❑ **Dual Employee**	❑ **Hazardous Duty**	**Date of hire/retirement** / /	**Has Spouse used tobacco in the last 6 months?** ❑ Yes ❑ No

Child 1		/ /	❑ Male ❑ Female	❑ Natural ❑ Adopted ❑ Court Ordered ❑ Foster ❑ Step ❑ Disabled
Child 2		/ /	❑ Male ❑ Female	❑ Natural ❑ Adopted ❑ Court Ordered ❑ Foster ❑ Step ❑ Disabled
Child 3		/ /	❑ Male ❑ Female	❑ Natural ❑ Adopted ❑ Court Ordered ❑ Foster ❑ Step ❑ Disabled
Are any Dependents Medicare eligible due to Social Security Disability? ❑Yes ❑No		If yes, who?		

TOBACCO USE DECLARATION

The Commonwealth of Kentucky is committed to fostering and promoting wellness and health in the workforce. As a part of the KEHP wellness program, KEHP provides a monthly discount in premium contribution rates for non-tobacco users. You are eligible for the non-tobacco user premium contribution rates provided you certify that you or any other person to be covered under your plan has not regularly used tobacco within the past six months.

TOBACCO USE INFORMATION
Check the applicable box below: Within the past six months, have you, or a spouse or dependent to be covered under your insurance plan, used tobacco regularly? **Yes ❑ No ❑**
NOTE: Regularly means tobacco has been used four or more times per week on average excluding religious or ceremonial uses.
NOTE: "Tobacco" means all tobacco products including, but not limited to, cigarettes, pipes, chewing tobacco, snuff, dip, and any other tobacco products regardless of the frequency or method of use.
NOTE: "Dependent" means, for the purpose of the Tobacco Use Declaration, only those dependents who are 18 years of age or older.

By submitting this form, I certify the following:

1. I have truthfully checked the Yes or No box above that accurately reflects the use of tobacco products in the past six months regarding myself and persons to be covered as a spouse or dependent under my insurance plan.
2. I understand that the tobacco-user premium contribution rates will apply beginning January 1, 2015 if I answered "Yes" to the question above.
3. I understand that it is my responsibility to notify KEHP of any changes in my tobacco-use or that of my spouse or a dependent covered under my insurance plan, including notification to KEHP if all tobacco users become ineligible for coverage or are otherwise terminated during the plan year. Notification shall be made by completing a Tobacco Use Change Form.
4. I understand that if I or a spouse or dependent to be covered under my insurance plan currently use tobacco products and stop using tobacco products during the plan year, I will be eligible for the discount non-tobacco premium contribution rates on the first day of the month following the signature date on the Tobacco Use Change Form certifying that neither I nor my

spouse/dependent(s) regularly used tobacco products during the six months prior to completion of the Tobacco Use Change Form.

5. I understand that if I answered "No" to the question above and either I or a spouse or dependent covered under my insurance plan become a regular tobacco user at any time, I must notify KEHP and my contribution rates will be adjusted to the tobacco user premium contribution rates on the first day of the month following the signature date on the Tobacco Use Change Form.
6. I understand that this Tobacco Use Declaration is a part of my KEHP application for health insurance coverage. Any person who knowingly, and with the intent to defraud, files an application for insurance containing any materially false information, or who conceals, for the purpose of misleading, information concerning any fact material to the application, commits a fraudulent insurance act which is a crime.
7. I understand that if I fail to complete this Declaration truthfully, KEHP may adjust my contribution rates retroactively to apply the applicable higher tobacco-user premium contribution rates. Upon written notification, I will pay to KEHP the difference between the tobacco-user and the non-tobacco user premium contribution rates for the period for which I falsely certified eligibility for the non-tobacco user premium contribution rates.
8. The KEHP offers monthly discounted premium contribution rates to non-tobacco users as a part of its wellness program. Each KEHP member has at least one opportunity per plan year to qualify for the 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 we 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.

Review the Authorization and Certification information below.

Authorization and Certification for elections made by the planholder for health insurance coverage through the Kentucky Employees' Health Plan (KEHP or Plan), administered by the Department of Employee Insurance (DEI).

My signature on this form creates a legal and binding contract. By affixing my signature, I understand that:

- If I am electing a KEHP plan option during open enrollment, the plan will be effective the first day of the following plan year. If I am a new employee electing a KEHP plan option outside of open enrollment, the plan will be effective in accordance with my employer's new hire waiting period rules (generally the first day of the second month after a new employee is eligible to enroll in the health plan).
- I have read and understand the 2015 KEHP Benefits Selection Guide (BSG). Plan rules and limitations are contained in the KEHP Summary Plan Descriptions (SPD) and the Summary of Benefits and Coverage (SBC).
- KEHP uses third parties, including Anthem Blue Cross/Blue Shield and CVS/caremark, to provide certain administrative functions. KEHP may communicate with me directly or through these third parties about my coverage, my benefits, or health-related products or services provided by, or included in KEHP's plan of benefits.
- If my spouse and I elect the cross-reference payment option, we are planholders with family coverage, and upon a loss of eligibility by either spouse, the remaining planholder will default to a parent plus coverage level. The cross-reference payment option ceases upon loss of eligibility or employment by either spouse/planholder.
- I certify that each enrolled dependent meets KEHP eligibility requirements of a dependent as set forth in the SPD and in the BSG. DEI may require supporting documentation to verify the eligibility of any dependent enrolled or requesting to be enrolled in the Plan.
- All KEHP benefits for my eligible dependents and me will be provided in accordance with the limitations in the SPDs, BSG, and SBCs. I will abide by all terms and conditions governing membership and receipt of services from the Plan in which I have enrolled and as set forth in the SPD. In the event of a conflict between the terms of coverage stated in the SPDs, the BSG, and the SBCs, the terms of coverage stated in the SPDs will govern.
- The elections indicated by this form may not be changed or cancelled during the plan year without a permitted Qualifying Event.
- I authorize my employer to deduct from my earnings the amount required to cover my employee share of the premium contribution for the plan(s) I have selected, including any arrears I may owe. I authorize payment of my employee premium contributions to be made on a pre-tax basis unless I sign a Post-Tax Request Form.
- Any premium payment submitted to KEHP that I intend to be used to pay for my health insurance premium contributions will first be used to pay other priority debts that may be due and owing such as taxes and child support.

Plan Year 2015

			-			-				

Retiree's SSN

Retiree's Name

- If I elect to waive KEHP health insurance coverage, with or without a stand-alone Waiver Health Reimbursement Account (HRA), I am doing so voluntarily. There are two options under the HRA: Waiver HRA and the Waiver Dental/Vision ONLY HRA.
- KEHP provides plan options that, under the Affordable Care Act, constitute minimum essential coverage that is affordable and provides a minimum value. As such, by receiving an offer of coverage through my employer, I am not eligible for a health insurance premium tax credit if purchasing insurance through the health insurance exchange.
- The four KEHP plan options and the Waiver HRA must pay primary to Medicare, and the Waiver Dental/Vision ONLY HRA will be secondary to Medicare.
- A KEHP HRA may only reimburse me for medical expenses, as authorized by 26 U.S.C. Sections 105(b) and 213(d), that are incurred during the applicable coverage period. Pursuant to federal law, the cost of over-the-counter medicines (other than insulin and those prescribed by a doctor) may not be reimbursed through my HRA. I have a 90-day run-out period (until March 31) for reimbursement of eligible HRA expenses incurred during my period of coverage.
- Any unused amount remaining in my HRA at the end of the plan year may be carried forward to the next plan year.
- My WageWorks® Healthcare Card will be suspended if the required HRA claim verification is not sent to WageWorks within sixty (60) days after the card swipe. I agree to follow all rules and guidelines established by the Plan concerning the WageWorks® Healthcare Card. The Plan reserves the right to deny access to the card, require repayment, deduct/withhold from my paycheck, and offset my HRA if I fail to properly substantiate a claim.
- The KEHP offers discounted premium contribution rates to non-tobacco users as a part of its wellness program. If either I or a spouse or dependent to be covered under my insurance plan have used tobacco regularly within the past six months, I will not qualify for the discounted employee premium contribution rates. Each KEHP member has at least one opportunity per plan year to qualify for the discount. KEHP is committed to helping you achieve your best health. Rewards for participating in a wellness program are available to all employees/retirees. 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 we 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.
- If you have chosen one of the KEHP LivingWell plan options, I agree to complete the KEHP LivingWell Promise by (1) completing the online Humana*Vitality* Health Assessment; **OR** (2) completing a VitalityCheck (biometric screening). If I am choosing a LivingWell plan during open enrollment, I will complete the LivingWell Promise between January 1, 2015 – May 1, 2015. If I am a new retiree and I choose a LivingWell plan outside of open enrollment, I will complete the Promise within 90 days of my coverage effective date.
- I have rights under HIPAA regarding the protection of my health information. KEHP will comply with the HIPAA privacy and security rules, and uses and disclosures of my protected health information will be in accordance with federal law. KEHP may use and disclose such information to business associates or other third parties only in accordance with KEHP's Notice of Privacy Practices available at kehp.ky.gov.
- Any person who knowingly, and with the intent to defraud, files an application for insurance containing any materially false information (including a forged signature or incorrect signature date), or conceals, for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act which is a crime. I can be held responsible for any fraudulent act that I could have prevented while acting within my duties related to the KEHP, and it may be used to reduce or deny a claim or to terminate my coverage.
- I have fully read the materials provided to me. My signature on this form certifies that all information provided during this enrollment opportunity is correct to the best of my knowledge.

PLEASE SUBMIT THIS FORM TO YOUR COMPANY IC/HRG

Employee Signature — Date

Spouse Signature – *REQUIRED* if electing the cross-reference payment option — Date

IC/HRG Signature — Date

Spouse's IC/HRG Signature – *REQUIRED* if electing the cross-reference payment option — Date