2018 OPEN ENROLLMENT

NOVEMBER 15th to DECEMBER 15th 2017

- ✓ ENROLLMENT DEADLINE: You MUST enroll no later than 4:30 pm on December 15, 2017. All legal documents and other required documents must be turned in to Stacey Cockroft at the District Office by the deadline as well.
- ✓ NO CHANGES? **No action is required from you; your current enrollment will remain the same.**
- ✓ Enrollment forms are included in this packet and will also be available online at http://www.kpbsd.k12.ak.us/employees.aspx?id=5232.
- ✓ All changes made during Open Enrollment will be effective ***January 1, 2018***.

YOUR MEDICAL OPTIONS

Choice of Traditional Plan or 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 Annual	 $388.70 $4,664.40	 $252.26 $3,027.12

**If you newly elect the HDHP, $375 will be credited on January 1st for January – June 2018. Another $750 will be credited on July 1st for the period July 2018 – June 2019.*

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 Open Enrollment, KPBSD will contribute $375 to your HRA account on January 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 can 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.

SEPARATE DENTAL AND VISION COVERAGE OPTIONS

DENTAL	TRADITIONAL OR HDHP PLAN
Annual Deductible Individual Family	 $50 $150
Reimbursement Percentage Preventive Basic Major	 Plan pays 100% (not subject to the deductible) Plan pays 100% Plan pays 50%
Calendar Year Benefit Maximum	$2,500

VISION	TRADITIONAL OR HDHP PLAN
Eye Exam	Plan pays 80%
Frames	Plan pays 80% up to $100 every two years
Lenses	Plan pays 80%
Contacts	Plan pays 80%

Allowable charges and all plan provisions apply. Please see the Summary Plan Description for more information.

YOU MAY BE ABLE TO DECLINE COVERAGE

- You may decline coverage if you 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 December 15, 2017 deadline.***

- 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, you may not decline coverage.

- DECLINING DENTAL/VISION COVERAGE: The dental/vision plan is separate from the medical and prescription plan. If you enroll in medical and prescription coverage, you are automatically enrolled in the dental/vision plan. You may decline coverage in the dental/vision plan, but your employee contribution amount will not change.

HOW DO I ENROLL?

➢ STEP 1:

Review your options. Select the option that is best for you and your family. If you do not want to make any changes, you do *not* need to submit a form.

➢ STEP 2:

Complete an enrollment form with applicable changes and submit documentation to Stacey Cockroft at the District Office by the 4:30 pm December 15, 2017 deadline. For newly enrolled dependents, legal documentation is required (copy of marriage certificate for spouse and birth certificate for dependent child). 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:

❑ 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