FINANCE AND ADMINISTRATION CABINET

Kentucky Public Pensions Authority

(Amended at Subject Matter Committee)

105 KAR 1:411. Hospital and medical insurance for retired members and Kentucky Retirement Systems Insurance Fund Trust.

RELATES TO: KRS 16.505, 16.576(4), 61.505(1)(g), 61.510, 61.701, 61.702, 78.510, 78.5536, 304.17A-005, 26 U.S.C. 105-106, 115, 213(d), 223, 18031, 18041, 42 U.S.C. 300bb-8(3), 300e, 1395y(b), Pub.L. 111-148

STATUTORY AUTHORITY: KRS 61.505(1)(g), 61.702, 78.5536

NECESSITY, FUNCTION, AND CONFORMITY: KRS 61.505(1)(g) authorizes the Kentucky Public Pensions Authority to promulgate administrative regulations on behalf of the Kentucky Retirement Systems and the County Employees Retirement System that are consistent with KRS 16.505 through 16.652, 61.505, 61.510 through 61.705, and 78.510 through 78.852. KRS 61.702 and 78.5536 provide for the systems operated by the Kentucky Public Pensions Authority to offer hospital and medical insurance coverage to recipients (including retired members and some beneficiaries of deceased members), their spouses, and their disabled or dependent children, and require the promulgation of administrative regulations concerning requirements for medical insurance reimbursement programs. This administrative regulation establishes procedures for the administration of the hospital and medical insurance benefits provided by the Kentucky Retirement Systems and the County Employees Retirement System, as well as establishes eligibility requirements, necessary documentation for proof of insurance, deadlines for filing for reimbursement, and forms.

Section 1. Definitions.

(1) "Eligible spouse and dependent children" means spouses and dependent children who are eligible to receive all or a portion of their premiums paid for by the boards in accordance with KRS 61.702 and 78.5536.

(2) "Hospital and medical insurance plan" means:

(a) A basic health benefit plan as defined by KRS 304.17A-005(4);

(b) A provider-sponsored integrated health delivery network as defined by KRS 304.17A-005(39);

(c) A self-insured health plan as defined by KRS 304.17A-005(43);

(d) A health maintenance organization contract that meets the requirements of 42 U.S.C. 300e;

(e) Other health benefit plan as defined by KRS 304.17A-005(22);

(f) A health savings account as permitted by 26 U.S.C. sec. 223;

(g) A health reimbursement arrangement or a similar account as permitted by 26 U.S.C. sec. 105 or 106; or

(h) A hospital and medical insurance premium reimbursement program where members purchase individual health insurance coverage through a health insurance exchange established under 42 U.S.C. sec. 18031 or 18041.

(3) "MEM" means:

(a) A Medicare eligible member who is retired and reemployed:

1. With a participating employer that offers the member a hospital and medical insurance benefit; or

2. By a participating employer that is prevented from offering a hospital and medical benefit to the member as a condition of reemployment under KRS 70.293, 95.022, or 164.952; and

(b) A Medicare eligible member who is retired and whose spouse meets the following criteria:

1. The spouse is also a member;

2. The spouse is reemployed with a participating employer that offers the spouse a hospital and medical insurance benefit, or by a participating employer that is prevented from offering a hospital and medical benefit to the spouse as a condition of reemployment under KRS 70.293, 95.022, or 164.952; and

3. The spouse's hospital and medical insurance plan coverage is provided by the retired member's benefits pursuant to KRS 61.702(2) and 78.5536(2).

(4) "Months of service" is defined by KRS 61.702(1)(c) and 78.5536(1)(c).

(5) "Premium" means the monthly dollar cost required to provide hospital and medical insurance plan coverage for a recipient, a recipient's spouse, or a disabled or dependent child.

(6) "Qualifying event" means a change in life circumstances that:

(a) Meets the agency's requirement for a member to alter an existing hospital and medical insurance plan, or sign up for a new one outside of new or open enrollment if the alteration is consistent with the change; and

(b) Is included on the list of qualifying events provided annually to the members by the agency.

(7) "Wellness" or "wellbeing promise" means an annual health assessment or screening that, if completed by the due date established by the Kentucky Employees' Health Plan, provides a discounted insurance rate for the following fiscal year's health insurance plan premium.

Section 2. Trust Fund.

(1) Pursuant to KRS 61.701, fund assets shall be dedicated for use toward health benefits, as established in KRS 61.702 and 78.5536, and as permitted under 26 U.S.C. 105 and 106 of the United States Internal Revenue Code, to retired recipients and employees of employers participating in the systems. Certain dependents or beneficiaries shall be included, such as qualified beneficiaries as established in 42 U.S.C. 300bb-8(3) of the United States Public Health Service Act.

(2) The boards may adopt a trust agreement and take all action authorized by KRS 61.701(6).

Section 3. Contribution Rates.

(1)

(a) The boards shall adopt monthly contribution rates for:

1. Medicare eligible coverage;

2. Non-Medicare eligible coverage; and

3. MEM coverage.

(b) The boards may choose to adopt a monthly contribution rate for MEM coverage that is separate from the monthly contribution rate the boards adopt for Medicare and non-Medicare eligible coverage, or may choose to adopt a monthly contribution rate that is the same for Non-Medicare eligible coverage and MEM coverage.

(2) The boards shall adopt a contribution plan for each monthly contribution rate in subsection (1) of this section.

Section 4. Payments by the Boards.

(1)

(a) The monthly contribution rate paid by the boards towards premiums for a recipient or eligible spouse or dependent child shall not exceed the monthly contribution rate to which the recipient is entitled under KRS 61.702 and 78.5536.

(b) The actual amount the systems will pay toward a retired member's hospital and medical insurance plan premium, or his or her eligible spouse and dependent children's

hospital and medical insurance plan premium, shall be dependent on the membership date of the member.

1. Except as established in subparagraph 3. of this paragraph, if the membership date is prior to July 1, 2003, the systems shall pay a percentage of the contribution rate toward the hospital and medical insurance plan premiums in accordance with KRS 61.702(4)(b) through (d) and 78.5536(b) through (d).

2. Except as established in subparagraph 3. of this paragraph, if the membership date is on or after July 1, 2003, the systems shall pay a dollar amount of the contribution rate toward hospital and medical insurance plan premiums in accordance with KRS 61.702(4)(e) and 78.5536(4)(e).

3. For a member with a membership date that began July 1, 2003 through July 31, 2004, his or her hire date shall be used to determine if the hospital and medical insurance plan premiums are paid as a percentage of the contribution rate as established in subparagraph 1. of this paragraph, or as a dollar amount of the contribution rate as established in subparagraph 2. of this paragraph.

(2) For a retired member who retired based on reciprocity with any other state-administered retirement system, the boards shall not pay more than a portion of the single monthly contribution rate for the hospital and medical insurance plan chosen by the retired member based on the retired member's service credit with the systems.

(3)

(a) A retired member who is not Medicare eligible or is a MEM may cross-reference health insurance coverage with a spouse enrolled in the same hospital and medical insurance plan.

(b) A retired member established in paragraph (a) of this subsection who has hazardous service and a membership date prior to July 1, 2003 may be able to use any unused portion of the monthly contribution rate the retired member is entitled to receive toward the premium cost attributable to the spouse, if the spouse's portion of the premium is not fully paid by the boards pursuant to KRS 61.702 and 78.5536.

(4) Pursuant to KRS 61.702(4)(d), 61.702(4)(e)5., 78.5536(4)(d), and 78.5536(4)(e)5., funds from the insurance trust fund or the 401(h) accounts provided for in KRS 61.702(3)(b) and 78.5536(3)(b) shall be used to pay the determined percentage of the monthly contribution rate for family coverage for eligible spouses and dependent children.

(5)

(a) Members not eligible for Medicare who began participation in the system on or after July 1, 2003 and have accrued an additional full year of service as a participating employee beyond his or her career threshold may receive an additional five (5) dollar contribution toward monthly hospital and medical insurance premiums in accordance with KRS 61.702(4)(e)6.b. and 78.5536(4)(e)6.b.

(b)

1. If a member who is eligible for an additional five (5) dollar contribution pursuant to paragraph (a) of this subsection has service in multiple systems operated by the agency, each system in which the member participates that meets the requirements of KRS 61.702(4)(e)6.b.iii. and 78.5536(4)(e)6.b.iii shall pay a portion of the additional five (5) dollar contribution based on the percentage of the member's service in each system.

2. If a member who is eligible for an additional five (5) dollar contribution pursuant to paragraph (a) of this subsection has service in multiple systems operated by the agency, and not all of the systems in which the member participates meet the requirements of KRS 61.702(4)(e)6.b.iii. and 78.5536(4)(e)6.b.iii, only those systems that meet the requirements of KRS 61.702(4)(e)6.b.iii. and 78.5536(4)(e)6.b.iii shall pay a portion of the additional five (5) dollar contribution based on the percentage of the member's service in each system.

Section 5. Premiums Paid by Recipient.

(1) A recipient may be charged one (1) or more of the following monthly fees related to his or her hospital and medical insurance coverage:

(a) Tobacco user fee; and

(b) Wellness or wellbeing promise incompletion fee.

(2) Any premium amount or fee that is not paid or payable by the insurance trust fund established under KRS 61.701 or a 401(h) account in accordance KRS 61.702 and 78.5536 shall be deducted from the monthly retirement allowance of the recipient.

(3)

(a) If the amount of a premium or fee is not fully paid by the insurance trust fund established under KRS 61.701, a 401(h) account, and the recipient's monthly retirement allowance, then the recipient shall pay the balance of the premium monthly by electronic transfer of funds by completing and filing a valid Form 6131, Bank Draft Authorization for Direct Pay Accounts.

(b) If a valid Form 6131, Bank Draft Authorization for Direct Pay Accounts, is required and is not filed, then the recipient, the recipient's spouse, and any disabled or dependent children shall not be enrolled in a hospital and medical insurance plan established pursuant to KRS 61.702 and 78.5536.

(c)

1. If the electronic transfer of funds based on a valid Form 6131, Bank Draft Authorization for Direct Pay Accounts, fails, then the agency shall provide an invoice to the recipient.

2. If a recipient fails to remit the balance of the premium or fee by the date provided on the invoice, then the enrollment of the recipient, the recipient's spouse, and any disabled or dependent children in the hospital and medical insurance plan shall be cancelled the month after the last month the recipient paid the premium.

(d) If the hospital and medical insurance plan coverage of a recipient, the recipient's spouse, or any disabled or dependent children is cancelled pursuant to this subsection, the recipient shall not be eligible to enroll in a hospital and medical insurance plan established pursuant to KRS 61.702 and 78.5536 until the next open enrollment period for hospital and medical insurance plan coverage.

Section 6. Eligibility to Participate in Hospital and Medical Insurance Plans.

(1) A person shall not be eligible to participate in the hospital and medical insurance plans established pursuant to KRS 61.702 and 78.5536 until the person is a recipient of a monthly retirement allowance, except as established in KRS 16.576(4).

(2) A person who retires under disability retirement shall not be eligible to participate in the hospital and medical insurance plans established pursuant to KRS 61.702 and 78.5536 until the month the person receives his or her first monthly retirement allowance payment.

(3) A recipient's spouse, disabled child, or dependent child shall not be eligible to participate in the hospital and medical insurance plans established pursuant to KRS 61.702 and 78.5536 unless the recipient is participating in the hospital and medical insurance plans established pursuant to KRS 61.702 and 78.5536.

(4) An alternate payee shall not be eligible for participation in the hospital and medical insurance plans established pursuant to KRS 61.702 and 78.5536.

Section 7. Participation in a Hospital and Medical Insurance Plan.

(1) A recipient, spouse, or disabled or dependent child who is Medicare eligible, except individuals established in subsection (2) of this section, shall participate in the hospital and medical insurance plan established for Medicare eligible recipients pursuant to KRS 61.702 and 78.5536.

(2) MEMs, and spouses of MEMs and disabled or dependent children of MEMs who are Medicare eligible, shall participate in the group hospital and medical insurance plan established for MEMs pursuant to KRS 61.702(2)(b)3.b. and 78.5536(2)(b)3.b.

(3) A recipient, spouse, or disabled or dependent child who is not Medicare eligible shall participate in a non-Medicare eligible group hospital and medical insurance plan established pursuant to KRS 61.702 and 78.5536.

(4) If a recipient, spouse, or disabled or dependent child is eligible for Medicare but the other persons enrolled in a group hospital and medical insurance plan are not, then the recipient, spouse, or disabled or dependent child who is not eligible for Medicare may continue to participate in the non-Medicare eligible group hospital and medical insurance plan established pursuant to KRS 61.702 and 78.5536.

(5) Members established in subsections (1) through (4) of this section may waive enrollment in the hospital and medical insurance plan by filing:

(a) A completed KPPA Health Plans for Medicare Eligible Persons form, for Medicare eligible recipients; or

(b) A completed Retiree Health Insurance Enrollment/Change Form, for MEMs and non-Medicare eligible recipients.

(6) Members established in subsections (1) through (4) of this section who do not enroll in or waive the hospital and medical insurance plan shall be automatically enrolled in an appropriate default plan in accordance with Section 9 of this administrative regulation.

Section 8. Required Forms.

(1) If the boards use the group hospital and medical insurance provided by the Kentucky Department of Employee Insurance to provide health insurance coverage for its non-Medicare eligible recipients, spouses, disabled or dependent children, and MEMs, then the agency shall provide these recipients and MEMs with the Retiree Health Insurance Enrollment/Change Form, required for enrollment, waiver, or changes to the group hospital and medical insurance plan.

(2) On behalf of the boards, the agency shall arrange hospital and medical insurance coverage for Medicare eligible recipients, spouses, and disabled or dependent children, except MEMs. The agency shall provide these recipients with the KPPA Health Plans for Medicare Eligible Persons form, required for enrollment, waiver, or changes to the hospital and medical insurance plans.

(3) The agency shall provide the Form 6256, Designation of Spouse and/or Dependent Child for Health Insurance Contributions, for recipients to complete to receive health insurance contributions toward an eligible spouse and dependent children who are between the ages of eighteen (18) and twenty-two (22).

Section 9. Default Plans.

(1) The boards shall adopt a default plan for new retired members upon initial enrollment, and for recipients who do not file a complete insurance enrollment form during annual open enrollment, if required.

(2) The boards shall adopt a default plan for retired members and recipients who are Medicare eligible, and a default plan for retired members and recipients who are non-Medicare eligible and recipients who are subject to 42 U.S.C. 1395y.

Section 10. Initial and Annual Enrollment and Qualifying Events.

(1)

(a) The recipient shall complete and file valid insurance enrollment forms as established in Section 8 of this administrative regulation by the last day of the month the initial retirement allowance is paid.

(b) If the recipient fails to file the valid insurance enrollment forms as required by paragraph (a) of this subsection, the retired member shall be automatically enrolled in

the appropriate default plan adopted by the boards as established in Section 9 of this administrative regulation.

(c) If the recipient established in paragraph (a) of this subsection files the valid insurance enrollment forms as established in Section 8 of this administrative regulation by the last day of the month in which he or she receives his or her initial retirement allowance payment, the retired member shall be enrolled in the selection indicated on the form effective the first day of the following month.

(2) If a recipient has a qualifying event, the recipient shall complete and file the valid insurance enrollment forms as established in Section 8(1) or (2) of this administrative regulation within the time period established by state and federal law and the health insurance plan documents.

(3)

(a) If enrollment is mandatory:

1. The recipient shall complete and file the valid insurance enrollment forms as established in Section 8 of this administrative regulation by the last day of the month of the annual open enrollment period; or

2. If the recipient fails to file the complete insurance enrollment forms as required by subparagraph 1. of this paragraph, the recipient shall be automatically enrolled in the default plan adopted by the boards as established in Section 9 of this administrative regulation.

(b) If enrollment is not mandatory:

1. The recipient may complete and file the valid insurance enrollment forms as established in Section 8 of this administrative regulation by the last day of the month of the annual open enrollment period; or

2. If the recipient does not file the valid insurance enrollment forms as required by subparagraph 1. of this paragraph, the recipient, and the recipient's spouse and disabled or dependent children as applicable, shall remain on the same plan with the same level of coverage as the previous plan year.

(4)

(a)

1. In order to receive health insurance contributions toward an eligible spouse or a dependent child who is between the ages of eighteen (18) and twenty-two (22), the recipient shall complete and file a valid Form 6256, Designation of Spouse and/or Dependent Child for Health Insurance Contributions, by the end-of-day on November 30th of the calendar year prior to the calendar year in which coverage is effective, regardless of whether enrollment is mandatory or not mandatory.

2. If a qualifying event results in a new eligible spouse or dependent child, in order to receive health insurance contributions toward the eligible spouse or a dependent child who is between the ages of eighteen (18) and twenty-two (22), the recipient shall complete and file a valid Form 6256, Designation of Spouse and/or Dependent Child for Health Insurance Contributions, and:

a. To add a spouse, the recipient shall file a copy of the marriage certificate; and

b. To add a dependent child, the recipient shall file a copy of the child's birth certificate or a court order establishing legal or natural parenthood.

(b)

1. If the recipient does not file a valid Form 6256, Designation of Spouse and/or Dependent Child for Health Insurance Contributions, in accordance with paragraph (a) of this subsection, health insurance contributions shall not be paid toward the premiums for an eligible spouse or dependent children unless a complete Form 6256 is filed in the calendar year in which coverage is in effect.

2. If the recipient files a valid Form 6256, Designation of Spouse and/or Dependent Child for Health Insurance Contributions, between December 1 and December 31 of

the calendar year prior to the calendar year in which coverage is effective, then health insurance contributions may be paid for an eligible spouse or a dependent child who is between the ages of eighteen (18) and twenty-two (22) as of January of the calendar year in which coverage is effective. If the health insurance contributions are not paid for an eligible spouse or a dependent child as of January of the calendar year in which coverage is effective, then health insurance contributions shall be paid starting in February of the calendar year in which coverage is effective and the recipient shall also be reimbursed for the January health insurance contributions for the eligible spouse or dependent child.

3. If the recipient files a valid Form 6256, Designation of Spouse and/or Dependent Child for Health Insurance Contributions, prior to December 31 of the calendar year in which coverage is in effect, health insurance contributions shall be paid toward premiums for an eligible spouse or a dependent child who is between the ages of eighteen (18) and twenty-two (22) in any month in the calendar year in which coverage is effective after the valid Form 6256 is filed. If a valid Form 6256 is filed prior to December 31 of the calendar year in which coverage is in effect, the recipient shall also be reimbursed for up to three (3) months of health insurance contributions for the eligible spouse and dependent children.

Section 11. Changes in Spouse and Disabled or Dependent Child Eligibility.

(1) Recipients, spouses, and disabled or dependent children shall notify the agency of any change that may affect the eligibility of the spouse, disabled child, or dependent child to enroll in a hospital and medical insurance plan offered by the agency or the eligibility of the spouse or dependent child to have all or a portion of their premiums paid for by the boards in accordance with KRS 61.702 and 78.5536.

(2)

(a) The recipient shall repay any premiums that were paid by the boards after the spouse or dependent child ceased to be eligible to have all or portion of their premiums paid in accordance with KRS 61.702 and 78.5536.

(b) If the agency is unable to recover from the recipient the full amount of premiums paid in accordance with paragraph (a) of this subsection, the agency may withhold any remaining amount from the recipient's monthly retirement allowance payment.

(c) If the agency is not able to recover the full amount of the premiums paid in accordance with paragraphs (a) and (b) of this subsection, the agency may recover any remaining amount from the spouse or dependent child.

Section 12. Medical Insurance Reimbursement Plan for Recipients Living Outside of Kentucky.

(1) A recipient may participate in the medical insurance reimbursement plan pursuant to KRS 61.702(6) and 78.5536(6) if the recipient lives in an area outside of the coverage of the group hospital and medical insurance plans offered by the agency.

(2) The medical insurance reimbursement plan shall be available in any month the recipient:

(a) Resides outside of Kentucky;

(b) Is not eligible for the same level of hospital and medical benefits as recipients who resided inside of Kentucky with the same Medicare status; and

(c) Has paid hospital and medical insurance plan premiums capable of being reimbursed.

(3) Recipients eligible to participate in the medical insurance reimbursement plan shall be reimbursed up to the applicable monthly contribution rate for premiums paid for hospital and medical coverage less any premiums paid by the recipient's employer.

(4)

(a) In order to receive the applicable reimbursement, an eligible recipient shall complete and file a valid Form 6240, Application for Out of State Reimbursement for Medical Insurance, and as applicable a valid Form 6256, Designation of Spouse and/or Dependent Child for Health Insurance Contributions, with one (1) or more of the following as proof of coverage and payment of premiums for hospital and medical insurance that covers the entire time period for the requested reimbursement:

1. A valid Form 6241, Employer Certification of Health Insurance for Health Insurance Reimbursement Plan, completed by the employer;

2. A valid Form 6242, Insurance Agency/Company Certification of Health Insurance for Health Insurance Reimbursement Plan, completed by the insurance agency or company;

3. A signed statement from the employer listing individuals covered, dates of hospital and medical insurance coverage, amount of premiums deducted from wages, and the cost of the single coverage; or

4. A signed statement or invoice from the insurance company listing individuals covered, the dates and cost of single hospital and medical insurance coverage, along with proof of payment such as a receipt or bank statement clearly indicating payment for the statement or invoice provided.

(b)

1. If any provided documentation is deemed insufficient by the agency, the agency may request additional proof of medical and hospital insurance coverage or payment.

2. The agency may verify the recipient's eligibility for reimbursement for hospital and medical insurance by requesting verification of coverage and payments directly from the insurance company indicated on the Form 6240, Application for Out of State Reimbursement for Medical Insurance.

(5) An eligible recipient may file for reimbursement quarterly each calendar year in accordance with subsection (4) of this section.

(6) If the eligible recipient files for reimbursement in accordance with subsection (4) of this section, the eligible recipient shall be reimbursed on the following schedule:

(a) In February, if all documentation is filed by January 20;

(b) In May, if all documentation is filed by April 20;

(c) In August, if all documentation is filed by July 20; or

(d) In November, if all documentation is filed by October 20.

(7) The agency shall not reimburse an eligible recipient for premiums for a calendar year in which the eligible recipient failed to file a request for reimbursement in accordance with subsection (4) of this section by March 20 of the following calendar year.

(8)

(a) If a recipient receives a payment from the agency that does not qualify as a premium reimbursement, the recipient shall return the payment to the agency at the retirement office.

(b) If the recipient fails to return the payment, the agency may withhold the payment from the recipient's monthly retirement allowance payment.

Section 13. Dollar Contribution Medical Insurance Reimbursement Plan for Recipients Hired on or after July 1, 2003.

(1)

(a) Except as established in paragraph (b) of this subsection, beginning January 1, 2003, a recipient with a hire date on or after July 1, 2003 may participate in the hospital and medical insurance dollar contribution reimbursement plan pursuant to KRS 61.702(6) and 78.5536(6), if the recipient chooses to purchase a hospital and medical insurance plan not provided by the systems.

(b) A recipient who retired with reciprocity with another state-administered retirement system in accordance with KRS 61.680 and 78.545 shall not be eligible for the hospital and medical insurance dollar contribution reimbursement plan established by KRS 61.702(6) and 78.6636(6) if the recipient elects to receive hospital and medical insurance coverage through another state-administered retirement system. The systems shall pay a pro rata share of the recipient's premium for hospital and medical insurance coverage in accordance with KRS 6.577, 21.427, and 105 KAR 1:020.

(2)

(a) Recipients eligible to participate in the dollar contribution medical insurance reimbursement plan shall be reimbursed up to the applicable monthly contribution rate for premiums paid for the cost of single hospital and medical insurance coverage.

(b)

1. The reimbursement established in this subsection shall be retroactive to January 1, 2023.

2. A recipient who previously received reimbursement that was reduced based on premiums paid by the recipient's employer or who was denied reimbursement solely based on premiums paid by the recipient's employer shall be reimbursed for an amount equal to the difference between what is owed to the recipient under this subsection and what was previously paid to the recipient.

(3)

(a) In order to receive the applicable reimbursement, an eligible recipient shall complete and file a valid Form 6280, Application for Dollar Contribution Reimbursement for Medical Insurance, with one (1) or more of the following as proof of payment of premiums for hospital and medical insurance coverage that covers the entire time period for the requested reimbursement:

1. A valid Form 6281, Employer Certification of Health Insurance for Dollar Contribution Reimbursement Plan, completed by the employer;

2. A valid Form 6282, Insurance Agency/Company Certification of Health Insurance for Dollar Contribution Reimbursement Plan, completed by the insurance agency or company;

3. A signed statement from the employer or state-administered retirement system listing individuals covered, dates of hospital and medical insurance coverage, amount of premiums deducted from wages, and the cost of the single coverage; or

4. A signed statement or invoice from the insurance company listing the individuals covered, dates, and cost of single hospital and medical insurance coverage, along with proof of payment such as a receipt or bank statement clearly indicating payment for the statement or invoice provided.

(b)

1. If any provided documentation is deemed insufficient by the agency, the agency may request additional proof of medical and hospital insurance coverage or payment.

2. The agency may verify the recipient's eligibility for reimbursement for hospital and medical insurance by requesting verification of coverage and payments directly from the insurance company indicated on the Form 6280, Application for Dollar Contribution Reimbursement for Medical Insurance.

(4) An eligible recipient may file for reimbursement in accordance with subsection (3) of this section, quarterly each calendar year.

(5) If the eligible recipient files a request for reimbursement in accordance with subsection (3) of this section, the eligible recipient shall be reimbursed:

(a) In February, if all documentation is filed by January 20;

(b) In May, if all documentation is filed by April 20;

(c) In August, if all documentation is filed by July 20; or

(d) In November, if all documentation is filed by October 20.

(6) The agency shall not reimburse an eligible recipient for premiums for a calendar year in which the eligible recipient failed to file a request for reimbursement in accordance with subsection (3) of this section by March 20 of the following calendar year.

(7)

(a) If a recipient receives a payment from the agency that does not qualify as a premium reimbursement, the recipient shall return the payment to the agency at the retirement office.

(b) If the recipient fails to return the payment, the agency may withhold the payment from the recipient's monthly retirement allowance payment.

Section 14. Incorporation by Reference.

(1) The following material is incorporated by reference:

(a) Form 6131, "Bank Draft Authorization for Direct Pay Accounts", April 2021;

(b) "KPPA Health Plans for Medicare Eligible Persons", September 2022;

(c) "Retiree Health Insurance Enrollment/Change Form", September 2022;

(d) Form 6240, "Application for Out of State Reimbursement for Medical Insurance," September 2022;

(e) Form 6241, "Employer Certification of Health Insurance for Health Insurance Reimbursement Plan", September 2022;

(f) Form 6242, "Insurance Agency/Company Certification of Health Insurance for Health Insurance Reimbursement Plan", September 2022;

(g) Form 6256, "Designation of Spouse and/or Dependent Child for Health Insurance Contributions", September 2022;

(h) Form 6280, "Application for Dollar Contribution Reimbursement for Medical Insurance", September 2023;

(i) Form 6281, "Employer Certification of Health Insurance for Dollar Contribution Reimbursement Plan", June 2024; and

(j) Form 6282, "Insurance Agency/Company Certification of Health Insurance for Dollar Contribution Reimbursement Plan", September 2022.

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