STATE EMPLOYEE HEALTH PLAN
PLAN YEAR 2016
NON STATE EMPLOYER GROUP EMPLOYEE GUIDEBOOK

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The information provided in this Employee Guidebook is subject to change without prior notice. Members are advised they should check the SEHP website and contact their HR office to verify they are using the most up to date version of this guidebook.

INTRODUCTION

This guide provides information to you on the State Employee Health Plan (SEHP). This guide should be read carefully and retained for reference. If there are additional questions, the employee should contact their Human Resources Office.

NOTE: This guide contains information which is effective January 1, 2016; however, benefit information is subject to change without notice. Go to this website and click on the link that contains the information that you are looking for: www.kdheks.gov/hcf/sehp/default.htm

Note: *The information in this guide is intended to summarize the benefits offered in language that is clear and easy to understand. Every effort has been made to ensure that this information is accurate. It is not intended to replace the legal plan document or contract which contains the complete provisions of a program. In case of any discrepancy between this guide and the legal plan document or contract, the legal plan document or contract will govern in all cases. An employee may review the legal plan document or contract upon request. The State of Kansas reserves the right to suspend, revoke or modify the benefit programs offered to employees. Information contained in this guide, in the State Employer's Health Plan Administrative Manual and in the insurance provider's certificate/contract takes precedence over verbal information. Nothing in this guide shall be construed as a contract of employment between the State of Kansas and any employee, nor as a guarantee of any employee to be continued in the employment of the State, nor as a limitation on the right of the State to discharge any of its employees with or without cause.*

The SEHP is authorized by K.S.A. 75-6501 et seq. The program is governed by the State of Kansas Employees Health Care Commission (HCC) which is comprised of the following five members:

- The Secretary of the Kansas Department of Administration
- The Kansas Insurance Commissioner
- A retiree from classified State of Kansas service (appointed by the Governor)
- An active employee from classified State of Kansas service (appointed by the Governor)
- A person from the general public (appointed by the Governor)

Generally, the SEHP bids and contracts with health plans for three-year periods. The contractual periods of the medical, prescription drug, dental, and vision are staggered so that not all contracts come due the same year.

All SEHP medical plans are self-insured. These include:

- Aetna (Plan A, Plan C – Qualified High Deductible Health Plan with Health Savings Account or Health Reimbursement Account),
- Blue Cross Blue Shield (Plan A, Plan C – Qualified High Deductible Health Plan with Health Savings Account or Health Reimbursement Account),
- The prescription drug program is self-insured with Caremark contracted as the prescription benefit manager.

Other health plan benefits available under the SEHP:

- The dental plan is self insured and administered by Delta Dental Plan of Kansas.
- The voluntary vision plan is fully insured by Superior Vision.
- COBRA (Consolidated Omnibus Budget Reconciliation Act) administered by CobraGuard

For each self-insured plan, the SEHP pays the plan provider an administrative fee per contract to process membership information and claims. The SEHP and plan members are directly responsible for the payment of all claims and utilization costs. SEHP rates are based on the amount spent on claims and the utilization costs.

GENERAL DEFINITIONS USED IN THIS GUIDEBOOK:

A. COBRA Participant—a participant who elects a temporary extension of health coverage where such coverage would otherwise end as defined by the COBRA act of 1986.

B. Coinsurance, Coinsurance—a cost-sharing requirement that provides that the member will be responsible for payment of a portion or percentage of the costs of covered services. It is a cost of health care that the member is responsible for paying, according to a fixed percentage or amount. Coinsurance is a type of cost sharing where the member and the plan share payment of the approved charge for covered services in a specified ratio after payment of the deductible.

C. Consolidated Omnibus Budget Reconciliation Act of 1986 (COBRA)—a federal law requiring that most employers sponsoring Group Health Insurance Plans offer employees and their families an opportunity to extend health coverage for a limited period of time.

D. Copayment, Copayment—a cost-sharing arrangement in which the member pays a specified flat amount for a specific service (such as $30 for an office visit or $15 for a prescription drug). It does not vary with the cost of the service, unlike co-insurance which is based on a percentage of cost.

E. Deductibles—an amount that's required to be paid by the member before benefits become payable by the SEHP. Deductibles are usually expressed in terms of an "annual" amount.

F. Direct Bill and Retirees—a program to extend health coverage to: 1) retiring participating state employees, 2) totally disabled former participating state employees, 3) surviving spouses and/or dependents of participating state employees eligible under the provisions of K.A.R. 108-1-1 and 4) active participating state employees who were covered under the health plan immediately before going on approved leave without pay.

G. Health Care Commission (HCC)—the entity that establishes and oversees all provisions under the State Employee Health Plan.

H. Health Plan—defined medical, drug, dental, and vision benefits offered to state employees under the State Employee Health Plan.

I. HealthQuest—the State of Kansas Health Promotion Program, which is a wellness program administered by the State Employee Health Plan.

J. HIPAA—The Health Insurance Portability and Accountability Act (HIPAA) of 1996 (P.L.104-191) [HIPAA] was enacted by the U.S. Congress and signed by President Bill Clinton in 1996. It was originally sponsored by Sen. Edward Kennedy (D-Mass.) and Sen. Nancy Kassebaum (R-Kan.). Title I of HIPAA protects health insurance coverage for workers and their families when they change or lose their jobs. Title II of HIPAA, known as the Administrative Simplification (AS) provisions, requires the establishment of national standards for electronic health care transactions and national identifiers for providers, health insurance plans, and employers. The Administration Simplification provisions also address the security and privacy of health data. The standards are meant to improve the efficiency and effectiveness of the nation's health care system by encouraging the widespread use of electronic data interchange in the U.S. health care system.

K. Member—individual who is eligible for and actively participates in the health care benefits offered through the State Employee Health Plan.

L. Membership Administration Portal (MAP)—The eligibility "system of record" for State Employee Health Plan (SEHP) benefits. This includes the Member Portal in which a member can make initial benefit elections, request mid-year changes to their benefits and maintain current contact information.

M. Membership Services—the unit within the State Employee Health Plan that is responsible for all daily management of all eligibility functions and membership activities for all members who participate in the

State Employee Health Plan. Members include Active state employees, Non-State Public Employer Group employees, Retirees, Direct Bill members and COBRA participants. The unit is also involved in managing and securing contracts with vendors that provide administrative services related directly to Membership programs.

N. Open enrollment period—the period of time during which all members of the SEHP have the opportunity to enroll in and make plan changes to their SEHP. Open enrollment is only held once a year during the month of October. If a member misses the SEHP's annual open enrollment period, the member will not be able to enroll in or make any plan changes to their SEHP coverage until the next annual open enrollment period. Certain exceptions apply for new employees or employees with midyear qualifying events.

O. Permanent and total disability—Defines the condition for an individual is unable to engage in any substantial gainful activity by reason of any medically determinable physical or mental impairment that can be expected to result in death or has lasted or can be expected to last for a continuous period of at least 12 months. An individual shall not be considered to have a permanent and total disability unless that person furnishes proof of the permanent and total disability in the form and manner, and at the times, that the health care benefits program may require.

P. Plan year—annual time period for benefits in the SEHP. Begins at 12:01 a.m., Central Standard Time, on January 1, through midnight, December 31.

Q. Premium—the total cost of the health plan option selected by the employee.

R. State Employee Health Plan (SEHP) —the state health care benefits program that may provide benefits for persons qualified to participate in the program for medical, prescription drug, dental, vision and other ancillary benefits to participating state employees and their eligible dependents as defined under the provisions of K.A.R. 108-1-1. The program may include such provisions as are established by the Kansas state employee's health care commission, including but not limited to qualifications for benefits, services covered, schedules and graduation of benefits, conversion privileges, deductible amounts, limitations on eligibility for benefits by reason of termination of employment or other change of status, leaves of absence, military service or other interruptions in service and other reasonable provisions as may be established by the commission.

Questions about the administration of the SEHP should be directed to the following address:

State Employee Health Plan
Membership Services
Room 900 – Landon State Office Building
900 SW Jackson Street
Topeka, Kansas 66612-1220

Telephone: (785) 296-3226
Fax: (785) 368-7180

Email: **SEHPMembership@kdheks.gov**

Visit our website at: **www.kdheks.gov/hcf/sehp/default.htm**

HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT (HIPAA)

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) protects health insurance coverage for workers and their families when they change or lose their jobs. HIPAA places requirements on employer-sponsored group health plans, insurance companies and health maintenance organizations that:

1 limit exclusions for preexisting conditions;
2 prohibit discrimination against employees and dependents based on their health status; and
3 guarantee renewability and availability of health coverage to certain employees and individuals.

PRE-EXISTING CONDITION EXCLUSIONS

The SEHP does not have a waiting period for coverage of pre-existing conditions.

SPECIAL ENROLLMENTS

HIPAA requires that group health plans allow individuals to enroll without having to wait for late or open enrollment. These special enrollment periods are for individuals who previously declined coverage for themselves and their dependents. A special enrollment period can occur if: (1) a current employee or dependent with other health coverage loses eligibility for coverage, or (2) a person becomes a dependent through marriage, birth, adoption or placement for adoption. The employee needs to complete enrollment within 31 days after their other coverage ends. Written documentation of the marriage, birth, adoption or placement for adoption must be provided. Please contact your Human Resources office for more information.

Some examples where special enrollment would apply are: 1) ceasing to be eligible under a plan due to cessation of dependent status (e.g. a child aging out of dependent coverage); 2) a plan ceasing to offer any benefits for a class of similarly situated individuals (e.g. all part-time workers); and 3) an employer of another plan stops contributions toward other coverage, even if the individual continues the other coverage by paying the amount that used to be paid by the employer.

NONDISCRIMINATION REQUIREMENTS

Individuals may not be denied eligibility or continued eligibility to enroll for benefits under the terms of the plan based on specified health factors. In addition, an individual may not be charged more for coverage than similarly situated individuals on these factors. These factors are: health status, medical condition (physical or mental), claims experience, receipt of health care, medical history, genetic information, and evidence of insurability or disability. For example, an individual cannot be excluded or dropped from coverage under the health plan just because the individual has a particular illness.

OTHER APPLICATIONS OF HIPAA LAW

HIPAA provisions also apply to services under the following laws: 1) Women's Health and Cancer Rights Act (WHCRA) which provides protections to patients who choose to have breast reconstruction in connection with a mastectomy; 2) Mental Health Parity Act (MHPA) which prevents the group health plan from placing annual or lifetime dollar limits on mental health benefits that are lower - less favorable - than annual or lifetime dollar limits for medical and surgical benefits offered under the plan; and, 3) Newborns' and Mothers' Health Protection Act (NMHPA) which affects the amount of time the member or beneficiary and newborn child are covered for a hospital stay following childbirth. For the mother or newborn child, that includes no restriction to less than 48 hours following a normal vaginal delivery or less than 96 hours following a cesarean section. Nor is it required that a hospital obtain authorization from the medical plan for prescribing a length of stay not in excess of the above periods. 4) The Genetic Information Nondiscrimination Act of 2008 generally prohibits the discrimination on the basis of genetic information as well as the release of your genetic information.

PLAN DISCLOSURE REQUIREMENTS

Under the Department of Labor's (DOL) rules governing plan disclosure requirements, group health plans must improve the summary plan descriptions and summaries of material modifications in the following ways: 1) Notify members and beneficiaries of any material reductions in covered services or benefits within 60 days of adoption of the change; 2) Disclose information about the role of insurance companies and health plans with respect to the group health plan, specifically the name and address, and to what extent benefits under the plan are under a contract, and the administrative services, such as paying claims; 3) Inform members and

beneficiaries which DOL office they can contact for assistance or information on their rights under HIPAA; and 4) Inform members and beneficiaries that federal law prohibits the plan and health insurance issuer from limiting hospital stays for childbirth to less than 48 hours for normal deliveries and 96 hours for cesarean sections.

PLAN MEMBERS RIGHTS

Should you have questions about your rights under HIPAA, you may contact the following office:

Office for Civil Rights
U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201

HIPAA ADMINISTRATIVE SIMPLIFICATION

The Administrative Simplification provisions of the HIPAA (Title II) require the Department of Health and Human Services to establish national standards for electronic health care transactions and national identifiers for providers, health plans, and employers. It also addresses the security and privacy of health data. Adopting these standards improves the efficiency and effectiveness of the nation's health care system by encouraging the widespread use of electronic data interchange in health care.

PRIVACY REGULATIONS

The privacy regulations (effective April 14, 2003) ensure a national floor of privacy protections for patients by limiting the ways that health plans, pharmacies, hospitals and other covered entities can use patients' personal medical information. The regulations protect medical records and other individually identifiable health information, whether it is on paper, in computers or communicated orally. Key provisions of these standards include: 1) Access to medical records; 2) Notice of privacy practices; 3) Limits on use of personal medical information; 4) Prohibition on marketing, and stronger state laws; 5) Confidential communications; and 6) Where to file complaints.

SECURITY REGULATIONS

The HIPAA Security requirements (effective April 20, 2005) ensure confidentiality of electronic protected health information that the health plan creates, receives, maintains or transmits.

WOMEN'S HEALTH AND CANCER RIGHTS ACT

Effective January 1, 1999, the Federal Women's Health and Cancer Rights Act of 1998 requires group health plans, insurance companies, and health maintenance organizations (HMOs) that provide benefits for mastectomies to also provide coverage for:

1. Reconstruction of the breast on which the mastectomy was performed;
2. Surgery and reconstruction of the other breast to produce a symmetrical appearance; and
3. Prostheses and treatment of physical complications for all stages of a mastectomy, including lymphedema (swelling associated with the removal of lymph nodes). The deductible and coinsurance provisions applicable to these benefits are consistent with the deductible and coinsurance provisions governing other benefits provided by the State Employee Health Plan. Coverage will be provided in a manner determined from consultation with the attending physician and the patient.

Any questions concerning the above benefits provided under the State Employee Health Plan should be directed to your medical plan.

EMPLOYEE ELIGIBILITY

Eligible employees who elect to participate in the SEHP are referred to as member(s) throughout this guidebook.

EMPLOYEE WAITING PERIOD

If you are eligible to participate in the SEHP, you have 31 days from your first day of employment with the state to elect or waive SEHP coverage. If you enroll in the SEHP, your coverage will be effective the first day of the month following completion of a 30-day waiting period starting from your first day of employment. If you miss this deadline, the next opportunity you have to elect coverage will be at the next annual Open Enrollment period. There may be certain situations or conditions in which the 30-day waiting period may not apply. Please contact your Human Resources office for additional information.

EFFECTIVE DATE OF COVERAGE

Your initial enrollment period for the SEHP is limited. You should complete an online initial Enrollment within 31 days of your starting date in a benefits-eligible position. The effective date of your coverage will be the 1st day of the month following the completion of the waiting period, provided you complete your online SEHP initial enrollment elections no later than 31 days from you date of hire and your enrollment is approved by SEHP Membership Services. Once your benefits have become effective, no changes to your elections can be made unless you experience a qualifying event.

If, in certain situations your employee waiting period is waived per approval by SEHP Membership Services, the effective date of coverage is the 1st day of the month following your date of hire. If your date of hire is the 1st day of a month, your coverage will begin on that day.

If you are a current employee who is changing from a non-benefits eligible position to a benefits eligible position and has already served the 30-day waiting period, your enrollment period is 31 days from the date that you started working in the eligible position. You should complete an online initial Enrollment within 31 days of your starting date in a benefits-eligible position. Your effective date of coverage is the 1st day of the month following your starting date in the eligible position. If your starting date in the eligible position is on the 1st day of the month, your coverage will begin on that day.

If you were rehired and your break in service is 30 calendar days or less, your effective date of coverage is the 1st day of the month following your rehire date (if you had SEHP coverage in effect prior to your break in service). If your rehire date is the 1st day of the month, your coverage effective date will be that day. If you are rehired or reactivated within 30 days, you must enroll in the same coverage you previously had, unless you experience a qualifying event.

PRE-EXISTING CONDITIONS

The SEHP does not apply an additional waiting period for pre-existing conditions. Certificates of Creditable Coverage from previous medical plans are not required for enrollment.

WAIVER OF INSURANCE COVERAGE

If you choose to waive SEHP coverage, you must go online to indicate that you wish to waive coverage or if you do not do anything, your benefits will be waived at the end of your initial enrollment period. Your next opportunity to request enrollment in the SEHP will be during the next annual open enrollment period or if you experience a qualifying event.

FULL-TIME/PART-TIME STATUS

Your contributions for your SEHP coverage Plan Year are dependent upon whether your position is full-time or part-time. If you are active in more than 1 eligible position, your employment status is based on the combined FTE (Full Time Equivalent) for all positions.

DENTAL PLAN

Member only dental coverage is provided for all members enrolled in medical coverage. If you choose to enroll your dependents in dental coverage the same dependents enrolled in dental coverage must be enrolled in medical coverage. Dependent dental coverage may not be dropped during the plan year unless dependent medical coverage is also dropped.

VISION PLAN

If you choose dependent vision coverage, and dependent children are also enrolled in the medical plan, the dependent children enrolled in the vision plan must match those enrolled in the medical plan. Please note that you can enroll or change your vision coverage only when you or a dependent first becomes eligible, during the annual open enrollment period, or if a dependent becomes ineligible. This holds true even if you pay your premiums on an after-tax basis.

OTHER ELIGIBLE INDIVIDUALS UNDER THE SEHP

In addition to covering yourself, you may also elect coverage for other eligible individuals of your family. These eligible individuals include:

1. Your lawful wife or husband, referred to as "spouse" throughout the rest of this guidebook.

2. Any of your eligible dependent child(ren) also referred to as "dependent(s)" throughout the rest of this guidebook.

If you divorce, coverage for your former spouse and stepchild(ren) ends on the last day of the month of the date your divorce is filed. If the date of your divorce is the first day of the month, coverage for your former spouse and stepchild(ren) ends on the first day of that month.

Other Eligible Individuals Important Information:

A. An individual who is eligible to enroll as a primary member in the SEHP can enroll as a dependent provided the individual who wants to enroll as a dependent spouse is the lawful spouse of another primary member currently enrolled in the SEHP. A qualifying event must occur to add eligible dependents under the SEHP.

B. An individual, who is eligible to enroll as a primary member in the SEHP can enroll as a dependent child of a primary member, provided they meet the definition of eligible dependent. A qualifying event must occur to add eligible dependents under the SEHP.

C. An individual who enrolls as a dependent spouse or child of a primary member cannot enroll as a primary member during that plan year unless a qualifying event occurs that directly impacts the individual's coverage.

D. Each individual who enrolls as a dependent spouse or child of a primary member is subject to the co-pays, deductibles, coinsurance and employer contribution levels as a dependent and not as a primary member.

E. An eligible dependent that is enrolled by one primary member is not eligible to be enrolled as a dependent by another primary member.

F. "Other eligible individual" excludes any individual who is not a citizen or national of the United States, unless the individual is a resident of the United States or a country contiguous to the United States, is a member of a primary member's household, and resides with the primary member for more than six months of the calendar year. The dependent shall be considered to reside with the primary member even when the dependent is temporarily absent due to special circumstances, including illness, education, business, vacation, and military service.

G. "Permanent and total disability" means that an individual is unable to engage in any substantial gainful activity by reason of any medically determinable physical or mental impairment that can be expected to result in death or has lasted or can be expected to last for a continuous period of at least 12 months. An individual shall not be considered to have permanent and total disability unless the individual furnishes proof of the permanent and total disability in the form and manner, and at the times, the SEHP may require.

H. The word "child" means:
1) Your natural son or daughter
2) Your lawfully adopted son or daughter. Lawfully adopted will include those instances in which a primary member has filed a petition for adoption with the court, has a placement agreement for adoption or has been granted legal custody.
3) Your stepchild. If the natural or adoptive parent of the stepchild is divorced from you, the child

no longer qualifies as your stepchild, and is no longer eligible for coverage.

4) A child of whom you as the primary member has legal custody. Legal custody ends once the child reaches the age of 18.
5) Your grandchild, if at least one of the following conditions is met:
   - **I.** You have legal custody of your grandchild or have lawfully adopted your grandchild
   - **II.** The grandchild lives in the your home and is the child of your covered eligible dependent child and you provide more than 50% of the support of your grandchild; or
   - **III.** The grandchild is the child of your covered eligible dependent child and is considered to reside with you even when your grandchild or your eligible dependent child is temporarily absent due to special circumstances including education of your covered eligible dependent child, and you provide more than 50% of the support for the grandchild. **NOTE:** A Dependent Grandchild affidavit must be completed and uploaded along with a copy of the grandchild's birth certificate and proof of financial dependency and residency when making the Change Request in MAP.

I. Eligible dependent child(ren) or stepchild(ren). To be covered under the SEHP, your child or stepchild must be less than 26 years of age.

J. Eligible dependent child(ren) or stepchild(ren) aged 26 or older who have a permanent and total disability as described in Section D above and has continuously maintained group coverage as an eligible dependent of yours before reaching the limiting age to be covered under the plan. The child must be chiefly dependent on the primary member for support (receive more than 50% of his or her support and maintenance from the primary member.) **NOTE:** An Application for Coverage of Permanent and Totally Disabled Dependent Child must be completed and uploaded along with a copy of the child's birth certificate and proof of financial dependency and residency when making the Change Request in MAP. If approved for continued coverage, medical documentation may be periodically requested. Coverage will not be continued and will not be reinstated once the dependent child is no longer considered permanent and totally disabled.

DEPENDENT DOCUMENTATION REQUIREMENT:

The State of Kansas and the SEHP require supporting dependent documentation to support proof of dependency and/or residency of your dependents. When enrolling your dependent(s) for coverage with the SEHP, you must certify:

1. That your dependent(s) meet the requirements for dependent coverage for the year in which the dependent(s) are being enrolled.
2. You must also provide appropriate supporting documentation for each dependent (such as the birth certificate, adoption papers, marriage license, copy of the current year's filed federal tax return, etc. See additional information on Page 11 of this Guidebook).
3. Any attempt to enroll dependent(s) who do not meet the SEHP requirements will be considered fraud and will be subject to penalties as prescribed by law.

Note: Requests that are submitted without supporting dependent documentation or with incomplete documentation will be returned to your Human Resources office with no action taken by the SEHP. The deadline for submitting the request will not be extended and the dependent will not be added to your SEHP coverage

DEPENDENT'S EFFECTIVE DATE OF COVERAGE

Your dependents shall become newly eligible on the later of:

1. Your initial date of eligibility; or
2. The 1st day of the month following the date the individual first becomes your dependent or becomes newly eligible for coverage according to the dependent definition. The newly eligible dependent must be added to your coverage within 31 days of the date you gain the new dependent or within 31 days of

the date the dependent becomes newly eligible according to the dependent definition. SEHP Membership Services must receive the online Change request and supporting dependent documentation within 31 days of the date of event.

3. The 1st day of the month following the loss of Medicaid or State Children's Health Insurance Program (SCHIP) coverage. The newly eligible dependent must be added to coverage within 60 days of the date of the loss of Medicaid or SCHIP coverage. The SEHP must receive the online Change request and supporting dependent documentation within 31 days of the date of event.

NEWLY ELIGIBLE DEPENDENTS

You must complete request to add newly eligible dependents within 31 days of the event that makes the dependent(s) newly eligible. SEHP Membership Services must receive an online Change request within 31 days of the event.

Coverage for newly eligible dependents may be added if you are enrolled in the SEHP on a pre-tax or an after-tax basis.

The change in coverage must be consistent with the event and/or must comply with HIPAA regulations.

Legible supporting documentation in English is required (copy of the birth certificate, petition for adoption, marriage license, legal custody agreement, copy of current year's filed federal tax return, etc.) as proof of the qualifying event. Please see the section below that outlines in detail the documents that must be submitted to the SEHP. Requests that are submitted without documentation or with incomplete or illegible documentation will be returned to your Human Resources office with no action taken by the SEHP. Any documentation submitted in any other language besides English must be accompanied with an English translation. The deadline for submitting the documentation will not be extended.

The following appropriate documentation is required to be submitted to the SEHP at the time of the online Enrollment or Change request:

1. Marriage License (for proof of spouse and stepchild eligibility)
2. Birth certificate or hospital birth announcement for newborns including full names of the parents. **(Birth registration cards are not acceptable proof for newborns)**
3. Petition for adoption or placement agreement for dependent child
4. Legal custody or guardianship document issued by the court
5. Court order for dependents who are not natural or adopted children of the primary member
6. Certificate of birth and Dependent Grandchild Affidavit for children born to a covered dependent (grandchild) and copy of current year's filed Federal tax return for proof of financial dependency and residency.
7. An Application for Coverage of Permanent and Totally Disabled Dependent Child affidavit for covered dependent children aged 26 or older and copy of current year's filed Federal tax return for proof of financial dependency and residency.
8. Copies of the current year's filed Federal tax return (for proof of spouse eligibility only.) **Please note all income information may be whited out prior to submission to SEHP Membership Services.** The pages needed from the current year's filed Federal tax return depends on which Tax form was filed:
   - Form 1040—pages 1 & 2 containing the filer's name, the employee and spouse's signature, and a written signature date the employee and spouse each signed the form.
   - Form 1040A—pages 1 & 2 containing the filer's name, the employee and spouse's signature, and a written signature date the employee and spouse each signed the form.
   - Form 8879 (IRS *e-file*)—containing the date filed, the filer's name, the employee and spouse's signature, and a written signature date the employee and spouse each signed the form.
9. Divorce decree (Only the first and last page of the court document are needed, but those pages must include the date stamp by the court and the signature of the judge)

10. A copy of a military ID and privilege card with the expiration date is acceptable as proof of Tricare coverage and to document the end of Tricare coverage.
11. For dependent loss of other group health coverage, a letter or certificate of other creditable coverage, listing the name of the member and all dependents that were covered under a previous employer's insurance is required. The letter or certificate must identify the previous employer, and list the date on which coverage ended.

Social Security and Individual Taxpayer Identification Numbers

According to Section 111 of the Federal Medicare, Medicaid, and SCHIP Extension Act of 2007 (the "Act"), group health plans are required to report eligibility information to the Centers for Medicare and Medicaid Services (CMS) for purposes of coordination of benefits. To satisfy the mandate, the SEHP is required to obtain valid Social Security Numbers (SSNs), Medicare Health Insurance Claim Number (HICN) or Individual Taxpayer Identification Number (ITIN) for non-resident alien individuals and their eligible dependents. Dependents include a spouse and other family members eligible to be covered by health plan benefits.

A HICN is the number assigned by the Social Security Administration to an individual identifying him/her as a Medicare beneficiary. This number is shown on the beneficiary's insurance card and is used in processing Medicare claims for that beneficiary. The Medicare program uses the HICN to identify Medicare beneficiaries receiving health care services, and to otherwise meet its administrative responsibilities to pay for health care and operate the Medicare program. In performance of these duties, Medicare is required to protect individual privacy and confidentiality in accordance with applicable laws, including the Privacy Act of 1974 and the Health Insurance Portability and Accountability Act Privacy Rule. The SSN is used as the basis for the Medicare HICN. While the HICN is required to identify a Medicare beneficiary, if the HICN is not available some beneficiaries may also be identified by the SSN. Please note that CMS has a longstanding practice of requesting HICNs or SSNs for coordination of benefit purposes.

Individual Taxpayer Identification number (ITIN): A non-resident alien individual engaged or considered to be engaged in a trade or business in the United States during the year is required to file a federal tax return each year. As a result, they must apply for an ITIN. These numbers are unique identifiers similar to SSNs and have the first 3 digits in the range of 900-999.

In order for Medicare to properly coordinate Medicare payments with other insurance and/or workers' compensation benefits, Medicare relies on the collection of HICN, SSN or ITIN numbers as applicable. The SEHP requires valid SSNs or ITINs for all eligible members to participate in the SEHP to ensure the Plan is in compliance with the Act.

- Newborn children— a temporary SSN of 777-77-7777 may be assigned for a newborn until the valid SSN is obtained. Generally, SSN are assigned and issued within 14 days of application for the SSN. The valid SSN must be provided to SEHP Membership Services within **41 days** of the child's date of birth.
- Non-resident alien individuals or their eligible dependents— a temporary SSN of 888-11-1111 may be assigned to a non-resident alien or their eligible dependents until a valid ITIN is obtained and sent to SEHP Membership Services. The valid ITIN must be provided to SEHP Membership Services within the **first 30 days of enrollment** in the SEHP. If an ITIN cannot be provided within this time frame, a Communication form must be submitted to SEHP Membership Services providing the reason the ITIN is not available. The request will be reviewed and a determination will be made on each individual case submitted.

If the SSN or ITIN is not provided within these time periods, the dependent may be removed from the SEHP. A copy of the SSN or ITIN card can be provided as documentation.

NOTE: Valid SSNs/ ITINs are required during annual Open Enrollment for any newly added dependents. If the information is not provided during Open Enrollment the dependents will not be added to the SEHP in the following plan year. If an ITIN cannot be provided by the annual Open Enrollment deadline, a Communication form must be submitted to SEHP Membership Services providing the reason the ITIN is not available. The request will be reviewed and a determination will be

made on each individual case submitted.

Please contact your Human Resources office for additional information.

NEWBORNS OR ADOPTIONS

Adding a Newborn to Your SEHP Coverage for coverage tier 1 (Employee Only) or tier 2 (Employee + Spouse)

You need to submit an online Change request through MAP to SEHP Membership Services within 31 days of the date of your newborn's birth to add them to your SEHP benefits. Appropriate dependent documentation and a valid SSN or ITIN are also required and should be sent at the same time as the online Change request. For grandchildren, a copy of the birth certificate and a completed Dependent Grandchild Affidavit must be submitted along with the online Change request. If the online Change request, SSN/ITIN and appropriate supporting dependent documentation is not received at the time of the request, the dependent will not be added for coverage.

- If you already have spouse coverage, your newly eligible dependent will have medical claims processed for only the first 31 days from the date of birth. Medical claims processing for your newborn ends on the 32nd day. If your child is successfully added within the first 31 days of their birth, claims processing will continue and a coverage level change to Employee and Family and an appropriate premium change will occur the first of the month following the date of birth of your newborn.
- If you have single coverage, your newly eligible dependent will have medical claims processed for only the first 31 days from the date of birth. Medical claims processing for your newborn ends on the 32nd day. If your child is successfully added within the first 31 days of their birth, claims processing will continue and an appropriate change in coverage level and premium change will occur the first of the month following the date of birth of your newborn.

Adding a Newborn to Your SEHP Coverage for coverage tier 3 (Employee + Children) or tier 4 (Employee + Family)

If you already have children or family coverage, your newly eligible dependent will have medical claims processed continuously beyond the first 31 days from the date of birth however the child is not permanently added to your SEHP coverage unless an online change request to add the newborn, the SSN/ITIN and proper documentation is provided to and approved by SEHP Membership Services. Members are still required to properly notify the SEHP of the birth of the newborn, provide a valid SSN/ITIN and appropriate dependent documentation. If the online Change request, SSN/ITIN and appropriate supporting dependent documentation is not received, claims processing for your dependent will end and your newborn will not be permanently added to your SEHP coverage.

NOTE: Regarding a newborn child of your dependent child (grandchild); your grandchild will only have medical claims processed for the first 5 days from the date of birth. Medical claims processing for your grandchild will end on the 6th day if you do not complete an online request to add your dependent grandchild to coverage (along with appropriate supporting dependent documentation) within 31 days from the date of birth.

In the case of adoption, your dependent must be added to your coverage within 31 days of the date that the petition for adoption or placement notice is filed or the date of adoption placement. A copy of the petition for adoption or placement notice must be submitted along with the online request to SEHP Membership Services within 31 days of the date of the event.

If the adoption is being handled through an adoption agency, they may require an adjustment period in your home prior to filing the petition for adoption. In this case, a copy of the adoption agency's placement letter must be submitted along with the online request and must indicate the date of placement as well as the length

of the adjustment period. When the adjustment period is over and the petition for adoption has been filed with the court, you must submit a copy of the petition for adoption in order to continue coverage for the dependent. If the dependent is removed from your home, or the petition for adoption is not filed, an online request must be submitted to remove the dependent from your coverage.

Your Human Resources office should contact SEHP Membership Services for guidance if the dependent is being adopted and a petition for adoption is never filed in a U.S. court (which is sometimes the case with foreign adoptions).

EFFECTIVE DATE OF COVERAGE

If the date of the filing for petition for adoption or placement in your home is within 31 days of the birth of the child, the coverage effective date is the date of birth, provided SEHP Membership Services receives documentation within 31 days of the birth of the child. If the filing placement is not within 31 days of the date of birth of the child, the effective date of coverage is the date of the filing date of the petition for adoption **or** the date of placement, whichever the case may be. The effective date of coverage cannot be earlier than the child's placement or arrival in your home within the United States.

If you add a newly eligible newborn or adopted dependent to coverage, you may add other eligible dependents to your coverage. The effective date of coverage for the newborn or adopted dependents will be the date of birth if an online request is completed within 31 days of the applicable child's birth. The effective date of coverage for other eligible dependents, such as your spouse and/or other children or stepchildren of yours, will be the first day of the month following the birth, date of placement for adoption, or date of petition for adoption.

CHANGE IN EMPLOYEE CONTRIBUTION

The change in contribution will be reflected on your paycheck that coincides with the date of birth, date of petition for adoption or date of the placement agreement. If the date of birth, date of petition for adoption, or date of the placement agreement occurs on the first day of the month, the change in your contribution will take place the first of that month.

NEW LEGAL CUSTODY/GUARDIANSHIP DEPENDENTS (for dependents who are not natural or adopted children of the member)

If you are adding a newly eligible legal custody/guardianship dependent to coverage, you need to complete an online Change request to add the dependent to coverage within 31 days of the date that the court issues a legal custody agreement. A copy of the court order or legal custody agreement must be submitted at the time of the online request.

The effective date of coverage will be the 1st day of the month following the date of legal custody or guardianship. If the date of legal custody or guardianship occurs on the 1st day of a month, the coverage effective date will be the 1st day of the month.

Your contributions will be due according to the dependent coverage effective date.

NEW SPOUSE OR STEPCHILDREN DUE TO MARRIAGE

If you want to add a new spouse and/or stepchild(ren) to coverage due to marriage, you need to submit an online Change request through MAP to request adding the spouse and/or dependents to coverage. The Change request along with the appropriate supporting documentation must be submitted within 31 days of the marriage.

The effective date of coverage will be the 1st day of the month following the date of marriage. If the marriage occurs on the 1st day of the month, the coverage effective date will be the 1st day of that month.

If you are adding a newly eligible spouse or stepchild(ren) to coverage, other eligible dependents may also be added to coverage, such as your other children. The effective date of coverage for these dependents will be the 1st day of the month following the date of marriage. Your contributions will be due according to the dependent coverage effective date.

If you have previously waived coverage, have acquired a newly eligible dependent, (marriage, birth, adoption, etc.), and you want to elect SEHP coverage, you must complete an online request along with the appropriate documentation within 31 days of the date of the event. Coverage for you and your newly eligible spouse and dependent(s) will be effective the first of the month following the date of the qualifying event. In the case of a newborn, coverage for the newborn will be the date of birth, but your coverage will be the first of the month preceding the newborn's date of birth. Any spouse or other dependents added during this qualifying event will be effective the date of birth of the newborn.

ANNUAL OPEN ENROLLMENT PERIOD

Active State Employee Open Enrollment for SEHP coverage occurs annually during the month of October. When you enroll during the Open Enrollment period, you will have coverage effective the 1st day of the new Plan Year as outlined in the current Enrollment booklet.

You must complete the Open Enrollment process to change medical plans, add or drop coverage, add or drop dependents from coverage, or to change pretax payment status. Open Enrollment will be completed via Membership Administrative Portal (MAP) - ***https://sehp/member/hrissuite.com*** . Information concerning online enrollment is published prior to the annual Open Enrollment period.

When requesting to add dependents during Open Enrollment, appropriate supporting documentation including valid SSNs or ITINs, must be submitted via MAP by during the enrollment process. Any documentation submitted in any other language besides English must be accompanied with an English translation. The deadline for submitting the documentation will not be extended.

NOTE: If the information is not provided during Open Enrollment the dependents will not be added to your SEHP coverage in the following plan year. If an ITIN cannot be provided by the annual Open Enrollment deadline, a Communication form must be submitted to SEHP Membership Services providing the reason the ITIN is not available. The request will be reviewed and a determination will be made on each individual case submitted.

For additional information, please contact your Human Resources office.

PRE-EXISTING CONDITIONS

The SEHP does not apply an additional waiting period for pre-existing conditions for you or your dependents that enroll in health coverage during the annual Open Enrollment period. Certificates of creditable coverage from other medical plans are not needed for Open Enrollment.

NEWLY ELIGIBLE MEMBERS

Newly eligible members, who have completed their 30 day waiting period, may enroll during their initial enrollment period for an effective date of coverage in the current Plan Year. In addition, during the month of October, you may complete Open Enrollment and select different coverage to be effective for the new Plan Year.

REVISED OPEN ENROLLMENT ELECTIONS

You may change your original Open Enrollment election online during the Open Enrollment period. Following the end of the Open Enrollment period, an online Change request will only be accepted if you have a qualifying event or family status change as listed in this Guidebook. You must complete an online Change request within 31 days of the qualifying event or family status change. Requests that are submitted without supporting dependent documentation or with incomplete supporting documentation will be returned to your Human Resources office with no action taken by the SEHP. The deadline for submitting the online request with documentation will not be extended.

IDENTIFICATION CARDS

Identification (ID) cards will be sent to you if you are newly enrolled or if you have made a coverage level change. If you are expecting a new ID card but do not receive one by the end of December, you should contact the applicable carrier to request new ID cards. Telephone numbers for the carriers are listed in the front of the Enrollment booklet.

COST OF COVERAGE

Your contribution amount for SEHP coverage is subject to change each Plan Year. State employer contributions are generally subject to change at the beginning of the State of Kansas fiscal year.

SEHP coverage is monthly and rates are based on semi-monthly payroll deduction periods.

NOTE: For current SEHP rates, please contact your Human Resources office.

MID-YEAR ENROLLMENT CHANGES

ADDITION AND DELETION OF NON-NEWLY ELIGIBLE EMPLOYEES AND DEPENDENTS

Non-newly eligible employees and dependents are defined as employees and/or dependents for which 31 days have passed since their initial eligibility for coverage.

Non-newly eligible employees and/or dependents may be added or dropped from the SEHP during the Plan Year but only if all of the following mid-year change requirements are met:

a. The change is a result of one of the events listed in this Guidebook;
b. You request the change within 31 calendar days of the event by completing an online Enrollment or Change request;
c. The change in coverage is consistent with the event and complies with HIPAA regulations; and
d. Written documentation of the event is provided (divorce decree, death certificate, custody agreement, or statement from a spouse's employer on their letterhead indicating which dependents are losing or gaining benefits and the date of the loss or gain) along with the online enrollment or Change request.

SUPPORTING DEPENDENT DOCUMENTATION

The following appropriate documentation is required to be submitted to SEHP Membership Services with your online Enrollment or Change request:

1. Marriage License (for proof of spouse and stepchild eligibility)
2. Birth certificate or hospital birth announcement for newborns including full names of the parents. **(Birth registration cards are not acceptable proof for newborns)**
3. Petition for adoption or placement agreement for dependent child
4. Legal custody or guardianship document issued by the court including Judge's signature and court date stamp
5. Court order for dependent children who are not natural or adopted children of the primary member including Judge's signature and court date stamp
6. Certificate of birth and Dependent Grandchild Affidavit for children born to a covered dependent (grandchild) and copy of current year's filed Federal tax return for proof of financial dependency and residency.
7. An Application for Coverage of Permanent and Totally Disabled Dependent Child affidavit for covered dependent children aged 26 or older and copy of current year's filed Federal tax return for proof of financial dependency and residency.
8. Copies of the current year's filed Federal tax return (for proof of spouse eligibility only.) **Please note all income information may be whited out prior to submission to SEHP Membership Services.** The pages needed from the current year's filed Federal tax return depends on which Tax form was filed:
   - Form 1040—pages 1 & 2 containing the filer's name, the employee and spouse's signature, and a written signature date the employee and spouse each signed the form.
   - Form 1040A—pages 1 & 2 containing the filer's name, the employee and spouse's signature, and a written signature date the employee and spouse each signed the form.
   - Form 8879 (IRS *e-file*)—containing the date filed, the filer's name, the employee and spouse's signature, and a written signature date the employee and spouse each signed the form.
9. Divorce decree (Only the first and last page of the court document are needed, but those pages must include the date stamp by the court and the signature of the judge)
10. A copy of a military ID and privilege card with the expiration date is acceptable as proof of Tricare coverage and to document the end of Tricare coverage.

11. For dependent loss of other group health coverage, a letter or certificate of other creditable coverage, listing the name of the member and all dependents that were covered under a previous employer's insurance is required. The letter or certificate must identify the previous employer, and list the date in which coverage ended.

NOTE: Valid SSNs/ ITINs are required when requesting to add dependents. If the information is not provided at the time of the request to add the dependent, the dependent will not be added to your SEHP coverage. If an ITIN cannot be provided, a Communication form must be submitted to SEHP Membership Services providing the reason the ITIN is not available. The request will be reviewed and a determination will be made on each individual case.

Please contact your Human Resources office for additional information.

ADDITIONS:

If you are adding dependent medical coverage, then you may add dependent dental coverage at the same time. If you elect dependent dental coverage, the level of dependent dental coverage must match the dependent medical coverage level.

Vision coverage may be added during the Plan Year only for newly eligible employees and/or dependents. You cannot change from Basic to Enhanced vision coverage, or vice versa during the Plan Year.

If you have waived vision coverage, newly eligible dependents may not be added even if a qualifying event occurs.

DELETIONS:

If you are enrolled on an after-tax basis, you may drop member or dependent coverage (both medical and dental) without restriction during the Plan Year but you may not change medical plans during the Plan Year.

You can only drop dependent dental coverage during the Plan Year if you drop dependent medical coverage.

Even if you are enrolled on an after tax basis, you many not drop Vision coverage during the Plan Year unless you are an ineligible member and/or dependent.

EFFECTIVE DATE OF COVERAGE

For mid-year enrollment changes, the effective date of coverage or change in coverage will generally be the 1st day of the month following the event (assuming all online request requirements have been met). For events that occur on the 1st day of a month, the coverage effective date will be that day, with the exception of a death. In that instance, the change effective date will be the 1st day of the following month.

The effective date of coverage is outlined in this Guidebook for newborns, adopted children, new spouses and/or new stepchildren, and changes in legal custody or guardianship of a dependent.

If you are enrolled on an after-tax basis and you are dropping member and/or dependent coverage, the effective date of change in coverage is the 1st day of the month following completion of the online Change Request. If the Change Request is completed on the 1st day of the month, the coverage effective date will be that day.

The effective date of coverage or change in coverage is outlined in this Guidebook for changes in Medicare eligibility.

MID-YEAR QUALIFYING EVENTS

Pretax events

If you are enrolled on a pretax basis, and any addition or deletion to coverage will result in a change in employee contribution, there must be a qualifying event for the change to be approved. Enrollment changes must also be consistent with the event and must comply with HIPAA regulations. You may

change pretax status only during the Open Enrollment period each year (unless the 30-day waiting period was waived for initial enrollment). The qualifying event must result in a gain/loss/change of coverage in an employer-sponsored group health insurance plan. This gain/loss/change can be for you, your spouse, or a dependent and can be under either the SEHP or a plan sponsored by your spouse or dependent's employer. The requested change of election must then correspond with the gain/loss/change of coverage, and must be confirmed with documentation in the form of a letter from the employer on the employer's letterhead. All changes must be requested within 31 days of the event.

If you are enrolled in the SEHP on a pretax basis, you may make mid-year additions and deletions from coverage based on the following events and subject to the requirements listed in this Guidebook:

1. **Your marriage** – you may add or drop your entire family if your family is added to the new spouse's employer's plan because the entire family is now newly eligible. If the marriage is a common law marriage, a notarized copy of Common Law Marriage Affidavit and proof of joint ownership must be uploaded via MAP with the enrollment/change request. Acceptable proof of joint ownership includes:
    - Current bank statement (bank account verification letter showing active status of account)
    - Active lease agreement
    - Current homeowners insurance statement
    - Current credit card statement
    - Current property tax statement
    - Current year federal filed tax return listing spouse
    - Current auto loan
    - Current brokerage account statement
    - Mortgage statement
2. **Your final divorce** – the first and last pages of the final divorce decree, which includes the date stamp by the court and the signature of the judge must be submitted with the online Enrollment or Change request. You are only allowed to remove ineligible dependents. If divorce results in loss of coverage for the member, proof of loss must be submitted.
3. **Birth or adoption of a dependent** – you may add your entire family. You may drop entire family only if the status change is due to a birth or adoption, and those family members are now newly eligible under some other employer's plan.
4. **Gain or loss of legal custody** of a dependent. A copy of the court order including court recorded date stamp and judge's signature must be uploaded via MAP with the change request.
5. **Changing from part-time to full-time or from full-time to part-time employment** by your spouse or dependent that affects cost, benefit level, or benefit coverage for you, your spouse, and/or your dependents.
6. **Changing from a benefits eligible position to a benefits ineligible position** by you, your spouse or a dependent.
7. **Termination or commencement of employment (including retirement)** of you, your spouse or a dependent which affects benefits coverage for you, your spouse and/or your dependents. You may change your medical plan at the time of retirement. Any employment status changes that affect eligibility. For spouse or dependent loss of other group health coverage, a letter or certificate of other creditable coverage, listing the name of the member and all dependents that were covered under a previous employer's insurance is required to be uploaded via MAP with the request. The letter or certificate must identify the previous employer, and list the date in which coverage ended

8. **Your death** and your surviving spouse/dependents wish to continue coverage under the Direct Bill program.

9. **Significant changes in the health insurance coverage** of you, your spouse or dependent. You can make a mid-year change during your spouse's or dependent's Open Enrollment period due to significant changes to a spouse's or dependent's employer sponsored group health insurance plan, such as premium increases or benefit plan changes. A change of network status of a physician is not a qualifying event.

10. **Loss of COBRA eligibility** (for other than non-payment of premium) from a previous employer for you, your spouse, or dependent constitutes a qualifying event. A change or loss of employer's contribution/subsidy to a spouse or dependent's COBRA continuation coverage prior to exhaustion of COBRA continuation coverage does not constitute a qualifying event.

11. **Military insurance changes** – You may make a mid-year change if you, your spouse, or dependent are called to **active military duty** and/or gain or lose eligibility for military insurance.

12. **Death** of your spouse or dependent.

13. **Your dependent child turns age 26** (coverage ends for your dependent the last day of the month of their birthday). If the birth date is on the first day of the month, the coverage ending date for your dependent will be the last day of the preceding month.

14. **Government sponsored medical card coverage** – If you, your spouse, or dependent gain or lose government sponsored medical card coverage you may make a mid-year change. Terminating coverage is not allowable if you become covered under programs like SCHIP (State Children's Health Insurance Program) because these programs are not supposed to replace existing insurance. This may apply to other government card coverage.

15. **Medicare eligibility** – You may make a mid-year change if you, your spouse, or dependent lose Medicare eligibility, or become eligible for Medicare and elect Medicare coverage as primary.

16. **Court Order requiring adding or dropping coverage** for a dependent child.

17. **Dependent children losing eligibility/coverage** under another group health insurance plan. For dependent loss of other group health coverage, a letter or certificate of other creditable coverage, listing the name of the member and all dependents that were covered under a previous employer's insurance is required to be uploaded via MAP with the change request. The letter or certificate must identify the previous employer, and list the date in which coverage ended.

18. **Dependent children identified under a Medical Withholding Order (K.S.A. 23-4,105) or Qualified Medical Child Support Order**. The SEHP has the authority from the Court to add or remove these dependent children without the consent of the employee).

19. **Children that change from non-dependent to dependent status** during the Plan Year under SEHP guidelines can only be added back on to your coverage at Open Enrollment.

20. **Dependent spouse or children who move to the U.S**. constitutes a qualifying event. You can be request to add them to your coverage through MAP.

After-tax events

If you are enrolled in SEHP coverage on an after-tax basis, you may make mid-year additions and deletions from coverage due to the following events and subject to the requirements listed above:

1. All events as listed under Pretax Events;

2. Removing yourself and/or dependents from SEHP coverage for any reason (no documentation is required).

Note: Vision coverage may not be added or dropped during the Plan Year.

ACTIVE MILITARY DUTY

If you go on military duty - leave without pay, you may continue coverage for the next 30 days. Your Agency will continue to make the SEHP employer contribution for those 30 days. You must pay your premium (regular payroll deduction amount) to your Agency to continue your coverage during the 30 days following the effective date of the military leave without pay.

You may continue coverage in the SEHP beyond the 30 days leave without pay timeframe, but you must pay the full premium amount directly to the premium billing vendor as a direct bill participant. There will be no Agency employer contribution. An employee with spouse, children, or full family coverage may elect to drop themselves and keep their spouse and/or children covered in the SEHP. You must make the change within 30 days of the effective date of the military leave without pay. To continue SEHP coverage, an online Change Request indicating LWOP must be submitted to SEHP Membership Services.

If SEHP coverage is continued, it will be the primary payer of claims and military coverage will be secondary.

You and/or your dependents who elect to discontinue SEHP coverage and who have primary coverage provided by the military will be allowed to re-enroll into the same SEHP plan and coverage when you return to active employee status.

If you are on military leave during Open Enrollment, you may enroll in any SEHP plan and coverage levels for which you are eligible, without penalty, upon your return to active employee status.

The effective date of coverage may be either the first day of the month following your return from active military duty or the first day of the month in which you return to active employee status.

If you are qualified for and elect to participate in the military's transitional health benefit program, you will be allowed to re-enter the SEHP without penalty when the transitional coverage terminates. You may be qualified for up to 180-days of transitional health benefits.

The effective date of coverage may be either the first day of the month following termination of the military transitional health coverage or the first day of the month in which the military coverage terminates, whichever is chosen.

Return from military leave policies also apply to dependents returning from military leave.

TERMINATION OF ACTIVE COVERAGE

Your active SEHP coverage terminates on your last day of active employment.

QUALIFIED HIGH DEDUCTIBLE HEALTH PLAN WITH HSA - (QHDHP W/HSA)

THE DIFFERENCE BETWEEN PLAN C – QHDHP W/HSA AND PLAN A

1. Premiums paid for coverage are lower.
2. The deductible you must pay under Plan C is higher, but your employer provides you with a contribution to your Health Savings Account that can be used to help you meet your deductible.
3. With Plan C, the Caremark Preferred Drug List is the same as with Plan A however, the benefits are different.
    a. **Note:** Prescription drugs are subject to the overall plan deductible. Also, under Medicare Part D rules, Plan C drug coverage is considered "creditable coverage".
4. Plan C drug coverage includes a generic incentive program. Members who have generics available to them will pay more for brand name drugs.
5. When you choose dependent coverage under Plan C, a family member may now satisfy the single deductible for claims to be paid versus the entire family deductible having to be met as in prior years.
6. Most covered services are subject to the deductible and coinsurance.
7. For members 65 and over, you are eligible to elect Plan C and contribute to an HSA as long you have not:
    - Applied to receive Social Security benefits, which automatically includes Medicare Part A coverage and / or:
    - Enrolled in Medicare Part B or D

HEALTH SAVINGS ACCOUNT (HSA)

The HSA is a required part of the QHDHP with minimum and maximum allowable contributions. The purpose of the HSA is to allow you to put tax advantaged savings aside for future medical expenses. The savings may be used for certain premiums, copayments, coinsurance, deductibles or any medical expenses that are not covered by the QHDHP.

The HSA is owned by you, administered by the HSA Bank, and can be funded up to the maximum amount determined by the U.S. Treasury Department each year. Members age 55 and over can make an annual “catch up” contribution of $1,000, as outlined in IRS Publication 969. The HSA account is portable and funds rollover from year to year.

If you enroll in the QHDHP and are eligible for an HSA, you must elect an HSA when you enroll in your SEHP benefits in MAP. You must make a minimum per paycheck contribution (based on 24 paychecks per year) of $25. Your HSA will automatically be set up by the HSA Bank.

To activate the HSA, federal law requires you to pass the Identification Verification (IDV) Process. In the event that you do not pass the IDV process, the HSA Bank will reach out to you directly and request the additional documentation that is needed. You are required to work directly with the HSA Bank to correct the IDV issue. If you do not correct the IDV issue, all your employee contributions will be returned to you as a taxable event.

You may change your HSA employee contribution during the plan year without a qualifying event. You can increase or decrease your employee contribution level by submitting a change request in MAP. The effective date of the change will be based on the next available paycheck once the request has been approved by SEHP Membership Services.

If you change from member only to member and dependent medical coverage or from member and dependent to member only medical coverage mid-year due to a qualifying event, you may also change your HSA employee contribution amount by submitting a Change Request in MAP. The effective date of the change will be based on the next available paycheck once the request has been approved by SEHP Membership Services.

The HSA employer contribution is made in 2 installments:

- The first installment is on the first paycheck in January

- The second installment is made on the first paycheck in July.

NOTE: You must be actively employed on January 1 to receive the first installment and then actively employed on July 1 to receive the second installment.

The HSA employer contribution amount to be effective January 1 of the next plan year will be based on:

- The coverage level selected at open enrollment for January 1; or
- The coverage level based on a qualifying event that took place between October 1st and December 31st of the preceding plan year that was approved by SEHP Membership Services.
- The second employer HSA contribution amount will be based on your coverage level as of June 30th each year.
  - If you have moved from Member Only coverage to Member and Dependent coverage, the second employer HSA contribution will be at the Member and Dependent level.
  - If you have moved from Member and Dependent level to Member Only level, the second employer HSA contribution will be at the Member Only Level.

HSA employer contributions for new enrollees during the plan year will be pro-rated based on their benefit effective date.

Plan C High Deductible Health Plan (HDHP) with Health REIMBURSEMENT Account (HRA)

A Health Reimbursement Account (HRA) is an employer sponsored plan that has similarities to both a Health Care FSA and an HSA. However, contributions are funded entirely by the employer – no employee contributions are permitted, the HRA is not portable and any remaining funds at the end of the year will not roll over into the next plan year. Members have sixty (60) days from the end of the plan year (December 31st) to file any claims incurred during that plan year.

Enrollment in an HRA is available to members as an alternative for those enrolling in Plan C, but who are not eligible to contribute to a HSA due to:

1. Medicare enrollment
2. Tri-Care enrollment
3. Concurrent enrollment in another health plan not considered a High Deductible Health Plan
4. Being eligible to be claimed as a dependent under a parent's tax return
5. Having dependent children between ages 23-26 (member may choose to enroll in either the HSA or an HRA in this situation)

KEY ITEMS

1. Employees electing to enroll in an HRA will be required to submit documentation, in pdf format, that indicates that they are eligible to participate in an HRA. The documentation will need to be scanned and uploaded into MAP at the time the member is enrolling. Examples of documentation are:
   - Medicare Card – for those enrolled in any part of Medicare
   - TriCare Card- for those enrolled in TriCare
   - VA Card- for those receiving Veterans Administration (VA) Services
   - For proof of being eligible to be claimed as a dependent under your parent's tax return:
     - **A.** Copies of parent's current year's filed Federal tax return showing your name as an eligible dependent Please note all income information may be whited out prior to submission to SEHP Membership Services. The pages needed from the current year's filed Federal tax return depends on which Tax form was filed:
       - Form 1040—pages 1 & 2 containing the filer's name, parents' signature, and a written signature date the parents' signed the form.
       - Form 1040A—pages 1 & 2 containing the filer's name, parents' signature, and a written signature date the parents' signed the form.

- Form 8879 (IRS e-file)—containing the date filed, the filer's name, parents' signature, and a written signature date the parents' signed the form

2. Participants will have sixty (60) days from the end of a plan year (December 31st) to file any claims incurred during that plan year. Should an employee terminate coverage with the SEHP prior to the end of the plan year, they will have sixty (60) days from the last date on SEHP Health Plan coverage to file any claims incurred while they were covered that plan year.
3. The HRA employer contribution frequency and amounts will be identical to that of the Health Savings Account
4. US Bank is the HRA administrator
5. Employees will need to register their HRA with US Bank at ***www.mycdh.usbank.com*** in order to view account details.
6. HRA members are also eligible to enroll in a Health Care FSA in order to make pre-tax contributions to pay for eligible health expenses.

For further details go to: ***www.kdheks.gov/hcf/sehp/HRA.htm***

US Bank – HSA & HRA Vendor Information

HSA Customer Service Line: 1-877-470-1771

Website: www.mycdh.usbank.com

Limited Purpose FSA - Available for Plan C (QHDHP w/HSA) members

A Limited Purpose (or Limited Scope) FSA is a savings option for members that are enrolled in Plan C with a Health Savings Account (HSA). The Limited Purpose FSA works the same way a standard FSA does: pre-tax, "use it or lose it" elections and expenses must occur within the plan year. The difference is that it limits what expenses are eligible for reimbursement. In a Limited Purpose FSA members can only submit claims for eligible dental and vision expenses. (Remember: Cosmetic procedures such as teeth bleaching are not eligible under any Flexible Spending Accounts).

As mentioned above, the Limited Purpose FSA funds are available only for certain expenses, including:

- Dental and orthodontia care such as fillings, X-rays, braces, caps, mouth guards and dentures
- Vision care, including exams, eyeglasses, contact lenses, solutions and supplies, and LASIK eye surgery
- Prescriptions and over-the-counter items **related to dental and vision care**

The annual contribution minimums and maximums are the same as the standard Health Care and Dependent Care FSA ($192.00 annual minimum and $2,500.00 annual maximum).

Note: The FSA Debit Card is available with the Limited Scope FSA. Claims may also be submitted via mail, fax, through the mobile app, or on-line.

IMPORTANT INFORMATION WHEN TRAVELING OUTSIDE OF THE U.S.

You should contact your medical plan carrier **before** traveling outside of the U.S. for coverage and claim submission requirements in the event that you and/or your eligible dependents need to seek medical treatment while traveling outside of the U.S. Each medical plan carrier has their own processes and procedures to ensure you and your eligible dependents have appropriate coverage while traveling.

PRESCRIPTION DRUG ADVANCE PURCHASE POLICY:

A. Travel in the United States
Because the SEHP uses the Caremark Pharmacy network, when you are traveling within the United States, you are not eligible for an advance prescription purchase. You may use your drug card at any Caremark network pharmacy throughout the U.S.

B. Travel Outside of the United States
1. Travel or work outside the U.S. for a period of sixty (60) days or less:
When you plan to leave the U.S. for 60 days or less you may call the toll-free number on the back of your card to arrange for a vacation supply of medications. Caremark may enter up to 30 days on an original fill for non-controlled and controlled medications or a 60 day override on refills of medications as allowed by the benefit description. You will be billed the applicable coinsurance or copayment for the quantity purchased.
2. Work outside the U.S. for a period of sixty (60) days or longer but not to exceed one {1} year:
This policy and its provisions apply only to active employees covered under the SEHP. When you will be outside of the country for a longer period of time, there are two options available:

- **Option 1 - Advance purchase through drug plan:**
You must work with your Human Resources office to arrange for advance purchase of maintenance medications required during a stay outside the U.S. The Advance Purchase Certificate certifying that health coverage will be maintained during the entire period of the extended absence must be signed by both you and your employer. An Advance Purchase Form must be submitted to SEHP Membership Services **at least fifteen (15) days prior to your departure date**. You and your employer will be notified when the Advance Purchase Form has been processed and the dates the medication will be available to pick up. Generally, the medication will be available for purchase one week in advance of the departure date. The following requirements apply:

    1. The Advance Purchase form must be completed stating that coverage will be maintained via payroll deductions during the term outside of the U.S. The form also requires information on your destination and duration of stay. The Advance Purchase form signed by you and your Human Resources representative acknowledges the SEHP's right to recovery from you and/ or your employer the cost of the medications if coverage is not maintained.
    2. The name and strength of each requested medication and the name of the prescribing doctor must be on the Advance Purchase form. For each medication, provide the name of pharmacy where the medication will be filled. You will be responsible for the applicable coinsurance percentage on the cost of the quantity of drug dispensed. You must agree to purchase the prescription medication at a local network pharmacy. You or your dependents using the Caremark mail service will need to obtain a prescription from your doctor so that the items can be purchased at a local network pharmacy.

    REMINDER: Medication can only be dispensed for the period of time allowed by the prescription written by the provider. For extended periods, the member may

need a new prescription. Advance purchases are available for period up to one (1) year.

3. Benefits available for emergency prescriptions purchased outside of the U.S. will be limited to those drugs which would have been covered had they been purchased within the U.S. Documentation of the purchase must be translated into English along with the exchange rate on the date of service and be submitted to the SEHP on a paper form with a statement indicating their purchase and use while outside of the U.S. Your membership status will be verified and the claim will be forwarded to Caremark for reimbursement.

- **Option 2 - Purchase medication(s), then submits claim(s) upon return:**
  If you do not have enough time to file an Advance Purchase Form in advance of your departure, you may pay the full price for your medications, and file a paper claim for reimbursement upon your return. The paper claim would need to be sent first to SEHP for processing.

Please contact your Human Resources office for additional information.

HEALTHQUEST PROGRAM

HealthQuest is the wellness program for benefits-eligible employees who are enrolled in the State Employee Health plan. As part of your benefits plan, a variety of services are offered at no additional cost. Participation in HealthQuest programs is always voluntary and strictly confidential. The toll-free telephone number for HealthQuest programs is 1-888-275-1205, TTY 1-888-277-1543. For full details on HealthQuest programs, please visit ***www.kdheks.gov/hcf/healthquest***.

Rewards Program

Employees enrolling in the medical portion of the State Employee Health Plan have an opportunity to earn a premium incentive discount on their health insurance premium through the HealthQuest Rewards Program. The HealthQuest Program year (also known as the earning period for the incentive) runs from November 16th through November 15th each year. Further information on the premium incentive program can be found at - ***www.kdheks.gov/hcf/healthquest/rewards.html***. Because the requirements to earn a discount may change from year to year, please refer to this webpage for full details on the current Rewards Program, including a flyer for new health plan members:

Employees will need to set up a HealthQuest account on the wellness portal to begin earning credits toward their discount. As a general guideline, new members should have access to the HealthQuest programs within three weeks of their HR Representative submitting their online enrollment request (they do not have to wait until their coverage begins). Instructions for registering an account are provided at:

www.kdheks.gov/hcf/healthquest/download/How_to_Register_an_Account.pdf

Employee Assistance Program (EAP)-Vendor ComPsych

All active benefits eligible employees of the State of Kansas, their dependents and other family members living in the same household are eligible to use the EAP.

With a single call to 1-888-275-1205 (option 7) you and your family members can receive confidential assistance 24 hours a day, 7 days a week at no cost to you.

Services include:

- Confidential Personal Counseling
- Work Life Solutions
- Legal Advice and Discounts
- Personal Money Management Advice

EAP Online—Expert information on the issues that matter most to you…relationships, work, school, children, legal, financial, free time and more all in one place. Access details, watch videos, conduct searches and get personal responses in one location.

For more details visit: www.GuidanceResources.com

CONTINUATION OF COVERAGE – DIRECT BILL PROGRAM

Important notice for Retirees: When you retire, you will receive information on the SEHP Direct Bill Program **and** a COBRA continuation notice as required by law. The retiree should choose only one of these options to continue their coverage.

MEMBERS ELIGIBLE TO CONTINUE IN THE DIRECT BILL PROGRAM

Eligible members may continue coverage through the SEHP after they retire from state employment.

The following members are eligible to continue under the SEHP Direct Bill Program:

A. Any former elected state official;

B. Any retired state officer or employee who is eligible to receive retirement benefits under K.S.A. 74-4925, and amendments thereto, or retirement benefits administered by the Kansas public employees retirement system (KPERS);

C. Any totally disabled former state officer or employee who is receiving disability benefits administered by the Kansas public employees retirement system;

D. Any surviving spouse or dependent of a qualifying member in the SEHP;

E. Any person who is in a class listed as an active member in Section 1, Chapter 2 and who is lawfully on leave without pay;

F. Any blind person licensed to operate a vending facility as defined in K.S.A. 75-3338, and amendments thereto;

G. Any former "state officer," as that term is defined in K.S.A. 74-4911f and amendments thereto, who elected not to be a member of the Kansas public employees retirement system as provided in K.S.A. 74-4911f and amendments thereto; and

H. Any former state officer or employee, who separated from state service when eligible to receive a retirement benefit but, in lieu of that, withdrew that individual's employee contributions from the retirement system.

CONDITIONS FOR DIRECT BILL MEMBERS

If you are within a class listed above, you will be eligible to participate on a Direct Bill basis only if you meet the following conditions:

1) You were covered by the SEHP program on one of the following bases:

   a) You were covered as an active member, as a COBRA member or as a spouse immediately before the date you ceased to be eligible for that type of coverage or the date you became newly eligible for a class listed in Section I. above

   b) You are a surviving spouse or eligible dependent child of a person who was enrolled as an active member or a direct bill member at the time of their death, and you were enrolled in the health care benefits program as a dependent at the time of their death.

RETIREMENT

When you retire from employment, your Human Resources representative will need to complete an online Change request indicating that you are retiring and whether or not you wish to continue SEHP coverage through the Direct Bill program. You must have continuous coverage under the SEHP to be eligible for the Direct Bill program. If continued coverage is desired, the Change request should be completed 90-days before your retirement in order to ensure continuous coverage between active employee coverage and Direct Bill coverage. Once the online Retirement request is received and approved by SEHP Membership Services, an online Direct Bill enrollment will be set up for you to elect SEHP coverage for yourself as well as any dependents you wish to cover.

The effective date of the change to the Direct Bill program will be the 1st day of the month following your last day in pay status, unless your last day is the 1st of the month, then your effective date will be that same day.

You may change your medical plan at the time of retirement. Your dependents may be dropped from coverage upon retirement; however, your dependents may be added to coverage only if there is a qualifying mid-year event. Qualified dependents may also be added to coverage during the next Open Enrollment period.

You may opt out of dental coverage at retirement or Open Enrollment. **NOTE: Once you opt out of dental coverage, you will not be able to re-enroll in dental coverage at a later date. The exception to this rule is if you would return to active employment.**

Vision coverage may not be dropped during the plan year unless due to a dependent becoming ineligible or unless all coverage is terminated. If dependent medical coverage is dropped, dependent vision coverage may be dropped. You may choose to keep your vision coverage even if you drop both medical and dental.

Important note: You do not have the option to re-enroll in the SEHP after you drop SEHP coverage. Retiring employees will be allowed to re-enroll only if they maintain continuous coverage under the SEHP as a dependent.

RETIREES NOT ELIGIBLE FOR MEDICARE

Employees who are not eligible for Medicare can enroll in the same health plans that are available to active employees. The benefits that are not available to enroll in at retirement are HealthyKids, the FSA, HSA or HRA.

RETIREES AND MEDICARE ELIGIBILITY

Employees and spouses who are age 65 at retirement or who are eligible for Medicare due to a disability

If you or your covered spouse is age 65 or over when you retire, you must apply for Medicare Part A and Part B if you do not currently have both Parts. Your enrollment into Direct Bill cannot be processed without this card. Medicare will automatically take over as paying primary for your medical coverage. The Social Security Administration requires that your agency provide you a memo or letter with health insurance information necessary to process the application for Medicare Part B coverage. When applying for Medicare Part B, you should present the memo or letter to the local Social Security Office.

Required information in the memo or letter is:

- Statement that you are covered under the SEHP,
- Date your coverage began,
- Date your coverage ended or will end, and
- Your spouse's name and Social Security Number if your spouse is covered by the SEHP and eligible for Medicare.

Please note the letter or memo must be on your employer's letterhead.

When you are Medicare eligible:

As a Medicare eligible retiree or member, you have 3 medical plans with prescription drug options to choose from:

- Coventry Advantra Freedom PPO with Coventry Part D prescription drug coverage
- Coventry Advantra Freedom PPO with Aetna Part D prescription drug coverage
- Coventry Advantra Liberty PPO with Coventry Part D prescription drug coverage
- Coventry Advantra Liberty PPO with Aetna Part D prescription drug coverage
- Kansas Senior Plan C with Aetna Part D prescription drug coverage
- Kansas Senior Plan C without Aetna Part D prescription drug coverage

Information on these plans can be found in the Retiree/Direct Bill Enrollment Booklet posted on the SEHP website here - ***www.kdheks.gov/hcf/sehp/DB-2016Book.htm***

When you and your covered spouse are both Medicare eligible:

If you and your covered spouse are both Medicare eligible, you have the same 3 medical plans with prescription drug options available as those listed above. When Medicare is an option, you and your spouse will be enrolled in separate plans.

SPLIT ENROLLMENT

Split Enrollment is required for the following situations:

1. When you and your spouse are both Medicare eligible
2. When you are Medicare eligible and your spouse/dependents are not Medicare eligible
3. When you are not Medicare eligible and your spouse/dependents are Medicare eligible

When Split Enrollment occurs, the Medicare member(s) may enroll in one of the following plans:

- Coventry Advantra Freedom PPO with Coventry Part D prescription drug coverage
- Coventry Advantra Freedom PPO with Aetna Part D prescription drug coverage
- Coventry Advantra Liberty PPO with Coventry Part D prescription drug coverage
- Coventry Advantra Liberty PPO with Aetna Part D prescription drug coverage
- Kansas Senior Plan C with Aetna Part D prescription drug coverage
- Kansas Senior Plan C without Aetna Part D prescription drug coverage

The non-Medicare member remains in the SEHP's Plan A or High Deductible Plan C options.

Special Note on Dental coverage for:

1) **Members that must split their coverage, or**
2) **Enrolling as a surviving spouse or dependent:**

If your spouse or dependent is not currently enrolled in dental coverage at the time coverage is split, or when enrolling as a surviving spouse or dependent, your spouse/dependent has a one-time option of picking up the dental coverage at the next Open Enrollment following this qualifying event.

Information on these plans can be found in the Retiree/Direct Bill Enrollment Booklet posted on the SEHP website here: - ***www.kdheks.gov/hcf/sehp/DB-2016Book.htm***

PAYMENT METHODS UNDER THE DIRECT BILL PROGRAM

Premiums for your Direct Bill coverage are administered by third party billing administrators. You will receive a bill for the 1st full month in retirement status. Once your coverage is set up, you have several ways to pay your SEHP premiums. Methods may include automatic bank draft, payment online, payment via credit card over the telephone, or payment via check or money order.

Currently, HP-Hewlett Packard-Member Services bills SEHP Direct Bill members for all SEHP premiums with the exception of Part D prescription drug coverage through First Health. If you have your Part D prescription drug coverage through First Health, you will be billed directly by them.

Payments for your SEHP premiums are due the first of the month for that month's coverage. For example, January premiums are due to the premium billing administrator by January 1. If premiums are not paid by the first of the month, your coverage may be terminated and may not be reinstated.

For additional information concerning the Direct Bill program, you or your Human Resources representative should contact:

Membership Services
State Employee Health Plan
900 SW Jackson, Suite 900
Topeka, Kansas 66612-1220

Telephone:
785-296-1715 (In Topeka)
1-866-541-7100 (Toll Free)
Fax: 785-368-7180

CONTINUATION OF COVERAGE - COBRA

The federal Consolidated Omnibus Budget Reconciliation Act (COBRA) law was enacted in 1986. This law requires that most employers sponsoring Group Health Insurance Plans offer employees and their families the opportunity for a temporary extension of health coverage at group rates in certain instances where coverage under the plan would otherwise end.

If you and your dependents lose insurance coverage under the SEHP, you have the right to elect to continue coverage by paying the required premiums. (Under **COBRA**, if you are a retiree or are covered through the Direct Bill program, you also have the same continuation rights as active employees.). If you are a retiree and have chosen COBRA over the SEHP Direct Bill coverage and COBRA runs out, you may enroll in Direct Bill coverage.

You, your spouse, and your dependents that are eligible to continue health insurance coverage are called Qualified Beneficiaries. The provisions under which you can continue coverage are called Qualifying Events. The number of months you and any dependents you may have, can continue coverage is specified based on your qualifying event. The maximum length of time a qualified beneficiary may carry COBRA coverage is 18 months. Coverage may be shortened or extended in lieu of a secondary qualifying event.

HEALTH COVERAGE TO BE CONTINUED

Qualified beneficiaries are eligible to continue only those medical, dental, prescription drug and vision benefits in which they were covered at the time of the qualifying event.

NOTE: If you go on Leave Without Pay (LWOP), then terminate employment AND do not continue SEHP coverage during the leave period, then you and any dependents will **NOT** be eligible for COBRA continuation. You are not eligible because you were not participating in the SEHP at the time of the qualifying event.

PROCEDURES TO BE FOLLOWED WHEN YOU EXPERIENCE A COBRA QUALIFYING EVENT

1. If the qualifying event is termination of employment (except for gross misconduct), the SEHP must notify your medical plan that termination of insurance coverage has occurred. Because there is a time limit in which you can elect to continue coverage, your employer must immediately notify SEHP Membership Services of your termination of employment so that SEHP Membership Services can cancel your coverage.
2. If the qualifying event is the reduction of work hours to less than 1,000 per year, the SEHP must notify your medical plan that termination of insurance coverage has occurred. The online Change request has been designed so that this information can be obtained via the online request. Because there is a time limit in which you can elect to continue coverage, the online Change request must be immediately submitted to SEHP Membership Services.
3. If the qualifying event is due to 1) Death (active employee and Direct Bill); 2) Divorce (active employee and Direct Bill); 3) Choosing Medicare as primary carrier and leaving dependents without health insurance coverage (active employees ONLY); or 4) A dependent of yours ceases to meet the SEHP's definition of dependent, i.e. turns age 26 (active employee and Direct Bill),

   The qualified beneficiary must notify their employer's Human Resources office **within 60 days** of the qualifying event. (Spouses and dependents of retirees should notify the SEHP **within 60 days** of the qualifying event). If notice is not received within 60 days of the qualifying event, the beneficiary will **not** be eligible for continuation coverage. Because of this time limit, the online Change request must be transmitted immediately to SEHP Membership Services.
4. Within 21 days of SEHP Membership Services receiving notification of the qualifying event, the qualified beneficiary will receive specific information, including a COBRA Enrollment packet setting forth the requirements for continuing insurance coverage, the plans available, and the applicable premium rates from the SEHP COBRA administrator.

5. An election by you or your spouse to continue coverage will be deemed to be an election for coverage by any other qualified beneficiary. However, each qualified beneficiary has an individual right to select continuation coverage. Each beneficiary may make a separate selection among the levels of coverage available.

ADMINISTRATIVE ISSUES

SEHP benefits will generally terminate on the last day of the month in which the qualifying event occurs.

For all terminations, COBRA notices are generated by the SEHP's third party COBRA administrator following notification of your termination by the SEHP. COBRA notices are generated from the Termination requests entered in MAP by the Agency HR Representative. If the Termination request is not entered into MAP, you will not receive a COBRA notice. Therefore, timeliness becomes a critical issue when completing and submitting Termination requests.

COBRA continuation is not automatic - it is a choice that the qualified beneficiary must make. Also, the online Change request does not activate COBRA continuation status. The qualified beneficiary must complete the COBRA election form that accompanies the COBRA notification letter sent by the COBRA Administrator. The qualified beneficiary has 60 days from the date of the COBRA notice to return the COBRA continuation election form to the COBRA Administrator. If you elect COBRA continuation, COBRA coverage will begin the day after active SEHP coverage ends.

COBRA notification letters will be sent to the qualified beneficiary at their last known address. It is important at the time of termination that your employer has your correct address. If you move, you should leave forwarding instructions at the Post Office.

COST OF BENEFITS - COBRA CONTINUATION RATES

Any qualified beneficiary who elects to continue coverage under the plan must pay the full cost of that coverage (including **both** the share you paid as an active employee, and the share paid by your employer), **plus** any additional amounts allowed by law. At present, COBRA Continuation rates are 102% of total premium. Those beneficiaries who elect the 11-month extension of benefits due to disability will pay 150% of premium for the additional 11-months of coverage.

For more information including the current plan year COBRA rates, view the COBRA Enrollment Booklet on our website here - ***www.kdheks.gov/hcf/sehp/COBRA-2016Book.htm***.

TERMINATION OF COVERAGE CONTINUATION

You and/or your eligible dependents will lose continuation of SEHP under COBRA if:

1. You do not pay or do not make timely payment of premiums in full;
2. You or your dependent(s) become(s) covered, either as an employee or dependent, under another employer-provided medical plan which does not limit or exclude coverage for preexisting conditions (does **not** apply to the surviving spouse in qualifying event I);
3. You or enrolled dependent(s) become eligible for Medicare (has enrolled in the Medicare program). However, if Medicare eligibility is due to ESRD, the individual may continue on COBRA.

   NOTE: **Only the person(s) eligible for Medicare coverage lose(s) COBRA Continuation benefits. Any other person(s) enrolled may continue for the duration of the COBRA eligibility period; or**
4. The State of Kansas no longer offers group health insurance to its employees.

For more information contact your Human Resources office.