



**STATE EMPLOYEE HEALTH PLAN
ACTIVE STATE EMPLOYEE HEALTH PLAN GUIDEBOOK**

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Contact Information - State of Kansas Health Plan Vendors

Aetna

Customer Service
Behavioral Health (Aetna BH)

www.aetnastateofkansas.com

All Areas (Toll Free): 866-851-0754

All Areas (Toll Free): 866-851-0754

Blue Cross and Blue Shield of Kansas

Customer Service

www.bcbsks.com/Customerservice/Members/State/

All Areas (Toll Free): 800-332-0307

Topeka: 785-291-4185

New Directions - **Behavioral Health**

All Areas (Toll Free): 800-952-5906

Topeka: 785-233-1165

New Directions - **Autism**

All Areas (Toll Free): 877-563-9347 Option 2

Caremark

Customer Service

www.caremark.com

All Areas (Toll Free): 800-294-6324

TDD (Toll Free): 800-863-5488

Caremark Connect Specialty Pharmacy

All Areas (Toll Free): 800-237-2767

COBRAGuard - COBRA Administrator

Customer Service

www.cobraguard.net

All Areas (Toll Free): 866-952-6272

Fax: 913-438-8385

Delta Dental of Kansas, Inc.

Customer Service

www.deltadentalks.com/

All Areas (Toll Free): 800-234-3375

Wichita: 316-264-4511

NueSynergy - Flexible Spending Accounts

State Employees Only

www.KansasFSA.com

Customer Service

All Areas (Toll Free): 855-750-9440

Fax (Toll Free): 855-890-7238

Preferred Lab Benefit Program

• **Quest Diagnostics Lab Card Program**

Customer Service

www.labcard.com

All Areas (Toll Free): 800-646-7788

Collection Site Listings

www.labcard.com/collection.html

• **Stormont-Vail Regional Lab Program**

Patient Financial Services

www.stormontvail.org/state-employees-lab

All Areas (Toll Free): 800-637-4716

Benefit Information and Collection Site Listings

Topeka: 785-354-1150

Surency Vision

Customer Service

www.surency.com/stateofkansas

All Areas (Toll Free): 866-818-8805

Wichita: 316-462-3316

Optum - HSA and HRA

Customer Service

www.mycdh.optum.com

All Areas (Toll Free): 877-470-1771

MetLife

Customer Service

www.metlife.com/stateofks

All Areas (Toll Free): 800-438-6388

MEMBERSHIP ADMINISTRATION PORTAL (MAP)

Membership Administration Portal (MAP) - <https://sehp.member.hrissuite.com/>

- If you are employed at ESU, KSU, KU, KUMC or PSU use this link to access MAP:
 - https://sso.cobraguard.net/seer_login.php

MAP Technical Support: E-mail: techsupport@hrissuite.com
Phone: 1-800-832-5337 (Toll Free)

MAP is supported by aall modern Internet browsers:

- Internet Explorer version 9 and above
- Chrome
- Firefox
- Safari
- Opera

Before you begin, make sure you have the following information ready:

- Your Kansas Employee ID number (available from your Human Resource Office)
- The last 6 digits of your Social Security number (SSN)
- Your date of birth

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.

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.

The following SEHP medical plans are self-insured:

- **Aetna:** Plan A, Plan C and N– Qualified High Deductible Health Plans with either Health Savings Account or Health Reimbursement Account, and Plan J and Q with Health Reimbursement Account.
- **Blue Cross Blue Shield:** Plan A, Plan C and N– Qualified High Deductible Health Plans with either Health Savings Account or Health Reimbursement Account, and Plan J and Q with Health Reimbursement Account.
- The prescription drug program is self-insured with **CVS/caremark** contracted as the prescription drug benefit manager. The dental plan is self-insured and administered by **Delta Dental Plan of Kansas**.

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.

Other health plan benefits available under the SEHP:

- The voluntary vision plan is fully insured by **Surency Vision**
- Flexible spending accounts administered by **NueSynergy**
- Health Reimbursement and Health Savings Accounts for the Qualified High Deductible Health Plan administered by **Optum Bank**.
- The fully insured voluntary Long Term Care insurance offer by **ASCIA Partners/LifeSecure**
- COBRA (Consolidated Omnibus Budget Reconciliation Act) administered by **COBRAGuard**
- Voluntary Insurance Plans for Hospital Indemnity, Critical Illness and Accidental Injury

GENERAL DEFINITIONS USED IN THIS GUIDEBOOK

- A.** 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.
- B.** 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.
- C.** 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.
- D.** Contribution—the total cost paid for the health plan option selected by the employee.
- E.** 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 coinsurance which is based on a percentage of cost.
- F.** 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.
- Direct Bill and Retirees—a program to extend health coverage to:
 - retiring participating State of Kansas employees,
 - totally disabled former participating State of Kansas employees,
 - surviving spouses and/or dependents of participating state employees eligible under the provisions of K.A.R. 108-1-1
 - active participating state employees who were covered under the health plan immediately before going on approved Leave Without Pay
 - Blind vendors
 - Elected Officials
- 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 Cerner Corporation.
- J.** HIPAA—The Health Insurance Portability and Accountability Act (HIPAA) of 1996 (P.L.104-191) the federal act which protects the privacy of individually identifiable health information under the Privacy Rule; the HIPAA Security Rule, which sets national standards for the security of electronic protected health information; and the confidentiality, integrity, and availability provisions of the Patient Safety Rule, which protect identifiable information being used to analyze patient safety events and improve patient safety.
- 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 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, enroll during open enrollment 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.
- 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.** 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 eligibility and membership in 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

Email: KDHE.SEHPMembership@ks.gov

Visit the SEHP website at: www.kdheks.gov/hcf/sehp/default.htm

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 your date of hire and your enrollment is approved by the SEHP. Once your benefits have become effective, no changes to your elections can be made unless you experience a qualifying event.

If the employee transfers from one state agency to another with no break in service, the employee will have continuous group health insurance coverage. The previous state HR office will submit a Request for Termination in MAP. The new state HR office will create a new member under their department. The MAP System will match the SSN and DOB and automatically create a transfer request from the new agency.

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.

WAIVER OF INSURANCE COVERAGE

If you choose to waive SEHP coverage, you may 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

.You must be enrolled in the medical plan to elect dental insurance. If you choose to enroll in dental for yourself and your dependents, the dependents enrolled in dental coverage must match those enrolled in the 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.

NOTE: Vision coverage terminates on the last day of the month after you terminate active employment or the last day of the month after the SEHP receives notification of your employment termination, whichever is later.

VOLUNTARY INSURANCE

Voluntary Insurance Plans for Hospital Indemnity, Critical Illness and Accidental Injury are offered on a voluntary basis. If you choose voluntary insurance plans and are covering dependent children, the dependent enrolled in the voluntary insurance plan must match those enrolled in the medical plan. Please note that you can enroll or change your voluntary insurance 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 though the plans are paid for on an after-tax basis.

NOTE: Voluntary Insurance Plans terminate on the last day of the month after you terminate active employment unless you elect to port the plans on an individual 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 spouse, subject to the documentation requirements of the HCC or its designee.
2. Any of your eligible dependent child(ren) also referred to as “dependent(s)” throughout the rest of this guidebook.

Note: In the case of a divorce, coverage for your former spouse and stepchild(ren) ends on the last day of the month of the date your divorce is final. If the date of your divorce is final on the first day of the month, coverage for your former spouse and stepchild(ren) ends on the last day of the month prior.

Other Eligible Individuals Important Information:

3. 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. The employer contribution for the employee covered as a dependent is limited to the standard dependent contribution and not that of an employee.
4. 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. The employer contribution for the employee covered as a dependent is limited to the standard dependent contribution and not that of an employee.
5. 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.
6. An eligible dependent that is enrolled by one primary member is not eligible to be enrolled as a dependent by another primary member.
7. “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.
8. “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.
9. 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 into MAP along with a copy of the grandchild's birth certificate and proof of financial dependency and residency when making the enrollment request.

10. Eligible dependent child(ren) or stepchild(ren) must be less than 26 years of age unless they are permanently and totally disabled.

11. Eligible dependent child(ren) or stepchild(ren) aged 26 or older who have a permanent and total disability as described in item 9 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 Enrollment 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 permanently and totally disabled.

DEPENDENT DOCUMENTATION REQUIREMENT:

The SEHP requires documentation to verify the dependent is eligible or continues to be eligible to be covered under the plan and/or to verify 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 to be eligible 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. for any new dependents added to the plan or upon request by the plan to re-certify eligibility for continued coverage. See additional information on Page 33 of this Guidebook).
3. Any attempt to enroll dependent(s) who do not meet the eligibility requirements will be considered fraudulent use of the plan and result in removal of the dependents from the plan and the member being responsible for any claims paid for by the plan for the ineligible member. The State may also pursue appropriate legal action against the member for their action. .

Note: Requests that are submitted with incomplete documentation will be not be processed and the dependent will not be added.

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. The SEHP must receive the request to add the dependent in MAP along with the supporting dependent documentation

within 31 days of the date of event. Members are able to submit the request directly to the SEHP using the Membership Administration Portal (MAP).

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 request to add the dependent in MAP along with the supporting dependent documentation within 60 days of the date of loss of coverage from Medicaid or SCHIP coverage.

NEWLY ELIGIBLE DEPENDENTS

You must complete a request for enrollment or change to add newly eligible dependents within 31 days of the event that makes the dependent(s) newly eligible. Members are able to submit the change request along with supporting documentation directly to the SEHP using the Membership Administration Portal (MAP). The change in coverage must be consistent with the event and/or must comply with HIPAA regulations. Coverage for newly eligible dependents may be added if you are enrolled in the SEHP on a pre-tax or an after-tax basis.

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 not be processed and the dependent will not be added to the plan. 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 NUMBERS (SSN) AND INDIVIDUAL TAXPAYER IDENTIFICATION NUMBERS (ITIN)

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. The SEHP is required to obtain valid SSN's, Health Care Identification Number (HICN) or ITINs for non-resident alien individuals and their eligible dependents. Dependents include a spouse and other family members eligible to be covered by health plan.

A Health Care Identification Number (HICN) is the number assigned by the Social Security Administration to an individual identifying them 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. Medicare is required to protect individual privacy and confidentiality in accordance with applicable laws, including the Privacy Act and HIPAA. 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.

Individual Taxpayer Identification number (ITIN): A non-resident alien individual engaged or considered to be engaged in a trade or business in the U.S. 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.

There are a few instances in which the SEHP will allow "temporary" SSNs to be used to set up members in the SEHP until a valid SSN or ITIN can be obtained by the primary member and sent to the SEHP.

1. Newborn children - a temporary SSN of 777-77-7777 may be entered for a newborn until the valid SSN is obtained. Generally, SSN are assigned within 14 days of application for the SSN. The valid SSN must be provided to the SEHP within 41 days of the child's date of birth.
2. Non-resident alien individuals or their eligible dependents - a temporary SSN of 888-11-1111 may be entered for a non-resident alien or their eligible dependents until a valid ITIN is obtained and sent to the SEHP. The valid ITIN must be provided to the SEHP 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 in MAP providing the reason the ITIN is not available. The request will be reviewed and a determination will be made on each case submitted.

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

Reporting under the Affordable Care Act (ACA) requires certain employers who sponsor self-

insured group health plans to report coverage of all participants in the group health plan. The SSN or ITIN of each covered individual is required to be included on the reporting form (Form 1095_C, Part III).

NOTE: Valid SSNs and ITINs will be 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 in MAP providing the reason the ITIN is not available. The request will be reviewed and a determination will be made on each case submitted.

Please contact your Human Resources office for additional information.

NEWBORNS OR ADOPTIONS

Adding a Newborn to SEHP Coverage

You will need to submit a request to enroll your newborn in the health plan through MAP within 31 days of the date of your newborn's birth. Appropriate dependent documentation and a valid SSN or ITIN are also required and should be sent at the same time as the enrollment request in MAP. For grandchildren, a copy of the birth certificate, a completed Dependent Grandchild Affidavit and appropriate proof of financial dependency and residency needs to be uploaded in MAP as part of the enrollment request. If the enrollment 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 coverage for only the first 31 days from the date of birth. Coverage by the plan for your newborn ends on the 32nd day unless your child is successfully added to your health plan. You will need to submit a request to enroll the dependent child within the first 31 days of their birth to continue their coverage. The addition of the child will result in a coverage level change to Employee and Family and the appropriate employee contribution will be charged from the dependent child's date of birth.
- If you have single coverage, your newly eligible dependent will have coverage only the first 31 days from the date of birth. Coverage ends on the 32nd day unless the child is added to the health plan. If your child is successfully added within the first 31 days of their birth, coverage will continue and an appropriate change in coverage level and premium change will occur as of the date of birth of your newborn.
- If you already have children or family coverage, your newly eligible dependent will have continuous coverage for the first 31 days from the date of birth however, the child is not permanently added to your SEHP coverage unless an online request to add the newborn is received. 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 enrollment request, SSN/ITIN and appropriate supporting dependent documentation is not received, coverage for your dependent will end and your newborn will not be permanently added to your SEHP coverage.

NOTE -- GRANDCHILDREN: Regarding a newborn child of your dependent child (grandchild); your grandchild will only have coverage for the first 5 days from the date of birth. Coverage 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 the Dependent Grandchild Affidavit and appropriate supporting dependent documentation) within 31 days from the date of birth.

ADOPTIONS

In the event of adoption of a child, 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 in MAP along with the request to enroll to the SEHP 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 enrollment request in MAP 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, a change request must be submitted in MAP to remove the dependent from your coverage.

Your Human Resources office should contact SEHP for guidance if the dependent is being adopted from a foreign country and a petition for adoption is never filed in a U.S. court.

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 receives an enrollment Request in MAP and the appropriate documentation is uploaded within 31 days of the event. 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 have member only coverage or member and spouse coverage, and the newly eligible adopted dependent is successfully added within the first 31 days of their eligibility an appropriate change in coverage level and employee contribution will occur on the coverage effective date described in the paragraph above.

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 and appropriate documentation is submitted within 31 days of the applicable child's birth. The effective date of coverage for your other eligible dependents, such as your spouse and/or other children or stepchildren of yours, will be the newborn's date of 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

(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 enrollment 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 in MAP along with the enrollment 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 will need to submit an enrollment request through MAP. The enrollment request along with the appropriate supporting documentation must be submitted within 31 days of the date of 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.

EMPLOYEE PREVIOUSLY WAIVED COVERAGE

If you have previously waived coverage, have acquired a newly eligible dependent, (marriage, birth, adoption, etc.), and you want to enroll in the SEHP, you must complete an enrollment request in MAP and provide 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 occurs annually during the month of October. Coverage elected during the Open Enrollment period, will be effective January 1 of the following year which is the 1st day of the new Plan Year.

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> or if you are employed at ESU, KSU, KU, KUMC or PSU use this link to access MAP: https://sso.cobraquard.net/seer_login.php. Information concerning online enrollment is published prior to the annual Open Enrollment period and is available on the SEHP's website at: www.kdheks.gov/hcf/sehp/default.htm.

When requesting to add dependents during Open Enrollment, appropriate supporting documentation including valid SSNs or ITINs, must be submitted via MAP during the enrollment process. Any documentation submitted in any other language besides English must be accompanied with an English translation.

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.

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 in MAP during the Open Enrollment period. Following the end of the Open Enrollment period, a 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 enrollment or 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 not be processed and the changes requested will not be made.

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 or want additional cards, contact the health plan vendor directly to request ID cards. Telephone numbers for the health plan vendors are listed in the front of the Open Enrollment booklet or on the SEHP's website at: www.kdheks.gov/hcf/sehp/default.htm. You may be able to download a card directly from the vendor's website or by using the vendor's mobile apps.

COST OF COVERAGE

Your contribution amount for SEHP coverage is subject to change each Plan Year. SEHP coverage rates except vision and voluntary insurance plans are based on semi-monthly payroll deduction periods.

NOTE: For current SEHP rates, please review the Open Enrollment booklet located on our website at: <http://www.kdheks.gov/hcf/sehp/Active-2018-Book.htm>

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 a Enrollment or Change request in MAP;
- 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 dependent children)**
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. A completed Application for Coverage of Permanent and Totally Disabled Dependent Child affidavit 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.** 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, as long as 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 providing the reason the ITIN is not available. 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 be equal to or less than the medical coverage level elected by the employee. You and any covered dependents must be enrolled in the medical plan to be eligible to enroll for dental coverage. A qualifying event will not allow you to change plans or to switch medical vendor. After your initial enrollment, this can only be done during open enrollment.

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.

Vision coverage and voluntary supplemental insurance end on the last day of the month. You may port your voluntary supplemental insurance plan to an individual policy after you leave state employment.

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.

MID-YEAR QUALIFYING EVENTS

Pretax events

If you are enrolled on a pretax basis, and any addition or deletion to coverage must be the result of 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 changes to their coverage based on the following qualifying events and subject to the plan enrollment requirements:

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. You will need to submit a copy of the marriage license along with the request to add family members to coverage or documentation of coverage under the spouse's health plan in order to drop coverage.
2. **Common Law marriage** - If the marriage is a common law marriage, accompanying your request to add the spouse to coverage, you will need 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
3. **Divorce** - In the event of divorce you will need to submit a copy of the first and last pages of the final divorce decree, which includes the date stamp by the court and the signature of the judge. This should be uploaded into MAP along with your enrollment change to remove the ineligible spouse and stepchildren. You are only allowed to remove ineligible dependents as a result of the divorce.
4. **Birth or adoption of a dependent** – In the event of the addition of a dependent due to birth or adoption, you may add your entire family to your plan. You will need to submit an enrollment request along with supporting birth certificate or a copy of the petition for adoption or placement in MAP. In this situation, you may only drop entire family if the family members are now eligible under another employer's plan.
5. **Gain or loss of legal custody** of a dependent. Along with the enrollment change request in MAP, you will need to supply a copy of the court order including court recorded date stamp and judge's signature in order to add or drop the dependent.
6. **Changing in Employment** – If you, your spouse or dependents change from part-time to full-time or from full-time to part-time employment that affects cost, benefit level, or benefit coverage for you, your spouse, and/or your dependents you are eligible to request a change in your health plan coverage. You will need to submit a request in MAP along with documentation from the employer that supports the change. **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. **Death** – You are eligible to request an enrollment change based on the death of your spouse or dependent. If the death is the employee, the surviving spouse/dependents may wish to continue coverage under the Direct Bill program. Requests in MAP as a result of the death of a covered member should include a copy of the death certificate.

A significant change in the health insurance coverage of you, your spouse or dependent is a qualifying event. 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. The MAP request for the enrollment change should include documentation of the change in the effected member's coverage.

9. **Loss of COBRA eligibility** if Cobra eligibility for you, your spouse, or dependent is lost for other than nonpayment of premium 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. You will need to submit a request for change in MAP and provide documentation of the loss of COBRA eligibility.
10. **Military insurance changes** – You may make a mid-year change if you, your spouse, or dependent are called to **active military duty** and this results in a gain or lose eligibility for military health insurance coverage. You will need to request the change in MAP and provide documentation of the gain or loss of the military coverage.
11. **Your dependent child turns age 26** (coverage ends for your dependent the last day of the month of their birthday). You will be notified by the SEHP prior to your dependent's birthday and the change will be automatically applied to your benefits. If the change results in a different coverage tier, this change will be made by SEHP and your contribution adjusted.
12. **Government sponsored VA benefits** – If you, your spouse, or dependent gain or lose government sponsored VA benefits you may make a mid-year change in MAP. You will need to upload documentation of the change in VA benefits to accompany your enrollment request
13. **Medicare eligibility** – You may make a mid-year change if you, your spouse, or dependent become newly eligible for Medicare and elect Medicare coverage as primary. Members gaining Medicare benefits will need to complete a TEFRA form to certify their election of Medicare coverage and whether or not they wish to remain enrolled in the SEHP coverage. These are sent out to members approximately 60 days prior to their 65th birthday. If a member loses Medicare eligibility, they will need to request an enrollment change in MAP and provide documentation on the loss of Medicare benefits.
14. **Entitlement to Medicaid** – If you, your spouse, or dependent is entitled to coverage (i.e., becomes enrolled) title XIX of the Social Security Act (Medicaid) (Public Law 89-97 (79 Stat. 343)), while enrolled in the SEHP, you may make a mid-year change to cancel or reduce coverage of SEHP coverage. In addition, if you, your spouse, or dependent who have been entitled to coverage under Medicaid loses eligibility for such coverage, you may make a mid-year change under SEHP. You will need to request the change in your enrollment in MAP and provide documentation of the
15. **Dependent children losing eligibility/coverage** under another group health insurance plan is a qualifying event to request a coverage change. For dependent's losing 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 enrollment request. The letter or certificate must identify the previous employer, and list the date in which coverage ended. For dependents gaining coverage under another group health plan a letter from the employer or group health plan indicating the effective date of coverage and the names of the individuals that are covered under that plan is needed along with the enrollment change.
16. **Dependent children identified under a Medical Withholding Order (K.S.A. 23-4,105) or Qualified Medical Child Support Order.** If the SEHP receives a court order requesting a coverage change, the SEHP has the authority to add or remove dependent children without the consent of the employee. Changes will be made by the SEHP to the member's coverage to comply with the courts order automatically. Coverage and member contribution levels will be adjusted to reflect these changes.
17. **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. You will need to upload copies of your marriage license and/or birth certificates for the dependents being added along with the enrollment request in 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 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. Return from military leave policies also apply to dependents returning from military leave.

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.

TERMINATION OF ACTIVE COVERAGE

Your active SEHP medical, dental and prescription drug coverage terminates on your last day of employment. If you have elected to enroll in the insured vision your coverage will end on the last day of the month. If you are enrolled in the voluntary insurance programs for hospital indemnity, critical illness or accidental injury, you may port your coverage to an individual plan and continue it after you leave the State. If you elect not to port your voluntary insurance plans, they will end on the last day of the month in which you terminate employment.

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.

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.

FLEXIBLE SPENDING ACCOUNT PROGRAM

The Flexible Spending Account program is subject to the federal rules and regulations of Internal Revenue Code (IRC) Section 125 concerning all cafeteria plans and is authorized by K.S.A. 75-6512 et al. Flexible Spending Accounts allow participants to pay for health plan premiums, non-reimbursed health care expenses and dependent daycare expenses using pre-tax dollars.

I. FLEXIBLE SPENDING ACCOUNT OPTIONS

There are currently three benefit plans offered:

- A.** Pretax Premium Option – allows you as a participant to pay their State Employee Health Plan medical, dental and/or vision premiums on a pre-tax basis.
- B.** Health Care Flexible Spending Account (HC FSA) – allows you as a participant to pay for qualified health expenses that are not otherwise reimbursable under the health plan, on a pre-tax basis. Eligible expenses are determined by IRS publication 502.
- C.** Limited Purpose Flexible Spending Account (LP FSA) – allows participants enroll in a high deductible health plan to pay for qualified dental and vision expenses on a pre-tax basis. Qualified expenses are determined by Section 129 of the IRS Code.
- D.** Dependent Care Flexible Spending Account (DC FSA) – allows you as a participant to pay for qualified work related daycare expenses on a pre-tax basis. Qualified DC FSA expenses are determined by Section 129 of the IRS code.

II. TAX SAVINGS

Salary reductions on a pre-tax basis means that you enter into an agreement with the State of Kansas to reduce your salary by the cost of Health Plan contributions and/or by the amounts you elect for inclusion in the Flexible Spending Accounts (FSA) listed above. Since your salary is reduced, you do not pay federal or state income taxes or Social Security taxes on these amounts. As a result, your take home pay will increase by the amount you do not pay in taxes.

III. EFFECTIVE DATE OF COVERAGE

The initial enrollment period for FSA is limited. During your initial enrollment opportunity, you may elect to enroll in a FSA. If the initial enrollment request is not submitted within 31 days, you will not be allowed to enroll until the next Open Enrollment period, unless you experience a mid-year qualified change in status.

IV. CARRYOVER PROVISION FOR HEALTHCARE AND LIMITED FSAs

The SEHP has adopted a provision that will replace the grace period and allow you to carry over up to \$500 of unused HC FSA or LP FSA funds into a new FSA plan year. This will allow you to spend FSA funds at a future date and reduces the likelihood that unused funds are forfeited.

Funds carried over from the previous plan year will not count against the new plan year's annual election and cannot exceed \$500.

V. 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 a Qualified High Deductible Health Plan 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 before, 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 FSA.

VI. **DEPENDENT CARE FSA**

To receive reimbursement for dependent care, you must submit your providers Social Security Number (SSN) or Employer Identification number (EIN). Members electing a DC FSA need to be aware that funds must be in your DC FSA before you can be reimbursed for dependent child care expenses. The DC FSA is a use it or lose it account and does not include the carryover provision. Members need to submit their claims for reimbursement under the DC FSA during the plan year or no later than April 30th of the next plan year. Funds remaining after April 30th of the next plan year will be forfeited.

For additional information, refer to the FSA information on the SEHP website at www.kdheks.gov/hcf/sehp/FSA.htm

FSA PARTICIPANTS: QUALIFIED RESERVIST DISTRIBUTIONS

The HEART Act (Heroes Earnings Assistance and Relief Tax of 2008) is designed to help military personnel called to active duty who may otherwise forfeit dollars set aside in a health care FSA. According to the Act, an employer and/or Plan Sponsor may make a cash distribution of unused FSA benefits to eligible reservists without disqualifying its cafeteria plan. The withdrawal is known as a Qualified Reservist Distribution or (QRD). However, there are qualifications that must be met before a QRD can be made:

- The individual must be a “reservist”, as defined in 37 U.S.C. Section 101, which means the reservist must be a member of one of the following;
 - Army National Guard of US
 - Army Reserve
 - Navy Reserve
 - Marine Corps Reserve
 - Air National Guard of US
 - Air Force Reserve
 - Coast Guard Reserve
 - Reserve Corps of the Public Health Service
- The participant is called to active duty for a period of 180 days or more or for an indefinite period.
- The request for distribution must be made after the order for active duty is issued, but before the last day of the plan year (or grace period, if applicable).

Finally, QRD’s are taxable, and should be included in the gross income and wages of the employee, and are subject to employment taxes. A QRD must be reported as wages on the employee’s W-2 for the year in which the QRD is paid to the employee.

For additional information, refer to the FSA information on the SEHP website at:

www.kdheks.gov/hcf/sehp/FSA.htm

QUALIFIED HIGH DEDUCTIBLE HEALTH PLAN WITH HEALTH SAVINGS ACCOUNT (HSA) OR HEALTH REIMBURSEMENT ACCOUNT (HRA)

QUALIFIED HIGH DEDUCTIBLE HEALTH PLAN (QHDHP)

The Qualified High Deductible Health Plan (QHDHP) is available with either a Health Savings Account (HSA) or Health Reimbursement Account (HRA). A QHDHP includes full coverage for preventive care with network providers. While the Preferred Drug List (PDL) is the same for all plans, the amount the member pays will vary depending on the plan that is selected as explained below.

When a member chooses dependent coverage (i.e., family coverage), the entire deductible amount for single coverage must be met by one covered individual before claims are paid for that individual. The remaining deductible amount for family coverage must be met similarly by the other covered family members until the full deductible amount for family coverage is reached. Covered medical services (except preventive care) and prescription drugs are subject to the deductible. (See the health plan website for further details on the plan coverage provided. The QHDHP plans offer members the choice of a Health Savings Account (HSA) or a Health Reimbursement Account (HRA) to help them pay their health care expenses.

HEALTH SAVINGS ACCOUNT (HSA)

The HSA is a health care bank account owned by you, administered by the Optum Bank. The HSA account is portable and funds rollover from year to year. An HSA is an account that the employee and employer can use to set aside funds to pay for current or future health care expenses. Funds can be deposited into an HSA on a pre-tax basis. The IRS establishes each year the HSA maximum allowable contributions for employee only or employee plus dependent coverage. The savings may be used for certain premiums, copayments, coinsurance, deductibles or other medical, dental, drug or vision expenses. . HSA funds can be used for your tax qualified family members.

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. Members age 55 and over can make an annual “catch up” contribution of \$1,000 annually into their HSA, as outlined in IRS Publication 969.

The HSA employer contribution is made in 4 equal payments. The employer payments are made the first pay period in January, April, July and October.

NOTE: You must be actively employed on to receive the employer contribution. The HSA employer contribution amount to will be based on the coverage level and employment status (FT or PT) in force on the date the employer payment is made.

Eligibility to Contribute to an HSA

Because employees are eligible to set aside funds pre-tax, the IRS has established guidelines on who is eligible to contribute to an HSA. This rules apply to the employee and not to any of their dependents. To be eligible to contribute to an HSA a member may not be:

- Enrolled in Medicare
- Enrolled in Tri-Care
- May not be enrollment in another health plan not considered a High Deductible Health Plan
- May not be claimed as a dependent under their parent’s tax return

If any of these qualifications applies to you, you will need to enroll in a Health Reimbursement Account (HRA) in order to receive the employer contribution

Activating Your HSA

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 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.

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

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.

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.

1. The HRA employer contribution frequency and amounts will be identical to that of the Health Savings Account
2. Optum Bank is the HRA administrator
3. Employees will need to register their HRA with US Bank at www.mycdh.usbank.com in order to view account details.
4. 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

Optum Bank – HSA & HRA Vendor Information

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

Website: www.mycdh.usbank.com

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 CVS/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 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 Wellness Portal - Vendor is Cerner

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. Employees and spouses are not required to participate in HealthQuest to be covered under the SEHP.

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 for the details on all the benefits and rewards available when participating in the wellness program.

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 premium incentive discount). Plans C, J, N and Q are also eligible to \$10 for each HealthQuest credit up to a maximum of \$500 for the employee and another \$500 for the covered spouse into an HSA or HRA account. Members are eligible to receive the Rewards payments for credits that are posted to their HealthQuest account by November 9th each year. After November 9th only HealthQuest credits toward the premium incentive discount can be earned. Further information on the premium incentive discount and the Rewards incentive payments are available on our website 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.

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. You can access details on the legal, financial and counseling services offered on the web at: www.GuidanceResources.com or by calling 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
- Library of information on health and other topics

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

HealthyKIDS PROGRAM

HealthyKIDS – Annual enrollment is required

The HealthyKIDS program helps eligible State employees cover the cost of the premiums for their eligible children enrolled in the SEHP. The State will make an additional contribution toward the cost of dependent children's health premiums for qualified families. Employees are responsible for the remaining contribution. HealthyKIDS does not change the benefits offered under the SEHP coverage.

Eligibility for the HealthyKIDS program is based in part on family income. Children in households with incomes up to 250% of the Federal Poverty Levels, who would otherwise qualify for the Federal/State HealthWave (Title 21), may be eligible. Current household gross income guidelines can be found on the SEHP web site at www.kdheks.gov/hcf/sehp/HealthyKids.htm

Annual enrollment in HealthyKIDS is required. You may apply mid-year due to a qualifying event if that event affects your medical insurance coverage. The qualifying events are the same as those established for mid-year enrollment changes. You must apply within 31 days of the event. The HealthyKIDS deduction will not be stopped mid-year because of an increase in income or stopped because of a dependent reaching the age of 19 during the year. If you believe you are eligible, complete the online application at:

<https://khap.kdhe.state.ks.us/hkapplication/>

When you apply for HealthyKIDS, your application is reviewed and a determination of qualification is made. You receive notice of whether you qualify or not at the time the application is made. If you are ultimately approved, your premiums for coverage of your dependent children will be adjusted based upon the current HealthyKIDS contributions.

If you do not qualify, you may change your coverage level, but not the medical plan (Example: You may go from Family coverage to Member and Spouse). An online Change request must be submitted to SEHP Membership Services within 31 days of the online denial notice.

Becoming eligible for Title XXI (SCHIP) coverage does not count as a qualifying event under section 125 rules. And therefore you cannot drop HealthyKIDS mid-year unless you no longer have at least one qualified dependent child on account. However, if Title XXI coverage is lost mid-year that does count as a qualifying event under section 125 and the plan is permitted to add that person for coverage and have the primary member apply for HealthyKIDS.

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.

Note: Your HR representative must complete an online Change request to transfer you onto the Direct Bill program. You must then go onto the Initial Enrollment portal and submit your Direct Bill elections to SEHP Membership Services. The request must be submitted no more than 30 days after you ceased to be eligible for coverage.

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 change to the Direct Bill program will be the first day following the employee's last day actively at work, 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. Vision coverage ends on the last day of the month of becoming ineligible or coverage is terminated, or the last day of the month that the SEHP is notified that you are no longer eligible or terminated, whichever is later.

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.

RETIRES 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.

RETIRES AND MEDICARE ELIGIBILITY

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

The SEHP offers a full menu of insurance health plan offerings to compliment your Medicare coverage once you retiree. You can learn more on our website at: <http://www.kdheks.gov/hcf/sehp/default.htm>.

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.

Information on these plans can be found in the Retiree/Direct Bill Enrollment Booklet posted on the SEHP website <http://www.kdheks.gov/hcf/sehp/default.htm>. For additional information concerning the Direct Bill program, you or your Human Resources representative can contact:

SEHP Direct Bill Program

Telephone:

785-296-1715 (In Topeka)

1-866-541-7100 (Toll Free)

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 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 Me.
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.

4. Within 21 days of SEHP 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 INFORMATION

SEHP active benefits will terminate on the day the COBRA qualifying event occurs.

For all terminations, COBRA notices are generated by the SEHP's third party COBRA administrator following notification of the employee's 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, the member does not receive a COBRA notice. Therefore, timeliness becomes a critical issue when completing and submitting Termination requests.

Also, if the termination request is not entered in MAP, the carriers will not be notified to cancel coverage and claims are paid without collection of premium.

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 2018 COBRA Enrollment Booklet on our website here - <http://www.kdheks.gov/hcf/sehp/COBRA-2018Book.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.