Kansas
Department of Administration
State Employee Health Plan

STATE EMPLOYEE HEALTH PLAN
NON-STATE GROUP EMPLOYEES BENEFIT GUIDEBOOK
PLAN YEAR 2020 - 2021

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CONTACT INFORMATION

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 Blue Shield of Kansas	**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 **New Directions - Autism** Topeka: 785-233-1165 All Areas (Toll Free): 877-563-9347 Opt.2
Caremark Customer Service Caremark Connect Specialty Pharmacy	**www.caremark.com** All Areas (Toll Free): 800-294-6324 TDD (Toll Free): 800-863-5488 All Areas (Toll Free): 800-237-2767
Delta Dental of Kansas, Inc. Customer Service	**www.deltadentalks.com/** All Areas (Toll Free): 800-234-3375 Wichita: 316-264-4511
Employee Assistance Program (EAP) ComPsych Company ID: SOKEAP	**www.guidanceresources.com** All Areas: (Toll Free) 888-275-1205 (option 1)
The Hartford Customer Service	**https://healthbenefitsprogram.ks.gov/sehp/vendors/The_Hartford** All Areas: (Toll Free) 866-547-4205
HealthQuest HealthQuest@cerner.com	**https://healthquest.phsstofks.wellness.us.healtheintent.com/onboarding** All Areas (Toll Free): 888-275-1205 Option 3
NueSynergy Customer Service	**www.MyKansasCDH.com** All Areas (Toll Free): 855-750-9440 Fax (Toll Free): 855-890-7238
Preferred Lab Benefit Program	
• **Quest Diagnostics Lab Card Program** Customer Service Collection Site Listings	**www.labcard.com** All Areas (Toll Free): 800-646-7788 **www.labcard.com/collection.html**
• **Stormont Vail Health** Patient Financial Services Benefit Information and Collection Site Listings	**www.stormontvail.org/state-employees-lab** All Areas (Toll Free): 800-637-4716 Topeka: 785-354-1150
• **The University of Kansas Health System** (TUKHS) Customer Service	**www.kansashealthsystem.com/lab** All Areas (Toll Free): 866-358-5227
Rx Savings Solutions	**https://portal.rxsavingssolutions.com** All Areas: (Toll Free) 800-268-4476 **info@rxsavingssolutions.com**
Surency Vision Customer Service	**www.surency.com/stateofkansas** All Areas (Toll Free): 866-818-8805 Wichita: 316-462-3316
TASC - COBRA Administration Customer Service	**www.tasconline.com** All Areas (Toll Free): 844-285-9985

MEMBERSHIP ADMINISTRATION PORTAL (MAP)

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

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

MAP is supported by most 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 **NueSynergy**.
- The fully insured voluntary Long Term Care insurance offer by **ASCIA Partners/LifeSecure**
- COBRA (Consolidated Omnibus Budget Reconciliation Act) administered by **TASC**
- Voluntary Insurance Plans for Hospital Indemnity, Critical Illness and Accidental Injury administered by **MetLife**

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.

G. Direct Bill and Retirees Program—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 Non-State Group employees who were covered under the health plan immediately before going on approved Leave Without Pay
- Blind vendors
- Elected Officials

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

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

J. HealthQuest—the State of Kansas Health Promotion Program, which is a wellness program administered by Cerner Corporation.

K. 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.

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

M. 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.

N. Membership Services—the unit within the State Employee Health Plan that processes eligibility and membership for all individuals enrolled in the State Employee Health Plan.

O. Open Enrollment Period—October 1st through the 31st of each year. This is the time when members will make elections for coverage in the following year. This is required each year in order to continue coverage under the SEHP.

P. Permanent and Total Disability—Defines the condition for an individual who 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.

A dependent age 26 or older shall not be considered to have a permanent and total disability unless a completed *Permanent Totally Disabled Dependent Child Application* has been uploaded in the Member portal with a Communication request to continue coverage for the dependent. Recertification is required every 24 months.

Q. Plan year—Begins at 12:01 a.m., Central Standard Time, on January 1st, through midnight, December 31st.

R. State Employee Health Plan (SEHP) —the state health care benefits program that may provide benefits for persons qualified to participate in the program for medical, prescription drug, dental, vision and other ancillary benefits to participating state employees and their eligible dependents as defined under the provisions of K.A.R. 108-1-1.

The program may include such provisions as are established by the Kansas State Employee's Health Care Commission (HCC), 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
109 SW 9th Street, Suite 600
Mills Building
Topeka, Kansas 66612-1220

Email: ***SEHPMembership@ks.gov***

Visit the SEHP website at:
https://healthbenefitsprogram.ks.gov/sehp/state-employee-health-plan

EMPLOYEE ELIGIBILITY

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

EMPLOYEE WAITING PERIOD

If you are eligible to participate in the SEHP, you have 30 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 on the 31st day of employment. If you miss this deadline, the next opportunity you will 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

You should complete your initial Enrollment in the Member Portal (***https://sehp.member.hrissuite.com/*** within 31 days of your starting date in a benefits-eligible position. The effective date of your coverage will be the 31st day of employment. Once your benefits have become effective, no changes to your elections can be

If you are hired by a participating NSE and were previously enrolled in the SEHP through the SOK, with a break in employment of **30 days or less**, the 30-day waiting period shall not apply. An Enrollment portal will be opened for you and you will have 31 days from the date of hire to elect benefits. Coverage will be effective the 1st day of the month following the date of hire.

If you are hired by a participating NSE and were previously enrolled in the SEHP through , with a break in employment of **31 days or more**, the 30-day waiting period will apply. A portal will be opened for you to make elections and your effective date of coverage is the 1st day of the month following the completion of the waiting period.

If you are a current employee who is changing from a non-benefits eligible position to a benefits eligible position and have worked at least 30-days, you have already served the waiting period and your benefits will be effective the day you are hired into a benefits eligible position. You should complete an online initial Enrollment within 31 days of your hire date in the benefits-eligible position.

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 to the Member portal and elect to waive coverage. If you do not do anything, your benefits will be waived at the end of your initial enrollment period. Your next opportunity to enroll 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

The Dental plan is a stand-alone product, meaning that employees and their dependents do not have to be enrolled in Medical coverage to be enrolled in Dental coverage.

VISION PLAN

The Vision plan is a stand-alone product, meaning that employees and their dependents do not have to be enrolled in Medical coverage to be enrolled in Vision coverage.

VOLUNTARY BENEFITS

Accident, Critical Illness and Hospital Indemnity Insurance are voluntary benefits offered to members through MetLife in 2020 and will be through The Hartford starting in 2021. These are ALSO stand-alone products.

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:

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

   NOTE: The employer contribution for the employee covered as a dependent is limited to the standard dependent contribution and not that of an employee.

2. 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 an eligible dependent. A qualifying event must occur to add eligible dependents under the SEHP.

   NOTE: The employer contribution for the employee covered as a dependent is limited to the standard dependent contribution and not that of an employee.

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

3. "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.

4. "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, manner and time required by the SEHP.

5. 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 you claim the grandchild as a dependent on your most recent Federal tax return and at least one of the following conditions is met:

   - You have legal custody of your grandchild or have lawfully adopted your grandchild
   - The grandchild lives in 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
   - 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.

   When submitting a change request in MAP to add your grandchild, a ***Dependent Grandchild Affidavit*** must be completed, notarized, and uploaded along with a copy of your Grandchild's birth certificate and a **copy of your most recently filed Federal Income Tax return showing that you claim the grandchild as a dependent**, as proof of financial dependency and residency.

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

7. Eligible dependent child(ren) or stepchild(ren) aged 26 or older who have a permanent and total disability as described in item 4 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 unmarried and receive more than 50% of his or her support and maintenance from the primary member.

   A ***Permanent Totally Disabled Dependent Child Application*** must be completed and uploaded along with a copy of the child's birth certificate and **copy of your most recently filed Federal Income Tax return showing that you claim the child as a dependent** 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 dependent(s).

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.

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.

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 the employee's current year's filed Federal tax return claiming the grandchild as a dependent 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 the employee's current year's filed Federal tax return claiming the child as a dependent for proof of financial dependency and residency.

8. Copies of the current year's filed Federal tax return. **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.

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 Member Portal.
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

To add a newly eligible dependent to coverage, a ***Newly Eligible Dependent*** request must be submitted within 31 days of the event that makes the dependent(s) newly eligible. Members are able to submit the request along with supporting documentation in the Member Portal - ***https://sehp.member.hrissuite.com/*** Click on the ***Mid-Year Benefit Change Request*** tab then select ***Newly Eligible Dependent*** and fill in the information on the next page. The Upload Documents button is located at the bottom of the home page.

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

ADD/DROP A DEPENDENT DUE TO A CHANGE IN COVERAGE

This request is for adding or dropping a dependent to or from your coverage and is also listed in your Member Portal on the Mid-Year Benefit Change Request tab.

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

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 2 instances in which the SEHP will allow **pending** SSNs to be used to set up coverage for dependents.

1. **Newborn children** - a temporary SSN of 777-77-7777 may be entered for a newborn until the valid SSN is obtained. Generally, SSNs 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. If the SSN is not provided, the dependent may be removed from coverage. A copy of the SSN card can be provided as documentation
2. **Non-resident alien dependents** - a temporary ITIN of 888-11-1111 may be entered for non-resident dependents until a valid ITIN (if applicable) is obtained and sent to the SEHP.

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 lll).

NOTE: Valid SSNs and ITINs (if applicable) 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 obtained, please submit a Communication form in MAP providing the reason.

Please contact your Human Resources office for additional information.

NEWBORNS

To add a newborn to coverage, a ***Newly Eligible Dependent*** request must be submitted within 31 days of the birth. Members are able to submit the request in the Member Portal - ***https://sehp.member.hrissuite.com/*** along with supporting documentation. After logging in, click on the **Mid-Year Benefit Change** Request tab then select ***Newly Eligible Dependent*** and fill in the information on the next page.

A birth certificate or hospital announcement and a valid SSN or ITIN (if applicable) must be uploaded in the member portal. To upload documents, Use the **Upload Documents** button located at the bottom of the home page.

GRANDCHILDREN

A grandchild born to your covered dependent child may be covered under the SEHP, if a copy of the birth certificate, a completed ***Dependent Grandchild Affidavit***, and appropriate proof of financial dependency and residency are uploaded in MAP at the time of the ***Newly Eligible Dependent*** request within 31 days of the grandchild's date of birth. You must claim your grandchild as a dependent on your Federal tax return and at least one of the following conditions must be met:

a. You have legal custody of **or** have lawfully adopted your grandchild;

b. Your grandchild lives in your home and is the child of your dependent child covered under the SEHP and you provide more than 50% of the support of the grandchild; or

c. Your grandchild is the child of your dependent child covered under the SEHP and is considered to reside with you even when your grandchild or your dependent child are temporarily absent due to special circumstances including education of your dependent child, and you provide more than 50% of the support for your grandchild.

NOTE: A Dependent Grandchild affidavit (Appendix E) must be completed, notarized, and uploaded in MAP along with a copy of your grandchild's birth certificate and a copy of the most recently filed Federal tax return showing that you claim your grandchild as a dependent, for proof of financial dependency and residency when submitting the Change Request in MAP.

NEWBORN Grandchildren - A ***Newly Eligible Dependent*** request must be submitted within 31 days of the grandchild's birth. Members are able to submit the request in the Member Portal along with supporting documentation. After logging in, click on the **Mid-Year Benefit Change** Request tab then select ***Newly Eligible Dependent*** and fill in the information on the next page.

When you file the current year's tax return, the return, with all financial information redacted and the grandchild claimed as a dependent, must be uploaded and a Communication Request stating that this has been done must be submitted in MAP by April 15^{the} of the following year.

ADOPTIONS

For adoptions, a ***Newly Eligible Dependent*** request must be submitted 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, issued by the court including Judge's signature and court date stamp, must be uploaded in MAP with the request.

If the adoption is being handled through an adoption agency, they may require an adjustment period in the primary member's home prior to filing the petition for adoption. In this case, a copy of the adoption agency's placement letter must be uploaded in MAP with the ***Newly Eligible Dependent*** request and must indicate the date of placement as well as the length of the adjustment period.

When the adjustment period is over and the petition for adoption has been filed with the court, a copy of the petition for adoption issued by the court that includes the Judge's signature and court date stamp, must be uploaded in MAP in order to continue coverage for the dependent. If the dependent is removed from the primary member's home, an ***Add/Drop Dependent*** request must be submitted in MAP to remove the dependent from the primary member's coverage.

The SEHP should be contacted for guidance if the dependent is being adopted from a foreign country and a petition for adoption has not been filed in a U.S. Court.

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 that a ***Newly Eligible Dependent*** request is submitted 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.

NOTE: If you add a newborn or newly adopted dependent to coverage, other eligible dependents may also be added to your coverage at this time. The effective date of coverage for the newborn or adopted dependent will be the date of birth. A ***Newly Eligible Dependent*** request and the appropriate documentation are required within 31 days of the child's birth, date of placement for adoption or date of petition for adoption or.

The effective date of coverage for your other eligible dependents, such as spouse and/or other children or stepchildren, will be the effective the same day as the newborn or newly adopted dependent.

CHANGE IN EMPLOYEE CONTRIBUTION

The change in premium (if applicable) will be reflected on the next paycheck after the SEHP receives and processes the request. The effective date will coincide 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 that day.

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 submit a ***Newly Eligible Dependent*** request within 31 days of the date that the court issues a legal custody agreement. A copy of the court order or legal custody agreement and birth certificate must be uploaded in MAP with the 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 that day.

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 a ***Newly Eligible Dependent*** request in the Member portal. 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, legal custody/guardianship, etc.), and you want to enroll in the SEHP, you will need to submit a ***Communication*** request to enroll in your Member Portal within 31 days of the qualifying event date and upload the required documentation for that 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

The Open Enrollment period for SEHP occurs annually from October 1st – 31st. Members are required to complete the Open Enrollment process to make their coverage elections for the following year during this time.

Open Enrollment elections are made in the Membership Portal - ***https://sehp/member/hrissuite.com***

Information concerning enrollment elections can be found in the enrollment booklet on the SEHP website - ***https://healthbenefitsprogram.ks.gov/sehp/state-employee-health-plan***.

When requesting to add dependents during Open Enrollment, the appropriate supporting documentation including valid SSNs or ITINs (if applicable), must be uploaded in the Membership portal during the enrollment process. Any documentation submitted in any language other than English must be accompanied with an English translation.

NOTE: If the appropriate information is not provided during Open Enrollment, the SEHP will be unable to add the dependents to your SEHP coverage for the following plan year. If an ITIN cannot be provided, please submit a Communication form to SEHP Membership Services providing the reason the ITIN can't be obtained.

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 are hired during or after the Open Enrollment period, must enroll in their initial coverage for the current Plan Year **and** complete the Open Enrollment process for the following year.

REVISED OPEN ENROLLMENT ELECTIONS

You may change your original Open Enrollment election in MAP any time before October 31st

IDENTIFICATION CARDS

If you are newly enrolled or have made a coverage level change, Medical, Dental, Vision Identification (ID) cards will be sent to you. If you do not receive your ID cards, please contact the health plan vendors directly using the telephone numbers listed in the front of this Guidebook or on the vendor page of the SEHP's website at: ***https://healthbenefitsprogram.ks.gov/sehp/state-employee-health-plan*****.** 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.

Note: SEHP premiums will be based on semi-monthly payroll deduction periods. This includes vision and voluntary plans.

For current SEHP rates, please review the current Enrollment booklet located on our website at: ***https://healthbenefitsprogram.ks.gov/sehp/state-employee-health-plan***.

MID-YEAR ENROLLMENT CHANGES

ADDING /DROPPING DEPENDENTS DUE TO A CHANGE IN COVERAGE

Dependents may be added or dropped from your coverage during the Plan Year if the following mid-year change requirements are met:

a. The change is a result of a dependent losing or gaining coverage on their own;
b. You request the change within 31 calendar days of the event by completing the Add/Drop request in your Member portal.
c. Written documentation of the event is provided (divorce decree, death certificate, custody agreement, or statement from a spouse/dependents employer on company letterhead indicating they are losing or gaining coverage and the effective date

REQUIRED SUPPORTING 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). After filing the current year's filed Federal tax return, a copy of the first two pages showing you have claimed the grandchild and signatures will need to be uploaded for proof of financial dependency and residency of the grandchild. Please white out any income information before uploading.
7. A completed *Permanent Totally Disabled Dependent Child* application and copy of the first two pages of the current year's filed Federal tax return for proof of financial dependency and residency of that child. Please white out any income information before uploading.
8. For proof of Spouse eligibility ONLY, the pages needed from the current year's filed Federal tax return depend 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, if those pages include the date stamp by the court and the signature of the judge)
10. Both a copy of a military ID and privilege card with the expiration date and a copy of the letter confirming benefits and the effective date are 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

the date in which coverage ended.

Valid SSNs/ ITINs (if applicable) are required when you add dependents to your coverage. If the information is not provided at the time of the request to add the dependent, the SEHP will be unable to add them to your SEHP coverage. If an ITIN cannot be provided, a Communication form must be submitted to SEHP providing the reason the ITIN can't be obtained.

NOTE: A qualifying event will not allow you to change plans or medical vendors, only coverage level changes can be made mid-year. After your initial enrollment, plan and vendor changes can only be done during open enrollment.

MID-YEAR QUALIFYING EVENTS – PRETAX EVENTS

If you are enrolled in the SEHP on a pretax basis, you may make mid-year changes to your coverage based on the following qualifying events:

1. **Your marriage** – you may add or drop your entire family as the entire family is now newly eligible. You will need to submit a copy of the marriage license along with the **Add/Drop** request in your Member portal to add family members to your coverage.

   If you are going on your Spouse's health plan coverage, submit a **Member Waive Coverage (Mid-Year)** request in your Member portal and upload documentation showing you are covered under the spouse's health plan with the effective date listed.
2. **Common Law marriage** – submit an **Add/Drop** request in your Member portal and upload a notarized copy of the completed **Common Law Marriage Affidavit** (found under the Forms tab in your Member Portal) and proof of joint ownership. Acceptable documents for proof of joint ownership are listed below. Please white out any financial information before uploading. Documents submitted should have both you and your spouse listed.
   - Active current bank statement
   - Active lease agreement
   - Current homeowners insurance statement
   - Current credit card statement
   - Current property tax statement
   - Current year federal filed tax return
   - Current mortgage statement
3. **Divorce -** In the event of divorce you will need to submit a *Remove Ineligible Dependent* request and upload a copy of the first and last pages of the final divorce decree in your Member portal, which includes the date stamp by the court and the signature of the judge. This will remove the ineligible spouse and stepchildren from your coverage.
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 **Add/Drop** request in your Member portal and upload the birth certificate or a copy of the petition for adoption or placement, whichever is appropriate, for the newborn and a marriage certificate and birth certificates for any other children.

   In this situation, you may only drop entire family if the family members are now covered under another employer's plan.
5. **Gain or loss of legal custody** of a dependent, you will need to submit a **Remove Ineligible Dependent** request in your Member portal and upload a copy of the court order including court recorded date stamp and judge's signature in order to add or drop the dependent.

6. **Change in Employment –** If you or your dependents have a change in employment like moving from part-time status to full-time status or vice versa or have been moved to a position that affects benefits eligibility that will affect the cost, benefit level, or benefit coverage, you are eligible to change your health plan coverage.

   To enroll yourself in coverage, you will submit a Communication form in your Member portal stating that you are changing employment status or benefits eligibility and would like to enroll in coverage due to this change. An enrollment portal will be opened, and an email will be sent to you explaining how to enroll.

   If you would like to drop coverage, you will submit a **Member Waive Coverage (Mid-Year)** request in your Member portal and coverage will be dropped effective the last day in the eligible position. You will need to upload the proper documentation when you submit the request.

7. **Termination or commencement of employment (including retirement)** If this pertains to you, your HR department will submit the appropriate request in the HR portal, and it will be worked by SEHP and an email will be sent to you if there is anything you need to do. You may change your medical plan at the time of retirement

   For your spouse or a dependent loss or gaining of coverage, you will need to submit an ***Add/Drop*** request in your Member portal and upload the appropriate documentation –

   - 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. The letter or certificate must identify the previous employer and list the date in which coverage ended.
   - For spouse or dependent gaining other group health coverage, proof of coverage from new vendor/employer showing the plans, effective date and who is covered.

8. **Death –**If the death is the employee, the request will be submitted by the HR department in the HR portal and the death certificate will be uploaded. Surviving spouse/dependents will be able to continue coverage under either the COBRA or Direct Bill program.

   If the death is the spouse or a dependent, you or your HR department will submit a ***Death of Spouse or Dependent*** request and upload of the death certificate.

9. **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.

10. **Your dependent child turns age 26** (coverage ends for your dependent on the last day of the month of their 26th 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.

11. **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

12. **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 or spouses turning 65 and becoming newly eligible for Medicare benefits will need to complete a TEFRA form to elect whether or not they wish to have Medicare or SEHP coverage by primary. If Medicare is chosen as primary, coverage under the SEHP will end the day before Medicare coverage is effective. Notices are sent out approximately 60 days prior to the 65th birthday and include instructions on completing and uploading the TEFRA form.

If a member, spouse or dependent lose Medicare eligibility, a communication form will need to be submitted in MAP and documentation of the loss of Medicare benefits uploaded.

13. **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. Contact your HR department to submit a request in the HR portal. Proof of coverage listing all covered individuals and the effective date of 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. Contact your HR department to submit a request in the HR portal. Proof of loss of coverage listing all covered individuals and the effective date of coverage termination.

14. **Dependent children losing eligibility/coverage** under another group health insurance plan is a qualifying event to request a coverage change. An ***Add/Drop*** request will need to be submitted and a letter or certificate of other creditable coverage listing the name of the dependents that were covered and the effective date of termination uploaded in your Member portal.

    For mid-year changes, the effective date of coverage or change in coverage will generally be the first day of the month following the event. For events that occur on the first day of a month, the coverage effective date will be the 1st day of the month. If a death occurs on the first day of a month, the change effective date will be the 1st day of the following month.

    For dependents gaining coverage under another group health plan, submit an ***Add/Drop*** request in your member portal and upload a letter or certificate 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 will need to be uploaded.

15. **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.

16. **Dependent spouse or children who move to the U.S**. is a qualifying event. Submit an ***Add/Drop*** request in your Member portal and upload copies of your marriage license, birth certificates and the stamped Visa or air flight itinerary showing when the dependent entered the U.S. for the dependents being added.

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.

TERMINATION OF ACTIVE COVERAGE

All active coverage including medical, dental, vision, prescription drug and voluntary benefits will terminate the last day of the month in which you terminate employment. If you terminate employment on the 1st of any month, all coverage will end that day.

If you are enrolled in the voluntary insurance programs for hospital indemnity, critical illness or accidental injury, you have the option to change that coverage to an individual plan and continue it after you leave the State.

ACTIVE MILITARY DUTY

If you go on military duty - leave without pay, you can either terminate your SEHP coverage effective the last day of the month in which you go on military duty or continue SEHP coverage for the next 30 days.

If you choose to terminate SEHP coverage, you and your covered dependents will be allowed to re-enroll into the same SEHP plan and coverage when you return to active employee status.

If you choose to continue coverage for the next 30 days, your Agency would pay the SEHP employer contribution for those 30 days and you would pay your regular payroll deduction amount to your Agency.

After the first 30 days have passed, you may continue SEHP coverage in the SEHP Direct Bill Program. You need to request the change to Direct Bill within 30 days of the effective date of the military leave without pay. You would enter your ACH information in your Member portal and the full (employer and employee portion) premium amount would automatically be deducted once a month from your bank account as a direct bill participant. There is 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.

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

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.

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.

LEAVE WITHOUT PAY AND RETURN FROM LEAVE WITHOUT PAY

LEAVE WITHOUT PAY

If you are on voluntary or involuntary Leave Without Pay for 30 continuous calendar days or less and elects to enroll in the Direct Bill program, the employer will pay their part of the premium and you will be billed by the agency for your part of the premium that is normally withheld you're your paychecks.

If you are on voluntary or involuntary Leave Without Pay for 31 or more continuous calendar days, and the leave is not approved as FMLA, the employer must notify you that your SEHP coverage as an active employee will end effective the last day on payroll, unless you sign up for Direct Bill.

NOTE: Nine (9) month Regent employees do not receive the 30 calendar days of agency premium contribution.

NOTE: Leave without Pay is not a qualifying event to enroll in COBRA.

A. Non-payment of Active Non-State Group Employee Premium

If you fail to pay on schedule, the employer will submit a request in MAP under Leave Without Pay for Cancellation Due to Non-Payment. You will not be offered COBRA coverage and will not be allowed to re-enroll in active or Direct Bill coverage for the remainder of the Leave Without Pay period.

B. Continued Payment of Active Non-State Employee Premium

If you are on leave longer than 30 days and have continued to pay for employee coverage on the scheduled time frame following the initial 30 calendar days, your employer will submit a Leave Without Pay request in MAP and indicate if you want to continue with Direct Bill coverage while on leave or not. Once the request has been processed, a portal will be opened for you to elect your health insurance coverage while on leave.

After completing your elections in their Member Portal, the employee will need to complete the ACH Form - Recurring Payment on the Billing tab under Payment Methods so their premiums can be deducted from their bank account on the 8th of each month for that month's premium. Direct Bill coverage will begin on the 1st day of the month.

RETURN FROM LEAVE WITHOUT PAY

When you return from Leave Without Pay (whether it is a regular Leave Without Pay or if it is FMLA Leave Without Pay) a Change Request must be entered in MAP within 31 days of the date of return to active pay status by your HR.

If you did not enroll in Direct Bill coverage while on leave, the health insurance coverage you were enrolled in before going on leave, will be effective the first day of the month after you return to work.

If you enrolled in Direct Bill coverage while on leave, the Direct Bill coverage will end the last day of the month in which you return to work and the same coverage you were enrolled in before going on leave will be effective the first of the following month.

NOTE: The only exception to what is listed above is if the Leave Without Pay extended over an Open Enrollment period. If that is the case, then a portal will be open for you to elect coverage for the new Plan Year.

FAMILY MEDICAL LEAVE ACT (FMLA), FURLOUGHS AND LAYOFFS

FMLA - APPROVED LEAVE WITHOUT PAY OF 31 OR MORE DAYS

If you are eligible for FMLA, you are eligible for 12 weeks of paid or unpaid leave during any 12-month period beginning with the first day leave was taken.

If you are on FMLA and continue to receive a paycheck, your health insurance premiums will continue to be deducted. When you go on FMLA Without Pay, your employer will bill you for your portion of the premium. If you do not pay these premiums your health insurance coverage will be canceled effective when FMLA began or when last payment was made. The employer will submit a request into MAP to cancel your health insurance due to non-payment of premiums while on FMLA.

Once FMLA ends and if you are still on Leave Without Pay, your employer will then need to submit a request in MAP indicating FMLA has ended and you are being put on Leave Without Pay. You will get the additional 30 days.

FURLOUGHS

If you are furloughed, your SEHP benefits will remain in effect the same as you had as an employee. If you do not have sufficient wages during the pay period to deduct the employee contribution, you will be required to remit the proper contribution amount on a schedule consistent with the semi-monthly pay periods. Your portion of the SEHP premium should be collected by the agency and remitted to the Division of Accounts and Reports – Payroll Section.

If you are on furlough during Open Enrollment, you will be able to make Open Enrollment changes to their SEHP coverage.

Upon the ending of your furlough period, if you have not sustained the requirements for membership in the SEHP, you will have the opportunity to re-enroll. You will be subject to all other applicable policies and regulations regarding enrollment in the SEHP. The ending of a furlough is a Qualifying Event according to IRS Section 125 guidelines.

LAYOFFS

In the event of a layoff, your SEHP coverage will end the last day of the month in which you work. A letter from the COBRA administrator will be sent to your home address in MAP, offering 18 months of coverage under COBRA. If you accept COBRA coverage, you will be responsible for paying the full cost of the coverage, which will include both the contribution you made as an active Non-State Group employee and the contribution paid by the employer.

If you are laid off from service under K.S.A. 75-2948, the 30-day waiting period shall not apply if you return to a benefits eligible position within 365 days from the date of layoff. If this occurs, the agency should enter an Enrollment Request indicating “Return from Layoff within 1 Year” within 31 days of you returning to work.

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.

NON-DISCRIMINATION 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

HIPAA includes a Security Rule (effective April 20, 2005) The Security Rule operationalizes the protections contained in the Privacy Rule by addressing the technical and non-technical safeguards that “covered entities” must put in place to secure individuals’ “electronic Protected Health Information” (e-PHI).

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

NOTE: In 2021, some of the Non-State Employer Groups in the State Employee Health Plan have elected to offer the Flexible Spending Account (FSA) Program to employees. Check with your Human Resource Department to see if your employer is offering FSAs

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. 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.

B. 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.

C. 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.

d. 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.

e. 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.

f. **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 ***https://healthbenefitsprogram.ks.gov/sehp/vendors/FSA***

FSA PARTICIPANTS: QUALIFIED RESERVIST DISTRIBUTIONS

NOTE: In 2021, some of the Non-State Employer Groups in the State Employee Health Plan have elected to offer the Flexible Spending Account (FSA) Program to employees. Check with your Human Resource Department to see if your employer is offering FSAs

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:
https://healthbenefitsprogram.ks.gov/sehp/vendors/FSA

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)

Note: If you are enrolled in Medicare Part A or B, you are not eligible for an (HSA) and must enroll in an HRA.

The HSA is a health care bank account owned by you, administered by NueSynergy. 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 by submitting an HSA Mid-Year Change request in your Member portal. 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 the first day of each quarter, in order to receive the employer contribution. The HSA employer contribution amount is 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. These 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 apply to you, you will need to enroll in a Health Reimbursement Account (HRA), in 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, NueSynergy will reach out to you directly and request the additional documentation that is needed. You are required to work directly with NueSynergy 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.

For more information on the Health Savings Account (HSA), go to
https://healthbenefitsprogram.ks.gov/sehp/vendors/health-savings-account-(hsa)

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 made 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. NueSynergy is the HRA administrator
3. Employees will need to register their HRA with NueSynergy at ***www.MyKansasCDH.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: ***https://healthbenefitsprogram.ks.gov/sehp/vendors/health-reimbursement-account-(hra).***

NueSynergy – FSA, HSA & HRA Vendor Information

Toll Free Customer Service Line: 1- 855-750-9440

Website: *www.MyKansasCDH.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, benefits and rewards for participation in the wellness program please visit:

https://healthbenefitsprogram.ks.gov/sehp/healthquest/home

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: - ***https://healthbenefitsprogram.ks.gov/sehp/healthquest/home*** 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***

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 retired school district employee who is eligible to receive retirement benefits;
- **B** Any totally disabled former school district employee who is receiving benefits under K.S.A. 74-7927 and amendments thereto;
- **C** Any surviving spouse or dependent of a qualifying member in the school district plan;
- **D** Any person who is a school district employee and who is on approved Leave Without Pay in accordance with the practices of the qualified school district;
- **E** Any individual who was covered by the health care plan offered by the qualified school district on the day immediately before the first day on which the qualified school district participates in the school district plan, except that no individual who is an employee of qualified school and who does not meet the definition of school district employee in K.A.R. 108-1-3
- **F** Any retired local unit employee who meets one of the following conditions:
    1) The employee is eligible to receive retirement benefits under the Kansas Public Employees Retirement System or the Kansas police and firemen's retirement system; or
    2) If the qualified local unit is not a participating employer under either the Kansas Public Employees Retirement system or the Kansas police or firemen's retirement system, the employee is eligible to receive retirement benefits under the retirement plan provided by the qualified local unit.
- **G** Any totally disabled former local unit employee who meets one of the following conditions:
    1) The employee is receiving benefits under the Kansas Public Employees Retirement System or the Kansas police and firemen's retirement system; or
    2) If the qualified local unit is not a participating employer under either the Kansas Public Retirement Employees Retirement system or the Kansas police and firemen's retirement system: the employee is receiving disability benefits under the retirement or disability plan provided by ther qualified local unit.
- **H** Any surviving spouse or dependent of a qualifying member in the local unit plan
- **I** Any person who is a local unit employee and who is on approved Leave Without Play in accordance with the practices of the qualified local unit; and
- **J** Any individual who was covered by the health care plan offered by the qualified local unit on the day immediately before the first day on which the qualified local unit participates in the local unit plan, except that no individual who is an employee of the qualified local unit and who does not meet the definition of the local unit employee in K.A.R. 10-8-1-4.

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:

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 active employee 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.

RETIREES NOT ELIGIBLE FOR MEDICARE

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

RETIREES AND MEDICARE ELIGIBILITY

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

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: ***https://healthbenefitsprogram.ks.gov/sehp/state-employee-health-plan***.

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. For the 2020 booklet click ***here***. For the 2021 booklet click ***here***. 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 1985. 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. If you are a retiree and have chosen COBRA over the SEHP Direct Bill coverage, when COBRA runs out you have the option to 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 will 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 submit a termination request in the HR portal. SEHP Membership will process that request, notify the COBRA vendor of your termination and a COBRA notice will be mailed out.
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 the last day of the month in which the COBRA qualifying event occurs.

For all terminations, COBRA notices are generated by the SEHP's third party COBRA administrator following the receipt of the termination on a file from the SEHP. Termination requests are entered in MAP by the Agency HR Representative.

COBRA continuation is not automatic - it is a choice that the qualified beneficiary must make. 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

The premiums for COBRA are calculated in accordance with the Internal Revenue Code and the Employee Retirement Income Security Act (ERISA).

For more information including the current plan year COBRA rates, view the 2020 COBRA Enrollment Booklet on our website **here**. The 2021 COBRA Enrollment Booklet is **here**

TERMINATION OF COVERAGE CONTINUATION

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

1. You do not pay premiums in full on time;
2. You or your dependent(s) become 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.