State Employee Health Plan
State of Kansas Agencies
Administrative Manual

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ACRONYM GLOSSARY

The information provided in this manual is subject to change without notice.

GENERAL HEALTH PLAN INFORMATION

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, 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 a classified State of Kansas service (appointed by the Governor)
- A person from the public (appointed by the Governor)
- A member of the Senate Ways & Means Committee
- A member of the House Appropriations Committee

State of Kansas bids and contracts with carriers for three-year periods. Medical, prescription drug, dental, and vision contracts are staggered so that not all contracts renew in the same year.

The State Employee Health Plan self-insured medical plan carriers are:

- Aetna
- Blue Cross Blue Shield of Kansas

Other benefits vendors under the SEHP:

- CVS Caremark - prescription drug coverage
- Delta Dental Plan of Kansas - dental plan
- Surency - voluntary vision plan
- NueSynergy - Flexible Spending Accounts (Health Care, Limited Scope, Dependent Care and Commuter)
- MetLife - Health Reimbursement Account and Health Saving Account
- COBRAGuard - administers COBRA Coverage

The SEHP pays the plan provider an administrative fee per contract to process membership information and claims. Therefore, the SEHP and plan members are directly responsible for all claims and utilization costs.

State Employee Health Plan contact information can be found on the SEHP website.

II. DEFINITIONS

A. After Tax Deduction – Money is taken from an employee's paycheck after all applicable taxes have been withheld.

B. Before Tax Deduction – Money taken out of an employee's gross pay before any taxes are withheld which reduces the employee's taxable income by the deduction amount.

C. Consolidated Omnibus Budget Reconciliation Act (COBRA) – Federal law requiring that most employers sponsoring Group Health Insurance offer covered employees and their participating eligible dependents an opportunity to extend health coverage for specified periods.

D. COBRA Participant – An eligible covered participant who elects a temporary extension of health coverage when coverage would otherwise end, as defined by COBRA.

E. Dependent – The primary member's eligible spouse or dependent child(ren) as defined in KAR 108-1-1.

F. Direct Bill and Retirees – Program to extend health coverage to:
   - Retiring participating State of Kansas employees,
   - Totally disabled former participating State of Kansas employees,
   - Surviving spouses and/or dependents of participating state employees eligible under the provisions of K.A.R. 108-1-1
   - Active participating state employees who were covered under the health plan immediately before going on approved Leave Without Pay
   - Blind vendors
   - Elected Officials

G. Employee Contribution – The contribution amount required to be paid by the employee for their SEHP coverage.

H. Employer Contribution – The contribution amount must be paid by the employer on behalf of the employee and/or eligible dependents.

I. Health Care Commission (HCC) – Entity that establishes and oversees all provisions under the SEHP.

J. Health Plan – Defined medical, drug, dental, and vision benefits offered to the State of Kansas and Non-State employer groups.

K. HealthQuest – Wellness program administered by the SEHP.

L. Health Insurance Portability and Accountability Act (HIPAA) – Federal act that protects the privacy of individually identifiable health information under the Privacy Rule; the HIPAA Security Rule, which sets national standards for the security of electronically 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.

M. Legal Custody/Guardianship Dependent – Child(ren) who is/are not a biological or adopted child of the primary member.

N. Member – An individual eligible for and actively participates in the health care benefits offered through the SEHP. This includes employees, spouses, and children. Members include Active state employees, Non-State employer groups, Retirees, Direct Bill members, and COBRA participants.

O. Membership Administration Portal (MAP) – Eligibility "system" for SEHP Benefits.

P. Membership Services—The State Employee Health Plan unit is responsible for managing all eligibility functions and membership activities for all SEHP members.

Q. Open Enrollment Period—the period during which all SEHP members can enroll and change their coverage. Open enrollment is held once a year in October.

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

S. Plan year – Annual period of coverage for benefits in the SEHP, beginning at 12:01 a.m. (CST) on January 1st and ending at midnight (CST) on December 31st.

T. Primary member – The individual who is actively employed by the State of Kansas. In the event of retirement, the primary member is the main participant covered under the SEHP and who is not considered a dependent of another active primary member.

U. Qualified Medical Child Support Order (QMCSO) – A QMSCO is designed to provide health coverage to a child of an employee through his or her employer's group health plan. The QMCSO process occurs through the court system. A Medical Child Support Order becomes qualified as a QMCSO if it satisfies the employer's legal and administrative qualification requirements. The Employee Retirement Income Security Act (ERISA) and the employer's group health plan guide the employer's QMCSO process.

   A 1993 amendment to the Employee Retirement Income Security Act (ERISA) requires employer-sponsored group health plans to extend health care coverage to the children of a parent/employee who is divorced, separated, or never married when ordered to do so by state authorities. The SEHP meets this requirement.

V. State Employee Health Plan (SEHP) – The state health care benefits program that may provide benefits for medical, prescription drug, dental, vision, and other ancillary benefits to eligible employees and their eligible dependents. The program may include such provisions as established by the State of Kansas employees' 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 because of termination of employment or other change of status, leave of absence, military service or other interruptions in service and other reasonable provisions as may be established by the commission.

W. Variable-hour employee – Variable-hour employee is any officer or employee of a state agency for whom, at the date of hire, it cannot be determined that the employee is reasonably expected to work at least 1,000 hours per 12-month period.

If you have specific questions regarding certain benefits offered within the SEHP or areas of administration of specific benefits, please get in touch with the SEHP at sehpmembership@ks.gov or the **website.**

NOTE: Current physical addresses, email addresses, and phone numbers must be maintained in MAP for HR contacts and employees so that members can receive health plan information on time.

EMPLOYEE ELIGIBILITY

All benefits-eligible employees must be entered in MAP, and an Enrollment for New Employee request must be submitted, even if the employee wants to waive benefits.

I. EMPLOYEE DEFINITION - PRIMARY PARTICIPANTS

According to provisions of K.A.R. 108-KAR1-1, the classes of persons eligible to participate in the SEHP as Primary Participants shall be the following persons:

A. Any elected official of the state

B. Any other officer or employee of a state Agency who meets both the following conditions:
   a. Is working in one or more positions that together require at least 1,000 hours of work per 12-month period; and
   b. Is not a variable-hour employee.

C. Any person engaged in a postgraduate residency-training program in medicine at the University of Kansas Medical Center or in a postgraduate residency or internship training program in Veterinary Medicine at Kansas State University

D. Any person serving with the Foster Grandparent program.

E. Persons participating under phased retirement agreements outlined in K.S.A. 76-746, and amendments thereto.

F. Any student employee and an adjunct professor at a state institution of higher learning if the individual works in one or more positions that together require at least 1,560 hours of work per 12-month period.

G. Any other class of individuals approved by the State of Kansas Employees HCC, within the limitations specified in K.S.A. 75-6501, *et seq.*, and amendments thereto.

Eligible active employees who elect to participate in the Plan shall be referred to as primary member(s) in the rest of this manual.

COVERAGE ELECTION PERIOD

Each person shall have 31 days from the date of hire to elect or waive SEHP coverage in MAP. If an employee misses their deadline, the next opportunity to elect coverage will be during the annual Open Enrollment period or with a Qualifying Event, that has occurred within 30 days of the effective date of the change.

A. SOK TO SOK TRANSFER

If the employee transfers from one SOK agency to another with **no break in service**, the employee will have continuous coverage. The previous agency will submit a Request for Termination in MAP. The new agency will create a new member under their department. The MAP System will match the SSN and DOB and create a transfer request for the new agency. The agency should add a note to the transfer request in MAP indicating the agency where the employee was previously employed.

B. EMPLOYMENT CHANGE FROM NSE TO SOK

An Enrollment portal will be opened, and the employee will have 31 days from the date of hire to elect benefits. Coverage will be effective the 1st day of the month following termination of the NSE benefits or the 1st day of work if there is a gap in employment. The hiring agency will create a new member under their department. MAP will match the SSN and DOB and create a transfer request from the hiring agency. The agency should add a note to the transfer request in MAP indicating the NSE group where the employee was previously employed.

C. **RETURNING TO WORK AND HAS HAD CONTINUOUS COVERAGE**

If a person who is returning to work for the SOK has had continuous SEHP coverage, with either the Direct Bill Program or COBRA the agency will create a new member under their agency. MAP will match the SSN and DOB and create a transfer request for the hiring agency. The agency should add a note to the transfer request in MAP indicating that the primary member is a current Direct Bill or COBRA member. Coverage will be effective on the 1st day of work.

NOTE: If a SEHP retiree is returning to work in a benefits-eligible position, they can continue their Direct Bill coverage or enroll in benefits as an active employee.

If a SOK retiree is returning to work and has had continuous coverage under a spouse's SEHP coverage, the agency will create a new member under their department. MAP will match the SSN and DOB and create a transfer request for the hiring agency. The agency should add a note to the transfer request in MAP providing the full name of the primary member's spouse and that the primary member is covered under that spouse's SEHP coverage. Coverage will be effective on the 1st day of work.

If an employee was laid off from the SOK under K.S.A. 75-2948, the agency will create a new member in MAP under the employee's SOK employee identification number. MAP will match the SSN and DOB and create a transfer request for the hiring agency. Coverage will be effective on the 1st day of work.

II. EMPLOYEE'S EFFECTIVE DATE OF COVERAGE

For newly hired individuals, coverage will be effective on the first day of work. The employee must complete an enrollment in MAP within 31 days of the first day of work. Employees should make their elections as soon as possible to avoid multiple premium deductions from one paycheck. Once benefits become effective, no changes in coverage level can be made without a mid-year Qualifying Event or the next Open Enrollment period.

For current employees who are changing from a non-benefits-eligible position to a benefits-eligible position, the effective date of coverage is the 1st day of work in the benefits-eligible position. The employee must complete an enrollment in MAP within 31 days of starting work in the benefits-eligible position.

For employees rehired with a break in employment of 30 days or less, the previous benefit coverage will be reinstated effective the 1st day the employee returns to work (if the employee had active SEHP coverage before termination).

For employees rehired with a break in employment of 31 days or more, an enrollment portal will be opened for the employee to make coverage elections. Employees should make their elections as soon as possible to avoid multiple premium deductions from one paycheck. Coverage will be effective on the 1st day of work.

III. OPT-OUT / WAIVE INSURANCE COVERAGE

If an eligible employee does not want to enroll in the SEHP, the employee must complete an enrollment in MAP indicating that they wish to waive SEHP coverage. If the employee does not complete their enrollment online within their enrollment period, all benefits will be waived in MAP. The next opportunity for the employee to enroll will be with a mid-year Qualifying Event or the next Open Enrollment period.

IV. FULL-TIME / PART-TIME STATUS

Employee contributions for group health insurance during the Plan Year are based on the FT or PT employment status of the position (benefit program code) as outlined below. If the employee is active in more than 1 eligible position, the employment status should be based on the combined FTE (Full-Time Equivalent) for all positions.

Employment Status (first 2 digits of benefit program code)

- FT = Full-time = employee that works a minimum of 1560 hours during the 12-month measurement period.
- PT = Part-time = employee that works a minimum of 1000 hours but less than 1560 during the 12-month measurement period.

V. BENEFIT PROGRAM CODE

Benefit program codes represent the employment status, FT or PT, and a tier for premiums. Currently, there is one tier for premium costs. SOK employees that have applied and been approved for the HealthyKIDS discount will have a benefits program code that starts with "HK" for "HealthyKIDS".

- FT1 = Full-time SOK employee
- PT1 = Part-time SOK employee
- HKF = Full-time SOK employee approved for HealthyKIDS discount
- HKP = Part-time SOK employee approved for HealthyKIDS discount

NOTE: Employment status and benefits program code must be changed during the Plan Year whenever the employee changes from an FT to a PT position or from a PT to an FT position (as outlined above). Requests must be submitted in MAP within 31 days of the change. If the employment status change occurs on the 1st day of a month, the new benefit effective date will be the 1st day of that month. If the employment status change occurs during the month, the effective date for the applicable status change will be the 1st day of the following month. If changes in SEHP coverage result from these employment status changes, the same effective dates shall apply.

OTHER ELIGIBLE INDIVIDUALS FOR THE SEHP

I. OTHER ELIGIBLE INDIVIDUALS

A. In addition to covering themselves, a primary member can also elect coverage for eligible dependents. This includes:

- The primary member's lawful spouse, subject to the documentation requirements of the HCC or its designee.
- Any of the primary member's eligible dependent child(ren) subject to the documentation requirements of the HCC or its designee. These individuals will be referred to as "dependent(s)" throughout the rest of this manual.

Parents are **not** eligible for coverage under the State Employee Health Plan.

NOTE: If a primary member divorces, coverage for their former spouse and stepchild(ren) ends on the last day of the month when the divorce is final. If the date the divorce is final is the 1st day of the month, coverage for the primary member's former spouse and stepchild(ren) ends on the last day of the month prior. COBRA coverage will be offered to the eligible participants.

B. An individual eligible to enroll as a primary member in the SEHP can enroll as a dependent, provided the individual who wants to enroll as a dependent spouse is the lawful spouse of another primary member currently enrolled in the SEHP. An eligible employee cannot be enrolled in SEHP medical, dental, vision, or voluntary coverage both as a primary member **and** as a covered spouse of an enrolled employee. Members are either eligible dependent on all SEHP coverage or the primary member on all coverage; they cannot be both. **Example:** Employee enrolls in medical as a primary member and <u>cannot</u> be enrolled as a dependent on medical, dental, vision, or other coverage. Eligible dependents

may be added with a mid-year Qualifying Event or during Open Enrollment.

C. An individual eligible to enroll as a primary member in the SEHP can enroll as a dependent child or spouse of a primary member, provided they meet the definition of eligible dependent. An eligible dependent cannot be enrolled in SEHP medical, dental, vision, or voluntary coverage as a primary member and a dependent of an enrolled employee. Members are either eligible dependent on all coverage or primary members on all coverage; they can't be both. **Example:** Employee enrolls in medical as a primary member and cannot be enrolled as a dependent on medical, dental, vision, or other coverage. Eligible dependents may be added during a mid-year qualifying event or open enrollment.

D. An individual who enrolls as a dependent spouse or child of a primary member cannot change that status and enroll as a primary member during that plan year unless a Qualifying Event directly impacts the individual's coverage.

E. Everyone who enrolls as a dependent spouse or child of a primary member is subject to the co-pays, deductibles, co-insurance, and employer contribution levels as a dependent and not as a primary member.

F. An eligible dependent enrolled by one primary member is not eligible to be enrolled in the same plans (medical, dental, vision, voluntary coverage) as a dependent by another primary member.

G. "Other eligible individual" excludes parents and any individual who is not a citizen or national of the U.S., unless the individual is a resident of the U.S., or a country contiguous to the U.S., is a member of a primary member's household, and resides with the primary member for more than six months of the 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.

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

I. The word "child" means:

- A biological son or daughter of the primary member
- A lawfully adopted son or daughter of the primary member. 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. for supporting documentation requirements.
- A stepchild of a primary member. If the biological or adoptive parent of the stepchild is divorced from the primary member, the child no longer qualifies as the primary member's stepchild and is no longer eligible for coverage.

  NOTE: If the primary member and spouse do not file their Federal tax return jointly, a Dependent Stepchild affidavit will need to be completed, notarized, and uploaded in MAP.
- A child of whom the primary member has legal custody.
- A grandchild, if the primary member (employee) claims the grandchild as a dependent on their most recent Federal tax return <u>and</u> at least one of the following conditions is met:
  a) The primary member has legal custody of the grandchild or has lawfully adopted the

grandchild,

b) The grandchild lives in the home of the primary member and is the child of a covered eligible dependent child, and the primary member provides more than 50% of the support of the grandchild; or

c) The grandchild is the child of a covered eligible dependent child and is considered to reside with the primary member even when the grandchild or eligible dependent child is temporarily absent due to special circumstances, including the education of the covered eligible dependent child and the primary member provides more than 50% of the support for the grandchild.

NOTE: When submitting the Change Request in MAP, a dependent grandchild affidavit must be completed, notarized, and uploaded in MAP along with a copy of the grandchild's birth certificate and a copy of the most recent Federal tax return showing the primary employee claims the grandchild as a dependent as proof of financial dependency and residency.

NEWBORN Grandchildren—When the employee files 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 Form stating that this has been done must be submitted in MAP by April 15th of the following year.

- Eligible dependent child(ren) or stepchild(ren): the child or stepchild must be less than 26 years of age.
- Eligible dependent child(ren) or stepchild(ren) aged 26 or older who have a permanent and total disability and have continuously maintained group coverage in the SEHP as an eligible dependent of the primary member before reaching the limiting age (26), under the plan or the child was over the age of 26 at the time of the employee's initial enrollment may be covered under the SEHP. The child must be unmarried and receive more than 50% of their support and maintenance from the primary member.

An Application for Coverage of Permanent and Totally Disabled Dependent Child must be completed and uploaded in MAP along with a copy of the child's birth certificate and proof of financial dependency and residency when submitting the Change Request in MAP. This form should be submitted no earlier than 60 days before the child turns 26. Recertification may be required if the disability prognosis could change. Coverage will not be continued and will not be reinstated once the dependent child is no longer considered permanent and totally disabled.

II. OTHER ELIGIBLE INDIVIDUAL'S EFFECTIVE DATE OF COVERAGE

Other eligible individuals shall become newly eligible on the later of:

A. The primary member's initial date of eligibility or

B. The 1st day of the month following the date the individual becomes an eligible spouse or dependent child of the primary member or becomes newly eligible for coverage according to the spouse or dependent child definition. The SEHP must receive a Change Request in MAP and any supporting documentation within 31 days of the date the spouse or dependent child becomes newly eligible, according to the spouse or dependent child definition.

C. The 1st day of the month following the loss of Medicaid (KanCare) or Children's Health Insurance Program (CHIP) coverage. The SEHP must receive a Change Request in MAP along with any supporting documentation within 60 days of the loss of Medicaid or CHIP coverage.

D.

III. NEWLY ELIGIBLE SPOUSE OR CHILDREN

All enrollment and change requests for adding a newly eligible spouse or dependent child must be submitted in MAP within 31 days of the event that makes the spouse or dependent child newly eligible. Coverage for the newly eligible spouse or dependent child may be added if the primary member is enrolled in the SEHP.

The change in coverage must be consistent with the event and/or comply with HIPAA regulations applicable to Special Enrollment Qualifying Events.

Supporting documentation must (appropriate documentation listed below) be uploaded when the request is submitted as proof of the Qualifying Event. Enrollment or Change Requests submitted without the appropriate supporting documentation will be denied and no change will be made by the SEHP. All documentation must be legible and completed in the English language. Any documentation submitted in any other language besides English must be accompanied by a certified English translation.

NOTE: Documentation must be uploaded through the primary member's record in MAP.

A. **Social Security (SSN) and Individual Taxpayer Identification Numbers (ITIN)**
The Federal Medicare, Medicaid, and SCHIP Extension Act of 2007 (the "Act") requires group health plans to report eligibility information to the Centers for Medicare and Medicaid Services (CMS) for purposes of coordination of benefits. The SEHP must obtain a valid SSN, Medicare HICN, or ITIN for nonresident alien individuals and their eligible dependents. Dependents include a spouse and eligible children to be covered by health plan benefits.

A Health Care Identification Number (HICN) is the number the Social Security Administration assigns to an individual identifying as a Medicare beneficiary. This number is shown on the beneficiary's insurance card and is used to process Medicare claims for that beneficiary. The Medicare program uses the HICN to identify Medicare beneficiaries receiving health care services and to meet otherwise 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 Foreign National individual engaged or considered engaged in a trade or business in the U.S. during the year must file a federal tax return each year. As a result, they must apply for an ITIN. These numbers are unique identifiers, similar to an SSN, and have the first 3 digits in the range of 900-999.

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

There are a few instances in which the SEHP will allow a "temporary" SSN to be used to set up members in MAP until the primary member can obtain a valid SSN or ITIN and send it to the SEHP.

1. Newborn children – a temporary SSN of 777-77-7777 should be entered in MAP for a newborn until a valid SSN is obtained. Generally, an SSN is assigned within 14 days of application for the SSN. The valid SSN must be provided to the SEHP within 41 days of the child's date of birth.
2. Foreign National individuals and their eligible dependents – a temporary SSN of 888-11-1111 should be entered in MAP for foreign national individuals and their eligible dependents until a valid number is obtained. The valid number must be provided to the SEHP within 30 days of

enrollment in the SEHP. If a number cannot be provided within this time frame, a Communication Form must be submitted in MAP providing the reason the number is not available. The request will be reviewed, and a determination will be made on each case submitted.

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

Reporting under the Affordable Care Act (ACA) requires certain employers who sponsor self-insured group health plans to report coverage of all participants in the group health plan. The SSN or ITIN for each covered individual is required to be included on the reporting form (Form 1095C, Part lll).

NOTE: A valid SSN or ITIN 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 a number cannot be provided by the annual Open Enrollment deadline, a Communication Form must be submitted in MAP explaining why the number is not available. The request will be reviewed, and a determination will be made on each case submitted.

B. **Appropriate Supporting Documentation**

The following items are appropriate supporting documentation that is required to be uploaded in MAP, completed in English, and legible with the Enrollment or Change Request when adding or removing other eligible individuals:

1. Marriage License for spouse and stepchild eligibility
2. Birth certificate or hospital birth announcement for dependent children including full name of parent(s). Birth registration cards are not acceptable for dependent children.
3. Petition for adoption or placement agreement for a dependent child, including the Judge’s signature and court date stamp,
4. Legal custody or guardianship document issued by the court, including the Judge’s signature and court date stamp,
5. Court Order for children who are not biological or adopted children of the primary member, including the Judge’s signature and court date stamp,
6. Birth certificate or hospital birth announcement and Dependent Grandchild Affidavit for a child (grandchild) born to a covered dependent and a copy of the most recently filed Federal tax return for proof of financial dependency and residency. All filers must sign and date the tax return. (See number 8 below for pages needed.)
7. Application for Coverage of Permanent and Totally Disabled Dependent Child affidavit for covered dependent children aged 26 or older and a copy of the most recently filed Federal tax return for proof of financial dependency and residency. All Filers must sign and date the federal tax return. (See number 8 below for pages needed.)
8. Copies of the most recently filed Federal tax return for proof of dependent eligibility. All Filers must sign and date the federal tax return. Income information may be omitted before uploading the document in MAP. The pages needed from the current year’s filed Federal tax return depend on which Tax form was filed:
   - Form 1040 and 1040A - pages 1 & 2 containing the filer’s name, the employee and spouse’s signature, and the date the employee and spouse signed the form.
   - Form 8879 (IRS *e-file*) - containing the date filed, the filer’s name, the employee and spouse’s signature, and the date the employee and spouse signed the form.
9. Divorce decree, official court document, including the Judge’s signature and the court date

stamp.

10. A copy of a military ID and privilege card (**front and back**) with the expiration date, for proof of Tricare coverage and documentation for the end of Tricare coverage.
11. For dependent loss of other group health coverage, a letter, on company or carrier letterhead, listing the member's name and all dependents covered under a previous employer's insurance. The letter must identify the previous employer and list the date coverage ended.

C. **Newborns**

A Newly Eligible Dependent request must be submitted in MAP within 31 days of the newborn's DOB. Appropriate dependent documentation and a valid SSN or ITIN must be uploaded in MAP with the request. The effective date of coverage for the child is the child's date of birth.

For newborn grandchildren, a copy of the birth certificate and a completed Dependent Grandchild Affidavit must be uploaded in MAP within 31 days of the newborn grandchild's DOB. If the Change Request, SSN, or ITIN and appropriate supporting dependent documentation is not received within the above time frame, the dependent will not be added to coverage. **NOTE:** A copy of the most recently filed tax return showing that the grandchild was claimed as a dependent will need to be uploaded with a communication form, with the first tax filing ending after the grandchild's DOB.

D. **Adoptions**

A Newly Eligible Dependent request must be submitted in MAP 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 the Judge's signature and court date stamp, must be uploaded in MAP with the request to add the child within 31 days of the date that the petition for adoption or placement notice is filed or the date of adoption placement.

If the adoption is being handled through an adoption agency, they may require an adjustment period in the primary member's home before 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. It must indicate the placement date and the adjustment period's length.

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, including the Judge's signature and court date stamp, must be uploaded in MAP 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.

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

Effective Date of Coverage

If the date of the filing for a 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 child's date of birth, the effective date of coverage is 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 adding a newborn or newly adopted dependent to coverage, other eligible dependents may also be added to coverage at this time. The effective date of coverage for the newborn or adopted dependent will be the date of birth if a Newly Eligible Dependent request and the appropriate

documentation is submitted within 31 days of the applicable child's birth.

The effective date of coverage for your other eligible dependents, such as a spouse and/or other children or stepchildren, will be the newborn's date of birth, date of placement for adoption, or date of petition for adoption.

Change in Employee Contribution

The change in employee required contribution for a change in coverage will be reflected on the employee's paycheck that coincides with the DOB, date of petition for adoption, or date of the placement agreement. If the DOB, date of petition for adoption, or date of the placement agreement occurs on the 1st day of the month, the change in employee premium will occur on the 1st day of that month.

E. **New Legal Custody/Guardianship Children** (children who are not biological, legal stepchildren, or adopted children of the primary member)

If the primary member is adding a newly eligible legal custody/guardianship child to coverage, a Newly Eligible Dependent request will need to be submitted 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, coverage will be effective that day.

F. **New Spouse or Stepchildren Due to Marriage**

If the primary member wants to add a newly eligible spouse and/or stepchild(ren) to coverage due to marriage, a Newly Eligible Dependent request must be submitted in MAP to add the spouse and/or stepchild(ren) to coverage within 31 days of the marriage. The change request and appropriate supporting documentation must be submitted in MAP within 31 days of the marriage.

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

If a newly eligible spouse or stepchild(ren) is added to coverage, other eligible children may also be added to coverage, such as other children of the primary member. The effective date of coverage for these dependents will be the 1st day of the month following the date of marriage. Employee-required premium contributions will be due according to the dependent coverage effective date.

G. **Employee Previously Opted Out / Waived Insurance Coverage**

If the employee has previously waived coverage and acquires a newly eligible spouse or child(ren) (marriage, birth, adoption, etc.), the employee must contact their Agency within 31 days of the event if the employee wants to elect coverage for themselves and the newly eligible spouse and/or children. A Communication Form to have an enrollment portal opened, along with uploading appropriate supporting documentation in MAP, must be submitted within 31 days of the event. Coverage for the employee and the newly eligible dependent(s) will be effective the 1st day of the month following the date of the Qualifying Event. In the case of a newborn, coverage for the newborn will be the DOB, but coverage for the employee will be the 1st day of the month preceding the newborn's DOB. Any spouse or other children added during this Qualifying Event will be effective the DOB of the newborn.

IV. ADDITIONAL INFORMATION

A. **Children of divorced parents**

A primary member may cover their dependent children:

- Who are under the age of 26, or
- Who has a permanent and total disability and has continuously maintained group coverage as an eligible dependent of the primary member before reaching the limiting age to be covered under the Plan. The child must chiefly depend on the primary member for support, receiving more than 50% of his or her support from the primary member.

B. **Ex-Spouse**

When the primary member is divorced from their lawful spouse, the ex-spouse and subsequent stepchild(ren) are no longer eligible to participate in the SEHP except as allowed under COBRA.

C. **Spouse or Dependent child(ren) residing out-of-country**

A spouse or dependent child(ren) (of an eligible primary member) who is not a U.S. citizen and resides in another country is eligible for SEHP coverage when the primary member is newly eligible, when newly married to the primary member when they move and maintain a permanent U.S. residence, including having an active SSN or ITIN or at Open Enrollment. The primary member will be allowed to add the spouse and/or child(ren) to coverage, provided the request is made by the primary member within 31 days of any of these events. If the spouse and/or child(ren) later return to another country, coverage <u>cannot</u> be dropped for the spouse or dependent child(ren) until the next Open Enrollment period (unless enrolled in coverage on an after-tax basis). Documentation is required to support the primary member’s request.

D. **Adopted child – Not U.S. Citizens**

A primary member may cover an adopted child if the petition for adoption has been filed with the court, if the primary member has a placement agreement for adoption, or if the primary member has been granted legal custody of the child. Supporting documentation is completed in English and must be uploaded to the member portal in MAP. Adopted children who are not U.S. citizens and who reside in another country are not eligible for coverage until they move to and maintain a permanent residence in the U.S. If the child(ren) later returns to another country, coverage cannot be dropped for the child(ren) until the next Open Enrollment period (unless enrolled in coverage on an after-tax basis).

E. **Court Ordered Dependents** (children)

When the SEHP receives a National Medical Support Notice that orders the employer of a primary member to provide health insurance coverage for a dependent child, that child will be automatically enrolled in the primary member’s coverage. A court-ordered dependent child can only be removed from coverage if one of the following occurs:

1. The issuing court sends the SEHP a rescinding order that voids the initial support notice.
2. The child is no longer an eligible dependent under the terms of the SEHP.
3. The primary member provides proof of other creditable coverage for the child. The child cannot be removed at Open Enrollment.

A court-ordered dependent child will be added on the 1st day of the month following receipt of the National Medical Support Notice by the SEHP. If the court order is rescinded, the child can be removed from the primary member’s coverage by submitting a Change Request in MAP requesting the child's removal and uploading a copy of the National Medical Support Notice of termination. The effective date of the removal would be the 1st day of the month following receipt of the Change Request and termination form.

F. **Special Notes**

- The State of Kansas and the SEHP require documentation to support proof of dependency and/or residency. When enrolling other eligible dependents for coverage with the SEHP, the primary member must certify:
    1. The spouse and/or children meet the requirements for other eligible dependents for the year the spouse and/or children are being enrolled in coverage.
    2. The primary member must also provide appropriate supporting documentation for their spouse and each child, such as birth certificates, adoption papers, marriage licenses, etc.
- Documentation must be uploaded through the primary member's record in MAP.
- The SEHP will deny requests submitted in MAP without the appropriate supporting documentation.

NOTE: Any attempt to enroll other eligible individuals who do not meet the SEHP requirements for a dependent will be considered fraud and subject to penalties as prescribed by law.

HEALTHQUEST PROGRAM

This applies to all active members and spouses enrolled in SEHP, Plan A, C, J, or N.

HealthQuest is the health and wellness program for employees. Services are available to eligible employees at no additional cost. There are two main program areas:

1. Wellness Offerings

- Nurse24
- Face-to-face and telephone coaching services (Lifestyle, Tobacco Cessation, Condition Management)
- New weight management program
- Wellness Challenges
- Rewards Program, and more!

Who is Eligible to use the Wellness Services?

- Benefits eligible State of Kansas and participating Non-State employees enrolled in the SEHP or who have waived coverage in the SEHP.
- Employees' spouses who are enrolled in the medical portion of the SEHP.

2. Employee Assistance Program

- Confidential Short-Term Personal Counseling
- Legal Advice and Discounts
- Personal Money Management Assistance and Information
- Work-Life Resources
- Eldercare/Childcare Information and Referral
- And more!

Who Is Eligible to Use the Employee Assistance Program (EAP)?

- All active, benefits-eligible employees of the State of Kansas, their dependents, and other family members living in the same household,
- All active, benefits-eligible employees of our Non-State Employer Groups, their dependents, and other family members living in the same household,

- Direct-Bill Retirees and COBRA participants are **not** eligible to participate.

NOTE: Benefits-eligible employees laid off or terminated are eligible to use the EAP for six months after layoff.

The toll-free telephone number for HealthQuest programs is 1-888-275-1205 Option 3.

For more information, please visit HealthQuest Programs

HEALTHQUEST REWARDS PROGRAM

Employees enrolling in medical plans with the SEHP can earn a premium incentive discount on their health insurance premiums through the HealthQuest Rewards Program. Plans C, J, and N members can also earn contributions into their HSA/HRA account. The HealthQuest Program year, also known as the earning period for the incentive, runs from January 1 through December 31 each calendar year. Because the requirements to earn a discount may change yearly, please refer to the HealthQuest website for full details.

Employees must set up a HealthQuest account on the wellness portal to begin earning credits toward their discount, then click on the HealthQuest Portal link. New members should have access to the HealthQuest programs within three weeks of submitting their Online Enrollment; they do not have to wait until their coverage begins.

Employee Assistance Program:

- **Critical Incident/Stress Management Counseling Sessions**

  Human Resource Managers can contact the EAP vendor, Compsych, at 1-800-270-8897 or TTD at 1-800-697-0353 for information about Critical Incident/Stress Management Counseling Sessions for employee groups experiencing trauma or significant loss. A counselor will come to the worksite and present to groups or talk with people one-on-one to help them process the grief or trauma. The counselor will bring materials and handouts that address dealing with grief.

- **Formal Referral Program**

  Occasionally, circumstances arise when we would question an employee's emotional stability or ability to perform safely in the workplace. We may also be concerned about the safety of other employees or the individuals we serve. The Formal Referral program is not designed to address chronic disciplinary or performance problems but behavioral changes in employees that may pose a potential threat to self or others in the workplace. If assistance is needed in dealing with chronic disciplinary or performance problems or you would like to discuss the Formal Referral program option, please call the HealthQuest number at 1-785-783-4080.

- **Conflict Resolution Program**

  This service partners a Kansas State Agency with the HealthQuest Employee Assistance Program (EAP), which would give employees the opportunity to resolve conflicts at work. The objective of the program is to provide a mechanism to aid the participants in the following: identifying the issues, reducing misunderstandings, clarifying priorities, exploring areas of commonality, and assisting the participants in resolving the conflict to improve job performance and their differences in work. The Conflict Resolution Program offers two avenues for employees to use the service. The first is confidential and voluntary. The second is a formal request from the Agency. For more information, call the HealthQuest number at 1-785-783-4080.

EMPLOYEE MEDICARE ELIGIBILITY

Congress has created a framework in the Medicare statutes and the Internal Revenue Code (IRC) that imposes responsibility on an employer for the actions taken under its plan in certain circumstances. The Medicare Secondary Payer (MSP) provisions of the Social Security Act (42 U.S.C. 1395y(b)) state that Medicare may seek to recover a mistaken primary payment from "any entity which is required or responsible" to pay for medical services under a primary plan. Accordingly, Medicare may seek recovery from the employer.

The MSP provisions generally require group health plans to make payments primary to Medicare for:

1. individuals entitled to Medicare based on age or disability if the individual has coverage under the group health plan based on the individual's own or a family member's current employment status; and
2. individuals who are or could be entitled to Medicare based on end-stage renal disease for a 30-month coordination period if the individual is covered under a group health plan, as defined in the IRC, on any basis. Taken together, the MSP provisions and the definition of group health plan establish that employers have, or at least share, responsibility for the group health plan's compliance with the MSP rules.

Ensuring that our members, their spouses, and dependents are accurately enrolled in the Health Plan is important. The SEHP must be aware of any Medicare eligibility and entitlement so that the SEHP can communicate this information to our carriers. If an Agency receives a demand letter from a Medicare secondary payer recovery contractor, forward the letter and any attached documentation to SEHP Health Plan Operations at sehbpbenefits@ks.gov.

I. EMPLOYEES AND SPOUSES APPROACHING AGE 65

The SEHP will notify any primary member or covered spouse approximately 60 days before the primary member or spouse's 65th birthday advising them that a TEFRA (Tax Equity & Fiscal Responsibility Act of 1982) form must be completed by the employee or spouse and uploaded in MAP. The employee or covered spouse must select Medicare or SEHP as their primary carrier on the TEFRA form. The TEFRA form must be completed 45 days before the 65th birthday of the employee or covered spouse, and a copy of a Medicare card and TEFRA form should be uploaded in MAP.

A. **If the employee selects the SEHP as primary on their TEFRA form:**

The employee/spouse will continue the same coverage at the same rate with the SEHP. The primary member and spouse claims will be processed with the SEHP coverage as primary.

B. **If the employee or spouse is newly eligible for Medicare and selects Medicare as primary on their TEFRA form:**

1. If Medicare is selected as primary, the employee/spouse will be removed from SEHP medical coverage effective the 1st day of the month in which they become Medicare eligible. If the employee/spouse turns age 65 on the 1st day of the month, Medicare eligibility will begin the 1st day of the prior month and SEHP medical coverage for the employee and any dependents will be terminated on the 1st day of the prior month. Dental, Vision, and Voluntary benefits are not affected by Medicare and will not be terminated.
2. If the employee selects Medicare as primary, the covered spouse and/or dependent children may continue coverage under COBRA for up to 36 months or until entitled to Medicare, whichever occurs first.

II. EMPLOYEES, SPOUSES, AND DEPENDENTS WITH MEDICARE DUE TO DISABILITY

New hires should be asked if they or any dependents they plan to cover under the SEHP are Medicare-eligible. A copy of the Medicare card should be uploaded to MAP at that time. Active employees, spouses, and/or dependents who become newly eligible for Medicare due to disability during the plan year may continue participating in the SEHP or have Medicare coverage as primary. The HR office should submit a request in MAP indicating that the member is newly eligible for Medicare. If they wish to remain on the SEHP, the HR office must upload the Medicare card in MAP. Those who want Medicare as a primary will be terminated from medical coverage under the SEHP. The member will be removed effective the 1st day of the month Medicare becomes effective. Federal law mandates Medicare to be the secondary payer of claims for active employees or their dependents who choose to remain covered by the SEHP, even though they are disabled and entitled to Medicare benefits.

III. EMPLOYEES, SPOUSES, AND DEPENDENTS WITH MEDICARE DUE TO END-STAGE RENAL DISEASE (ESRD)

Persons with End Stage Renal Disease (ESRD) may be eligible for Medicare primary coverage for a period as determined by Federal guidelines. The HR office must upload the completed ESRD Questionnaire and Medicare card in MAP when ESRD is diagnosed for a covered primary member, spouse, or dependent.

When Medicare is primary for a covered person with ESRD, there is no change in active employee rates, coverage eligibility, or benefits.

COST OF COVERAGE

Employee rates for the SEHP are subject to change each Plan Year, and agency contributions are generally subject to change at the beginning of the fiscal year.

SEHP coverage is monthly, and rates are based on semi-monthly payroll deduction periods. All benefits will terminate on the last day of the month when the employee terminates employment. Benefits will terminate on the 1st day of the month if employment terminates on the 1st day of the month.

I. EMPLOYEE CONTRIBUTIONS

SEHP employee rates are based on the following criteria:

A. FT or PT employment status of the employee's position.
    - The employee and employer rates are reviewed annually by the Health Care Commission.

B. Health plan selected.

C. HealthQuest Rewards Program

D. Coverage level selected.

E. HealthyKIDS discount eligibility

NOTE: For Active State Employee rates, refer to the Enrollment Booklet on the SEHP website:

II. HEALTHQUEST REWARDS PROGRAM INCENTIVE

Member Participation in the HealthQuest Rewards Program Incentive is voluntary.

Employees have until December 31st of the current year, when they become benefits-eligible, to complete the Health Assessment Questionnaire and earn the credits to get the premium incentive discount. Primary members will pay the full health plan premium rate until they have earned the HealthQuest Rewards premium incentive discount. Once the primary member earns the HealthQuest Rewards premium incentive discount, the SEHP will be notified, and the discount will be applied. The timing of the discount will depend on the primary member's payroll cycle. The HealthQuest Rewards earning period is January 1st through December 31st. The wellness portal is reset to zero credits for all primary members each year.

After the primary member's first 12 months, the member will follow the same guidelines as all primary members and will have until December 31st of each year to earn the premium incentive discount for the next calendar year.

Information on the HealthQuest Rewards program.

OPEN ENROLLMENT

I. ANNUAL OPEN ENROLLMENT

Open Enrollment occurs annually during October. All primary members must complete and submit their Open Enrollment elections for coverage in their member portal each year. This includes eligible employees on Leave without Pay (LWOP), under Worker's Compensation, or FMLA leave.

Open Enrollment information will be posted on the SEHP website during the annual Open Enrollment period. Members can elect, change, or waive benefits; add or drop a spouse or child(ren) from coverage; change pre-tax payment status; or enroll/re-enroll in benefits with the SEHP. Elections made during Open Enrollment will be effective January 1st of the following plan year.

Primary Members can change their Health Savings Account (HSA) contribution amount if enrolled in the Qualified High Deductible Health Plan and Flexible Spending Account (FSA) contribution amount. The contribution amount must be within the IRS maximum contribution amount for that plan year.

HR offices have access to online reports on open enrollment activity in the Agency & Department (HR) portal so they can monitor employees' enrollments and ensure that they complete them promptly.

Special Notes:

- Each employee must have a valid email address, work or personal, to access MAP.
- A valid SSN or ITIN must be submitted to the SEHP to add a spouse or dependent during Open Enrollment. If a valid SSN or ITIN is not received, the spouse or dependent will not be added to the primary member's coverage in the new Plan Year.
- Acceptable dependent documentation for the spouse and/or dependent(s) must be uploaded via MAP to add a spouse or dependent during Open Enrollment. If acceptable documentation is not received, the spouse or dependent(s) will not be added to the primary member's coverage for the new Plan Year.
- A primary member cannot remove a spouse from coverage during the Open Enrollment period due to pending divorce. The spouse can be removed from coverage once the divorce is final. A copy of the divorce decree must be uploaded to MAP within 31 days of the divorce's final date.
- If the primary member provides documentation for their spouse and/or dependent(s) to their HR office, it must be uploaded through the primary member's record in MAP.
- Application for the HealthyKIDS discount program is required annually during Open Enrollment. To apply, the employee must complete and submit the online HealthyKIDS application found with the Online Enrollment in MAP. The employee receives either an approval or denial at the time of the application, subject to SEHP eligibility guidelines.

II. PRE-EXISTING CONDITIONS

Pursuant to the ACA, the SEHP does not apply an additional waiting period for pre-existing conditions for primary members, their spouses, or their dependents who enroll in health care coverage. Certificates of Creditable Coverage from other medical plans are not needed for Open Enrollment, but similar documentation may be required for mid-year enrollment due to a Qualifying Event.

III. NEWLY ELIGIBLE PRIMARY MEMBERS

Newly eligible primary members may enroll via MAP during their enrollment period for an effective date of coverage for the current Plan Year. In addition, during October, during Open Enrollment, the primary

member may enroll via MAP and elect coverage to be effective for the new Plan Year. An otherwise eligible member must have completed their Enrollment or waiver election in MAP before they can enroll during the Open Enrollment period.

IV. REVISED OPEN ENROLLMENT ELECTIONS

A primary member may change their Open Enrollment elections anytime during the Open Enrollment period. Following the end of the Open Enrollment period, revised enrollment election requests in MAP will be accepted only if the primary member has a Qualifying Event or family status change. Documentation to establish dependent status must be uploaded in MAP with the Change Request. This must be completed within 31 days of the Qualifying Event or family status change.

Change Requests submitted in MAP without the appropriate supporting documentation will be denied by the SEHP.

V. OPEN ENROLLMENT PENDING ELECTIONS STATEMENT

Primary members will receive a Pending Election statement via email once they make elections in their member portal and save and submit the elections. Pending election statements are also available in the members portal under the forms tab, then Pending Elections. HR offices will be able to run a report at the end of Open Enrollment to see their employees' elections for the next plan year.

VI. IDENTIFICATION CARDS

Identification (ID) cards will be sent to new members and members making changes in their elected coverage options. If a new ID card is not received by the end of December, the member should contact each applicable carrier/vendor to request a new ID card. Telephone numbers for the carriers are listed on the back page of the Health Plan Open Enrollment booklet and can be found on the SEHP website on each vendor's page.

HEALTH PLAN MATERIALS

I. BENEFIT DESCRIPTIONS, CERTIFICATES and BOOKLETS

SEHP contracted Plan Administrators will mail Benefit Descriptions for coverage options under the self-insured plans, and the carriers will mail Certificates of Coverage for coverage options under the fully insured plans to all enrolled members directly to the home address on file with the SEHP. Certificate books will be sent after the SEHP has processed the primary member's enrollment elections and the Plan Administrator has processed the primary member's information.

The Certificate of Coverage and Benefit Description are also available on each vendor's page on the SEHP website.

II. IDENTIFICATION CARDS (ID Cards)

Separate ID Cards are issued **by the appropriate Plan Administrator or carrier** for medical, prescription drug, dental, and vision coverage. SEHP Plan Administrators or carrier(s) will mail Identification Cards directly to the member's home address listed in MAP. Members should allow 2 to 3 weeks after the date the SEHP has processed their elections for coverage to be established with the applicable Plan Administrator or carrier(s). If a member has not received an ID card after 3 weeks, the member should contact their Plan Administrator or carrier and request that a new card be sent. Dental and vision ID cards may also be obtained by accessing the Plan Administrator's website. Members should always carry their ID cards and present the appropriate ID card whenever covered services or benefits are needed.

III. PROVIDER LISTINGS

The most current provider lists are available on each Plan Administrator or carrier's website. This information can be found on the SEHP website under each Plan Administrator.

CHANGE REQUESTS

It is the **primary member's responsibility** to:

- Notify their agency of changes concerning name, address, marital status, geographic relocation, or other applicable personal life changes within the required deadline and supply the appropriate supporting documentation. ***Change Requests must be submitted within 31 days of the Qualifying Event***. Changes will not be made until the Change Request has been completed in MAP. Requests submitted in MAP without the appropriate supporting documentation or more than 31 days after the qualifying event will be denied, with no action taken by the SEHP.
- Provide legible, appropriate documentation in English.

It is the **agency HR office's responsibility** to:

- Submit the Change Request for changes in eligibility due to Qualifying Events, such as Leave Without Pay or return from Leave Without Pay in MAP. Change Requests must be submitted within 31 days of the Qualifying Event.
- Ensure that the primary member has provided legible, appropriate, and completed supporting documentation in English. The documentation must be uploaded through the primary member's record in MAP.
- Changes in coverage prescribed by law or contract (i.e., dependents losing coverage due to divorce at the end of the coverage period) will take effect retroactively to the last day of eligibility regardless of when a Change Request was entered. Refunds should not be initiated if the employee fails to notify

their agency of the change within 31 days of the event.

NOTE: A qualifying event does not allow plans or vendors to be changed. Only coverage level changes can be made mid-year. After the initial enrollment, plan, and vendor changes can only be made during open enrollment.

I. COMPLETING MAP CHANGE REQUEST

A. Before completing a Change Request in MAP, have the following information available:

- Username and password for employer access to the MAP website.
- Date of the employee's Qualifying Event
- State of Kansas Employee ID#, the HR office should assign a number from the payroll system.
- Documentation that may be required to process the change (i.e., documentation to establish dependent status)

B. **Employee Information**

This includes demographic information supplied by the employee and includes:

- Employee's full name
- Physical address
- Contact telephone number
- SSN or ITIN for non-resident alien
- Gender
- Date of birth
- Valid Employee email address
- Marital Status

C. Enrollment Change

The HR office completes this to indicate the primary member's change to:

- Medical coverage level,
- Dental coverage level,
- Vision coverage level,
- Voluntary benefit level, if applicable, and
- The date of the Qualifying Event for the change
- Direct Bill - If the primary member is electing Direct Bill coverage.

NOTE: If the primary member elects to drop Dental when they enroll in Direct Bill coverage, they will not be allowed to re-enroll in Dental later.

D. Dependent Information (Add/Drop Dependent) All changes must be made within 31 days of the Qualifying Event.

1. Select the appropriate option for the primary member's requested action.
2. Upload supporting documentation for the spouse and each covered dependent. The SEHP and/or the Plan Administrator/carrier may request documentation to support proof of relationship or dependency.
3. Enter the dependent's name.

4. Enter the dependent's SSN or ITIN
5. Select the dependent's gender.
6. Enter the dependent's date of birth in MM/DD/YYYY
7. The primary member must provide the dependent's address if it differs from theirs.
8. Add/Drop dependent Medical, Dental, Vision, and voluntary benefits coverage.

E. Medicare

Suppose the primary member, spouse, and/or dependent are eligible for Medicare and are to be covered under the SEHP. In that case, the primary member should provide the following information for the HR office to complete this in MAP. The member must also provide copies of all Medicare cards that need to be uploaded in MAP.

- Name – first, middle initial, and last
- Hospital Effective Date (Part A – month/day/year)
- Medical Effective Date (Part B – month/day/year)
- Medicare Claim Number (HICN)

MID-YEAR ENROLLMENT CHANGES

I. ADDITION AND DELETION OF NON-NEWLY ELIGIBLE EMPLOYEES AND OTHER INDIVIDUALS

Non-newly eligible employees and other individuals are defined as:

- Employees and/or spouses and children for which 31 days have passed since their initial eligibility for coverage.
- Non-newly eligible employees and/or spouses and children may be added or dropped from the SEHP during the Plan Year if all the following mid-year change requirements are met:
  A. The change results from one of the events listed in III or IV.
  B. The change is requested by the employee/member within 31 days of the qualifying event and submitted in MAP,
  C. The change in coverage is consistent with the qualifying event and complies with HIPAA regulations and
  D. Written, legible supporting documentation of the qualifying event is provided, completed in English, and submitted to the SEHP within the required deadline (divorce decree, court-ordered custody agreement, marriage certificate, etc.)

Appropriate Supporting Documentation
The following items are appropriate supporting documentation required to be uploaded in MAP with the Enrollment or Change Request when adding or removing other eligible individuals:

1. Marriage License completed in English for proof of spouse and stepchild eligibility.
2. Birth certificate or hospital birth announcement completed in English for dependent children, including the full name of the parent(s). Birth registration cards are not acceptable proof for dependent children.
3. Petition for adoption or placement agreement completed in English for a dependent child.
4. Legal custody or guardianship document completed in English issued by the court.
5. Court order completed in English for dependents not biological, stepchildren, or adopted children of the primary member.
6. Certificate of birth completed in English and Dependent Grandchild Affidavit for children (grandchild)

born to a covered dependent, along with a copy of the current year filed Federal tax return for proof of financial dependency and residency.

7. Application for Coverage of Permanent and Totally Disabled Dependent Child affidavit for covered dependent children aged 26 or older and a copy of current year filed Federal tax return for proof of financial dependency and residency. (See number 8 below for pages needed)
8. Copies of the current year filed Federal tax return for proof of spouse eligibility. Please note all income information may be whited out before submission to the SEHP. The pages needed from the current filed Federal tax return depend on which Tax form was filed:
   - Form 1040 and 1040A - pages 1 & 2 containing the filer's name, the employee and spouse's signature, and the date the employee and spouse signed the form.
   - Form 8879 (IRS e-file)—containing the date filed, the filer's name, the employee and spouse's signature, and the date the employee and spouse signed the form.
9. Divorce decree court document, including the Judge's signature and the court date stamp.
10. A copy of a military ID and privilege card (**front and back**) 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 creditable coverage listing the member's name and all dependents covered under a previous employer's insurance is required. The letter or certificate must identify the previous employer and list the dates) on which coverage was terminated.
12. For dependent gain of other group health coverage, a letter or certificate of creditable coverage identifies the coverage, effective date, and covered dependent. **NOTE:** Gaining CHIP or marketplace coverage is not a qualifying event to remove dependents from coverage during a plan year.
13. For dependents entering the US, they must have a passport showing the date of entry or an I-94 form from Homeland Security with the date of entry.
14. Death certificate, obituary notice, or document approved by legal counsel.

When a member adds dependent (s) to their coverage, a valid SSN or ITIN number (if applicable) is required. If the information is not provided at the time of the request, the SEHP will be unable to add them to coverage. If a number cannot be provided, a Communication Form explaining the reason must be submitted in MAP.

NOTE: A qualifying event does not allow plans or vendors to be changed. Only coverage level changes can be made mid-year after the initial enrollment, and plan and vendor changes can only be made during open enrollment.

Additions: If the primary member is already enrolled, voluntary benefits may be added during the Plan Year for newly eligible dependents. Primary members cannot change voluntary plan levels i.e., high to low or low to high.

If the primary member has opted out of voluntary benefit coverage, newly eligible dependents may not be added to these coverages, even with a Qualifying Event.

Permitted Deletions: Primary members enrolled in coverage on an **after-tax** basis may drop primary member and/or dependent coverage (medical, dental, and vision) without a qualifying event during the Plan Year. Documentation is not required.

II. EFFECTIVE DATE OF COVERAGE

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

month will be that day. If a death occurs on the 1st day of a month, coverage will terminate on the last day of that month.

- The effective date of coverage is outlined for newborns, adopted children, new spouses and/or new stepchildren, and changes in legal custody or guardianship of a dependent child.
- If a primary member is enrolled on an after-tax basis and is dropping primary member and/or dependent coverage, the effective date of change in coverage is the 1st day of the month following completion of the Change Request and approval by SEHP. If the change is on the 1st day of a month, the coverage effective date will be that day.
- The effective date of coverage or change in coverage for changes in Medicare eligibility.

III. PRE-TAX EVENTS

If a primary member is enrolled in coverage on a pre-tax basis, and any addition or deletion to coverage will result in a change in employee contributions, there must be a Qualifying Event, or an IRS 125 permissible change, for the change to be approved. Enrollment changes must also be consistent with the event and must comply with HIPAA regulations or IRS 125 and accompanying regulations. Primary members may change coverage provided on a pre-tax basis only during open enrollment each year. The change in status event must result in a gain, loss, or change of coverage in an employer-sponsored group health insurance plan. This gain, loss, or change can be for the employee, spouse, or dependent children and can be under either the SEHP or a group health plan sponsored by the employer of the spouse or dependent(s). The requested change of election must then correspond with the gain, loss, or change of coverage and must be confirmed with documentation from the employer or carrier. All Change Requests must be submitted in MAP within 31 days of the Qualifying Event.

Primary members who are enrolled in the SEHP on a pre-tax basis may make mid-year additions to and deletions from coverage based on the following events and subject to the requirements listed in I:

A. Employee's marriage – the member may add or drop all their eligible family members if they are added to the new spouse's employer's plan because they are newly eligible. For common law marriage, a notarized copy of the Affidavit of Common Law Marriage and proof of joint ownership (dated after the date of the common law marriage), must be uploaded in MAP with the enrollment/Change Request. Acceptable proof of joint ownership includes:
    1. Current bank statement (bank account verification letter showing the active status of a joint account)
    2. Active lease agreement
    3. Current home-owners insurance statement
    4. Current credit card statement
    5. Current property tax statement
    6. Current year federal filed tax return, listing spouse.
    7. Current auto loan
    8. Current brokerage account statement
    9. Mortgage statement

B. Final divorce - Divorce decree court document, including the Judge's signature and the court date stamp must be uploaded in MAP with the Change Request.

C. Birth or adoption of a child—The primary member may add all eligible family members. They may drop enrolled family members only if the Qualifying Event is due to a birth or adoption and the family members are newly eligible under another employer-sponsored group health insurance plan.

D. Gain or loss of legal custody of a dependent child - A copy of the court order with the court date

stamp and the judge’s signature must be uploaded in MAP with the Change Request.

E. Change from part-time to full-time or full-time to part-time employment by the employee, spouse, or dependent child that affects cost, benefit level, or benefit coverage for the employee, spouse, and/or dependent child(ren).

F. Change from benefits-eligible position to benefits-ineligible by the employee, spouse, or dependent child.

G. Termination or commencement of employment, including Retirement of employee. An employee can change their medical plan at the time of retirement.

H. Death of employee and surviving spouse/dependents who wish to continue coverage under the Direct Bill program.

I. Employee, spouse, or dependent’s gain or loss of coverage through their employer affects benefits coverage for employee, spouse, and/or dependents. Any employment status changes that affect eligibility. If the gain or loss of coverage for the individual is with the SEHP, that must be indicated on the Change Request in MAP. For loss of group health coverage by a spouse or dependent, a letter or certificate of creditable coverage listing the member's name and all dependents covered under a previous employer’s insurance must be uploaded in MAP with the request. The letter or certificate must identify the previous employer and list the date coverage was terminated.

J. Unpaid leave of absence by an employee affects the benefits coverage of the employee, spouse, and/or dependents. If the employee wishes to continue coverage during this leave of absence that must be indicated on the Change Request in MAP. If the employee is rehired or reactivated within 30 days, they must return to the same plan and coverage levels unless they experienced a status change event during the leave of absence.

K. Return from Leave Without Pay.

L. Cancellation of primary member’s coverage due to non-payment of employee premium contributions while on active status.

M. An employee can make a mid-year change during a spouse’s or dependent’s Open Enrollment period due to significant changes to a spouse’s or dependent’s employer-sponsored group health insurance plan, such as premium increases or benefit plan changes as permitted under IRS 125 and accompanying regulations. Exhaustion or termination of a spouse or dependent’s COBRA coverage under their employer-sponsored group health insurance plan is a Qualifying Event. A change or loss of employer’s contribution/subsidy to a spouse or dependent’s COBRA coverage before exhaustion of COBRA coverage is <u>not</u> a Qualifying Event. A change of network status of a physician is <u>not</u> a Qualifying Event.

N. Employee, spouse, or dependent being called to active military duty and/or gaining or losing eligibility for military insurance.

O. Loss of COBRA eligibility (other than non-payment of premium) from a previous employer for an employee, spouse, or dependent.

P. Employee, spouse, or dependent gaining or losing government-sponsored VA benefits.

Q. Dependent turning age 26 (coverage will terminate the last day of the month when the dependent turns age 26).

R. Removal of an ineligible grandchild.

S. Employee, spouse, or dependent losing Medicare eligibility or becoming **newly** eligible for Medicare and electing Medicare coverage as primary.

T. Death of a spouse or dependent

U. Dependent children identified under a Medical Withholding Order (K.S.A. 23-4,105) or Qualified

Medical Child Support Order. The SEHP has the authority to add these dependent children without the employee's consent to comply with the Order.

V. Dependent children losing eligibility/coverage under another employer-sponsored group health plan. For loss of group health coverage for a dependent, a letter or certificate of creditable coverage listing the member's name and all dependents covered under a previous employer's insurance must be uploaded in MAP with the request. The letter or certificate must identify the previous employer and list the date coverage was terminated.

W. Dependent spouse or children who move to the U.S. Please select "Other" as a type of event and indicate the dependent spouse and/or child moving to the U.S.

X. **Newly** Entitled to Medicare or Medicaid. If the employee, spouse, or dependent becomes entitled to coverage (becomes newly eligible) under Part A or Part B of title XVIII of the Social Security Act (Medicare) (Public Law 89-97 (79 Stat. 291)) or title XIX of the Social Security Act (Medicaid) (Public Law 89-97 (79 Stat. 343)), while enrolled in the SEHP, they may make a mid-year change to cancel their SEHP coverage. In addition, if the employee, spouse, or dependent entitled to coverage under Medicare or Medicaid loses eligibility for such coverage, they may make a mid-year change for coverage under the SEHP.

Y. Children's Health Insurance Program (CHIP) – Dependents losing CHIP coverage is a mid-year qualifying event and they can be added to SEHP coverage.

NOTE: Gaining CHIP coverage is not a qualifying event for removing dependents mid-year.

IV. AFTER-TAX EVENTS

Members who are enrolled in coverage under the SEHP on an after-tax basis may make mid-year additions and deletions from coverage due to the following events and subject to the requirements listed in II:

A. Add dependents using all events as listed under Pre-tax Events.

B. Removing employee, spouse, and/or dependents from SEHP coverage for any reason.

C. Vision coverage may NOT be added during the Plan Year.

D. Voluntary benefit plans are on an after-tax basis and may **not** be changed or dropped during the plan year.

Documentation for the qualifying event is not required.

V. PAID SABBATICAL LEAVE

Primary members enrolled in coverage on an after-tax basis may drop coverage while on paid sabbatical leave. If the primary member participates in the pre-tax option, the primary member's salary while on sabbatical leave must be reduced so that the primary member can drop or change existing coverage.

A. A Change Request must be submitted in MAP indicating the date the sabbatical leave will begin, the expected duration, and whether coverage will be dropped or changed.

B. If a primary member drops coverage due to paid sabbatical leave and returns to active status during the same Plan Year, they must return to the same plan and the same, or a reduced, coverage level as they had before going on leave. No additions to coverage will be allowed unless the change is due to a Qualifying Event.

C. If the employee returns from sabbatical leave in a new Plan Year, the employee may enroll in or change to any medical plan or coverage option for which the employee is eligible.

RESIDING OUT OF THE U.S. FOR SABBATICAL LEAVE:

If residing out of the U.S. for a sabbatical leave, the primary member should pay out-of-pocket for needed medical, drug, or dental services. A receipt (in English) showing the type of service and cost at the current exchange rate must be obtained. This receipt may be submitted to the appropriate medical, dental, vision, or prescription drug plan carrier for reimbursement following the primary member's return to the U.S.

In addition, if residing out of the U.S. for a sabbatical leave, the primary member may request an advance supply of a maintenance prescription drug. The primary member should submit a written request indicating the length of the sabbatical leave and a completed Prescription Drug Advance Purchase Certificate (to the SEHP). To utilize the voluntary benefits, treatments must be administered in the United States

LEAVE WITHOUT PAY AND FAMILY MEDICAL LEAVE ACT (FMLA)

I. APPROVED LEAVE WITHOUT PAY

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

If an employee is on voluntary or involuntary Leave Without Pay for 31 or more continuous calendar days, and the leave is not approved as FMLA, the agency must notify the employee that their SEHP coverage as an active employee will end effective the last day on payroll unless the employee signs 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 for enrollment in COBRA.

A. Non-payment of Active Employee Premium

If the employee fails to pay within the scheduled timeframe, the agency will submit a request in MAP under Leave Without Pay for Cancellation Due to Non-Payment. The employee 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.

If the agency fails to submit this request, it will be assumed the employee is still active. If the agency fails to notify the SEHP of any cancellation within 31 days of the Qualifying Event, the agency could be assessed a fee of $250.00 per employee per month for every month the request is not received by the SEHP. The assessed fee is payable to SEHBP and sent to SEHBP Data Management.

B. Continued Payment of Active Employee Premium

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

After completing their elections in their Member Portal, the employee will need to complete the ACH form and 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.

For example, the first day of leave without pay is January 15, 20xx. The employee's 30 days of

Leave Without Pay with Employer contributions will end on February 13, 20xx. Active coverage will end on February 28, 20xx, and Direct Bill coverage will begin on March 1, 20xx.

Employees may change their coverage level when going on Direct Bill. Still, when returning to active employment, their coverage will revert to the coverage they were enrolled in before going on leave unless the period of Leave Without Pay is extended over an Open Enrollment period. If the leave is extended over an Open Enrollment period, a portal will be opened for the employee to elect coverage for the new Plan Year.

II. FMLA - APPROVED LEAVE WITHOUT PAY OF 31 OR MORE DAYS

If the employee is eligible for FMLA, they are eligible for 12 weeks of paid or unpaid leave during any 12 months beginning with the first-day leave was taken.

If the employee is on FMLA and receives a paycheck, their health insurance premiums will continue to be deducted. When the employee goes on FMLA Without Pay, the agency will bill the employee for their portion of the premium. If an employee does not pay these premiums, their health insurance coverage will be canceled, effective when the FMLA begins or when the last payment is made. The Agency will submit a request to MAP to cancel an employee's health insurance due to non-payment of premiums while on FMLA.

Once the FMLA ends, if the employee is still on Leave Without Pay, the agency must submit a request in MAP indicating that the FMLA has ended and the employee is being put on Leave Without Pay. The employee will get an additional 30 days.

Example—The FMLA ended on May 14, 20xx. June 13, 20xx, will be the end of the employee's 30 days of Leave Without Pay with Employer contributions. Active coverage will end June 30, 20xx, and Direct Bill coverage will begin July 1, 20xx.

III. ACTIVE MILITARY DUTY

Employees on Military Leave Without Pay may continue coverage for 30 days following the beginning of leave (assuming no time for paid leave is included). The Agency will continue to pay the SEHP employer premium for those 30 days. The employee must remit their premium (regular payroll deduction amount) to the Agency to retain coverage during the 30 days following the effective date of the Military Leave Without Pay.

Employees may continue coverage in the SEHP beyond the 30-day Leave Without Pay timeframe. Still, they must remit the full premium amount (employer and employee share) directly to the Plan Administrator (or its designee) responsible for administering premium billing as a Direct Bill participant. There will be no agency contribution. An employee with spouse and/or children or full family coverage may drop their employee coverage and continue with their spouse and/or children on direct bill covered in the SEHP. Employees must make the change within 30 days of the effective date of Military Leave Without Pay. To continue SEHP coverage, a Change Request indicating Leave Without Pay, Military Leave must be entered in MAP.

In addition, employees eligible for this type of leave are eligible for 24 months of COBRA coverage.

If SEHP coverage is continued, either as COBRA or Direct Bill, SEHP will be the primary payer of claims, and the employee's military coverage will be secondary.

Primary members, spouses, and/or dependents who elect to discontinue SEHP coverage and have primary coverage provided by the military will be allowed to re-enroll in the same SEHP plan and

coverage option when the member returns to active employee status.

Employees on military leave during Open Enrollment may enroll in any SEHP plan options and coverage level for which they are eligible, without penalty, upon their return to active employee status. The effective date of coverage may be either the 1st day of the month following the employee's return from active military duty or the 1st day of the month in which the employee returns to active employee status, whichever the employee chooses.

If an employee is qualified for and elects to participate in the military's transitional health benefits program, the employee will be allowed to reinstate SEHP coverage without penalty when the transitional coverage terminates. The employee may be qualified for up to 180 days of transitional health benefits. The effective date of coverage may be either the 1st day of the month following termination of the military transitional health coverage or the 1st day of the month after the date the member returns to work, whichever the employee chooses.

Return from military leave policies also apply to the primary member's spouse and dependent(s) returning from military leave.

IV. RETURN FROM LEAVE WITHOUT PAY

When an employee returns from Leave Without Pay (whether regular or FMLA Leave Without Pay), a Change Request must be entered in MAP within 31 days of the date of return to active pay status. When submitting the request, indicate the date the employee returned to work.

If the employee did not enroll in Direct Bill coverage while on leave, the health insurance coverage they were enrolled in before going on leave will be effective the 1st day of the month after they return to work.

NOTE: Health Savings Account, Health Reimbursement Account, and Flexible Spending Account deductions will be reinstated using the same annual election amount previously elected by the employee.

If the employee enrolled in Direct Bill coverage while on leave, the coverage will end on the last day of the month they return to work. The same coverage the employee was enrolled in (including the HSA, HRA, and FSA annual election amount) 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 is extended over an Open Enrollment period. Then, a portal will be opened for the employee to elect coverage for the new Plan Year.

V. TREATMENT FOR MEMBERS AND THEIR ELIGIBLE SPOUSE AND CHILDREN WHILE TRAVELING OUTSIDE OF THE U.S.

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

VI. PRESCRIPTION DRUG ADVANCE PURCHASE POLICY

Travel in the United States - Members traveling within the United States are not eligible for an advance purchase of prescription drugs, since members may use their drug card at any CVS Caremark network pharmacy throughout the U.S.

A. Travel Outside of the United States

1. **Travel or work outside the U.S. for sixty (60) days or less:**
   Members who leave the U.S. for 60 days or less may call the TOLL-FREE number on the back of their CVS Caremark card to arrange for a vacation supply of medications. CVS 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. The member will be billed the applicable coinsurance or copayment for the quantity purchased.

2. **Work outside the U.S. for 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 a member will be outside of the country for a longer period, there are two options available:
   - Advance purchase through drug plan:
     The member must work with the agency's personnel/benefits office to arrange for advance purchase of maintenance medications required during a stay outside the U.S. The Advance Purchase Form certifying that health coverage will be maintained during the entire period of the extended absence must be signed by both the member and the agency. An Advance Purchase Form must be submitted to the SEHP **fifteen (15) days before departure**. The agency and the member will be notified when the Advance Purchase Form has been processed and when the medication will be available to pick up. Generally, the medication will be available for purchase one week before the departure date. The following requirements apply:
     a. 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 destination and duration of stay. The Advance Purchase Form signed by the member and the HR office acknowledges the SEHP's right to recover from the agency and/or employee the cost of the medications if coverage is not maintained.
     b. The name and strength of each requested medication and the prescribing doctor's name must be on the Advance Purchase Form. For each medication, provide the pharmacy's name where the medication will be filled. The member will be responsible for the applicable coinsurance percentage on the cost of the quantity of drug dispensed. The member must agree to purchase the prescription medication at a local network pharmacy. Members or their dependents using the CVS Caremark mail service will need to obtain a prescription from their doctor to purchase the items at a local network pharmacy.

        REMINDER: Medication can only be dispensed for the period allowed by the provider's prescription. For extended periods, the member may need a new prescription. Advance purchases are available for up to one (1) year.
     c. Benefits available for emergency prescriptions purchased outside of the U.S. will be limited to those drugs that 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 prescription reimbursement claim form with a statement indicating their purchase and use while outside of the U.S. Membership status will be verified, and the claim will be forwarded to CVS Caremark for reimbursement.
   - **Member purchases medication(s), then submits claim(s) upon return:**
     If the member does not have enough time to file an Advance Purchase Certificate Form before their departure, they may pay the full price for their medications and file a paper claim for reimbursement upon their return. The paper claim would need to be filed first to SEHP for processing.

FURLOUGHS AND LAYOFFS

I. FURLOUGH

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

If an employee is on furlough during Open Enrollment, they can make Open Enrollment changes to their SEHP coverage.

Upon the end of their furlough period, if an employee has not sustained the requirements for membership in the SEHP, they can re-enroll. The employee 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 125 guidelines.

II. LAYOFFS

In the event of a layoff, a primary member's SEHP coverage will end on the last day of the month the employee works. A letter from the COBRA administrator will be sent to the employee's home address in MAP, offering 18 months of coverage under COBRA. If they accept COBRA coverage, they will be responsible for paying the full cost, which will include both the contribution they made as an active employee and the contribution paid by the employer.

WORKERS COMPENSATION - TEMPORARY TOTAL DISABILITY

I. WORKERS COMPENSATION – TEMPORARY TOTAL DISABILITY

For employees receiving temporary total disability (TTD) payments from the State Self Insurance Fund (SSIF), K.A.R. 1-9-4 and 1-9-5 state for purposes of those regulations, hours in pay status shall include time off while receiving workers compensation wage replacement for loss of work time (this means that the employee is not to be put on Leave Without Pay and the hours must be counted for ACA purposes). The employee's group health insurance should be continued as an active employee member with Employer contributions. If the employee chooses to be paid for their accrued leave and the amount of their paycheck is sufficient to take the SEHP premium deduction, benefits and premium deductions will continue unchanged.

A. If the employee chooses to be paid for accrued leave and their paycheck is insufficient to take the SEHP premium deduction, the agency must inform the employee immediately following each pay period to submit a personal check to the agency to cover the cost of their SEHP premium deduction. The amount due must be paid before the next paycheck date. The agency should then process an adjustment.

   If the employee fails to pay on the scheduled time frame, the Agency must submit a Cancellation Due to a Non-Payment request in MAP.

   The employee will not be allowed to re-enroll in coverage until the employee's return to active work status or Open Enrollment is earlier.

B. If the employee does not choose to be paid for their accrued leave, the agency should contact the employee immediately following each premium deduction period to request a personal check be sent to the agency to cover their SEHP premium deduction. The employee must pay the amount due before the next paycheck date. The agency must then process an adjustment.

If the employee fails to pay according to these guidelines, a Change Request indicating "Cancellation due to Non-payment" must be submitted in MAP. The employee will not be allowed to re-enroll in coverage until the employee's return to active work status or open enrollment is earlier.

HEALTH PLAN DEDUCTIONS NOT TAKEN

I. EMPLOYEE WITH NO HOURS WORKED AND NOT ON FMLA

Agencies should contact members with an expected leave time of 31 calendar days or less and/or who have had no hours worked for one pay period. The agency must contact the members immediately following each pay period to inform the member that they must submit a personal check for their portion of the SEHP premium to the agency. The member should pay the amount due before the next paycheck date. The agency must then process an adjustment. If the member fails to pay within the scheduled timeframe, a Change Request indicating "Cancellation due to Non-payment" must be submitted in MAP. The employee will not be allowed to re-enroll in coverage until the next Open Enrollment period.

Note: if the member continues to have no hours worked for 31 or more calendar days, a Change Request for Leave Without Pay must be entered in MAP. The member will then be enrolled in the Direct Bill program. All active members' SEHP premiums must be paid in full before enrolling in the Direct Bill.

II. INADEQUATE PAYCHECK AMOUNT (Employee not on FMLA)

If the employee's paycheck is insufficient to cover the SEHP premium deduction, the agency must contact the employee immediately following the pay period to submit a personal check to the agency for the SEHP premium. The employee must pay the amount due before the next paycheck date. The agency must then process an adjustment. If the employee fails to pay within the scheduled timeframe, a Change Request must be entered in MAP indicating "Cancellation due to Non-payment". The employee will not be eligible to re-enroll in coverage until the next Open Enrollment period.

RETROACTIVE TERMINATIONS OR ENROLLMENTS

Retroactive terminations and enrollments are those in which the SEHP is not notified within 31 days of the date of the Qualifying Event.

I. RETROACTIVE TERMINATIONS

Retroactive terminations are processed due to late notification of a Qualifying Event if the member does not wish to continue with the SEHP (termination, death, retirement, Leave Without Pay, change to an ineligible position, or non-payment of premium). **Failure of the agency to notify the SEHP by entering a Termination Request in MAP within 31 days of the Qualifying Event will cause the termination effective date to be the last day of the month <u>before</u> the request was submitted.** Late notification could result in the assessment of a fee of $250.00 per member per month for every month the request is not entered in MAP. The SEHP will notify the agency of the penalty amounts that are due.

Example: An employee terminates employment on April 19, 2xxx, but the agency does not enter the termination request in MAP until October 18, 2xxx**.** The agency is responsible for the assessment fee of $250.00 per month from May through October.

If the SEHP does not receive timely notification of the termination of the employee, spouse, or dependent benefits and the employee, spouse, or dependent is eligible for and wishes to continue SEHP coverage under the Direct Bill program, retroactive enrollment may be allowed. Enrollment in the Direct Bill program will be made effective the first of the month after the last day worked.

II. ENROLLMENT CHANGES DUE TO INELIGIBLE SPOUSE or DEPENDENT CHILDREN

If a retroactive enrollment change is processed due to late notification of an ineligible spouse and/or dependent child, the change will be effective the first day of the month following the date of the event. Refunds will not be processed due to late notification.

TERMINATION OF COVERAGE

The Agency is responsible for advising terminating employees when their coverage will end.

I. EMPLOYEE TERMINATION

All SEHP coverage will terminate on the last day of the month in which an employee terminates employment, except those:

A. Employees who terminate employment on the first day of the month will have coverage end on the first day of the month.

B. Employees whose spouse is also employed by the SOK or NSE and has enrolled the former employee as a dependent; or

C. Employees who are eligible to continue upon cessation of active employment:

1. Employees are suspended under the agency's guidelines.
2. Employees are granted Leave Without Pay under a policy established by the appointing authority, in which the employee has a definite appointment or commitment to return to SOK service. For sickness or disability, an employee may still be employed by the SOK for the full period of such leave but not exceeding a maximum of 1 year.
3. Individuals eligible to continue coverage because of retirement from the SOK or others, as indicated by K.A.R. 108-1-1.

Due to the change to coverage being effective on the first day of work.

When an employee terminates within their election period, the first 31 days of work. K.A.R. 108-1-1 states that each eligible employee "shall become eligible for enrollment in the health care benefits program on the ***first day of work*** for Kansas. Each person shall have 31 days after becoming eligible to elect coverage." When an employee terminates in their election period, the agency will need to reach out to the former employee and advise them of their right to enroll in the health plan and for them to make their coverage elections. They will have 31 days to make their coverage elections from their first workday. The same coverage and termination rules apply. The SEHP coverage will terminate on the last day of the month in which they terminate employment. If they terminate employment on the 1st day of the month, all coverage will terminate that day.

The former employee will be responsible for paying for the coverage elected. If the member elect's coverage exceeds the funds available from their paycheck or if they are making elections after they have been paid all funds due to them, they will need to remit payment to the agency for the amounts due. If the terminating employee is Medicare eligible for any reason (age 65, disabled, etc.), the agency must provide them with a Memo for Medicare Part B coverage on the agency's letterhead. This Memo is for the employee to provide to the Social Security Administration to allow them to apply for Medicare without incurring any penalties. The memo should be provided to the employee upon their termination or mailed to their address in MAP.

II. OTHER ELIGIBLE INDIVIDUAL'S TERMINATION

SEHP coverage for other eligible individuals terminates on the earliest of the following dates:

A. When the group policy terminates.
B. The last day of the month in which the employee terminates employment; or
C. The last day of the month in which the individual ceases to be an eligible spouse or dependent under the SEHP's definition of an eligible spouse or dependent.

For terminations other than termination of employment, if the event that causes the spouse or dependent to lose eligibility occurs on the 1st day of the month, then the 1st is the last day of coverage.

If the member's spouse or dependent is terminating SEHP coverage and is Medicare eligible for any reason (age 65, disabled, etc.), the agency must provide the member with a Memo for Medicare Part B coverage on the agency's letterhead. This Memo is necessary for the spouse or dependent to provide to the Social Security Administration to allow them to apply for Medicare without incurring any penalties. The Memo should be provided to the member upon terminating coverage for the spouse or dependent or mailed to the member's last known address.

VII. RETIREMENT

When an employee retires from an agency, they must notify their agency HR office whether they wish to continue SEHP coverage with the SOK through the Direct Bill program. They will automatically be offered COBRA coverage. Members 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 30 days before the employee's retirement to ensure continuous coverage as an active employee and coverage under the Direct Bill option; the Direct Bill premiums are cheaper than COBRA.

If the employee's last work is 2/1/20XX, their benefits will be remunerated as 2/1/20XX. If their last day worked is any other day of the month, their active benefits will be termed the last day of the month they last worked. Example: The last day worked was 2/2/20XX; their active benefits will be 2/28/20XX. month's coverage. The primary member pays the entire monthly premium while on Direct Bill coverage.

Whether the employee is Medicare eligible or not, the effective date of the change to the Direct Bill program will be the 1st day of the month following the employee's last day of work as an active employee. Invoices will be generated by SEHP and posted in the Member Portal around the 22nd of each month for the next month's Direct Bill coverage. Premiums are paid by recurring bank draft (ACH) for that month's coverage on the 8th of each month. The primary member pays the entire monthly premium while on Direct Bill coverage.

The retiree may change their coverage and drop coverage for dependent(s) at retirement. However, dependents may only be added mid-year if there is a Qualifying Event. Dependents may also be added to coverage during the next Open Enrollment period.

VIII. DEATH OF A PRIMARY MEMBER WITH DEPENDENT CHILDREN

In the event of the death of a primary member who had a dependent child(ren) covered under their SEHP coverage, the surviving dependent child(ren) may elect to continue coverage under the SEHP through the COBRA or Direct Bill programs.

The eligible dependent child(ren) or authorized representative for the eligible dependent child(ren) must contact the SEHP within 31 days of the death of the primary member to continue coverage under the Direct Bill program. If elected, the Direct Bill coverage will be set up under the youngest eligible dependent child as the primary member with other eligible dependent child(ren) set up as dependents under that new primary member.

I. 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:

- limit exclusions for pre-existing conditions
- prohibit discrimination against employees and dependents based on their health status; and
- guarantee renewability and availability of health coverage to certain employees and individuals.

A. SPECIAL ENROLLMENTS

HIPAA requires that group health plans allow specific individuals to enroll without waiting for late or Open Enrollment upon the occurrence of specified events. These special enrollment periods are for employees who previously declined coverage for themselves and their dependents because they had other coverage but then lost it or if an employee adds an eligible dependent gained through marriage or by birth, adoption, or placement for adoption. The employee must complete an add/drop request within 31 days after their other coverage ends. Written documentation of loss of other employer-sponsored group health coverage, the marriage, birth, adoption, or placement for adoption must be provided.

Some examples where special enrollment situations may apply are:

1. Loss of eligibility under a plan due to termination 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 premium contributions toward other coverage, even if the individual continues the other coverage by paying the amount that the employer previously paid.

B. NON-DISCRIMINATION REQUIREMENTS

Individuals may not be denied eligibility or continued eligibility to enroll for benefits under the plan's terms based on specified health factors. In addition, an individual may not be charged more for coverage than similarly situated individuals based 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.

C. 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 and Addiction Equity Act (MHPAEA), which generally prevents group health plans (and health insurance issuers) that provide mental health or substance use disorder (MH/SUD) benefits from imposing less favorable benefit limitations on those benefits than on medical/surgical benefits offered under the plan.
3. Newborns' and Mothers' Health Protection Act (NMHPA) affects how long the member or beneficiary, and newborn child are covered for a hospital stay following childbirth. For the

mother or newborn child includes no restriction to less than 48 hours following a normal vaginal delivery or less than 96 hours following a cesarean. Nor is it required that a hospital obtain authorization from the medical plan for prescribing a length of stay not more than the above periods.

4. The Genetic Information Nondiscrimination Act of 2008 generally prohibits discrimination based on genetic information and the release of a member's genetic information.

D. **PLAN DISCLOSURE REQUIREMENTS**

Under the Department of Labor's (DOL) rules governing plan disclosure requirements, group health plans must improve the Summary Plan Descriptions (SPD)and Summaries of Material Modifications (SMM) in the following ways:

1. Notify members and beneficiaries of any material reductions in covered services or benefits within 60 days of the change being adopted.
2. Disclose information about the role of insurance companies and health plans concerning the group health plan, specifically the name and address, 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, including HITECH; 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 s.

E. **PLAN MEMBERS RIGHTS**

If a member has questions about their rights under HIPAA, they may contact the following office:

Office for Civil Rights
U.S. Department of Health & Human Services
200 Independence Ave, SW
Rm 509F, HHH Bldg.
Washington, D.C

II. 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 healthcare 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.

A. PRIVACY REGULATIONS

The Privacy Rule (effective April 14, 2003) establishes national standards to protect individuals' medical records and other Personal Health Information (PHI) and applies it to health plans, healthcare clearinghouses, and those healthcare providers ("covered entities") that conduct certain healthcare transactions electronically. Under the Privacy Rule, the ways the individual's PHI can be used are limited and specified. The Rule and accompanying regulations apply to PHI 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 the use of personal medical information; 4) Prohibition on marketing and stronger state laws; 5) Confidential communications; and 6) Where to file complaints.

B. 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).

C. Within HHS, the Office for Civil Rights (OCR) enforces the Privacy and Security Rules through voluntary compliance activities and civil money penalties.

D. SPECIAL NOTES:

- At times, it may be necessary to obtain information regarding a member's protected health information. SEHP will request that the member complete an Authorization for Release of Protected Health Information form.
- Members may complete an Appointment of Personal Representative Form and submit it to the SEHP to allow another individual to discuss and act on behalf of that member regarding their coverage under the SEHP. Without this form, the SEHP will not discuss anything or act upon any requests from any individual other than the member regarding a member's SEHP coverage.
- If a member currently has a Personal Representative Form on file with the SEHP and no longer wishes to have that individual act on behalf of a member, the member must submit a Revocation of Personal Representative Form to the SEHP.
- If the employee's last worked is 2/1/20XX, their active benefits will be termed 2/1/20XX. If their last day worked is any other day of the month, their active benefits will be termed the last day of the month they last worked. Example: Last day worked is 2/2/0XX, their active benefits will term 2/28/20XX. The last day worked is 21/20XX, and the active benefits term is 2/1/20XX.

CONTINUATION OF COVERAGE – DIRECT BILL PROGRAM

Retirees will receive both information on the SEHP Direct Bill Program and a COBRA notice as required by law. The retiree should choose only one of these options to continue their coverage.

I. MEMBERS ELIGIBLE TO CONTINUE IN THE DIRECT BILL PROGRAM

Subject to the provisions of sub (e) of K.A.R. 108-1-1, the classes of persons eligible to participate as members of the SEHP on a Direct Bill basis shall be those classes of persons listed below:

A. Any former elected state official

B. Any retired state officer or employee who is eligible to receive retirement benefits under K.S.A. 74-4925 and amendments thereto or retirement benefits administered by the Kansas Public Employees Retirement System (KPERS)

C. Any totally disabled former state officer or employee who is receiving disability benefits administered by KPERS,

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

E. Any person who is in a class listed as an active member and who is lawfully on Leave Without Pay

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

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

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

II. CONDITIONS FOR DIRECT BILL MEMBERS

Each person who is within a class listed above will be eligible to participate on a Direct Bill basis only if the person meets both of the following conditions:

A. The person was covered by the SEHP program on one of the following bases:

- The person was covered as an active member, as a COBRA member, or as a spouse immediately before the date that person ceased to be eligible for that type of coverage or when the individual became newly eligible for a class listed above.
- The person is a surviving spouse or eligible dependent of a person who was enrolled as an active or a Direct Bill member. The person was enrolled in the health care benefits program as a dependent when the primary member passed away.

B. The agency must submit a request in MAP indicating that the member is retiring and wishes to continue with Direct Bill coverage. Active coverage will end on the last day of the month in which an employee terminates employment, and Direct Bill coverage will begin on the first of the following month.

Member Only Coverage

- Direct Bill coverage will begin on the first day of the month following the employee's last day of work.

Member and Spouse Coverage

If the member is not Medicare eligible and the spouse is eligible for Medicare, below are their options.

- The member is eligible to enroll in a non-Medicare Direct Bill. Once the member enrolls in the Direct Bill program, the spouse can be added to the Direct Bill program during the next open enrollment period.
- If the member is Medicare eligible but the spouse is not eligible for Medicare. Members can enroll in the Medicare Direct Bill program and elect one of the Medicare options the state offers. The spouse can enroll in a non-Medicare Direct Bill.
- If both member and spouse are Medicare eligible, they can enroll in the Medicare Direct Bill program. They would both be enrolled under their own name and ID numbers and be able to elect separate coverage. For the spouse to be eligible for Medicare Direct Bill coverage, the member would need to continue with Medicare Direct Bill coverage. The only time the spouse is eligible to continue by themselves is as a Surviving Spouse

PAYMENT METHOD UNDER THE DIRECT BILL PROGRAM

- Members eligible to continue coverage under the SEHP must pay their premiums by bank draft (ACH).
- Bank drafts will be processed for that month's coverage around the 8th of each month. If bank drafts are rejected twice in one month, coverage will be terminated on the last day of the payment received.
- For additional information on the Direct Bill program, call 1-866-541-7100 (Toll-Free) or 785-296-1715 (in Topeka) or email sehpbenefits@ks.gov.
- SEHP produces member invoices in our MAP Member Portal on the 26th of the month before the month is covered.

III. RETIREMENT, SEHP BENEFITS AND MEDICARE ELIGIBILITY

A. RETIREMENT

When an employee retires, the employee needs to:

1. Notify their agency of their retirement date approximately 60 days before the retirement effective date.
2. Decide if they want to continue with the SEHP coverage upon retirement.
3. If Medicare eligible, the primary member must be enrolled in Medicare Part A and Part B to enroll in a Medicare Direct Bill. If the member is enrolled only in Part A, the member must obtain from their agency Medicare Part B memo (forms in MAP) to take to their local Social Security office to enroll in Medicare Part.
4. If the member is electing one of the Kansas Senior Plans, they must indicate if they want to maintain the SEHP drug coverage. If the member does not keep the SEHP drug coverage, they need to obtain an Agency Medicare Memo Part B from their agency HR that indicates they have had creditable drug coverage before retirement.
5. Decide if they want to maintain the SEHP dental coverage. If the member elects to opt out of

dental coverage at retirement, they cannot re-enroll in SEHP dental coverage later.

6. If the employee waived dental coverage as an active member, dental coverage will not be an option when they first retire. However, they can add dental coverage at the next open enrollment period. If they do not choose to enroll in dental coverage at that time, they will not be able to enroll in dental later.
7. If medical coverage is dropped, dental and/or vision coverage can continue. The employee may drop medical coverage and still have dental and/or vision coverage. It is important to note that if medical or dental is dropped, they cannot add either later.
8. Include a copy of all applicable Medicare cards or a letter from Social Security indicating their Medicare number and effective dates for Medicare Part A and B. Enrollment in the Medicare Direct Bill program cannot be completed without the Medicare information.
9. If dependent documentation has not previously been submitted to the SEHP, provide appropriate dependent documentation for any dependents to be included in their coverage.
10. If the Member does not elect Direct Bill nor COBRA, they cannot return to State coverage later.

NOTE: Retirement is considered a termination of employment, making the primary member and their covered dependents eligible to continue coverage under COBRA. The SEHP COBRA administrator will automatically send a COBRA Qualifying Event notice to the primary member and their dependents. The primary member and their dependents may continue their coverage under either the SEHP Direct Bill program or COBRA.

NOTE: Please tell the employee that if they do not take Direct Bill or COBRA, they will NOT be able to return to State coverage later. Medical & and dental can only be waived/removed at open enrollment. If canceled at any other time of the year, all benefits will be canceled, and they will not be able to return to state coverage later.

When an employee retires, the Agency needs to:

1. Ask the employee if they want to continue their coverage under the SEHP Direct Bill program or through COBRA. If the employee wishes to continue their SEHP under the SEHP Direct Bill program, please mark 'Yes' to the question on the mid-year change request in MAP, "Is the employee continuing Direct Bill?" If the answer is unknown, mark 'Yes'.
2. Ask the employee if they or any covered spouse or dependent is Medicare eligible now or will be at the time of enrollment.
3. If needed, provide the employee with an Agency Medicare Part B Memo, Direct Bill Enrollment booklet, and charts, including non-Medicare and Medicare plan options.
4. SEHP will open either a Medicare or non-Medicare enrollment portal for the member to make their elections for Direct Bill coverage.

REMINDERS:

- **NOTE:** As of January 21, 2001, a person will not be eligible for Direct Bill coverage if they do not maintain continuous coverage with the SEHP. This is in accordance with K.A.R. 108-1-1. If there is a break between the last day worked and the effective date of Direct Bill coverage, members can elect COBRA to maintain continuous coverage.
- Members must have continuous coverage under the SEHP to be eligible for the Direct Bill program. If continued coverage is desired, the Retirement request in MAP must be completed

approximately 60 days before the employee's retirement to ensure continuous coverage between active employee coverage and Direct Bill coverage.

- The employee may change their medical plan at the time of retirement. Dependents may be dropped from coverage upon retirement; however, dependents may only be added to coverage mid-year with a Qualifying Event. Dependents may also be added to coverage during the next Open Enrollment period.
- The effective date for the Direct Bill program for members will be the 1st day of the month following the employee's last day worked.

B. EMPLOYEES, SPOUSES, AND/OR DEPENDENTS WHO ARE MEDICARE ELIGIBLE AT RETIREMENT

If the employee or covered spouse/dependent is Medicare eligible when the employee retires, they must have applied for Medicare Part A and Part B or will need to apply for coverage. The Social Security Administration requires that the agency provide retiring employees a memo or letter with health insurance information necessary to process the Medicare Part B coverage application. When applying for Medicare Part B, the Agency needs to complete for the employee to present to

Required information in the memo or letter is:

1. Statement that the employee is covered under the SEHP
2. Date employment began
3. Date employment ends
4. Date coverage began
5. Date coverage ended or will end
6. Spouse's name if the spouse is covered by the SEHP.

C. SPLIT ENROLLMENT

Split Enrollment is required for the following situations:

- When the primary member and spouse are both Medicare-eligible,
- When the primary member is Medicare eligible, and the spouse/dependents are not Medicare eligible,
- When the member is not Medicare eligible, and the spouse/dependents are Medicare eligible.

If the primary member does not enroll in Direct Bill coverage, the non-Medicare spouse/dependents will be offered COBRA coverage.

If the primary member elects to enroll in Direct Bill coverage, the non-Medicare spouse/dependent will have an enrollment portal opened to make elections for their own Direct Bill coverage. The agency must complete a Retirement Request in MAP indicating that the employee is retiring and wishes to continue with the SEHP Direct Bill coverage. A Direct Bill enrollment portal will be opened in MAP for the member and spouse with split coverage.

NOTE: If a member has member-only Dental coverage at retirement, the split dependent will be given a one-time opportunity to enroll in their Dental coverage at the next Open Enrollment period.

Information on the retiree can be found on the SEHP website.

D. DEATH OF PRIMARY DIRECT BILL MEMBER WITH DEPENDENT CHILDREN

In the event of the death of a primary Direct Bill member who had a dependent child(ren) enrolled

under their coverage, the surviving dependent child(ren) may elect to continue coverage under the SEHP Direct Bill program until they no longer meet the definition of an eligible dependent (i.e., the child reaches the limiting age of 26).

The eligible dependent child(ren) or authorized representative for the eligible dependent child(ren) must contact the SEHP within 31 days of the death of the Direct Bill primary member to elect to continue coverage under the Direct Bill program. If elected, the Direct Bill coverage will be set up under the youngest eligible dependent child as the primary member, with other eligible dependent child(ren) set up as dependents under that new primary member.

NOTE: A surviving dependent child who did not have previous dental coverage will have a one-time opportunity to enroll in Dental coverage at the next Open Enrollment period.

PREMIUM REFUNDS DUE TO DEATH OF DIRECT BILL MEMBER, SPOUSE, OR DEPENDENT DEATH

I. PREMIUM REFUNDS – IMPORTANT

The primary member enrolled in the Direct Bill program, or a primary member’s authorized representative, is responsible for notifying the SEHP in writing within 31 days of a change in family status, including due to the death of a primary member, spouse, or dependent. If the primary member or authorized representative does not notify the SEHP within 31 days of a change in family status due to the death of the primary member, spouse, or dependent, their premium refund for any premiums paid during this period is limited to the following:

- If the SEHP is notified after 31 days but within 24 months of the date of death of a primary member, spouse, or dependent, a maximum of 12 months of paid premiums will be fully refunded.
- If the SEHP is notified 24 months after the date of death of a primary member, spouse, or dependent, the primary member or their authorized representative will not be eligible for any premium refund.

Example: If a primary member’s monthly premium payment is $200.00 per month and the SEHP is notified in writing in the 8th month after death, the primary member or their authorized representative would receive a premium refund of eight months of the actual monthly premium paid on behalf of by the primary member for a total refund of $1,600.

COBRA COVERAGE

I. COBRA Coverage

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

Employees, spouses, and dependents who lose insurance coverage under the SEHP can continue coverage by paying the required COBRA premiums. If a retiree has chosen COBRA over the SEHP Direct Bill coverage and COBRA runs out, the retiree may enroll in Direct Bill coverage.

COBRA coverage is administered through the SEHP's third-party COBRA administrator.

Former employees, spouses, and dependents eligible to continue health insurance coverage are called Qualified Beneficiaries. The provisions under which they can continue coverage are called Qualifying Events. The number of months they can continue coverage is specified based on the Qualifying Event. The maximum length of time a Qualified Beneficiary may carry COBRA coverage is 18 months. Coverage may be shortened or extended upon the occurrence of a secondary Qualifying Event.

II. HEALTH COVERAGE TO BE CONTINUED

Qualified beneficiaries are eligible to continue only those medical, dental, prescription drug, vision, and voluntary benefits for which they are covered at the time of the Qualifying Event.

NOTE: If an employee goes on Leave Without Pay, terminates employment, and does not continue SEHP coverage during the leave period, the employee and any dependents would not be eligible for COBRA. They are not eligible because they were not participating in the SEHP at the time of the Qualifying Event.

III. COBRA QUALIFYING EVENT PROCEDURES

A. If the Qualifying Event is termination of employment (except for gross misconduct), the SEHP notifies the carriers to terminate insurance coverage. Since there is a time limit when the Qualified Beneficiary can elect COBRA coverage, the Agency must submit a termination request in MAP as soon as possible.

B. If the Qualifying Event is the reduction of hours of work to less than 1,000 per year, the SEHP notifies the carriers to terminate insurance coverage. Since there is a time limit when the Qualified Beneficiary can elect COBRA coverage, the Agency must submit a termination request in MAP as soon as possible.

C. Within 14 days of the SEHP receiving notification of the Qualifying Event, the qualified Beneficiary will receive specific information from the third-party COBRA administrator, including a COBRA Enrollment Form with the requirements for continuing insurance coverage, the plans available, and the applicable premium rates.

D. If the Qualifying Event is due to the following:
   1. Death of covered employee (active employee and Direct Bill).
   2. Divorce from covered employee (active employee and Direct Bill).
   3. Covered employee choosing Medicare as primary carrier, leaving dependents without health insurance coverage (active employees only), or
   4. Ceases to meet the SEHP's definition of eligible dependent, i.e., turns age 26 (active employee & Direct Bill):

The Qualified Beneficiary must notify the third-party COBRA administrator within 60 days of the Qualifying Event. If notice is not received within 60 days of the Qualifying Event, the Qualified Beneficiary will not be eligible for COBRA coverage. Because of this time limit, the completed Change Request must be entered into MAP immediately.

E. An election by a covered employee or spouse to continue coverage will be deemed an election for coverage by any other Qualified Beneficiary. However, each Qualified Beneficiary has an individual right to elect COBRA coverage. Each Qualified Beneficiary may make a separate selection among the levels of coverage available.

IV. TERMINATION OF COBRA COVERAGE

A. Non-payment or untimely payment of premiums

B. The employee or their dependent(s) become(s) covered, either as an employee or dependent, under another employer-provided medical plan

C. The employee or enrolled dependent(s) becomes eligible for Medicare. Termination includes all medical, prescription, dental, vision, and voluntary benefits coverage. However, if Medicare eligibility is due to ESRD, the individual may continue COBRA.

NOTE: Only the person(s) eligible for Medicare coverage lose(s) COBRA benefits. Any other person(s) enrolled may continue for the COBRA eligibility period.

D. The State of Kansas no longer offers group health insurance to its employees.

V. ADMINISTRATION

A. All SEHP active benefits will terminate on the last day of the month on which the employee's COBRA Qualifying Event occurs unless the qualifying event occurs on the 1st day of the month; then, benefits will terminate on the 1st day of the month.

For all terminations, COBRA notices are generated by the SEHP's third-party COBRA administrator. COBRA notices are generated from the Termination requests entered in MAP by the Agency. The member does not receive a COBRA notice if the Termination request is not entered into MAP. Prompt submission of requests is essential.

B. COBRA coverage is not automatic. The member must complete the COBRA election form accompanying the COBRA notification sent by the third-party COBRA administrator if they want to enroll in COBRA coverage. The member has 60 days from the date of the notice to return the COBRA election form to the third-party COBRA administrator.

C. If the member elects COBRA, COBRA coverage will begin the day after active SEHP coverage terminates.

D. COBRA notices are sent to the member at the last address in MAP. Therefore, it is very important that the correct address appears in MAP at the time of termination. Former employees should be reminded to update their mailing address information or leave forwarding instructions with the Postal Service if they change addresses.

VI. COST OF BENEFITS - COBRA RATES

Any individual that elects COBRA coverage under the plan must pay the full cost (including the contribution they spent as an active employee and the contribution paid by the employer), plus any additional amounts allowed by law. Currently, COBRA rates are 102% of the total premium. However, those beneficiaries who elect the 11-month extension of benefits due to disability will pay 150% of premiums for the additional 11 months of coverage.

NOTE: COBRA premiums are billed monthly. For example:

- An employee terminates employment on March 5th. Their active SEHP coverage ends on March 31st.
- The employee elects COBRA coverage
- COBRA coverage becomes effective April 1st.
- COBRA premiums are billed from the 1st through the end of each month.

For the current Plan Year, [COBRA rates]

APPEALS FOR EXCEPTION DUE TO AGENCY ERROR

Most enrollment options or enrollment changes are available only for a limited amount of time from a specific date or occurrence of an event. Requests not entered in MAP within the specified time frames will result in denials or significant restrictions on the employee's enrollment options.

Most policies use the event date, the date completed, and the date received by the SEHP as the determining dates for timely notification. The agency is responsible for ensuring that appropriate requests are correctly completed and the appropriate documentation is uploaded in MAP within the applicable timeframe.

If the employee notifies their Agency of a Qualifying Event and the Agency fails to submit the appropriate request in MAP before the deadline, the employee may be penalized. Appeals for exception due to agency error shall also include circumstances in which agency staff provided inaccurate health plan information to the member and the member detrimentally relied on such incorrect information. If the agency chooses to appeal any restrictions or denials due to agency error the agency should:

1. Submit a Communication Form via MAP, appealing the denial or restriction that was due to agency error. The Communication Form must include:
    - The name of the employee in question
    - Upload copies of documentation and other information provided by the employee.
    - The nature of the error; and
    - Any steps the agency has taken to prevent a reoccurrence of the error.
2. A Communication Form is required for each employee. Acknowledgment of agency error does not provide a blanket exception for all similar circumstances.
3. The appeal must be made by the agency within 10 days following notification of a denial.

If the SEHP approves the appeal, the agency may be fined up to $1,000 per incident.

HEALTHYKIDS DISCOUNT

HealthyKIDS discount is a program that helps eligible State of Kansas employees with the cost of their premium for children's health insurance coverage in the SEHP. State employees with dependent children who are eligible will have approximately 90% of the premium contribution for their covered children paid for by the State of Kansas instead of the traditional 55%. The employee will pay for the remaining amount. Employees may enroll in any of the available plan options.

If an employee does not qualify for KanCare (Title 21) because they are a State of Kansas employee, they may qualify for the HealthyKIDS discount if their household size and income fall within the guidelines. Current household gross income guidelines can be found on the SEHP website.

Gaining Title XXI (CHIP) coverage is not a Qualifying Event under IRS 125 rules. If Title XXI (SHIP) coverage is lost mid-year that is a Qualifying Event under IRS Rules 125, and the plan is permitted to add that person to coverage and have the primary member apply for the HealthyKIDS discount. The HealthyKIDS discount will not be removed mid-year if there is at least one qualified dependent child on the program.

If living in the same household, the employee should count themselves, their spouse, and their eligible dependent children under age 19 who live with the employee, including adopted children and minors for whom the employee has legal custody.

During Open Enrollment, employees will enroll in a health plan and coverage tier of their choice. If the employee thinks they may be eligible for the HealthyKIDS discount, they should complete the HealthyKIDS application when making their enrollment elections in their member portal.

Employees may apply mid-year due to a Qualifying Event if that event affects their medical insurance coverage. The Qualifying Events are the same as those established for mid-year enrollment changes.

Employees must apply within 31 days of the event. The HealthyKIDS discount will not be stopped mid-year because of an increase in income or because a dependent reaches the age of 19 unless the child turning 19 is the only child being covered.

The employee receives either an approval or denial at the time of the application, subject to SEHP eligibility guidelines. If the member is approved, the SEHP will change the employee's benefit program code to reflect the discounted premiums. The increase in the employer contribution will be effective:

- January 1st for Open Enrollment
- The date the new employee becomes first eligible.
- The effective date of the approved mid-year change

Employees who do not qualify for the HealthyKIDS discount may change their coverage level, but not the medical plan (Example: change from Family coverage to Member/Spouse). A Communication Form must be submitted in MAP within 31 days of the HealthyKIDS discount denial notification. Please include "*Denial of HealthyKIDS*" and the coverage level Change Requested in the Communication Form request.

Employees must reapply during Open Enrollment each year for the HealthyKIDS discount.

FLEXIBLE SPENDING ACCOUNT PROGRAM

The Flexible Spending Account (FSA) program is offered by the SEHP and administered by the FSA vendor. The FSA program is subject to the federal rules and regulations of Internal Revenue Code (IRS) 125 concerning all cafeteria plans and is authorized by K.S.A. 75-6512 et al. FSAs allow participants to pay for non-reimbursed health care, dependent daycare, and commuter expenses using pre-tax dollars.

I. FLEXIBLE SPENDING ACCOUNT OPTIONS

A. Health Care Flexible Spending Account (HC FSA): This account allows participants 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. Dependent Care Flexible Spending Account (DC FSA): This account allows participants to pay for qualified work-related daycare expenses on a pre-tax basis. Qualified DCARE FSA expenses are determined by IRS 129.

C. Limited Purpose Flexible Spending Account (LP FSA): This account allows participants to pay for qualified dental and vision expenses on a pre-tax basis. Qualified Limited Purpose FSA expenses are determined by IRS 129.

D. Mass Transit Flexible Spending Account—This account allows for reimbursement of qualified mass transit tickets or passes or State of Kansas Vanpools.

E.Parking Flexible Spending Account: This account allows for reimbursement for parking associated with your daily commute to and from work.

II. TAX SAVINGS

Salary reduction on a pre-tax basis means that the participant agrees with the State of Kansas to reduce their salary by the cost of Health Plan premiums and/or by the amounts elected for FSA. Since the participant's salary is reduced, the participant does not pay federal or state income taxes or Social Security taxes on these amounts. As a result, the participant's take-home pay should increase by the amount they don't pay in taxes.

NOTE: This information is not intended as tax advice for participants in the FSA options. It is intended solely to provide general information on the tax benefit of participating in the sponsored accounts. Employees are encouraged to seek professional tax counseling to determine a specific tax benefit.

III. EFFECTIVE DATE

Employees can elect to enroll in an FSA at the time they complete their online enrollment elections, which must be completed within 31 days from the date of hire or new benefits eligibility. If the election is not submitted within 31 days, the employee will not be allowed to enroll in an FSA for the current plan year unless there is a Qualifying Event or during the next Open Enrollment period.

IV. CARRY OVER PROVISION

The SEHP allows the employee to carry over a percentage of the unused HC FSA or LP FSA funds into a new FSA plan year. This allows the employee to spend FSA funds at a future date and reduces the likelihood that unused funds are forfeited. The current plan year carryover amount can be found on the FSA vendor's website: **www.MyKansasCDH.com**.

Funds carried over from the previous plan year will not count against the new plan year's annual election. The availability of carryover funds differs when carried over to the same type of FSA or rolled to a different type of FSA.

A. HC FSA to HC FSA – When carrying over funds from an HC FSA from the previous plan year to an HC FSA in the new plan year, the carryover funds will be available immediately to reimburse claims incurred in the previous and new plan year. Claims with dates of service from the previous plan year can still be submitted for reimbursement during the run-out period, which is 120 days after the plan year's end. Claims incurred during the new plan year will first be paid from any new plan year elections (if any) before being paid from any available Carryover funds.
B. HC FSA to LP FSA – When carrying over funds from an HC FSA to an LP FSA, funds in the HC FSA as of the end of the previous plan year can reimburse expenses for previous plan years' medical, dental, and vision expenses until the end of the plan run-out period. The remaining funds from the previous year's HC FSA funds will not carry over to the new plan year until the run-out period has ended. Currently, the funds from the Carryover may only be used for dental or vision expenses. Any dental or vision expenses incurred during the new plan year can be reimbursed immediately from the elected LP FSA or carryover when funds are available.
C. LP FSA to LP FSA – When carrying over funds from an LP FSA from the previous plan year to an LP FSA in the new plan year, the carryover funds will be available immediately to reimburse claims incurred during the last and new plan years. Claims with dates of service from the prior plan year can still be submitted for reimbursement during the run-out period, which is 120 days after the plan year's end. Claims incurred during the new plan year will first be paid from any new plan year elections (if any) before being paid from any available Carryover funds.
D. LP FSA to HC FSA – When carrying over funds from an LP FSA from the previous plan year to an HC FSA in the new plan year, the carryover funds will be available immediately to reimburse claims incurred during the last and new plan years. Claims with dates of service from the previous plan year can still be submitted for reimbursement during the run-out period, which is 120 days after the plan year's end. Claims incurred during the new plan year will first be paid from any new plan year elections (if any) before being paid from any available Carryover funds.

NOTE: If a member terminates employment or stops their contributions to the HC or LH FSA before the plan year's end, the member will have 90 days from the date the benefit is terminated to file claims for eligible medical expenses incurred. In contrast, the FSA benefit was active that plan year.

NOTE: A debit card is issued by NueSynergy for FSA accounts. Claims reimbursement requests may be submitted via mail, fax, mobile app, or online.

NUESYNERGY – FSA Vendor Information
FSA Customer Service Line: **1-855-750-9440**
Website: **www.MyKansasCDH.com**

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

I. QUALIFIED HIGH DEDUCTIBLE HEALTH PLAN (QHDHP)

The Qualified High Deductible Health Plan (QHDHP) is a Preferred Provider Organization (PPO) with either a Health Savings Account (HSA) or Health Reimbursement Account (HRA). With the QHDHP, there are both network and non-network pricing structures for health coverage. A QHDHP also provides broader nationwide services, and there is an allowance for preventive care. Employees enrolling in a QHDHP must elect an HSA or an HRA when they elect their benefits elections in MAP.

II. HEALTH SAVINGS ACCOUNT (HSA)

An HSA has IRS minimum and maximum contribution limits. The account can be made up of both employer and employee contributions. The purpose of the HSA is to allow members to put pre-tax savings aside for future medical expenses. The savings may be used for eligible unreimbursed medical expenses not covered by the QHDHP, as outlined by the IRS.

To activate the HSA, federal law requires each employee to pass the Identification Verification (IDV) Process. If the employee does not pass the IDV process, the HSA vendor will contact the employee directly and request additional documentation. The employee must work directly with the vendor to correct the IDV issue. If the employee does not correct the IDV issue, an HSA cannot be opened, and any employee contributions that have been made will be returned to the employee as taxable income. Members will automatically have their HSA set up by the HSA vendor once they have passed the IDV process.

The HSA is owned by the member, administered by the HSA vendor, and can be funded up to the maximum amount determined by the U.S. Treasury Department each year. Members who are 55 and older can make a “catch-up” contribution of up to $1,000 each year, as outlined in IRS Publication 969. The HSA account is portable, and funds roll over from year to year. The funds in the account belong to the member (account holder).

Members electing Plan C must make a minimum contribution of $25 per paycheck to receive the quarterly employer contributions. Members electing Plan N do not have a minimum per paycheck contribution due to a reduced quarterly employer contribution. The HSA will be effective the first day of the month following the medical benefit effective date unless medical benefits are effective on the 1st.

The HSA employer contribution is made in 4 quarterly installments:

- The first paycheck in January
- The first paycheck in April
- The first paycheck in July
- The first paycheck in October

NOTE: To receive each quarterly installment, the employee must be actively employed on January 1, April 1, July 1, and October 1.

The HSA employer contribution amount is based on:

- The primary member’s coverage level on the 1st day of each quarter
- The employment status of the member (part-time or full-time) on the 1st day of each quarter
- The medical plan the member is enrolled in on the 1st day of each quarter.

HSA employer contributions for new enrollees during the plan year will be based on the medical coverage level, employment status, and medical plan enrollment on the 1st day of the quarter following the effective date of the medical benefits.

Members may change their HSA contribution during the plan year without a Qualifying Event by submitting a Change Request in MAP. Once the request has been approved by the SEHP, the effective date of the change will be based on the next available paycheck.

If an employee changes from member-only to member and dependent medical coverage or from member and dependent to member-only medical coverage mid-year due to a Qualifying Event, the quarterly employer contribution will change with the next quarterly employer contribution, January, April, July, and October.

III. HEALTH REIMBURSEMENT ACCOUNT (HRA)

A Health Reimbursement Account (HRA) is an employer-sponsored plan similar to an HC FSA and an HSA. Contributions are funded entirely by the employer; no employee contributions are permitted. The HRA is not portable, and any remaining funds at the end of the year will not roll over to the next plan year. Members have 60 days from the end of the plan year (December 31st) to file claims for eligible medical expenses incurred during that plan year while the benefit was active.

The HRA employer contribution frequency and amounts are identical to the HSA's.

With an HRA, members can also enroll in a Health Care FSA.

If a member terminates coverage with the SEHP before the end of the plan year, the member has 60 days from the last date on the SEHP coverage to file claims for eligible medical expenses incurred while the HRA benefit was active that plan year.

NOTE: MetLife issues a debit card for HSA and HRA accounts. Claims may also be submitted via mail, fax, mobile app, or online.

METLIFE – HSA & HRA Vendor Information
HSA Customer Service Line: **1-877-759-3399** Website

IV. LIMITED PURPOSE FSA - AVAILABLE FOR PLAN C AND N (QHDHP W/HSA) MEMBERS

A Limited Purpose (Limited Scope) FSA is an option for members enrolled in Plan C or Plan N with a Health Savings Account (HSA). The LP 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. With an LP FSA, members can only submit claims for eligible dental and vision 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 HC and LP FSA ($192 annual minimum and $3,050 annual maximum).

NOTE: NueSynergy issues a debit card for FSA accounts. Claims may also be submitted via mail, fax, through the mobile app, or online.

NUESYNERGY – FSA Vendor Information
FSA Customer Service Line: **1-855-750-9440** Website

FSA PARTICIPANTS: QUALIFIED RESERVIST DISTRIBUTIONS (QRD)

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 FSA. According to the Act, an employer and/or Plan Sponsor may cash out unused FSA account balance to eligible reservists without disqualifying its cafeteria plan. The withdrawal is known as a Qualified Reservist Distribution or (QRD). However, some qualifications must be met before a QRD can be made:

- The individual must be a "reservist", as defined in 37 U.S.C. 101, which means the reservist must be a member of one of the following:
    - Army National Guard of the US
    - Army Reserve
    - Navy Reserve
    - Marine Corps Reserve
    - Air National Guard of the US
    - Air Force Reserve
    - Coast Guard Reserve
    - Reserve Corps of the Public Health Service
- The participant is called to active duty for 180 days or more or indefinitely.
- 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).

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

NUESYNERGY – FSA Vendor Information
FSA Customer Service Line: **1-855-750-9440**

State Employee Health Plan contact information can be found on the SEHP website:

HEARING IMPROVEMENT PROGRAM (K-SHIP)

Hearing Improvement Program (K-SHIP)

The following is information about the K-SHIP program. For more information, please contact the Speech and Hearing departments listed below.

K-SHIP is a hearing improvement program utilizing the Hearing and Speech Departments at participating Universities and allows members and their covered dependents to receive a discount on certain hearing services. The Speech and Hearing Departments of the University of Kansas, University of Kansas Medical Center, Kansas State University, Wichita State University, and Fort Hays State University currently participate in K-SHIP.

Services include hearing evaluations and testing, as well as hearing testing required to determine the need for hearing aids. Hearing evaluations may be eligible for coverage under an SEHP coverage option. To maximize benefit options, be sure to contact the insurer or Plan Administrator and ask about coverage.

Employees enrolled in the SEHP and their covered family members are eligible to receive a 10 percent discount off the cost of eligible services. A member does not have to apply for coverage or fill out any forms to be eligible for the discount. The member will need to contact the Speech and Hearing Department of their choice, tell them they are a member of the SEHP, and make an appointment. At the time of the appointment, the member will need to show their prescription drug coverage card to verify eligibility.

The plan addresses and phone numbers for these programs are:

Schiefelbusch Clinic
University of Kansas
1200 Sunnyside Ave
2101 Haworth Hall
Lawrence, KS 66045
Voice: (785) 864-4690
TTY: (785) 864-0667

Hearing and Speech Dept
KU Medical Center
3901 Rainbow Blvd
Kansas City, KS 66160
Voice: (913) 588-5730

Speech-Language-Hearing Clinic
Wichita State University
5015 E. 29th
Wichita, KS 67260
Voice: (316) 978-3289

The Speech and Hearing Center
Kansas State University
139 Campus Creek Complex
Manhattan, KS 66506-3503
Voice: (785) 532-6879

Herndon Speech-Language-Hearing Clinic
Fort Hays State University
600 Park St
Albertson Hall, Rm 131
Hays, KS 67601-4099
Voice: (785) 628-5366

ACRONYM GLOSSARY

ACH – Automated Clearinghouse Network

CHIP – Children's Health Insurance Program

COBRA – Consolidated Omnibus Budget Reconciliation Act

DOB – Date of Birth

DOL – United States Government Department of Labor

ESRD – End Stage Renal Disease

FMLA – Family Medical Leave Act

FSA – Flexible Spending Account

LTC – Long Term Care

HC FSA – Health Care Flexible Spending Account

HICN – Health Insurance Claim Number

HIPAA – Health Insurance Portability and Accountability Act

HCC – Health Care Commission

HRA – Health Reimbursement Account

HSA – Health Savings Account

ID Cards – Identification Cards

IRS – United States Government Internal Revenue Service

ITIN – Individual Tax Identification Number

K.A.R. – Kansas Administrative Regulation

KPERS – Kansas Public Employees Retirement System

K.S.A. – Kansas Statute Annotated

LP FSA – Limited Purpose Flexible Spending Account

LWOP – Leave Without Pay

MAP – Membership Administration Portal

MHPAEA - Mental Health Parity and Addiction Equity Act

MSP – Medicare Secondary Payer

NMHPA - Newborns' and Mothers' Health Protection Act

PPO – Preferred Provider Organization

QHDHP – Qualified High Deductible Health Plan

QMCSO – Qualified Medical Child Support Order

SEHP – State Employee Health Plan

SOK – State of Kansas

SSIF – State Self Insurance Fund

SSN – Social Security Number

TIN – Taxpayer's Identification Number

TEFRA – Tax Equity and Fiscal Responsibility Act

TPA – Third Party Administrator

TTD – Temporary Total Disability

USERRA – Uniformed Services Employment and Reemployment Rights Act

WHCRA - Women's Health and Cancer Rights Act