Member User Guide

State Employee Health Plan

Member Benefit Guidebook

- *Active Members*
- *NonState Members*

Kansas
Department of Administration
State Employee Health Plan

updated: July 2026

MEMBERSHIP ADMINISTRATION PORTAL (MAP)

The information provided in this manual is subject to change.

SEHP Membership Administration Portal (MAP):

https://sehp.member.hrissuite.com

If you are employed at ESU, KSU, KU, KUMC or PSU use this link to access MAP

https://sso.cobraguard.net/seer_login.php

MAP Technical Support:

- Email: techsupport@hrissuite.com
- Phone: 1-800-832-5337 (Toll Free)

Most Internet browsers:

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

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

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

State Employee Health Plan contact information can be found on the SEHP website: https://sehp.healthbenefitsprogram.ks.gov/about-us/contact-us

NOTE: Current physical addresses, personal email addresses, and phone numbers must be maintained in the SEHP Member Portal so that members can receive health plan information in a timely manner.

GENERAL HEALTH PLAN INFORMATION

The State Employee Health Plan (SEHP), established under K.S.A. 75-6501 et seq., is governed by the State Employees Health Care Commission (HCC), composed of appointed officials and legislative members.

The SEHP contracts with carriers for medical, prescription drug, dental and vision coverage on staggered three-year cycles.

Medical plan administrators include Aetna and Blue Cross Blue Shield of Kansas. Prescription coverage is provided by CVS Caremark, dental by Delta Dental and vision by Surency. NueSynergy is the Flexible Spending Account vendor. MetLife is the Health Reimbursement and Health Savings Accounts for the Qualified High-Deductible Health Plans. COBRAGuard is the COBRA (Consolidated Omnibus Budget
Reconciliation Act) vendor. MetLife is the voluntary plans for hospital indemnity, critical illness and accidental injury vendor

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.

IMPORTANT NOTE

Current physical addresses, email addresses, and phone numbers must be maintained in the Membership Administration Portal (MAP) for HR contacts and employees so that members can receive health plan information on time.

DEFINITIONS USED IN THIS GUIDEBOOK

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

Before Tax Deduction - Money is taken out of an employee's gross pay before any taxes are withheld, reducing the employee's taxable income by the premium deduction amount.

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

Coinsurance - It is the percentage of costs of a covered health care service that you pay after you've paid your deductible. It is the amount an insured must pay against a health insurance claim after their deductible is satisfied.

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

Copayment - a cost-sharing arrangement in which the member pays a specified flat amount for a specific service (such as $30 for an office visit or $15 for a prescription drug). It does not vary with the cost of the service.

Deductible - an amount that must be paid by the member before benefits become payable by the SEHP. Deductibles are usually "annual" amounts.

Dependent - the primary member's eligible spouse or dependent child(ren) as defined in K.A.R. 1081-1.

Direct Bill and Retiree Program - a program to extend health coverage to

- Retiring participating State of Kansas employees
- Totally disabled former participating State of Kansas employees
- Surviving spouses and/or dependents of participating state employees are 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

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

Employer Contribution - The contribution amount required to be paid by the employer on behalf of the employee and/or eligible dependents.

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

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

HealthQuest - the State of Kansas Health Promotion Program.

HIPAA - The Health Insurance Portability and Accountability Act (HIPAA) of 1996 (P.L.104-191), the 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 electronic protected health information; and the confidentiality, integrity, and availability provisions of the Patient Safety Rule, which protect identifiable information being used to analyze patient safety events and improve patient safety.

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

Membership Administration Portal (MAP) - The system for State Employee Health Plan (SEHP) benefits. Where an employee can make initial benefit elections, request mid year changes to their benefits, enroll during open enrollment, and maintain current contact information.

Member Portal - https://sehp.member.hrissuite.com

If you are employed at ESU, KSU, KU, KUMC, or PSU, you may access your member portal via this link: https://sso.cobraguard.net/seer_login.phpin

Membership Services - the SEHP unit responsible for managing eligibility functions and membership activities for members who participate in the SEHP.

Open Enrollment - October 1st through the 31st of each year. This is when members must submit elections for coverage for the following plan year. This is required each year to continue elected coverage under the SEHP.

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

A dependent age 26 or older can continue coverage if they are permanently and totally disabled. A Permanent and Totally Disabled Dependent Child application must be completed and uploaded in the SEHP Member Portal, along with a communication form submitted to continue coverage for the dependent after age 26.

Plan year - The annual period of coverage for benefits in the SEHP, beginning at 12:01 a.m. (CST) Time, on January 1st, through midnight, December 31st.

Primary member - The individual actively employed with the State, or a non state employer Group covered under the SEHP.

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.

The 1983 amendment to ERISA requires employer sponsored group health plans to extend health care coverage to the children of the parent/employee who are divorced, separated, or never married when ordered to do so by the state authorities.

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

If you have specific questions regarding certain benefits offered within the SEHP or areas of administration of specific benefits, please contact the SEHP at SEHPMembership@ks.gov.

Visit our website at: https://healthbenefitsprogram.ks.gov/sehp/sehp-home.

Eligible employees who elect to participate in the SEHP are referred to as members throughout this guidebook

EMPLOYEE ELIGIBILITY

For newly hired employees, coverage will be effective on the first day of work.

- Employees hired during or after the Annual Open Enrollment period must enroll in both their Initial Enrollment for the current plan year and Open Enrollment for the following year.

EFFECTIVE DATE OF COVERAGE

Your coverage will become effective on your first day of work in a benefits eligible position. Once your benefits become effective, no elections can be changed unless you experience a qualifying event.

ENROLLMENT PERIOD

Employees will have 31 days from their first day of work to enroll in benefits.

- If the 31-day deadline is missed, the next opportunity to elect coverage will be during the next annual Open Enrollment period which is October 1st – October 31st or with a Qualifying Event.
- It is important to make your elections as soon as possible to avoid multiple deductions from one paycheck.

You should complete your Enrollment in the SEHP Member Portal https://sehp.member.hrissuite.com.

If you are employed at ESU, KSU, KU, KUMC, or PSU, you may access the SEHP Member Portal via https://sso.cobraguard.net/seer_login.php.

NON-BENEFITS ELIGIBLE TO BENEFITS ELIGIBLE

For current employees who are changing from a non-benefits eligible position to a benefits eligible position, the effective date of coverage is the first day of employment in the benefits eligible position. The Employee must complete an Enrollment in the SEHP Member Portal within 31 days of starting work in the benefit eligible position.

REHIRE

For employees rehired with a break in service of 31 days or less, IF there was active benefit coverage before the termination, the previous benefit coverage will be reinstated effective the first day of the month following the rehire date or first date of eligibility.

> Example: employee terminates on 01/20 and rehires on 02/12; there would be a break in coverage from 02/01-02/11.

If the break in service is 31 days or more, an enrollment portal will be opened, and elected benefits will be effective on the first day of work in the new position.

AGENCY TRANSFER

If an employee transfers from one state agency to another with no break in service, there will be continuous group health insurance coverage. Coverage will end with the prior agency termination date and coverage under the new agency will begin on the date of hire with the new agency.

For employees rehired with a break in service of 31 days or less, IF there was active benefit coverage before the termination, the previous benefit coverage will be reinstated as the following examples show:

- Example: employee terminates on 01/02 and rehires 01/20; benefits would end on 01/31 and start on 02/01
- Example: employee terminates on 01/20 and rehires on 02/12; there would be a break in coverage from 02/01-02/11.

If the break in service is **31 days or more**, an enrollment portal will be opened, and elected benefits will be effective on the first day of work in the new position.

SOK termination to NSEG new hire (or vice versa) within the same month, benefits with the terming agency/group will end on the last day of the month of employment. A portal will be opened with the hiring group/agency and benefits will be effective on the first day of the following month.

Example: term 02/05; hire 02/15 – benefits with the hiring agency/group will be effective 03/01

If the termination and hire are in different months, a portal will be opened with the hiring agency/group for benefits effective the date of eligibility

> Example: term date 02/15 with benefits ending 02/28; hire 03/05 – benefits with the hiring agency/group will be effective 03/05

PRE EXISTING CONDITIONS

SEHP does not apply an additional waiting period for pre existing conditions for you or your dependents who enroll in health coverage.

WAIVER OF INSURANCE COVERAGE

If you choose to waive SEHP coverage, you must go to the Member portal and elect to waive coverage. Your next opportunity to enroll in the SEHP will be during the next annual open enrollment period or with a qualifying event.

FULL TIME or PART TIME EMPLOYMENT STATUS

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

DENTAL PLAN

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

VOLUNTARY PRESCRIPTION EYEWEAR INSURANCE

The voluntary prescription eyewear plan is a stand-alone product, meaning that employees and their dependents do not have to be enrolled in medical coverage to be enrolled in voluntary prescription eyewear insurance coverage.

VOLUNTARY BENEFITS

Accident, Critical Illness, and Hospital Indemnity Insurance are voluntary benefits offered to members through MetLife. These are also stand-alone products.

OTHER ELIGIBLE INDIVIDUALS UNDER THE SEHP

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

Your lawful spouse, subject to the documentation requirements of the HCC or its designee.

Your eligible dependent children, also referred to as “dependent(s)” throughout the rest of this guidebook.

Important Information:

NOTE: An eligible primary member cannot be enrolled as both a dependent and a primary member. Members are either the primary member or dependent; you cannot be both. Double SEHP benefit coverage is not allowed. If you are an active dependent and enroll as a primary member, you will be removed from the dependent coverage upon primary enrollment.

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

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

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

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

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

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

The word ‘child’ means:

- Your biological child
- Your lawfully adopted child. Lawfully adopted will include those instances in which a primary member has filed a petition for adoption by the court, has a placement agreement for adoption, or has been

granted legal custody of a non-biological child.

- Your stepchild. If the natural or adoptive parent of the stepchild is divorced from you, the child no longer qualifies as your stepchild and is no longer eligible for coverage.
- A non-biological child of whom you, as the primary member, have legal custody of.
- Your grandchild, if you claim the grandchild as a dependent on your most recent Federal tax return and at least one of the following conditions is met:
    - You have legal custody of your grandchild or have lawfully adopted your grandchild.
    - The grandchild lives in your home and is the child of your covered eligible dependent child, and you provide more than 50% of the support of your grandchild or
    - The grandchild is the child of your covered eligible dependent child and is considered to reside with you even when your grandchild or your eligible dependent child is temporarily absent due to special circumstances, including the education of your covered eligible dependent child, and you provide more than 50% of the support for the grandchild.
    - When submitting a change request in SEHP Member Portal to add your grandchild, a Dependent Grandchild Affidavit must be completed, notarized, and uploaded along with a copy of your Grandchild's birth certificate and a copy of your most recently filed Federal Income Tax return showing that you claim the grandchild as a dependent, as proof of financial dependency and residency.

NOTE: Eligible dependent children must be less than 26 years of age unless they are permanently and totally disabled.

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 a permanent and total disability unless the individual furnishes proof of the permanent and total disability in the form, manner, and time required by the SEHP.

Eligible dependent child(ren) or stepchild(ren) aged 26 or older 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 (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 his or her 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.

REQUIRED DEPENDENT SUPPORTING DOCUMENTATION

The SEHP requires documentation to verify the dependent is eligible or continues to be eligible to be covered under the plan and/or to verify the residency of your dependent(s).

You must also upload appropriate supporting documentation in your SEHP Member Portal (birth certificate, adoption papers, marriage license, copy of the current year's filed federal tax return, etc.) for any new dependents added to the plan or upon request by the plan to re certify eligibility for continued coverage.

Legible supporting documentation in English is required (birth certificate, petition for adoption, marriage license, legal custody agreement, copy of current year's filed federal tax return, etc.) as proof of the qualifying event.

The following required documentation must be uploaded to your SEHP Member Portal at the time of the online Enrollment or Change request:

- Marriage License (for proof of spouse and stepchild eligibility)
- A birth certificate or hospital birth announcement for children, including the
- Date of birth and full name of the parents. Birth registration cards are not acceptable proof for newborns.
- Petition for adoption or placement agreement for a dependent child.
- Legal custody or guardianship documents that are issued and signed by the court.
- Court order for children, not biological, stepchildren, or adopted children of the primary member.
- Birth Certificate and Dependent Grandchild Affidavit for children (grandchildren) born to a covered dependent and copy of the employee's current year's filed Federal tax return claiming the grandchild as a dependent for proof of financial dependency and residency.
- An Application for Coverage of Permanent and Totally Disabled Dependent Child affidavit for covered dependent children aged 26 or older and a copy of the employee's current year's filed Federal tax return claiming the child as a dependent for proof of financial dependency and residency.
- Proof of Spouse eligibility only, the pages needed from the current year's filed Federal tax return depends on which Tax form was filed, financial information should be blacked out:
    - Form 1040A— pages 1 and 2 containing the filer's name, the employee and spouse's signatures, and a written signature date on which the employee and spouse each signed the form.
    - Form 8879 (IRS e-file) pages 1 and 2 containing the filer's name, the employee and spouse's signatures, and a written signature date on which the employee and spouse each signed the form.
- Divorce decree (court document), including the Judge's signature and the court date stamp.

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

NOTE: Divorce is not a qualifying event to have a portal opened to elect benefits. You must provide a loss of group coverage letter to be considered a qualifying event.

- 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.
- For dependent loss of other group health coverage, a letter or certificate of creditable coverage must list the member's name, all dependents that were covered, the previous employer, and the date coverage ended.

DEPENDENTS EFFECTIVE DATE OF COVERAGE

Your dependents shall become newly eligible on the later of:

- Your initial date of eligibility; or
- The first day of the month following the date the individual first becomes your dependent or becomes newly eligible for coverage according to the dependent definition. The newly eligible dependent must be added to your coverage within 31 days of the date you gain the new dependent or within 31 days of the dependent becoming newly eligible, according to the dependent definition. You must submit a mid year change request to add the dependent to your SEHP Member Portal along with supporting dependent documentation within 31 days of the event date.

- The first day of the month following the loss of Medicaid or Children's Health Insurance Program (CHIP) coverage. The newly eligible dependent must be added to coverage within 60 days of losing Medicaid or CHIP coverage. The SEHP must receive the request to add the dependent in MAP along with the supporting dependent documentation within 60 days of the date of loss of coverage from Medicaid or CHIP coverage.

SOCIAL SECURITY NUMBERS (SSN) AND INDIVIDUAL TAXPAYER IDENTIFICATION NUMBERS (ITIN)

According to Section 111 of the Federal Medicare, Medicaid, and SCHIP Extension Act of 2007 (the "Act"), group health plans are required to report eligibility information to the Centers for Medicare and Medicaid Services (CMS) for purposes of coordination of benefits. The SEHP is required to obtain valid SSNs, Health Insurance Claim Number (HICN), or ITINs for Foreign National individuals and their eligible dependents. Dependents include a spouse and other family members eligible to be covered by the health plan.

A Health Insurance Claim Number (HICN) is the number the Social Security Administration assigns to an individual identified 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 receive health care services and otherwise meet their administrative responsibilities to pay for health care and operate the Medicare program. Medicare is required to protect individual privacy and confidentiality per applicable laws, including the Privacy Act and HIPAA.

Individual Taxpayer Identification Number (ITIN): A foreign national engaged or considered to be engaged in a trade or business in the U.S. during the year is required to file a federal tax return each year. As a result, they must apply for an ITIN. These numbers are unique identifiers like SSNs and have the first three 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 valid SSNs or ITINs for all eligible members to participate in the SEHP to ensure the Plan complies with the Act.

The SEHP will allow pending SSNs to be used to set up coverage for dependents in two instances.

- **Newborn children** - a temporary SSN of 777-77-7777 may be entered for a newborn until the valid SSN is obtained. Generally, SSNs are assigned within 14 days of application for the SSN. The valid SSN must be provided to the SEHP within 31 days of the child's date of birth. The dependent may be removed from coverage if the SSN is not provided. A copy of the SSN card can be provided as documentation.
- **Foreign National Dependents** - a temporary ITIN of 888-11-1111 may be entered for non-resident dependents until a valid number is obtained and sent to the SEHP.

ANNUAL OPEN ENROLLMENT PERIOD

The Open Enrollment period for SEHP occurs annually from October 1st through October 31st.

Members must complete the Open Enrollment process to make their coverage elections for the following year during this time.

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

If you are employed at ESU, KSU, KU, KUMC, or PSU https://sso.cobraguard.net/seer_login.php

Information concerning enrollment elections can be found in the enrollment booklet on the SEHP website.

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

NOTE: If the appropriate information is not provided during Open Enrollment, the SEHP cannot add the dependents to your SEHP coverage for the following plan year. If an ITIN cannot be provided, please submit a Communication Form to your SEHP Member Portal explaining why the ITIN can't be obtained.

REVISED OPEN ENROLLMENT ELECTIONS

You may change your original Open Enrollment election in your SEHP Member Portal any time before October 31st.

IDENTIFICATION CARDS

If you are a new enrollee or have made a coverage level change, Medical, Dental, and Voluntary Prescription Eyewear Identification (ID) cards will be sent to you. If you do not receive your ID cards, please contact the health plan vendors directly using the telephone numbers listed on the vendor page of the SEHP website. You may be able to download a card directly from the vendor's website or by using the vendor's mobile apps.

COST OF COVERAGE

Your contribution amount for SEHP coverage is subject to change each Plan Year.

NOTE: SEHP premiums will be based on semi-monthly payroll deduction periods. This includes voluntary prescription eyewear and voluntary plans.

For current SEHP rates, please review the current Enrollment booklet located on the SEHP website.

MID YEAR ENROLLMENT CHANGES

EMPLOYEE PREVIOUSLY WAIVED COVERAGE

If you have previously waived coverage, have acquired a newly eligible dependent, (marriage, birth, adoption, legal custody/guardianship, etc.), and want to enroll in the SEHP, you will need to submit a Communication Form to enroll in your Member Portal within 31 days of the qualifying event date and upload the required documentation for that event. Coverage for you and your newly eligible spouse and dependent(s) will be effective the first of the month following the date of the qualifying event. In the case of a newborn, coverage for the newborn will be the date of birth, but your coverage will be the first of the month preceding the date of birth. Any spouse or other dependents added during this qualifying event will be effective on the newborn's date of birth.

ADDING /DROPPING DEPENDENTS

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

The change is a result of a dependent losing or gaining group coverage.

You request the change within 31 calendar days of the event by completing the Add/Drop request in your Member Portal.

Written documentation of the event is provided (divorce decree, death certificate, custody agreement, or statement from a spouse/dependent employer on company letterhead indicating they are losing or gaining coverage and the effective date.

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

MID YEAR QUALIFYING EVENTS – PRETAX EVENTS

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

NEWLY ELIGIBLE DEPENDENTS

To add a newly eligible dependent to coverage, a Newly Eligible Dependent request must be submitted within 31 days of the event that makes the dependent(s) newly eligible. Members must submit the request along with supporting documentation in their SEHP Member Portal.

Click on the Mid Year Benefit Change Request tab, then select Newly Eligible Dependent, and fill in the information on the next page. The document upload button is located at the bottom of the Member & Family screen.

MARRIAGE

You may add or drop your entire family as the entire family is now newly eligible. To add family members to your coverage, you will need to upload a copy of the marriage license along with the Add/Drop request in your Member Portal.

If you have been added to your Spouse's group health plan coverage, submit a Member Waive Coverage (Midyear) request in your Member Portal and upload documentation showing you are covered under the spouse's health plan with the effective date listed.

To add a new spouse and/or stepchild(ren) to coverage due to marriage, you will need to submit a Newly Eligible Dependent request in your SEHP Member portal. The enrollment request, along with the appropriate supporting documentation, must be uploaded within 31 days of the date of 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 effective coverage date will be the first day of that month.

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

COMMON LAW MARRIAGE

Submit a Newly Eligible Dependent request in your Member Portal and upload a notarized copy of the completed Common Law Marriage Affidavit (under the Forms tab in your Member Portal) and proof of joint ownership. Acceptable documents for proof of joint ownership are listed below. Please block out any financial information before uploading. Documents submitted should have both you and your spouse listed.

- Current bank statement
- Current lease agreement
- Current homeowners' insurance statement
- Current credit card statement
- Current property tax statement
- Current year federal filed tax return
- Current mortgage statement

DIVORCE

In the event of divorce, you will need to submit a Remove Ineligible Dependent request and upload a copy of the divorce decree court document, including the Judge's signature and the court date stamp. The ineligible spouse and stepchildren will be removed from your coverage on the last day of the month the divorce is final.

A divorce removes your ineligible ex-spouse and any stepchildren that may have been covered.

NEWBORNS

Birth or adoption of a dependent – In the event of the addition of a dependent due to birth or adoption, you may add your entire family to your plan. You will need to submit a Newly Eligible Dependent request in your Member Portal and upload the birth certificate or a copy of the petition for adoption or placement, whichever is appropriate, for the newborn and a marriage certificate and birth certificate for any other children.

In this situation, you may only drop the entire family if the family members are now covered under another employer's group plan.

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

- A birth certificate, hospital announcement, and a valid SSN or ITIN (if applicable) must be uploaded to the member portal. To upload documents, use the Upload Documents button located at the bottom of the Member and Family screen.

ADOPTIONS

For adoptions, a Newly Eligible Dependent request must be submitted within 31 days of the date that the petition for adoption or placement notice is filed or the date of adoption placement. A copy of the petition for adoption or placement notice, issued by the court including the Judge's signature and court date stamp, must be uploaded in SEHP Member Portal with the request.

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

When the adjustment period is over and the petition for adoption has been filed with the court, a copy of the petition for adoption issued by the court that includes the Judge's signature and court date stamp must be uploaded in SEHP Member Portal to continue coverage for the dependent. If the dependent is removed from the primary member's home, a Newly Eligible Dependent request must be submitted in SEHP Member Portal 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.

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 SEHP Member Portal, and the appropriate documentation is uploaded within 31 days of the event. If the filing placement is not within 31 days of the date of birth of the child, the effective date of coverage is the date of the filing date of the petition for adoption or the date of placement, whichever the case may be. The effective date of coverage cannot be earlier than the child's placement or arrival in your home within the United States.

NOTE: To add a newborn or newly adopted dependent to coverage, other eligible dependents may also be added to your coverage at this time. The effective date of coverage for the newborn or adopted dependent

will be the date of birth. A Newly Eligible Dependent request and the appropriate documentation are required within 31 days of the child's birth, date of placement for adoption, or date of petition for adoption.

GRANDCHILDREN

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

- You have legal custody of or have lawfully adopted your grandchild.
- Your grandchild lives in your home and is the child of your dependent child covered under the

  SEHP and you provide more than 50% of the support of the grandchild or;

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

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

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

NEW LEGAL CUSTODY/GUARDIANSHIP CHILDREN

(Dependents who are not biological, stepchildren or adopted children of the member)

To add a newly eligible legal custody/guardianship child to coverage, you need to submit a Newly Eligible Dependent request within 31 days of the date that the court issues a legal custody agreement. A copy of the court order or legal custody agreement and birth certificate must be uploaded in SEHP Member Portal with the request.

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

- For loss of legal custody of a dependent child, you will need to submit a Remove Ineligible Dependent request in your Member Portal and upload a copy of the court order including court recorded date stamp and judge's signature to add or drop the dependent.

CHANGE IN EMPLOYMENT

If you or your dependents have a change in employment, like moving from part time status to full time status or vice versa or moving to a position that affects benefits eligibility that will affect the cost, benefit level, or benefit coverage, you are eligible to change your health insurance coverage. Please contact your HR for assistance.

To enroll in coverage, you will submit a Communication Form in your Member portal stating that you are changing employment status or benefits eligibility and would like to enroll in coverage due to this change.

An enrollment portal will be opened, and an email will be sent to you explaining how to enroll.

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

TERMINATION OR COMMENCEMENT OF EMPLOYMENT (INCLUDING RETIREMENT): Your HR department will submit the appropriate request in the HR portal, and the SEHP will process it, and a response will be sent to your HR department. You may change your medical plan at retirement if you continue Direct Bill.

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

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

For spouses or dependents gaining

other group health coverage, a certificate of creditable coverage from a new vendor/employer showing the plans, effective date, and who is covered is needed.

DEATH

For the death of the employee, the employee's HR department will submit a request in the HR portal and the death certificate, obituary or document approved by legal counsel will be uploaded. Surviving spouses/ dependents can continue coverage under either the COBRA or Direct Bill program.

If the death is the spouse or a dependent, you or your HR department will submit a Death of Spouse or Dependent request and upload the death certificate, obituary, or document approved by legal counsel.

MILITARY INSURANCE CHANGES — You may make a mid-year change if you, your spouse, or your dependent are called to active military duty, and this results in a gain or loss of eligibility for military health insurance coverage. You will need to request a change in MAP and provide documentation of the gain or loss of the military coverage.

Your dependent child turns 26 (coverage ends for your dependent on the last day of the month of their 26th birthday). The SEHP will notify you before your dependent's birthday, and the change will be automatically applied to your benefits. If the change results in a different coverage tier, this change will be made by SEHP, and your contribution will be adjusted.

Government sponsored VA benefits – If you, your spouse, or your dependent gain or lose government sponsored VA benefits, you may make a mid-year change in MAP. You will need to upload documentation of the change in VA benefits to accompany your enrollment request.

Medicare eligibility – You may make a mid-year change if you, your spouse, or your dependent become newly eligible for Medicare and elect Medicare coverage as primary within 31 days of Medicare effective date.

Members or spouses turning 65 and becoming newly eligible for Medicare benefits will need to complete a TEFRA form to elect whether they want Medicare or SEHP coverage as primary. If Medicare is chosen as primary, medical coverage under the SEHP will end the last day of the month before the Medicare effective date. Notices are sent out approximately 60 days before the 65th birthday, including instructions on completing and uploading the TEFRA form.

If a member, spouse, or dependent loses Medicare eligibility, a communication form must be submitted in MAP, and documentation of the loss of Medicare benefits must be uploaded.

Entitlement to Medicaid – If you, your spouse, or dependent is entitled to coverage (i.e., becomes enrolled) title XIX of the Social Security Act (Medicaid) (Public Law 89-97 (79 Stat. 343)), while enrolled in the SEHP, you may make a mid-year change to cancel or reduce coverage of SEHP coverage. Contact your HR department to submit a request in the HR portal. Proof of coverage listing all covered individuals and the effective date of coverage.

In addition, if you, your spouse, or a dependent entitled to coverage under Medicaid loses eligibility for such coverage, you may make a mid-year change under SEHP. Contact your HR department to submit a request in the HR portal. Provide proof of loss of coverage, listing all covered individuals and the effective date of coverage termination.

Dependent children losing eligibility/coverage under another group health insurance plan is a qualifying event for requesting a coverage change. An Add/Drop request must be submitted, and a letter or certificate of creditable coverage listing the name of the dependents covered and the effective date of termination must be uploaded in your Member Portal.

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

For dependents gaining coverage under another group health plan, submit an Add/Drop request in your member portal and upload a letter or certificate from the employer or group health plan indicating the effective date of coverage and the names of the individuals that are covered under that plan will need to be uploaded.

Dependent children identified under a Medical Withholding Order (K.S.A. 23-4,105) or Qualified Medical Child Support Order. If the SEHP receives a court order requesting a coverage change, the SEHP has the authority to add or remove dependent children without the employee's consent. The SEHP will automatically change the member's coverage to comply with the court's order. Coverage and member contribution levels will be adjusted to reflect these changes.

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

Children's Health Insurance Program (CHIP) – Dependents losing CHIP coverage is a mid-year qualifying event and they can be added to SEHP coverage. Gaining CHIP coverage is not a qualifying event for removing dependents mid year.

CHANGE IN EMPLOYEE CONTRIBUTION

The change in premium (if applicable) will be reflected on the next available paycheck after the SEHP receives and processes the request. The effective date will coincide with the date of birth, the date of petition for adoption, or the date of the placement agreement. If the date of birth, the date of the petition for adoption, or the date of the placement agreement occurs on the first day of the month, the change in your contribution will take place that day.

AFTER TAX EVENTS

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

All events are listed under Pretax Events.

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

NOTE: Vision coverage may not be added during the Plan Year.

TERMINATION OF ACTIVE COVERAGE

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

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

LEAVE WITHOUT PAY - ACTIVE MILITARY DUTY

If you go on leave without pay due to active military duty, you can either terminate your SEHP coverage effective the last day of the month in which you go on military duty or continue SEHP coverage for the next 30 days. If you choose to continue coverage for the next 30 days, your Agency will pay the SEHP employer contribution for those 30 days, and you will pay your regular payroll deduction amount to your Agency after the first 30 days have passed, you may continue coverage through the SEHP Direct Bill program. You need to notify your HR Department within 30 days of the effective date of military leave without pay that you want to continue with Direct Bill

An enrollment portal will be opened. An employee with a spouse, children, or family coverage may elect to drop themselves and keep their spouse and/or children covered in the SEHP. If SEHP coverage is continued, it will be the primary payer of claims, and military coverage will be secondary.

ACH information must be entered under the billing tab of your SEHP Member Portal after making your elections. the full (employer and employee portion) premium amount would automatically be drafted once a month from your bank account as a direct bill participant. There is no Agency employer contribution.

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

RETURN FROM LEAVE WITHOUT PAY - ACTIVE MILITARY DUTY

The effective date of coverage may be either the first day of work after returning from active military duty or the first day of the month following your return from active military duty. Return from military leave policies also apply to dependents returning from military leave.

If you are qualified for and elect to participate in the military’s transitional health benefit program, you will be reenrolled in the SEHP without penalty when the transitional coverage terminates.

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

LEAVE WITHOUT PAY

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

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

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

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

NON-PAYMENT OF ACTIVE EMPLOYEE PREMIUM

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

CONTINUED PAYMENT OF ACTIVE EMPLOYEE PREMIUM

If you are on leave longer than 30 days and have continued to pay for active employee coverage on as scheduled following the initial 30 calendar days, your employer will submit a Leave Without Pay request in MAP and indicate if you want to continue with Direct Bill coverage while on leave. If you want to continue Direct Bill an enrollment portal will be opened for you to elect your health insurance coverage while on leave.

After completing your elections in the Member Portal, you will need to enter your ACH information on the Billing tab under Payment Methods so your premiums will be drafted from your bank account on the 8th of each month for that month's premium. Direct Bill coverage will be effective on the first day of the month.

RETURN FROM LEAVE WITHOUT PAY

When you return from Leave Without Pay (regular or FMLA) your HR must submit a request in MAP within 31 days of your return to active employee status.

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

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

NOTE: If the Leave Without Pay is extended over an Open Enrollment period. A portal will be open for you to elect coverage for the new Plan Year.

FMLA - APPROVED LEAVE WITHOUT PAY OF 31 OR MORE DAYS

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

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

Once the FMLA ends, if you are still on Leave Without Pay, your HR Department will submit a request in MAP indicating that the FMLA has ended and that you are being put on Leave Without Pay. You will get an additional 30-day coverage.

FURLOUGH

If you are furloughed, your SEHP benefits will remain the same as you had as an employee. If you do not have sufficient wages during the pay period to deduct the employee contribution, you will be required to remit the proper contribution amount on a schedule consistent with the semi-monthly pay periods. The agency will collect your portion of the SEHP premium and remits to the Division of Accounts and Reports.

If you are on furlough during Open Enrollment, you may enroll in any SEHP plan and coverage levels for which you are eligible upon your return to active employee status.

Upon the end of your furlough period, if you did not enroll in Direct Bill coverage while on furlough, the health insurance coverage you were enrolled in before going on furlough will be effective the first day of the month after you return to work.

You will be subject to all other applicable policies and regulations regarding enrollment in the SEHP.

LAYOFFS

In the event of a layoff, your SEHP coverage will end on the last day of the month in which you work. A notice from the COBRA vendor will be sent to your home address on file in your Member Portal. If you accept COBRA coverage, you will be responsible for paying the full cost of the coverage, which will include both the contribution you made as an active employee and the contribution paid by the employer.

FLEXIBLE SPENDING ACCOUNT PROGRAM

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

FLEXIBLE SPENDING ACCOUNT OPTIONS

There are currently five benefit plans offered:

- Health Care Flexible Spending Account (HC FSA) – allows you as a participant to pay for qualified health expenses that are not otherwise reimbursable under the health plan, on a pretax basis. Eligible expenses are determined by IRS publication 502.
- Limited Purpose Flexible Spending Account (LP FSA) – allows participants to enroll in a high-deductible health plan to pay for qualified dental and vision expenses on a pretax basis. Qualified expenses are determined by Section 129 of the IRS Code.
- Dependent Care Flexible Spending Account (DC FSA) – allows you as a participant to pay for qualified work-related daycare expenses on a pretax basis. Qualified DC FSA expenses are determined by Section 129 of the IRS code.
- Mass Transit Flexible Spending Account – allows for reimbursement of qualified mass transit tickets or passes, or State of Kansas Vanpools.
- Parking Flexible Spending Account – allows for reimbursement for parking associated with your daily commute to and from work.

TAX SAVINGS

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

EFFECTIVE DATE OF COVERAGE

During your initial enrollment opportunity, you may elect to enroll in an FSA. If the initial enrollment is not submitted within 31 days of your first day of work, you will not be allowed to enroll until the next Open Enrollment period, unless you experience a mid-year qualifying event.

CARRYOVER PROVISION FOR HEALTHCARE AND LIMITED FSAs

The SEHP has adopted a provision that will allow you to carry over a percentage of unused HC FSA or LP FSA funds into a new FSA plan year. This will allow you to spend FSA funds at a future date and reduce the likelihood that unused funds are forfeited.

Funds carried over from the previous plan year will not count against the new plan year's annual election.

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

A Limited Purpose FSA is a savings option for members who are enrolled in a Qualified High-Deductible Health Plan with a Health Savings Account (HSA). The Limited Purpose FSA works the same way a

Healthcare FSA does: pretax, “use it or lose it” elections and expenses must occur while the benefit is active.

The difference between a Healthcare FSA and a Limited Purpose FSA is Limited Purpose FSA funds can only be used for eligible dental and vision expenses.

The annual contribution minimums and maximums are the same as the standard Health Care FSA.

DEPENDENT CARE FSA

Members electing a DCARE FSA must have the funds in their DCARE FSA account before they can be reimbursed for dependent childcare expenses. The DCARE FSA is to use it or lose it account and does not include the carryover provision. Members need to submit their claims for reimbursement under the DC FSA during the plan year or no later than April 30th of the next plan year. Funds remaining after April 30th of the next plan year will be forfeited.

For additional FSA information, visit the SEHP website.

FSA PARTICIPANTS: QUALIFIED RESERVIST DISTRIBUTIONS

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

The individual must be a “reservist”, as defined in 37 U.S.C. Section 101, which means the reservist must be a member of one of the following:

- Army National Guard of United States
- Army Reserve
- Navy Reserve
- Marine Corps Reserve
- Air National Guard of United States
- 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 an indefinite period.

The request for distribution must be made after the order for active duty is issued, but before the last day of the plan year (or grace period, if applicable).

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

For further details, visit the SEHP website.

QUALIFIED HIGH-DEDUCTIBLE HEALTH PLAN (QHDHP) - PLAN C AND N

The Qualified High-Deductible Health Plan (QHDHP) is available with either a Health Savings Account (HSA) or a Health Reimbursement Account (HRA).

HEALTH SAVINGS ACCOUNT (HSA)

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

The HSA is a health care bank account owned by you, administered by MetLife. The HSA account is portable and funds rollover from year to year. An HSA is an account that the employee and employer both contribute to. Funds are deposited into an HSA on a pretax basis. The IRS establishes annual HSA maximum allowable contributions for employee only or employee dependent coverage. The HSA funds may be used for certain premiums, copayments, coinsurance, deductibles, or other medical, dental, drug, or vision expenses. HSA funds can be used for your tax qualified family members.

You may change your HSA employee contribution during the plan year without a qualifying event by submitting an HSA Mid-Year Change request in your Member Portal. The effective date of the change will be based on the next available paycheck.

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

The HSA employer contribution is deposited in 4 equal payments. The employer deposits are made on the first paycheck of January, April, July, and October.

NOTE: You must be actively employed on the first day of each quarter, to receive the employer contribution. The HSA employer contribution amount is based on the coverage level, medical plan, and employment status (FT or PT) on the first day of each quarter.

ELIGIBILITY TO CONTRIBUTE TO AN HSA

The IRS has established guidelines on who is eligible to contribute to an HSA on a pretax basis. These rules apply to the employee and not to any of their dependents. To be eligible to contribute to an HSA a member may not be:

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

If any of these disqualifiers apply to you, you will need to enroll in a Health Reimbursement Account (HRA), to receive an employer contribution.

ACTIVATING YOUR HSA

To activate the HSA, federal law requires you to pass the Identification Verification (IDV) process. If you do not pass the IDV process, MetLife will reach out to you directly and request documentation. You must work directly with MetLife to complete the IDV process, by providing MetLife with the documents they requested. Your HSA account cannot be opened, and funds cannot be deposited until you pass the IDV process.

For further details, visit the SEHP website.

HEALTH REIMBURSEMENT ACCOUNT (HRA)

A Health Reimbursement Account (HRA) is an employer sponsored plan with contributions made entirely by the employer – no employee contributions are permitted. The HRA is not portable and any remaining funds at the end of the year will not roll over into the next plan year. Members have sixty (60) days from the end of the plan year (December 31st) to file any claims incurred during that plan year while the benefit was active.

Should an employee terminate coverage with the SEHP before the end of the plan year, they will have sixty (60) days from the last date on SEHP Health Plan coverage to file any claims incurred while the benefit was active during that plan year.

The HRA employer contribution is deposited in 4 equal payments. The employer deposits are made on the first paycheck of January, April, July, and October.

Employees will need to register their HRA with MetLife to view account details.

HRA members are also eligible to enroll in a Health Care FSA to make pretax contributions to pay for eligible health expenses.

For further details, visit the SEHP website.

METLIFE HSA & HRA VENDOR INFORMATION

Toll Free Customer Service Line: 1- 877-759-3399

Email: SEHPsupport@healthaccountservices.com

Website: Tax Advantaged Accounts | State Employee Health Plan

IMPORTANT INFORMATION WHEN TRAVELING OUTSIDE OF THE U.S.

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

PRESCRIPTION DRUG ADVANCE PURCHASE POLICY:

Travel in the United States

SEHP uses the CVS/Caremark Pharmacy network when you travel within the United States. You are not eligible for an advance prescription purchase. You may use your drug card at any network pharmacy throughout the U.S.

Travel or work outside the U.S. for sixty (60) days or less:

When you plan to leave the U.S. for 60 days or less, you may call the toll-free number on the back of your card to arrange for a 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. You will be billed the applicable coinsurance or copayment for the quantity purchased.

Work outside the U.S. for sixty (60) days or longer but not to exceed one year:

This policy and its provisions apply only to active employees covered by the SEHP. When you are outside of the country for a longer period, there are two options available:

- Option 1 - Advance purchase through drug plan:
  You must work with your Human Resources office to arrange for advance purchase of maintenance medications required during a stay outside the U.S. The Advance Purchase Certificate certifies that health coverage will be maintained during the entire period of the extended absence must be signed by

both you and your employer. An Advance Purchase Form must be submitted to SEHP Benefits at least fifteen (15) days before your departure date. You and your employer will be notified when the Advance Purchase Form has been processed and the dates the medication will be available to pick up.

Generally, the medication will be available for purchase one week before the departure date. The following requirements apply:

The Advance Purchase form must be completed stating that coverage will be maintained via payroll deductions during the term outside of the U.S. The form also requires information on your destination and duration of stay. The Advance Purchase form signed by you and your Human Resources representative acknowledges the SEHP's right to recover from you and/ or your employer the cost of the medications if coverage is not maintained.

The name and strength of each requested medication and the name of the prescribing doctor must be on the Advance Purchase form. For each medication, provide the name of the pharmacy where the medication will be filled. You will be responsible for the applicable coinsurance percentage on the cost of the quantity of drug dispensed. You must agree to purchase the prescription medication at a local network pharmacy. You or your dependents using the CVS/Caremark mail service will need to obtain a prescription from your doctor so that the items can be purchased at a local network pharmacy.

REMINDER: Medication can only be dispensed for the period 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.

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 paper form with a statement indicating their purchase and use while outside of the U.S. Your membership status will be verified, and the claim will be forwarded to CVS/Caremark for reimbursement.

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

HEALTHQUEST PROGRAM

HealthQuest Wellness Portal Vendor is Marathon Health.

HealthQuest is the wellness program for benefits eligible employees who are enrolled in the State Employee Health Plan. As part of your benefits plan, a variety of services are offered at no additional cost. Participation in HealthQuest programs is always voluntary and strictly confidential. Employees are not required to participate in HealthQuest to be covered under the SEHP.

The telephone number for HealthQuest (785) 783-4080. For full details on HealthQuest programs, benefits and rewards for participation in the wellness program please visit the website.

REWARDS PROGRAM

Employees enrolling in the medical portion of the State Employee Health Plan have an opportunity to earn a premium incentive discount on their health insurance premiums through the HealthQuest Rewards Program.

The HealthQuest Program year (also known as the earning period for the premium incentive discount). Employees enrolled in Plans C, J, and N are eligible for $10 for each HealthQuest credit up to a maximum of $500 for the HSA or HRA account.

Members are eligible to receive the Rewards payments for credits that are posted to their HealthQuest account by November 9th each year. After November 9th only HealthQuest credits toward the premium incentive discount can be earned.

Further information on the premium incentive discount and the Rewards incentive payments are available online.

EMPLOYEE ASSISTANCE PROGRAM (EAP)

Vendor is ComPsych.

All active benefits eligible employees of the State of Kansas, their dependents, and other family members living in the same household are eligible to use the EAP. You can access details on the legal, financial, and counseling services offered on the web at www.GuidanceResources.com or by calling 1-888-275-1205 (option 7). You and your family members can receive confidential assistance 24 hours a day, 7 days a week, at no cost to you.

For more details visit, www.GuidanceResources.com.

HealthyKIDS PROGRAM

HealthyKIDS – Annual application submission is required.

The HealthyKIDS program helps eligible State employees cover the cost of the premiums for their eligible children enrolled in the SEHP. The State will make an additional contribution toward the cost of dependent children's health premiums for qualified families, and employees are responsible for the remaining contribution.

HealthyKIDS does not change the benefits offered under the SEHP coverage.

Eligibility for the HealthyKIDS program is based in part on family income. Children in households with incomes up to 250% of the Federal Poverty Level, who would otherwise qualify for the Federal/State KanCare or CHIP (Title 21), may be eligible. Current household gross income guidelines can be found on the SEHP website at https://healthbenefitsprogram.ks.gov/sehp/HealthyKIDS.

Annual application for HealthyKIDS is required to be submitted during Open Enrollment.

You may apply mid-year due to a qualifying event if that event affects your medical insurance coverage. The qualifying events are the same as those established for mid-year enrollment changes. You must apply within 31 days of the event date. The HealthyKIDS deduction will not be stopped mid-year because of an increase in income or stopped because of a dependent reaching the age of 19 during the year. The HealthyKids discount will only be removed if the medical coverage level changes to employee only or employee and spouse. If you believe you are eligible, complete the online application in your Member Portal.

When you submit your HealthyKids application online you will automatically receive and approval or denial message. If your application is approved and you meet the eligibility requirements, your premium will be adjusted based on the HealthyKids contribution amount.

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

Becoming eligible for Title XXI (CHIP) coverage does not count as a qualifying event under section 125 rules. If Title XXI coverage is lost mid-year that does count as a qualifying event under section 125, and the plan is permitted to add that child to coverage and the primary member can apply for HealthyKIDS.

RETIREMENT

When you retire from employment, your HR Department will submit a Change request indicating that you are retiring and whether you wish to continue SEHP coverage through the Direct Bill program. You must have continuous coverage under the SEHP to be eligible for the Direct Bill program.

Once the Retirement Request is received and approved, an online Direct Bill enrollment portal will be opened for you to elect Direct Bill coverage for yourself as well as any eligible dependents.

The effective date of coverage under the Direct Bill program will be the first day of the month following termination of active employee benefits.

If the last day of active benefits is the first day of the month, Direct Bill benefits will be effective on the second day of the same month.

When making elections in your Direct Bill enrollment portal, you can drop your dependents from coverage or make benefit plan changes.

You may opt out of dental coverage when electing Direct Bill or during Open Enrollment, however; once you opt out of dental coverage, you will not be able to re-enroll in dental.

Important note: Once you waive medical or dental benefits through Direct Bill, you cannot re-enroll. If you maintain an active medical or dental benefit, changes to vision can be made during Open Enrollment.

RETIREES NOT ELIGIBLE FOR MEDICARE

Retirees who are not eligible for Medicare can enroll in the same health plans under the Direct Bill program that are available to active employees. The benefits that are not available to enroll in at retirement are the FSA, HSA, HRA and Voluntary MetLife benefits.

RETIREES AND MEDICARE ELIGIBLE

The SEHP offers a full menu of insurance health plan offerings to complement your Medicare coverage once you retire. You can learn more on our website or https://sehp.healthbenefitsprogram.ks.gov/retiree.

If you or your covered spouse is age 65 or over when you retire, you must apply for Medicare Part A and Part B if you do not currently have both parts. Your enrollment in the Direct Bill cannot be processed without a Medicare card on file. Medicare will automatically be your primary payer for your medical coverage.

If applying for Medicare Part B after age 65 Social Security Administration requires that your agency provide you a memo or letter with health insurance information necessary to process the application. When applying for Medicare Part B, you should present the memo or letter to the local Social Security Office.

Required information in the memo or letter is:

- The letter or memo must be on your employer's letterhead.
- Statement that you are covered under the SEHP
- Date your coverage began
- Date your coverage ended or will end
- Your spouse's name and Social Security Number if your spouse is covered by the SEHP and eligible for Medicare.

For additional information on the Direct Bill program, please contact your HR Department, SEHPDirectBill@ks.gov or call 1-866-541-7100

MEMBERS ELIGIBLE TO CONTINUE IN THE DIRECT BILL PROGRAM

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

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

- Any former elected state official.
- 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).
- Any totally disabled former state officer or employee who is receiving disability benefits administered by the Kansas Public Employees Retirement System.
- Any surviving spouse or dependent of a qualifying member in the SEHP.
- Any person who is in a class listed as an active member and who is lawfully on leave without pay.
- Any blind person licensed to operate a vending facility as defined in K.S.A. 75- 3338, and amendments thereto.
- 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
- Any former state officer or employee, who separated from state service when eligible to receive a retirement benefit but, instead of that, withdrew that individual's employee contributions from the retirement system.

DIRECT BILL MEMBERS

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

- You were covered as an active member, as a COBRA member, or as a spouse immediately before the date you ceased to be eligible for that type of coverage.
- You are a surviving spouse or eligible dependent child of an active member who was enrolled in active employee benefits or the Direct Bill program at the time of their death, and you were enrolled in the health care benefits program as a dependent at the time of their death.

NOTE: Your HR representative must submit a Change Request within 31 days after you cease to be eligible for active employee coverage for you to be offered the Direct Bill program. You must submit your benefit elections in your SEHP Member portal and then enter your ACH information on the Billing tab.

MEMBER & SPOUSE COVERAGE

If you are not Medicare eligible and your spouse is eligible for Medicare, you can elect a non-Medicare option under the Direct Bill program. Your spouse, who is Medicare eligible, can elect a Medicare option under the Direct Bill program

If you are Medicare eligible and your spouse is not eligible for Medicare, you can elect a Medicare option under the Direct Bill program. Your spouse, who is non-Medicare eligible can elect a non-Medicare option under the Direct Bill program.

If both you and your spouse are Medicare eligible, you both can elect a Medicare option under the Direct Bill program. You would both be enrolled under your own name and ID number and elect separate coverage. For your spouse to be eligible for Direct Bill coverage you must continue coverage. The only time a spouse is eligible to continue by themselves is as a Surviving Spouse.

PAYMENT METHOD UNDER THE DIRECT BILL PROGRAM

Members who are eligible and elect Direct Bill coverage under the SEHP must pay their premiums by bank draft (ACH).

Bank drafts will be processed on or around the 8th of each month for that month's coverage. If bank drafts are rejected twice in one month, coverage will be termed the last day of the month in which payment was received.

PREMIUM REFUNDS DUE TO DIRECT BILL MEMBER'S DEATH

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 (CONTINUATION OF COVERAGE)

The federal Consolidated Omnibus Budget Reconciliation Act (COBRA) law was enacted in 1985. This law requires that most employers sponsoring Group Health Insurance Plans offer employees and their families the opportunity for a temporary extension of health coverage at group rates in certain instances where coverage under the plan would otherwise end.

If you and your dependents lose insurance coverage under the SEHP, you have the right to elect to continue coverage by paying the required premiums. If you are a retiree and have chosen COBRA over the SEHP Direct Bill coverage, when COBRA runs out you have the option to enroll in Direct Bill coverage.

You, your spouse, and your dependents who are eligible to continue health insurance coverage are called Qualified Beneficiaries. The provisions under which you can continue coverage are called Qualifying Events. The number of months you and any dependent you may have, can continue coverage is specified based on your qualifying event.

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

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

COBRA QUALIFYING EVENT PROCESS

If the qualifying event is termination of employment (except for gross misconduct) your HR Department must submit a termination request in MAP. The SEHP will process the request and notify the COBRA vendor of your termination. The COBRA vendor will mail a COBRA notice to the address on file in your Member Portal.

If the qualifying event is the reduction of work hours to less than 1,000 per year, your HR Department will submit an eligible to ineligible request in MAP. The SEHP notifies the COBRA vendor of your termination. The COBRA vendor will mail a COBRA notice to the address on file in your Member Portal

If the qualifying event is due to

- Death
- Divorce
- Choosing Medicare as the primary carrier and leaving dependents without health insurance coverage (active employees ONLY)
- A dependent of yours ceases to meet the SEHP’s definition of dependent, i.e., turns age 26 (active employee or Direct Bill)

The qualified beneficiary must notify the member's HR Department office within 31 days of the qualifying event. (Spouses and dependents of retirees should notify the SEHP within 31 days of the qualifying event). If notice is not received within 31 days of the qualifying event, the beneficiary will not be eligible for COBRA.

The qualified beneficiary will receive specific information, including a COBRA notice with requirements for continuing insurance coverage, the plans available, and the applicable premium rates from the SEHP COBRA vendor.

Each qualified beneficiary has an individual right to elect COBRA coverage. Each beneficiary may make a separate election among the levels of coverage available.

ADMINISTRATIVE INFORMATION

SEHP active benefits will terminate on the last day of the month in which the COBRA qualifying event occurs. For all terminations, COBRA notices are generated by the SEHP's third party COBRA vendor following the receipt of the termination on a file from the SEHP. Termination requests are entered in MAP by the Agency HR Department.

COBRA coverage is not automatic - it is a choice that the qualified beneficiary must make. The qualified beneficiary must complete the COBRA election form that accompanies the COBRA notice sent by the COBRA vendor. The qualified beneficiary has 60 days from the date of the COBRA notice to return the COBRA election form to the COBRA vendor. If you elect COBRA, COBRA coverage will begin the day after active SEHP coverage ends.

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

COST OF BENEFITS - COBRA RATES

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

For more information including the current plan year COBRA rates, view the COBRA Enrollment Booklet https://sehp.healthbenefitsprogram.ks.gov/cobra.

TERMINATION OF COBRA

- You and/or your eligible dependents COBRA coverage if:
- You do not pay premiums in full in a timely manner.
- You or your dependent(s) become covered, either as an employee or dependent, under another employer provided medical plan which does not limit or exclude coverage for preexisting conditions.
- You or enrolled dependent(s) become eligible for Medicare. However, if Medicare eligibility is due to ESRD, the individual may remain on COBRA.

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

The State of Kansas no longer offers group health insurance to its employee

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 preexisting conditions.

Prohibit discrimination against employees and dependents based on their health status.

Guarantee renewability and availability of health coverage to certain employees and individuals.

SPECIAL ENROLLMENTS

HIPAA requires that group health plans allow individuals to enroll without waiting for late or open enrollment. These special enrollment periods are for individuals who previously declined coverage for themselves and their dependents. A special enrollment period can occur if:

A current employee or dependent with other health coverage loses eligibility for coverage or

A person becomes dependent through marriage, birth, adoption, or placement for adoption. The employee needs to complete enrollment within 31 days after their other coverage ends. Written documentation of the marriage, birth, adoption, or placement for adoption must be provided. Please contact your Human Resources office for more information.

Some examples where special enrollments would apply are:

Ceasing to be eligible under a plan due to cessation of dependent status (e.g., a child aging out of dependent coverage).

A plan ceasing to offer benefits to a class of similarly situated individuals (e.g., all part time workers).

An employer of another plan stops contributions toward other coverage, even if the individual continues the other coverage by paying the amount that used to be paid by the employer.

NON-DISCRIMINATION REQUIREMENTS

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

OTHER APPLICATIONS OF HIPAA LAW

HIPAA provisions also apply to services under the following laws:

Women's Health and Cancer Rights Act (WHCRA), which provides protection to patients who choose to have breast reconstruction in connection with a mastectomy.

Mental Health Parity Act (MHPA) which prevents the group health plan from placing annual or lifetime dollar limits on mental health benefits that are lower - less favorable - than annual or lifetime dollar limits for medical and surgical benefits offered under the plan; and,

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

The Genetic Information Nondiscrimination Act of 2008 generally prohibits discrimination based on genetic information and the release of your genetic information.

PLAN DISCLOSURE REQUIREMENTS

Under the Department of Labor's (DOL) rules governing plan disclosure requirements, group health plans must improve the summary plan descriptions and summaries of material modifications in the following ways:

Notify members and beneficiaries of any material reductions in covered services or benefits within 60 days of the change being adopted.

Disclose information about the role of insurance companies and health plans concerning the group health plan, specifically the name and address, and to what extent benefits under the plan are under a contract, and the administrative services, such as paying claims.

Inform members and beneficiaries which DOL office they can contact for assistance or information on their rights under HIPAA.

Inform members and beneficiaries that federal law prohibits the plan and health insurance issuer from limiting hospital stays for childbirth to less than 48 hours for normal deliveries and 96 hours for cesarean sections.

PLAN MEMBERS RIGHTS

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

Office for Civil Rights

U.S. Department of Health and Human Services

200 Independence Avenue, SW

Room 509F, HHS Building Washington, D.C. 20201

HIPAA ADMINISTRATIVE SIMPLIFICATION

The Administrative Simplification provisions of the HIPAA (Title II) require the Department of Health and Human Services to establish national standards for electronic 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.

PRIVACY REGULATIONS

The privacy regulations (effective April 14, 2003) ensure a national floor of privacy protection for patients by limiting how health plans, pharmacies, hospitals, and other covered entities can use patients' personal medical information. The regulations protect medical records and other individually identifiable health information, whether on paper, on computers, or communicated orally. Key provisions of these standards include:

- Access to medical records
- Notice of privacy practices
- Limits on the use of personal medical information
- Prohibition on marketing and stronger state laws
- Confidential communications
- Where to file complaints

SECURITY REGULATIONS

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

WOMEN'S HEALTH AND CANCER RIGHTS ACT

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

Reconstruction of the breast on which the mastectomy was performed.

Surgery and reconstruction of the other breast to produce a symmetrical appearance; and

Prostheses and treatment of physical complications for all stages of a mastectomy, including lymphedema (swelling associated with the removal of lymph nodes). The deductible and coinsurance provisions applicable to these benefits are consistent with the deductible and coinsurance provisions governing other benefits provided by the State Employee Health Plan. Coverage will be provided in a manner determined from consultation with the attending physician and the patient.

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