State Employee Health Plan
NonState Employer Groups
Administrative Manual

GENERAL HEALTH PLAN INFORMATION

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

GENERAL HEALTH PLAN INFORMATION

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

- The Secretary of the Kansas Department of Administration
- The Kansas Insurance Commissioner
- A retiree from classified State of Kansas service (appointed by the Governor)
- An active employee from classified State of Kansas service (appointed by the Governor)
- A person from the public (appointed by the Governor)
- A member of the Senate Ways & Means Committee
- A member of the House Appropriations Committee

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

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

- Aetna
- Blue Cross Blue Shield of Kansas

Other benefits vendors under the SEHP:

- CVS Caremark - prescription drug coverage
- Delta Dental Plan of Kansas - dental plan
- Avesis - voluntary vision plan
- NueSynergy - Flexible Spending Accounts (Health Care, Limited Scope, Dependent Care and Commuter)
- MetLife - Health Reimbursement Account and Health Saving Account
- COBRAGuard - administers COBRA Coverage
- ASCIA Partners/LifeSecure LTC - voluntary Long Term Care Insurance
- Metlife – administers Voluntary benefits including Hospital Indemnity, Critical Illness and Accident Policies

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

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

II. GENERAL DEFINITIONS

A. After Tax Deduction – Money is taken out of an employee's paycheck after all applicable taxes have been withheld.
B. Before Tax Deduction – Money taken out of an employee's gross pay before any taxes are withheld which reduces the employee's taxable income by the premium/deduction amount.
C. Consolidated Omnibus Budget Reconciliation Act (COBRA) - A Federal law requiring that most employers sponsoring Group Health Insurance offer covered employees and their participating eligible dependents an opportunity to extend health coverage for specified periods.
D. COBRA Participant – An eligible covered participant who elects a temporary extension of health coverage, when coverage would otherwise end, as defined by COBRA.
E. Dependent – The primary member's eligible spouse or dependent child(ren) as defined in KAR 108-1-1.
F. Direct Bill and Retirees – A program to extend health coverage to:
G. Retiring participating NonState Employer Group employees,
H. Disabled former participating NonState Employer Group employees,
I. Surviving spouses and/or dependents of participating NonState employees eligible under the provisions of K.A.R. 108-1-3 and 108-1-4
J. Active participating NonState Employer Group employees who were covered under the health plan immediately before going on approved Leave Without Pay
K. Blind vendors
L. Elected Officials
M. Employee Contribution - The contribution amount required to be paid by the employee for their SEHP coverage.
N. Employer Contribution – The contribution amount required to be paid by the employer on behalf of the employee and/or eligible dependents.
O. Health Care Commission (HCC) - The entity that establishes and oversees all provisions under the SEHP.
P. Health Plan – Defined medical, drug, dental and vision benefits offered to the State of Kansas and NonState employer groups.
Q. HealthQuest – The wellness program administered by the SEHP.

R. Health Insurance Portability and Accountability Act (HIPAA) – Federal act which protects the privacy of individually identifiable health information under the Privacy Rule; the HIPAA Security Rule, which sets national standards for the security of electronically protected health information; and the confidentiality, integrity, and availability provisions of the Patient Safety Rule, which protect identifiable information being used to analyze patient safety events and improve patient safety.

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

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

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

V. Membership Services – The State Employee Health Plan unit is responsible for managing all eligibility functions and membership activities for all members who participate in the SEHP.

W. Open Enrollment Period – time during which members of the SEHP can enroll and make changes to their SEHP coverage. Open enrollment is held once a year during the month of October.

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

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

Z. Primary member – The individual who is the person actively employed by a NonState Employer group. In the event of retirement, the primary member is the main participant covered under the SEHP and who is not considered a dependent of another active primary member.

Additional information:

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

Retirement Income Security Act (ERISA) and the employer's group health plan guide the employer's QMCSO process.

- A 1993 amendment to the Employee Retirement Income Security Act (ERISA) requires employer-sponsored group health plans to extend health care coverage to the children of a parent/employee who is divorced, separated, or never married when ordered to do so by state authorities. The SEHP meets this requirement.
- State Employee Health Plan (SEHP) – The state health care benefits program that may provide benefits for medical, prescription drug, dental, vision, and other ancillary benefits to eligible employees and their eligible dependents. The program may include such provisions as established by the State of Kansas employees' HCC, including but not limited to qualifications for benefits, services covered, schedules and graduation of benefits, conversion privileges, deductible amounts, limitations on eligibility for benefits because of termination of employment or other change of status, leave of absence, military service or other interruptions in service and other reasonable provisions as may be established by the commission.
- Variable-hour employee – Variable-hour employee is any officer or employee of a NonState Employer group for whom, at the date of hire, it cannot be determined that the employee is reasonably expected to work at least 1,000 hours per 12-month period.

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

NOTE: The current physical address, email address, and phone numbers must be maintained in MAP for both HR contacts and employees so that members can receive health plan information timely.

The Appendices of this manual contain current forms and other important information.

NONSTATE EMPLOYER GROUP ELIGIBILITY

A. All benefits-eligible employees must be entered in MAP and an Enrollment for New Employee request submitted, even if the employee wants to waive benefits.
B. NONSTATE EMPLOYER GROUP DEFINITION: As defined by the HCC, NonState Employer (NSE) groups may include but are not limited to the following: qualified school districts, community colleges, area vocational-technical schools, or technical colleges, special districts, or other local governmental units or entities; persons on the payroll of a county, township, city, county extensions, hospitals (city, district, or community), libraries, and

C. Community mental health centers as outlined in Supp. 2005 K.S.A. 75-6506(c) and supporting regulations.

PARTICIPATION REQUIREMENTS

A. NonState Employer groups must maintain the below requirements to qualify to participate in the SEHP.
B. A minimum of seventy (70) percent of all benefits-eligible employees must be enrolled in the SEHP. NonState Employers will certify their compliance with the seventy (70) percent enrollment each year. Plan design and funding are determined by the HCC and are not subject to negotiation.
C. The SEHP requires NonState Employers to sign a contract to participate for a minimum of three (3) years. If the NonState Employer qualifies for a financial option (premium ramp-up), participation in the plan is required for a minimum of five (5) years.
D. NonState Employers may not create, maintain, or provide incentives for employees not to join the SEHP. NonState employers may not permit any exemption from participation in the SEHP for their group's employees. This prohibition includes Internal Revenue Code Section 125 cash-out options.
E. The SEHP must be considered a "core" benefit in the NonState Employer's cafeteria benefit plan.
F. The rate of the premium contribution paid by the NonState Employer shall at least equal the rate paid by the State of Kansas for its employees.
G. NonState Employers must contribute toward, and participate in, HealthQuest, the state's health wellness program. Each employer must provide a contact person and must participate in HealthQuest initiatives.
H. NonState Employers must provide staff for enrollment, general information, and first-level assistance to employees and members.
I. NonState Employers must adhere to the established administrative processes and procedures set up by the Health Care Commission.
J. NonState Employer groups joining the SEHP after the beginning of the Plan Year will incur the plan deductibles and coinsurance amounts beginning on the effective date of participation in the group in the plan. Deductible and coinsurance amounts do not carry over and must be met for each Plan Year (January 1-December 31).

NOTE: Please refer to the "State of Kansas NonState Public Employer Contract" for additional requirements and provisions.

EMPLOYEE ELIGIBILITY

A. Employee Definition – Primary Participants- According to provisions of K.A.R. 108-131 and K.A.R. 108-1-4 the classes of persons eligible to participate in the State Employee Health Plan (SEHP) as Primary Participants shall be the following classes of persons: Any individual who is employed by a NonState Employer group and who meets the definition of employee under K.S.A. 74-4932(4), and amendments thereto, except that the employee shall be employed in a position that requires at least 1,000 hours of work per year.
B. The individual is an appointed or elective officer or employee of a qualified local unit whose employment requires at least 1,000 hours of work per year.
C. The individual is an appointed or elective officer or employee who is employed concurrently by two or more qualified local units in positions that involve similar or related tasks and whose combined employment by the qualified local units requires at least 1,000 hours of work per year.
D. The individual is a member of a board of county commissioners of a county that is a qualified local unit, and the compensation paid for service on the board equals or exceeds $5,000 per year.
E. The individual is a council member or commissioner of a city that is a qualified local unit, and the compensation paid for service as a council member or commissioner equals or exceeds $5,000 per year.
F. Eligible active employees who elect to participate in the SEHP shall be referred to as primary member(s) throughout the rest of this manual. The term SEHP means the State Employee Health Plan.
G. Coverage Election Period- Each person shall have 31 days from the date of hire to elect or waive SEHP coverage in MAP. If an employee misses their deadline, the next opportunity to elect coverage will be during the annual Open Enrollment period or with a Qualifying Event, that has occurred within 30 days of the effective date of the change.
H. Employee's Effective Date of Coverage- For newly hired individuals, coverage will be effective on the 1st day of work. The employee must complete an enrollment in MAP within 31 days of their 1st day of work. Employees should make their elections as soon as possible to avoid multiple premium deductions from one paycheck. Once benefits have become effective, no changes in coverage level can be made without a mid-year Qualifying Event or the next Open Enrollment period.
I. For current employees who are changing from a non-benefits-eligible position to a benefits-eligible position, the effective date of coverage is the 1st day of work in the benefits-eligible position. The employee must complete an enrollment in MAP within 31 days of the date they first started work in the benefits-eligible position.

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

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

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

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

   Employment Status (first 2 digits of benefit program code):

   a. LF1 = Full-time = employee that works a minimum of 1560 hours during the 12-month measurement period.
   b. LP1 = Part-time = employee that works a minimum of 1000 hours but less than 1560 during the 12-month measurement period.

N. Benefit Program Code - Benefit program codes represent the employment status, FT or PT, and a tier for premiums. Currently, there is one tier for premium costs. NSE employees who are eligible and enrolled in an HRA will have a benefit program code that starts with “LH” for HRA.

   a. LF1 = Full-time NSE employee
   b. LP1 = Part-time NSE employee
   c. LHF = Full-time NSE employee enrolled in an HRA
   d. LHP = Part-time NSE employee enrolled in an HRA

NOTE: Employment status and benefits program code must be changed during the Plan Year whenever the employee changes from an FT to a PT position or from a PT to an FT position (as outlined above). Requests must be submitted in MAP within 31 days of the change.

If the employment status change takes place on the 1st day of a month, the new benefit effective date will be the 1st day of that month. If the employment status change takes place during the month, the effective date for the applicable status change will be the 1st day of the following month. If changes in SEHP coverage result from these employment status changes, the same effective dates shall apply.

OTHER ELIGIBLE INDIVIDUALS FOR THE SEHP

A. In addition to covering themselves, a primary member can also elect coverage for eligible dependents. This includes:
B. The primary member's lawful spouse, subject to the documentation requirements of the HCC or its designee.
C. Any of the primary member's eligible dependent child(ren) subject to the documentation requirements of the HCC or its designee. These individuals will be referred to as "dependent(s)" throughout the rest of this manual.
D. Parents are not eligible for coverage under the State Employee Health Plan.
E. NOTE: If a primary member divorces, coverage for their former spouse and stepchild(ren) ends on the last day of the month in which the divorce is final. If the date the divorce is final is the 1st day of the month, coverage for the primary member's former spouse and stepchild(ren) ends on the last day of the month prior. COBRA coverage will be offered to the eligible participants.
F. An individual who is eligible to enroll as a primary member in the SEHP can enroll as a dependent provided the individual who wants to enroll as a dependent spouse is the lawful spouse (section I.1., first bullet point) of another primary member currently enrolled in the SEHP. An eligible employee cannot be enrolled in SEHP medical, dental, vision, or voluntary coverage both as a primary member and as a covered spouse of an enrolled employee. Members are either eligible dependent on all SEHP coverage or the primary member on all coverage, they cannot be both. Example: Employee enrolls in medical as a primary member, and cannot be enrolled as a dependent on medical, dental, vision, or other coverage. Eligible dependents may be added with a mid-year Qualifying Event or during Open Enrollment.
G. An individual who is eligible to enroll as a primary member in the SEHP can enroll as a dependent child or spouse of a primary member, provided they meet the definition of eligible dependent. An eligible dependent cannot be enrolled in SEHP medical, dental, vision, or voluntary coverage both as a primary member and a dependent of an enrolled employee. Members are either eligible dependent on all coverage or the primary member on all coverage, they can't be both. Example: Employee enrolls in

medical as a primary member, and cannot be enrolled as a dependent on medical, dental, vision, or other coverage. Eligible dependents may be added with a mid-year Qualifying event or during Open Enrollment.

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

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

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

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

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

M. The word "child" means:

   a. A biological son or daughter of the primary member

   b. A lawfully adopted son or daughter of the primary member. Lawfully adopted will include those instances in which a primary member has filed a petition for adoption with the court, has a placement agreement for adoption or has been granted legal custody. See Section III. A. for supporting documentation requirements.

   c. A stepchild of a primary member. If the biological or adoptive parent of the stepchild is divorced from the primary member, the child no longer qualifies as the primary member's stepchild and is no longer eligible for coverage.

NOTE: If the primary member and spouse do not file their Federal tax return jointly, a Dependent Stepchild affidavit will need to be completed, notarized, and uploaded in MAP.

- A child of whom the primary member has legal custody.
- A grandchild, if the primary member (employee) claims the grandchild as a dependent on their most recent Federal tax return and at least one of the following conditions is met:
    - The primary member has legal custody of the grandchild or has lawfully adopted the grandchild,
    - The grandchild lives in the home of the primary member and is the child of a covered eligible dependent child and the primary member provides more than 50% of the support of the grandchild; or
    - The grandchild is the child of a covered eligible dependent child and is considered to reside with the primary member even when the grandchild or eligible dependent child is temporarily absent due to special circumstances including the education of the covered eligible dependent child, and the primary member provides more than 50% of the support for the grandchild.

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

Newborn Grandchildren - When the employee files the current year's tax return, the return, with all financial information redacted and the grandchild claimed as a dependent, must be uploaded and a Communication Form stating that this has been done must be submitted in MAP by April 15th of the following year.

A. Eligible dependent child(ren) or stepchild(ren), the child or stepchild must be less than 26 years of age.
B. Eligible dependent child(ren) or stepchild(ren) aged 26 or older who has a permanent and total disability as described in Section H and has continuously maintained group coverage in the SEHP as an eligible dependent of the primary member before reaching the limiting age (26), under the plan or the child was over the age of 26 at the time of the employee's initial enrollment may be covered under the SEHP. The child must be unmarried and receive more than 50% of his or her support and maintenance from the primary member.
C. An application for coverage of a permanent and 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 disabled.

OTHER ELIGIBLE INDIVIDUAL'S EFFECTIVE DATE OF COVERAGE

A. Other eligible individuals shall become newly eligible on the later of:
    a. The primary member's initial date of eligibility; or
    b. The 1st day of the month following the date the individual first becomes an eligible spouse or dependent child of the primary member or becomes newly eligible for coverage according to the spouse or dependent child definition. The SEHP must receive a Change Request in MAP along with any supporting documentation within 31 days of the date the spouse or dependent child becomes newly eligible according to the spouse or dependent child definition.
    c. The 1st day of the month following the loss of Medicaid (KanCare) or Children's Health Insurance Program (CHIP) coverage. The SEHP must receive a Change Request in MAP along with any supporting documentation within 60 days of the date of loss of Medicaid or CHIP coverage.

B. NEWLY ELIGIBLE SPOUSE OR CHILDREN
    a. All Enrollment and Change Requests adding newly eligible spouse or dependent children must be submitted in MAP within 31 days of the event that makes the spouse or dependent child newly eligible. Coverage for the newly eligible spouse or dependent child may be added if the primary member is enrolled in the SEHP.
    b. The change in coverage must be consistent with the event and/or must comply with HIPAA regulations applicable to Special Enrollment Qualifying Events.
    c. Supporting documentation must (appropriate documentation listed below) be uploaded when the request is submitted as proof of the Qualifying Event. Enrollment or Change Requests submitted without the appropriate supporting documentation will be denied and no change will be made by the SEHP. All documentation must be legible and completed in the English language. Any documentation submitted in any other language besides English must be accompanied by a certified English translation.

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

A. Social Security (SSN) and Individual Taxpayer Identification Numbers (ITIN). 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 a valid SSN, Medicare HICN, or ITIN for nonresident alien individuals and their eligible dependents. Dependents include a spouse and eligible children to be covered by health plan benefits.

1. A Health Care Identification Number (HICN) is the number assigned by the Social Security Administration to an individual identifying as a Medicare beneficiary. This number is shown on the beneficiary's insurance card and is used in processing Medicare claims for that beneficiary. The Medicare program uses the HICN to identify Medicare beneficiaries receiving health care services and to otherwise meet its administrative responsibilities to pay for health care and operate the Medicare program. Medicare is required to protect individual privacy and confidentiality per applicable laws, including the Privacy Act and HIPAA. The SSN is used as the basis for the Medicare HICN. While the HICN is required to identify a Medicare beneficiary, if the HICN is not available some beneficiaries may also be identified by the SSN.
2. Individual Taxpayer Identification Number (ITIN): A Foreign National individual engaged or considered to be engaged in a trade or business in the U.S. during the year is required to file a federal tax return each year. As a result, they must apply for an ITIN. These numbers are unique identifiers, are like an SSN, and have the first 3 digits in the range of 900-999.
3. For Medicare to properly coordinate Medicare payments with other insurance and/or workers' compensation benefits, Medicare relies on the collection of HICN, SSN, or ITIN numbers as applicable. The SEHP requires a valid SSN or ITIN for all eligible members to participate in the SEHP to ensure the Plan complies with the Act (Section 111 of the Federal Medicare, Medicaid, and SCHIP Extension Act of 2007).

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

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

valid number is obtained. The valid number must be provided to the SEHP within 30 days of enrollment in the SEHP. If a number cannot be provided within this time frame, a Communication Form must be submitted in MAP providing the reason the number is not available. The request will be reviewed, and a determination will be made on each case submitted.

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

C. Reporting under the Affordable Care Act (ACA) requires certain employers who sponsor self-insured group health plans to report coverage of all participants in the group health plan. The SSN or ITIN for each covered individual is required to be included on the reporting form (Form 1095C, Part III). NOTE: A valid SSN or ITIN will be required during annual Open Enrollment for any newly added dependents. If the information is not provided during Open Enrollment the dependents will not be added to the SEHP in the following plan year. If a number cannot be provided by the annual Open Enrollment deadline, a Communication Form must be submitted in MAP providing the reason the number is not available. The request will be reviewed, and a determination will be made on each case submitted.

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

1. Marriage License for spouse and stepchild eligibility
2. Birth certificate or hospital birth announcement for dependent children including full name of parent(s). Birth registration cards are not acceptable for dependent children.
3. Petition for adoption or placement agreement for a dependent child, including the Judge's signature and court date stamp,
4. Legal custody or guardianship document issued by the court including the Judge's signature and court date stamp,
5. Court Order for children who are not biological or adopted children of the primary member including the Judge's signature and court date stamp,
6. Birth certificate or hospital birth announcement and Dependent Grandchild Affidavit for a child (grandchild) born to a covered dependent and a copy of most the recently filed Federal tax return for proof of financial dependency and residency. The tax return must be signed and dated by all filers. (See number 8 below, for pages needed.)

7. Application for Coverage of Permanent and Totally Disabled Dependent Child affidavit for covered dependent children aged 26 or older and a copy of the most recently filed Federal tax return for proof of financial dependency and residency. The Federal tax return must be signed and dated by all filers.
8. Copies of the most recently filed Federal tax return for proof of dependent eligibility. The Federal tax return must be signed and dated by all filers. Income information may be written out before uploading the document in MAP. The pages needed from the current year's filed Federal tax return depend on which Tax form was filed:
    i. Form 1040 and 1040A —pages 1 & 2 containing the filer's name, the employee and spouse's signature, and the date the employee and spouse each signed the form.
    ii. Form 8879 (IRS e-file)—containing the date filed, the filer's name, the employee and spouse's signature, and the date the employee and spouse each signed the form.
        1. Divorce decree, official court document, including the Judge's signature and the court date stamp.
        2. 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.
        3. For dependent loss of other group health coverage, a letter, on company or carrier letterhead, listing the name of the member and all dependents that were covered under a previous employer's insurance. The letter must identify the previous employer and list the date on which coverage ended.

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

F. For newborn grandchildren, a copy of the birth certificate and a completed Dependent Grandchild Affidavit must be uploaded in MAP within 31 days of the newborn grandchild's DOB. If the Change Request, SSN, or ITIN and appropriate supporting dependent documentation is not received within the above time frame, the dependent will not be added to coverage.

NOTE: A copy of the most recently filed tax return showing that the grandchild was claimed as a dependent will need to be uploaded with a communication form, with the first tax filing ending after the grandchild's DOB.

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

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

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

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

K. Effective Date of Coverage - If the date of the filing for a petition for adoption or placement in your home is within 31 days of the birth of the child, the coverage effective date is the date of birth provided that a Newly Eligible Dependent request is submitted in MAP and the appropriate documentation is uploaded within 31 days of the event. If the filing placement is not within 31 days of the date of birth of the child, the effective date of coverage is the date of the filing date of the petition for adoption or the date of placement, whichever the case may be. The effective date of coverage cannot be earlier than the child's placement or arrival in your home within the United States.

   NOTE: If adding a newborn or newly adopted dependent to coverage, other eligible dependents may also be added to coverage at this time. The effective date of coverage for the newborn or adopted dependent will be the date of birth if a Newly Eligible Dependent request and the appropriate documentation is submitted within 31 days of the applicable child's birth. The effective date of coverage for your other eligible dependents, such as a spouse and/or other children or stepchildren, will be the newborn's date of birth, date of placement for adoption, or date of petition for adoption.

L. **Change in Employee Contribution -** The employee change required contribution for change in coverage will be reflected on the employee's paycheck that coincides with the DOB, date of petition for adoption, or date of the placement agreement. If the DOB, date of the petition for adoption, or date of the placement agreement occurs on the 1st day of the month, the change in employee premium will take place on the 1st day of that month.

New Legal Custody/Guardianship Children (children who are not biological, legal stepchildren, or adopted children of the primary member). If the primary member is adding a newly eligible legal custody/guardianship child to coverage, a Newly Eligible Dependent request will need to be submitted within 31 days of the date that the court issues a legal custody agreement. A copy of the court order or legal custody agreement and birth certificate must be uploaded in MAP with the request. The effective date of coverage will be the 1st day of the month following the date of legal custody or guardianship. If the date of legal custody or guardianship occurs on the 1st day of a month, the coverage effective date will be that day.

New Spouse or Stepchildren Due to Marriage - If the primary member wants to add a new spouse and/or stepchild(ren) to coverage due to marriage, a Newly Eligible Dependent request must be submitted in MAP to add the spouse and/or stepchild(ren) to coverage within 31 days of the marriage. The change request and appropriate supporting documentation must be submitted in MAP within 31 days of the marriage. The effective date of coverage will be the 1st day of the month following the date of marriage. If the marriage occurs on the 1st day of the month, the coverage effective date will be the 1st day of that month. If adding a newly eligible spouse or stepchild(ren) to coverage, other eligible children may also be added to coverage, such as other children of the primary member. The effective date of coverage for these dependents will be the 1st day of the month following the date of marriage. Employee-required premium contributions will be due according to the dependent coverage effective date.

Employee Previously Opted Out/ Waived Insurance Coverage

If the employee has previously waived coverage and acquires a newly eligible spouse or child(ren), (marriage, birth, adoption, etc.) the employee must contact their Employer within 31 days of the event if the employee wants to elect coverage for themselves and the newly eligible spouse and/or children. A Communication Form to have an enrollment portal opened, along with uploading appropriate supporting documentation in MAP, must be submitted within 31 days of the event. Coverage for the

employee and the newly eligible dependent(s) will be effective the 1st day of the month following the date of the Qualifying Event. In the case of a newborn, coverage for the newborn will be the DOB, but coverage for the employee will be the 1st day of the month preceding the newborn's DOB. Any spouse or other children added during this Qualifying Event will be effective the DOB of the newborn.

Children of divorced parents

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

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

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

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

D. Adopted child – Not U.S. Citizens

   A primary member may cover an adopted child if the petition for adoption has been filed with the court, if the primary member has a placement agreement for adoption, or if the primary member has been granted legal custody of the child. Supporting documentation is completed in English and must be uploaded to the member portal in MAP. Adopted children who are not U.S. citizens and who reside in another country are not eligible for coverage until they move to, and maintain a permanent

residence in, the U.S. If the child(ren) later returns to another country, coverage cannot be dropped for the child(ren) until the next Open Enrollment period (unless enrolled in coverage on an after-tax basis).

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

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

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

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

Special Notes

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

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

HEALTHQUEST PROGRAM

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

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

1. Wellness Offerings

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

    Who is Eligible to use the Wellness Services?

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

2. Employee Assistance Program

    - Confidential Short-Term Personal Counseling
    - Legal Advice and Discounts
    - Personal Money Management Assistance and Information
    - Work-Life Resources
    - Eldercare/Childcare Information and Referral
    - Who Is Eligible to Use the Employee Assistance Program (EAP)?
        - All active, benefits-eligible employees of the State of Kansas, their dependents, and other family members living in the same household,
        - All active, benefits-eligible employees of our Non-State Employer Groups, their dependents, and other family members living in the same household,
        - Direct-bill retirees and COBRA participants are not eligible to participate.

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

The telephone number for HealthQuest programs is 785-783-4080.

HEALTHQUEST REWARDS PROGRAM

Employees enrolling in medical plans with the SEHP have an opportunity to earn a premium incentive discount on their health insurance premiums through the HealthQuest Rewards Program. Plans C, J, and N members can also earn contributions to their HSA/HRA accounts. The HealthQuest Program year (also known as the earning period for the incentive) runs from January 1 through December 31 each calendar year. Further information on the premium incentive program can be found in 'Cost of Coverage'. Because the requirements to earn a discount may change from year to year, please refer to the HealthQuest website for full details.

Employees will need to set up a HealthQuest account on the wellness portal to begin earning credits toward their discount, then click on the HealthQuest Portal link.

New members should have access to the HealthQuest programs within three weeks of submitting their Online Enrollment, they do not have to wait until their coverage begins.

Employee Assistance Program:

- Critical Incident/Stress Management Counseling Sessions: Human Resource Managers can contact the EAP vendor, Compsych, at 800-270-8897 for information about Critical Incident/Stress Management Counseling Sessions for employee groups experiencing trauma or major loss. A counselor will come to the worksite and present to groups or talk with people one-on-one to help them process the grief or trauma. The counselor will bring materials and handouts that address dealing with grief.
- Formal Referral Program: Occasionally circumstances arise when we would question the emotional stability of an employee or their ability to perform safely in the workplace. We may also be concerned about the safety of other employees or the individuals we serve. The Formal Referral program is not designed to address chronic disciplinary or performance problems, but behavioral changes in employees that may pose a potential threat to self or others in the workplace. If assistance is needed in dealing with chronic disciplinary or performance problems or you would like to discuss the Formal Referral program option, please call the HealthQuest number at 785-783-4080.

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

EMPLOYEE MEDICARE ELIGIBILITY

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

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

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

EMPLOYEES AND SPOUSES WHO ARE APPROACHING AGE 65

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

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

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

EMPLOYEES, SPOUSES, AND DEPENDENTS WITH MEDICARE DUE TO DISABILITY

1. New hires should be asked if they or any dependents they plan to cover under the SEHP are Medicare eligible. A copy of the Medicare card should be uploaded to MAP at that time.
2. Active employees, spouses, and/or dependents who become newly eligible for Medicare due to disability during the plan year may continue to participate in the SEHP or have Medicare coverage as primary. A request should be submitted in MAP by the HR office indicating that the member is newly eligible for Medicare. If they wish to remain on the SEHP, the HR office must upload the Medicare card in MAP. Those who want Medicare as a primary will be terminated from medical coverage under the

SEHP. The member will be removed effective the 1st day of the month that Medicare becomes effective.

3. Federal law mandates Medicare to be the secondary payer of claims for active employees or their dependents who choose to remain covered by the SEHP, even though they are disabled and entitled to Medicare benefits.
4. Persons with End Stage Renal Disease (ESRD) may be eligible for Medicare primary coverage for a period as determined by Federal guidelines. The HR office must upload the completed ESRD Questionnaire and Medicare card in MAP when ESRD is diagnosed for a covered primary member, spouse, or dependent.
5. When Medicare is primary for a covered person with ESRD, there is no change in active employee rates, coverage eligibility, or benefits.

COST OF COVERAGE

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

SEHP coverage is monthly. All benefits will terminate on the last day of the month in which the employee terminates employment. If employment terminates on the 1st day of the month benefits will terminate on the 1st day of the month.

EMPLOYEE CONTRIBUTIONS

A. SEHP employee rates are based on the following criteria:
   - LF1, LP1, LHF, and LHP employment status of the employee's position. For LF1 and LHF employees, the NSE contributes approximately 95% of the cost of single coverage and approximately 55% of the additional cost for dependent coverage.
   - For LP1 and LHP employees, the NSE contributes approximately 75% of the amount contributed for the cost of coverage for full-time employees.
     - Health plan selected
     - HealthQuest Rewards Program
     - Coverage level selected

HEALTHQUEST REWARDS PROGRAM INCENTIVE

Member Participation in the HealthQuest Rewards Program Incentive is voluntary.

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

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

ANNUAL OPEN ENROLLMENT

A. Open Enrollment occurs annually during the month of October. All primary members are required to complete and submit their Open Enrollment elections for coverage in their member portal each year. This includes eligible employees who are on Leave without Pay (LWOP).
B. Open Enrollment information will be posted on the SEHP website during the annual Open Enrollment period. Members can elect, change, or waive benefits; add or drop a spouse or child(ren) from coverage, change pre-tax payment status, or enroll/re-enroll in benefits with the SEHP. Elections made during Open Enrollment will be effective January 1st of the following plan year.
C. Primary Members can change their Health Savings Account (HSA) contribution amount if enrolled in the Qualified High Deductible Health Plan and Flexible Spending Account (FSA) contribution amount. The contribution amount must be within the IRS maximum contribution amount for that plan year.
D. HR offices have access to online reports in the Agency & Department (HR) portal on Open Enrollment activity so they can monitor employee's enrollments and ensure that they complete their Open Enrollment promptly.
E. Special Notes:
    - Each employee must have their personal email address, work or personal, to access MAP.

- A valid SSN or ITIN must be submitted to the SEHP to add a spouse or dependent during Open Enrollment. If a valid SSN or ITIN is not received, the spouse or dependent will not be added to the primary member's coverage in the new Plan Year.
- Acceptable dependent documentation for the spouse and/or dependent(s) must be uploaded via MAP to add a spouse or dependent during Open Enrollment. If acceptable documentation is not received, the spouse or dependent(s) will not be added to the primary member's coverage for the new Plan Year.
- A primary member cannot remove a spouse from coverage during the Open Enrollment period due to a pending divorce. The spouse can be removed from coverage once the divorce is final. A copy of the divorce decree must be uploaded in MAP within 31 days of when the divorce is final.
- If the primary member provides documentation for their spouse and/or dependent(s) to their HR office, the documentation must be uploaded through the primary member's record in MAP.

F. PRE-EXISTING CONDITIONS

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

G. NEWLY ELIGIBLE PRIMARY MEMBERS

- Newly eligible primary members may enroll via MAP during their enrollment period for an effective date of coverage for the current Plan Year. In addition, during the month of October during Open Enrollment, the primary member may enroll via MAP and elect coverage to be effective for the new Plan Year. An otherwise eligible member must have completed their Enrollment or waiver election in MAP before they can enroll during the Open Enrollment period.

H. REVISED OPEN ENROLLMENT ELECTIONS

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

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

I. OPEN ENROLLMENT PENDING ELECTIONS STATEMENT

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

J. IDENTIFICATION CARDS

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

HEALTH PLAN MATERIALS - BENEFIT DESCRIPTIONS, CERTIFICATES and BOOKLETS

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

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

IDENTIFICATION CARDS (ID Cards)

C. Separate ID Cards are issued by the appropriate Plan Administrator or carrier for medical, prescription drug, dental, and vision coverage. SEHP Plan Administrators or carrier(s) will mail Identification Cards directly to the member's home address listed in MAP. Members should allow 2 to 3 weeks after their elections have been processed by the SEHP for coverage to be established with the applicable Plan Administrator or carrier(s). If a member has not received an ID card after 3 weeks, the member should contact their Plan Administrator or carrier and request a new card be sent.

D. Dental and vision ID cards may also be obtained by accessing the Plan Administrator's website. Members should always carry their ID cards and present the appropriate ID card whenever covered services or benefits are needed.

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

F. Members may call their Plan Administrator or carrier using a local or toll-free number as listed on the ID card or the SEHP website.

CHANGE REQUESTS

A. It is the primary member's responsibility to:

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

B. It is the NSE HR office's responsibility to:

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

NOTE: A qualifying event will not allow changes to plan or vendors. Only coverage level changes can be made mid-year.

COMPLETING MAP CHANGE REQUEST

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

B. Username and password for employer access to the MAP website:

   a. Date of the employee's Qualifying Event

   b. State of Kansas Employee ID#, the HR office should assign a number from the MAP system.

   c. Documentation that may be required to process the change (i.e., documentation to establish dependent status)

C. Employee Information - This section includes demographic information supplied by the employee and includes:

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

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

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

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

E. Dependent Information (add/drop a dependent), all changes must be made within 31 days of the Qualifying Event.

F. Select the option that is appropriate for the primary member's requested action.

G. Upload supporting documentation for the spouse and each covered dependent. The SEHP and/or the Plan Administrator/carrier may request documentation to support proof of relationship or dependency.

H. Enter the dependent's name

I. Enter the dependent's SSN or ITIN

J. Select the dependent's gender.

K. Enter the dependent's date of birth in MM/DD/YYYY

L. The primary member must provide the dependent's address if it is different from theirs.

M. Add/Drop dependent Medical, Dental, Vision, and voluntary benefits coverage.

N. Medicare - If the primary member, spouse, and/or dependent are eligible for Medicare and are to be covered under the SEHP, the primary member should provide the following information for the HR office to complete this section in MAP. The member is also required to provide copies of all Medicare cards that should be uploaded in MAP.

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

MID-YEAR ENROLLMENT CHANGES- ADDITION AND DELETION OF NON-NEWLY ELIGIBLE EMPLOYEES AND OTHER INDIVIDUALS

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

Appropriate Supporting Documentation

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

1. Marriage License completed in English for proof of spouse and stepchild eligibility.
2. Birth certificate or hospital birth announcement completed in English for dependent children including full name of the parent(s). Birth registration cards are not acceptable proof for dependent children.
3. Petition for adoption or placement agreement completed in English for a dependent child.
4. Legal custody or guardianship document completed in English issued by the court.
5. Court order completed in English for dependents who are not biological, stepchildren or adopted children of the primary member.
6. Certificate of birth completed in English and Dependent Grandchild Affidavit for children (grandchild) born to a covered dependent, along with a copy of the current year filed Federal tax return for proof of financial dependency and residency. (See number 8 below, for pages needed)
7. Application for Coverage of Permanent and Disabled Dependent Child affidavit for covered dependent children aged 26 or older and a copy of current year filed Federal tax return for proof of financial dependency and residency.
8. Copies of the current year filed Federal tax return for proof of spouse eligibility. Please note all income information may be whited out before submission to the SEHP. The pages needed from the current filed Federal tax return depends on which Tax form was filed:
    a. Form 1040 and 1040A —pages 1 & 2 containing the filer's name, the employee and spouse's signature, and the date the employee and spouse each signed the form.
    b. Form 8879 (IRS e-file)—containing the date filed, the filer's name, the employee and spouse's signature, and the date the employee and spouse each signed the form.
9. Divorce decree court document, including the Judge's signature and the court date stamp.
10. A copy of a military ID and privilege card (front and back) with the expiration date is acceptable as proof of Tricare coverage and to document the end of Tricare coverage.
11. For dependent loss of other group health coverage, a letter or certificate of creditable coverage, listing the name of the member and all dependents that were covered under a previous employer's insurance is required. The letter or certificate must identify the previous employer and list the dates) on which coverage was terminated.

12. For dependent gain of other group health coverage, a letter or certificate of creditable coverage identifying the coverage, the effective date and the dependent that is covered. NOTE: Gaining CHIP or marketplace coverage is not a qualifying event to remove dependents from coverage during a plan year.
13. For dependents entering the US. The passport showing the date of entry, or the I-94 form from Homeland Security with the date of entry.
14. Death certificate, obituary notice, or document approved by legal counsel.
15. A valid SSN or ITIN number (if applicable) is required when a member adds dependent(s) to their coverage. If the information is not provided at the time of the request to add the dependent(s), the SEHP will be unable to add them to coverage. If a number cannot be provided, a Communication Form must be submitted in MAP providing the reason.

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

- Voluntary benefits may be added during the Plan Year for newly eligible dependents if the primary member is already enrolled. Primary members cannot change voluntary plan levels i.e., high to low or low to high.
- If the primary member has opted out of voluntary benefit coverage, newly eligible dependents may not be added to these coverages, even with a Qualifying Event.
- Permitted Deletions: Primary members who are enrolled in coverage on an after-tax basis may drop primary member and/or dependent coverage (medical, dental, and vision) without a qualifying event during the Plan Year. Documentation is not required.

EFFECTIVE DATE OF COVERAGE

1. For mid-year changes, the effective date of coverage or change in coverage will be the 1st day of the month following the event. For events that occur on the 1st day of a month, the coverage effective date will be that day. If a death occurs on the 1st day of a month, coverage will terminate on the last day of that month.
2. The effective date of coverage is outlined for newborns, adopted children, new spouses and/or new stepchildren, and changes in legal custody or guardianship of a dependent child.
3. If a primary member is enrolled on an after-tax basis and is dropping primary member and/or dependent coverage, the effective date of change in coverage is the 1st day of the month following

completion of the Change Request and approval by SEHP. If the change is on the 1st day of a month, the coverage effective date will be that day.

PRE-TAX EVENTS

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

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

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

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

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

M. Gain or loss of legal custody of a dependent child - A copy of the court order with the court date stamp and the judge's signature must be uploaded in MAP with the Change Request.

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

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

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

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

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

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

T. Return from Leave Without Pay.

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

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

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

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

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

Z. Dependent turning age 26 (coverage will terminate the last day of the month in which the dependent turns age 26).

Additional Events:

1. Removal of ineligible grandchild.
2. Employee, spouse, or dependent losing Medicare eligibility or becoming newly eligible for electing Medicare coverage as primary.
3. Death of a Medicare and spouse or dependent
4. Dependent children identified under a Medical Withholding Order (K.S.A. 23-4,105) or Qualified Medical Child Support Order. The SEHP has the authority to add these dependent children without the consent of the employee, to comply with the Order.
5. Dependent children losing eligibility/coverage under another employer-sponsored group health plan. For loss of group health coverage for a dependent, a letter or certificate of creditable coverage, listing the name of the member and all dependents that were covered under a previous employer's insurance must be uploaded in MAP with the request. The letter or certificate must identify the previous employer and list the date on which coverage was terminated.
6. Dependent spouse or children who move to the U.S. Please select "Other" as a type of event and indicate the dependent spouse and/or child moving to the U.S.

7. Newly Entitled to Medicare or Medicaid. If the employee, spouse, or dependent becomes entitled to coverage (becomes newly eligible) under Part A or Part B of title XVIII of the Social Security Act (Medicare) (Public Law 89-97 (79 Stat. 291)) or title XIX of the Social Security Act (Medicaid) (Public Law 89-97 (79 Stat. 343)), while enrolled in the SEHP, they may make a mid-year change to cancel their SEHP coverage. In addition, if the employee, spouse, or dependent who has been entitled to coverage under Medicare or Medicaid loses eligibility for such coverage, they may make a mid-year change for coverage under the SEHP.
8. Children's Health Insurance Program (CHIP) – Dependents losing CHIP coverage is a mid-year qualifying event and they can be added to SEHP coverage.

NOTE: Gaining CHIP coverage is not a qualifying event to remove dependents mid-year.

AFTER-TAX EVENTS

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

A. Add dependents using all events as listed under Pre-tax Events.
B. Removing employee, spouse, and/or dependents from SEHP coverage for any reason.
C. Vision coverage may NOT be added during the Plan Year.
D. Voluntary benefit plans are on an after-tax basis and may not be changed or dropped during the plan year.
E. Documentation for the qualifying event is not required.

RETIREMENT

When an employee retires from an NSE, the employee must notify their NSE HR office whether they wish to continue SEHP coverage with the SOK through the Direct Bill program. They will automatically be offered COBRA coverage. Members must have continuous coverage under the SEHP to be eligible for the Direct Bill program. If continued coverage is desired, the Change Request should be completed 30 days before the employee's retirement to ensure continuous coverage between coverage as an active employee and coverage under the Direct Bill option.

Whether the employee is Medicare eligible or not, the effective date of the change to the Direct Bill program will be the 1st day of the month following the employee's last day of work as an active employee. Invoices will be generated by SEHP and posted in the Member Portal around the 22nd of each month for the next month's

Direct Bill coverage. Premiums are paid by recurring bank draft (ACH) on the 8th of each month for that month's coverage. The primary member pays the entire monthly premium while on Direct Bill coverage.

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

ACTIVE MILITARY DUTY

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

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

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

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

Primary members, spouses, and/or dependents who elect to discontinue SEHP coverage and who have primary coverage provided by the military will be allowed to re-enroll in the same SEHP plan and coverage option when the member returns to active employee status.

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

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

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

PAID SABBATICAL LEAVE

Primary members enrolled in coverage on an after-tax basis may drop coverage while on paid sabbatical leave. If the primary member is participating in the pre-tax premium option, the primary member's salary while on sabbatical leave must be reduced for the primary member to drop or change existing coverage.

A. A Change Request must be submitted in MAP indicating the date the sabbatical leave will begin, the expected duration of the leave, and whether coverage will be dropped or changed.
B. If a primary member drops coverage due to paid sabbatical leave and returns to active status during the same Plan Year, they must come back into the same plan and the same, or a reduced, coverage level as they had before gone on leave. No additions to coverage will be allowed unless the change is due to a Qualifying Event.
C. If the employee returns from sabbatical leave in a new Plan Year, the employee may enroll in or change to any medical plan or coverage option for which the employee is eligible.

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

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

In addition, if residing out of the U.S. for a sabbatical leave, the primary member may request an advance supply of a maintenance prescription drug. The primary member should submit a written request indicating the length of the sabbatical leave and a completed Prescription Drug Advance Purchase Certificate to the SEHP.

To utilize the voluntary benefits, treatments must be administered in the United States.

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

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

PRESCRIPTION DRUG ADVANCE PURCHASE POLICY

A. Travel in the United States: Members traveling within the United States are not eligible for an advance purchase of prescription drugs, since members may use their drug card at any CVS Caremark network pharmacy throughout the U.S.
B. Travel Outside of the United States
    - Travel or work outside the U.S. for a period of sixty (60) days or less: Members who leave the U.S. for 60 days or less may call the TOLL-FREE number on the back of their CVS Caremark card to arrange for a vacation supply of medications. CVS Caremark may enter up to 30 days on an original fill for non-controlled and controlled medications or a 60-day override on refills of medications as allowed by the Benefit Description. The member will be billed the applicable coinsurance or copayment for the quantity purchased.
    - Work outside the U.S. for a period of sixty (60) days or longer (but not to exceed one (1) year): This policy and its provisions apply only to active employees covered under the SEHP. When a member will be outside of the country for a longer period, there are two options available:

Advance purchase through drug plan:

The member must work with the NSE's personnel/benefits office to arrange for the advance purchase of maintenance medications required during a stay outside the U.S. The Advance Purchase Form certifying that health coverage will be maintained during the entire period of the extended absence must be signed by both the member and the NSE. An Advance Purchase Form must be submitted to the SEHP at least fifteen (15) days before the departure date. The NSE and the member will be notified when the Advance Purchase Form has been processed and the dates the medication will be available to pick up. Generally, the medication will be available for purchase one week in advance of the departure date. The following requirements apply:

a) The Advance Purchase Form must be completed stating that coverage will be maintained via payroll deductions during the term outside of the U.S. The form also requires information on destination and

duration of stay. The Advance Purchase Form signed by the member and the HR office acknowledges the SEHP's right to recover from the NSE and/or employee the cost of the medications if coverage is not maintained.

b) 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. The member will be responsible for the applicable coinsurance percentage on the cost of the quantity of drug dispensed. The member must agree to purchase the prescription medication at a local network pharmacy. Members or their dependents using the CVS Caremark mail service will need to obtain a prescription from their doctor so that the items can be purchased at a local network pharmacy. REMINDER: Medication can only be dispensed for the period allowed by the prescription written by the provider. For extended periods, the member may need a new prescription. Advance purchases are available for a period of up to one (1) year.

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

d) Member purchases medication(s), then submits the claim(s) upon return: If the member does not have enough time to file an Advance Purchase Certificate Form in advance of their departure, they may pay the full price for their medications and file a paper claim for reimbursement upon their return. The paper claim would need to be filed first to SEHP for processing.

DEATH OF A PRIMARY MEMBER WITH DEPENDENT CHILDREN

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

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

LEAVE WITHOUT PAY AND FAMILY MEDICAL LEAVE ACT (FMLA)

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

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

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

1. Non-payment of Active Employee Premium: If the employee fails to pay within the scheduled timeframe, the NSE will submit a request in MAP under Leave Without Pay for Cancellation Due to Non-Payment. The employee will not be offered COBRA coverage and will not be allowed to re-enroll in active or Direct Bill coverage for the remainder of the Leave Without Pay period.
2. If the NSE fails to submit this request, it will be assumed the employee is still active. If the NSE fails to notify the SEHP of any cancellation within 31 days of the Qualifying Event, the NSE could be assessed a fee of $250.00 per employee per month for every month the request is not received by the SEHP. The payment for the assessed fee is made payable to SEHBP and sent to SEHBP Data Management.
3. Continued Payment of Active Employee Premium: If the employee is on leave longer than 30 days and has continued to pay for active employee coverage on the scheduled time frame following the initial 30 calendar days, the NSE will submit a Leave Without Pay request in MAP and indicate if the employee wants to continue with Direct Bill coverage while on leave or not. Once the request has been processed, a portal will be opened for the employee to elect their health insurance coverage while on leave.
4. After completing their elections in their Member Portal, the employee will need to complete the ACH form, and recurring payment on the Billing tab under Payment Methods so their premiums can be deducted from their bank account on the 8th of each month for that month's premium. Direct Bill coverage will begin on the 1st day of the month.
5. For example - the first day of leave without pay is January 15, 20xx. February 13, 20xx will be the end of the employee's 30 days of Leave Without Pay with Employer contributions. Active coverage will end February 28, 20xx, and Direct Bill coverage will begin March 1, 20xx.

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

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

1. If the employee is eligible for FMLA, they are eligible for 12 weeks of paid or unpaid leave during any 12 months beginning with the first day leave was taken.
2. If the employee is on FMLA and continues to receive a paycheck, their health insurance premiums will continue to be deducted. When the employee goes on FMLA Without Pay, the NSE will bill the employee for their portion of the premium. If an employee does not pay these premiums their health insurance coverage will be canceled effective when FMLA began or when the last payment was made. The NSE will submit a request to MAP to cancel an employee's health insurance due to non-payment of premiums while on FMLA.
3. Once FMLA ends and if the employee is still on Leave Without Pay the NSE will then need to submit a request in MAP indicating FMLA has ended, and the employee is being put on Leave Without Pay. The employee will get an additional 30 days.
4. Example—FMLA ended on May 14, 20xx. June 13, 20xx will be the end of the employee's 30 days of Leave Without Pay with Employer contributions. So active coverage will end June 30, 20xx, and Direct Bill coverage will begin July 1, 20xx.

B. RETURN FROM LEAVE WITHOUT PAY

1. When an employee returns from Leave Without Pay (whether it is a regular Leave Without Pay or if it is FMLA Leave Without Pay) a Change Request must be entered in MAP within 31 days of the date of return to active pay status. When submitting the request, indicate the date the employee returned to work.
2. If the employee did not enroll in Direct Bill coverage while on leave, the health insurance coverage they were enrolled in before going on leave, will be effective the first day of the month after they return to work.

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

3. If the employee enrolled in Direct Bill coverage while on leave, the Direct Bill coverage will end the last day of the month in which they return to work and the same coverage the employee was enrolled in (including HSA, HRA, or FSA annual election amount) before going on leave will be effective the first of the following month.

   NOTE: The only exception to what is listed above is if the Leave Without Pay is extended over an Open Enrollment period. Then a portal will be opened for the employee to elect coverage for the new Plan Year.

FURLOUGHS AND LAYOFFS

I. FURLOUGH

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

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

Upon the end of their furlough period, if an employee has not sustained the requirements for membership in the SEHP, they can re-enroll. The employee will be subject to all other applicable policies and regulations regarding enrollment in the SEHP. The ending of a furlough is a Qualifying Event according to IRS Section 125 guidelines.

II. LAYOFFS

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

RETROACTIVE TERMINATIONS OR ENROLLMENTS

Retroactive enrollments are those in which notification is not made to the SEHP within 31 days of the date of the Qualifying Event.

A. Retroactive terminations are processed due to late notification of a Qualifying Event if the member does not wish to continue with the SEHP (termination, death, retirement, Leave Without Pay, change to an ineligible position, or non-payment of premium). Failure of the NSE to notify the SEHP by entering a Termination Request in MAP within 31 days of the Qualifying Event will cause the termination effective date to be the last day of the month before the month the request was submitted. Late notification could result in the assessment of a fee of $250.00 per member per month for every month the request is not entered in MAP. The SEHP will notify the NSE of the penalty amounts due.
B. Example: An employee terminates employment on April 19, 2xxx but the NSE does not enter the termination request in MAP until October 18, 2xxx. The NSE is responsible for the assessment fee of $250.00 per month from May through October.
C. If the SEHP does not receive timely notification of termination of employee, spouse, or dependent benefits and the employee, spouse, or dependent is eligible for and wishes to continue SEHP coverage under the Direct Bill program, retroactive enrollment may be allowed. The enrollment in the Direct Bill program will be made effective the first of the month after the last day worked.

RETROACTIVE ENROLLMENT and ADDITIONS

A. After 60 days have passed from the effective date of coverage, retroactive additions to coverage may be made on any medical, prescription drug, and dental plan if a Communication Form is submitted in MAP and approved by the SEHP. Retroactive vision enrollment is not allowed.
B. Failure of the NSE to notify the SEHP of enrollment or addition by entering a request in MAP within 31 days of the Qualifying Event could result in the assessment of a fee of $250.00 per member per month for every month the request is not entered in MAP. The SEHP will notify the NSE of the penalty amounts due.

ENROLLMENT CHANGES DUE TO INELIGIBLE SPOUSE or DEPENDENT CHILDREN

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

TERMINATION OF COVERAGE

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

EMPLOYEE TERMINATION

A. All SEHP coverage will terminate on the last day of the month in which an employee terminates employment, except those:
    i. Employees that terminate employment on the 1st day of the month. Coverage will end on the 1st day of the month.
B. Employees whose spouse is also employed by the SOK or NSE and has enrolled the former employee as a dependent; or
C. Employees who are eligible to continue upon cessation of active employment:
    i. Employees suspended under the NSE's guidelines.
    ii. Employees granted Leave Without Pay under a policy established by the appointing authority in which the employee has a definite appointment or commitment to return to NSE service. For sickness or disability, an employee may still be considered employed by the NSE for the full period of such leave, but not exceeding a maximum of 1 year.
    iii. Individuals who are eligible to continue coverage because of retirement from the NSE or others as indicated by K.A.R. 108-1-1.
D. Due to the change to coverage being effective on the first day of work.
E. When an employee terminates within their election period which is the first 31 days after reporting to work. K.A.R. 108-1-1 states that each eligible employee "shall become eligible for enrollment in the health care benefits program on the first day of work for the NSE. Each person shall have 31 days after becoming eligible to elect coverage." When an employee terminates in their election period, the NSE will need to reach out to the former employee and advise them of their right to enroll in the health plan and for them to make their coverage elections. They will have 31 days from their first day of work to make their coverage elections. The same coverage and termination rules apply. The SEHP coverage will terminate on the last day of the month in which they terminate employment. If they terminate employment on the 1st day of the month, all coverage will terminate that day.
F. The former employee will be responsible for paying for the coverage elected. If the member elect's coverage exceeds the funds available from their paycheck or if they are making elections after they have been paid all funds due to them, they will need to remit payment to the NSE for the amounts due.

G. If the terminating employee is Medicare eligible for any reason, (age 65, disabled, etc.), the NSE must provide them with a Memo for Medicare Part B coverage, on the NSE's letterhead. This Memo is for the employee to provide to the Social Security Administration to allow them to apply for Medicare without incurring any penalties. The memo should be provided to the employee upon their termination or mailed to the employee's address in MAP.

OTHER ELIGIBLE INDIVIDUAL'S TERMINATION

A. SEHP coverage for other eligible individuals terminates on the earliest of the following dates:
   - When the group policy terminates
   - The last day of the month on which the employee terminates employment; or
   - The last day of the month in which the individual ceases to be an eligible spouse or dependent under the SEHP's definition of an eligible spouse or dependent.

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

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

BILLING AND PAYMENT

A. BILLING AND PAYMENT FOR PARTICIPATING NONSTATE EMPLOYER GROUPS
   - The SEHP will post the billing statement to participating NonState Employer Groups around the 23rd of the month before the coverage period. NonState Employer Groups pay by bank draft on the 8th of the month or have the option to sign up for automatic draft payments that would occur every month.
   - The billing cycle ends on the 23rd day of each month. Payment is due by the 15th of the month for that month's coverage period. Any payments received on or after this date are considered late.
   - The billing statement includes a detailed list of covered members, their enrollment coverage level, and the amount due for coverage as of the 23rd day of the previous month. The NSE

group must pay the total amount invoiced each month to prevent late payment penalties. The NSE Group should not change the amount paid and pay what they feel is correct. If the NSE Group pays less than the amount billed, they will be assessed the late payment penalty on the next month's billing cycle. **THE NONSTATE EMPLOYER GROUP MUST ENSURE THAT ANY CHANGES FOR EMPLOYEES' COVERAGE ARE SUBMITTED VIA MAP.**

HIPAA - HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT (HIPAA)

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

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

SPECIAL ENROLLMENTS

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

B. Some examples where special enrollments may apply are:
    1. Loss of eligibility under a plan due to termination of dependent status (e.g., a child aging out of dependent coverage).
    2. A plan ceasing to offer any benefits for a class of similarly situated individuals (e.g., all part-time workers); and 3) an employer of another plan stops premium contributions toward other coverage, even if the individual continues the other coverage by paying the amount that was previously paid by the employer.

NON-DISCRIMINATION REQUIREMENTS

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

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 protections to patients who choose to have breast reconstruction in connection with a mastectomy.
- Mental Health Parity and Addiction Equity Act (MHPAEA) which generally prevents group health plans (and health insurance issuers) that provide mental health or substance use disorder (MH/SUD) benefits from imposing less favorable benefit limitations on those benefits than on medical/surgical benefits offered under the plan.
- Newborns' and Mothers' Health Protection Act (NMHPA) which affects the amount of time the member or beneficiary and newborn child are covered for a hospital stay following childbirth. For the mother or newborn child, that includes no restriction to less than 48 hours following a normal vaginal delivery or less than 96 hours following a cesarean section. Nor is it required that a hospital obtain authorization from the medical plan for prescribing a length of stay not more than the above periods,
- The Genetic Information Nondiscrimination Act of 2008 generally prohibits discrimination based on genetic information as well as the release of a member’s genetic information.

PLAN DISCLOSURE REQUIREMENTS

A. Under the Department of Labor’s (DOL) rules governing plan disclosure requirements, group health plans must improve the Summary Plan Descriptions (SPD)and Summaries of Material Modifications (SMM) in the following ways:
    1. Notify members and beneficiaries of any material reductions in covered services or benefits within 60 days of adoption of the change.
    2. Disclose information about the role of insurance companies and health plans for the group health plan, specifically the name and address, and to what extent benefits under the plan are under a contract, and the administrative services, such as paying claims.

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

PLAN MEMBERS RIGHTS

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

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

HIPAA ADMINISTRATIVE SIMPLIFICATION

A. 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

A. The Privacy Rule (effective April 14, 2003) establishes national standards to protect individuals' medical records and other Personal Health Information (PHI) and applies it to health plans, healthcare clearinghouses, and those healthcare providers (“covered entities”) that conduct certain health care transactions electronically. Under the Privacy Rule, the ways that the individual’s PHI can be used are limited and specified. The Rule and accompanying regulations apply to PHI, whether it is on paper, on computers, or communicated orally. Key provisions of these standards include:
    a. Access to medical records.
    b. Notice of privacy practices.
    c. Limits on the use of personal medical information.
    d. Prohibition on marketing, and stronger state laws.
    e. Confidential communications; and

f. Where to file complaints.

SECURITY REGULATIONS

A. 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).
   1. Within HHS, the Office for Civil Rights (OCR) has responsibility for enforcing the Privacy and Security Rules with voluntary compliance activities and civil money penalties.

B. SPECIAL NOTES
   1. At times it may be necessary to obtain information regarding a member's protected health information. SEHP will request that the member complete an Authorization for Release of Protected Health Information form.
   2. Members may complete an Appointment of Personal Representative Form and submit it to the SEHP to allow another individual to discuss and act on behalf of that member regarding their coverage under the SEHP. Without this form, the SEHP will not discuss anything or act upon any requests from any individual other than the member regarding a member's SEHP coverage.
      i. If a member currently has a Personal Representative Form on file with the SEHP and no longer wishes to have that individual act on behalf of a member, the member must submit a Revocation of Personal Representative Form to the SEHP.

CONTINUATION OF COVERAGE – DIRECT BILL PROGRAM

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

MEMBERS ELIGIBLE TO CONTINUE IN THE DIRECT BILL PROGRAM

A. Eligible members may continue coverage through the SEHP after they retire from the participating NonState Employer Group. Coverage will continue in the SEHP for as long as the participating NSE is covered under the Plan. If the NSE elects to terminate coverage in the SEHP, the Direct Bill members from that NSE will be terminated as well. It is the responsibility of the NSE to contact its Direct Bill members when the NSE terminates its contract with the SEHP.

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

a. Any retired school district employee who is eligible to receive retirement benefits,
b. Any disabled former school district employee who is receiving benefits under K.S.A. 74-4927 and amendments thereto,
c. Any surviving spouse or dependent of a qualifying member in the school district plan

C. Any person who is a school district employee and who is on approved Leave Without Pay following the practices of the qualified school district,
D. Any individual who was covered by the health care plan offered by the qualified school district on the day immediately before the first day on which the qualified school district participates in the school district plan, except that no individual who is an employee of the qualified school district and who does not meet the definition of a school district employee in K.A.R. 108-1-3
E. Any retired local unit employee who meets one of the following conditions:
    a. The employee is eligible to receive retirement benefits under the Kansas Public Employees Retirement System (KPERS) or the Kansas Police and Firemen's Retirement System (KP&F), the employee is eligible to receive retirement benefits under the retirement plan provided by the qualified local unit.
    b. If the qualified local unit is not a participating employer under KPERS or KP&F, the employee is eligible to receive retirement benefits under the retirement plan provided by the qualified local unit.
F. Any disabled former local unit employee who meets one of the following conditions:
    a. The employee is receiving benefits under KPERS or KP&F or
    b. If the qualified local unit is not a participating employer under either KPERS or KP&F.
G. Any surviving spouse or dependent of a qualifying member in the qualified local unit plan.
H. Any person who is a school district employee and who is on approved Leave Without Pay (LWOP).
I. Any individual who was covered by the health care plan offered by the qualified local on the day immediately before the first day on which the qualified local unit participates in the school district plan, except that no individual who is an employee of the qualified local unit and who does not meet the definition of school district employee in K.A.R. 108-1-4.

CONDITIONS FOR DIRECT BILL MEMBERS

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

A. The person was covered by the qualified school district plan or health care insurance plan offered by the qualified school district on one of the following:

- The person was covered as an active member, as a COBRA member, or as a spouse immediately before the date that person ceased to be eligible for that type of coverage with the qualified school district or for any person identified in paragraph E above immediately before the first day on which the qualified school districts participates in the SEHP.
- The person is a surviving spouse or eligible dependent child of a person who was enrolled as an active or a Direct Bill member and the person was enrolled in the health care benefits program as a dependent when the primary member passed away.
- The person is a surviving spouse or dependent of a primary member who was enrolled under the health care insurance plan offered by the member's qualified school district when the member passed away, and the person has maintained continuous coverage under the qualified school district's health care insurance plan before joining the health care benefits program.
- The person contacts the NSE to submit a request in MAP to transfer to the Direct Bill program. The request must be submitted no more than 30 days after the person ceased to be eligible for coverage, or in the case of any individual identified in paragraph E above, no more than 30 days after the first day on which the qualified school district participates in the SEHP.

B. The person was covered by the qualified local unit plan or the health care insurance plan offered by the qualified local unit on one of the following:

- The person was covered as an active member, as a COBRA member, or as a spouse immediately before the date that person ceased to be eligible for coverage with the qualified local unit or for any person identified in paragraph J above, immediately before the first day on which the qualified local unit participates in the SEHP.
- The person is a surviving spouse or eligible dependent child of a person who was enrolled as an active member, or a direct bill member, and the person was enrolled in the health care benefits program as a dependent when the primary member passed away.
- The person is a surviving spouse or dependent of a primary member who was enrolled under the health care insurance plan offered by the member's qualified local unit when the member passed away, and the person has maintained continuous coverage under the qualified local unit's health care insurance plan before joining the health care benefits program.

- The person contacts the NSE to submit a request in MAP to transfer to the Direct Bill program. The request must be submitted no more than 30 days after the person ceased to be eligible for coverage, and no more than 30 days after the first day on which the qualified local unit participates in the SEHP.
- Member Only Coverage For all employees, Direct Bill coverage will begin the 1st day of the month following their last day worked.

Member and Spouse Coverage

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

- The member can enroll in COBRA coverage, since COBRA premiums are cheaper, for 18 months. When COBRA coverage terminates the member can enroll in the Direct Bill program. The spouse, who is Medicare eligible, would need to enroll in coverage in the Private Market. Once the member enrolls in the Direct Bill program the spouse can come on the Direct Bill program at the next Open Enrollment period.
- If the member is Medicare eligible but the spouse is not eligible for Medicare, below are their options. Members can enroll in the Direct Bill program and elect one of the Medicare options the state offers. The spouse can go on COBRA coverage for 18 months and then enroll in Direct Bill once COBRA terminates.
- If both member and spouse are Medicare eligible, they can enroll in the Direct Bill program. They would both be enrolled under their own name and ID numbers and be able to elect separate coverage. For the spouse to be eligible for Direct Bill coverage the member would need to continue with the coverage. The only time the spouse is eligible to continue by themselves is as a Surviving Spouse.

PAYMENT METHOD UNDER THE DIRECT BILL PROGRAM

Members who are eligible to continue coverage under the SEHP must pay their premiums by bank draft (ACH).

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

For additional information on the Direct Bill program, call 1-866-541-7100.

RETIREMENT, SEHP BENEFITS, AND MEDICARE ELIGIBILITY

A. RETIREMENT
    a. When an employee retires, the employee needs to:
    b. Notify their NSE of their date of retirement 60 days before the effective date.
    c. Decide if they want to continue with the SEHP coverage after retirement.

NOTE: Retirement is considered a termination of employment and therefore makes the primary member and their covered dependents eligible to continue their SEHP coverage under COBRA. The primary member and their covered dependents will automatically receive a COBRA Qualifying Event notice from the SEHP COBRA administrator.

B. The primary member and their dependents may choose to continue their coverage under either the SEHP Direct Bill program or COBRA.
C. If Medicare eligible, the primary member must be enrolled in both Medicare Part A and Part B. If the member is enrolled only in Part A, the member must obtain from their NSE HR to take to their local Social Security office to enroll in Medicare Part B.
D. If the member is electing one of the Kansas Senior Plans, they must indicate if they wish to maintain the SEHP drug coverage. If the member does not keep the SEHP drug coverage, they need to obtain (a Sample NSE Medicare Part B Memo) from their NSE HR that indicates they have had creditable drug coverage before retirement.
E. Decide if they want to maintain the SEHP dental coverage. If the member elects to opt out of dental coverage at retirement, they cannot re-enroll in SEHP dental coverage later.
F. If the employee had waived dental coverage as an active member, dental will not be an option when they first retire. At the next Open Enrollment period, they can add dental coverage. If they do not choose to enroll in dental at that time, they will not be able to enroll in dental later.
G. If medical coverage is dropped, dental and/or vision coverage can continue.
H. Include a copy of all applicable Medicare cards or a letter from Social Security indicating their Medicare number and effective dates for Medicare Part A and B. Enrollment in the Direct Bill program cannot be completed without the Medicare information.
I. Provide appropriate dependent documentation for any dependents to be included on their coverage if dependent documentation has not previously been submitted to the SEHP.

When an employee retires, the NSE needs to:

1. Ask the employee if they want to continue their SEHP coverage under the SEHP Direct Bill program or through COBRA coverage. If the employee wants to continue their SEHP under the SEHP Direct Bill program, please continue as set forth below.
2. Ask the employee if they or any covered spouse or dependent is Medicare eligible now or will be at the time of enrollment.
3. If needed, provide the employee with a Direct Bill Enrollment booklet, and charts including Medicare plan options if applicable.
4. SEHP will open either a Medicare or non-Medicare enrollment portal for the member to make their elections for Direct Bill coverage.
5. Indicate in the note section of the online Change Request if the primary member is eligible for split coverage (See Split Enrollment section below).

REMINDERS:

- NOTE: As of January 21, 2001, a person will not be eligible for Direct Bill coverage if they do not maintain continuous coverage with the SEHP. This is by K.A.R. 108-1-3 and K.A.R. 108-1-4. If there is a break between the last day worked and the effective date of Direct Bill coverage, members can elect COBRA for that time to maintain continuous coverage.
- Members must have continuous coverage under the SEHP to be eligible for the Direct Bill program. If continued coverage is desired, the Retirement request in MAP must be completed 60 days before the employee's retirement to ensure continuous coverage between active employee coverage and Direct Bill coverage.
- The employee may change their medical plan at the time of retirement. Dependents may be dropped from coverage upon retirement; however, dependents may only be added to coverage mid-year with a Qualifying Event. Dependents may also be added to coverage during the next Open Enrollment period.
- The effective date for the Direct Bill program for members will be the 1st day of the month following the employee's last day worked.

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

If the employee or covered spouse/dependent is Medicare eligible when the employee retires, they must have applied for Medicare Part A and Part B or will need to apply for such coverage. The Social Security Administration requires that the NSE provide retiring employees a memo or letter with health insurance

information necessary to process the application for Medicare Part B coverage. When applying for Medicare Part B, the NSE needs to complete for the employee to present to their local Social Security Office. Please note the letter or memo should be on the NSE's letterhead.

Required information in the memo or letter is:

- Statement that the employee is covered under the SEHP,
- Date employment began,
- Date employment ends,
- Date coverage began,
- Date coverage ended or will end,
- Spouse's name if the spouse is covered by the SEHP.

SPLIT ENROLLMENT

Split Enrollment is required for the following situations:

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

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

- Aetna Freedom PPO with Aetna Standard Part D prescription drug coverage
- Aetna Elite PPO with Aetna Standard Part D prescription drug coverage
- Kansas Senior Plan C with or without SilverScript Part D – Premier or Economy prescription drug coverage
- Kansas Senior Plan C Select with or without SilverScript Part D - Premier or Economy prescription drug coverage.
- Kansas Senior Plan G with or without SilverScript Part D - Premier or Economy prescription drug coverage
- Kansas Senior Plan G Select with or without SilverScript Part D – Premier or Economy prescription drug coverage.
- Kansas Senior Plan N with or without SilverScript Part D – Premier or Economy prescription drug coverage

NOTE: The Kansas Senior Plans listed above can also waive SEHP Part D coverage and enroll in a Part D plan on the private market.

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

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

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

Retiree information can be found on the SEHP website.

DEATH OF PRIMARY DIRECT BILL MEMBER WITH DEPENDENT CHILDREN

In the event of the death of a primary Direct Bill member who had only a dependent child(ren) enrolled under their coverage, the surviving dependent child(ren) may elect to continue coverage under the SEHP Direct Bill program until they no longer meet the definition of an eligible dependent (i.e., the child reaches the limiting age of 26).

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

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

PREMIUM REFUNDS DUE TO DIRECT MEMBER'S DEATH – IMPORTANT

The primary member enrolled in the Direct Bill program, or a primary member's authorized representative is responsible for notifying the SEHP in writing within 31 days of a change in family status, including 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 recovery is limited to the following:

- If the SEHP is notified after 31 days but within the first 6 months of a death, the member will be eligible to receive a premium refund equal to 95% of the actual monthly premium paid by the member.
- If the SEHP is notified after 6 months but before 12 months of a member, spouse, or dependent's death, the member is eligible to receive a premium refund equal to 95% of the actual monthly premium paid by the member for the first 6 months, plus a premium refund of 50% of the actual monthly premium paid by the member for months 7, 8, 9, 10, 11 and 12. (Example: If a member's monthly premium payment is $200.00 per month and the SEHP is notified in writing in the 8th month after death, the member would receive a premium refund of 95% of the actual monthly premium paid by the member for the first 6 months and a premium refund of 50% of the actual monthly premium paid by the member for months 7 and 8 for a total refund of $1,340.00)
- If the SEHP is notified after the 12th month of a member, spouse, or dependent's death, the member will not be eligible for any premium refund.

COBRA COVERAGE

A. COBRA Coverage
    a. The federal Consolidated Omnibus Budget Reconciliation Act (COBRA) law was enacted in 1986. The law requires that most employers sponsoring Group Health Insurance Plans offer employees and their covered family members the opportunity for a temporary extension of health coverage at group rates in certain instances where coverage under the plan would otherwise end.
    b. Employees, spouses, and dependents who lose insurance coverage under the SEHP can elect to continue coverage by paying the required premiums. If a retiree has chosen COBRA over the SEHP Direct Bill coverage and COBRA runs out, the retiree may enroll in Direct Bill coverage.
    c. COBRA coverage is administered through the SEHP's third-party COBRA administrator.

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

B. HEALTH COVERAGE TO BE CONTINUED

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

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

C. COBRA QUALIFYING EVENT PROCEDURES

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

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

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

D. If the Qualifying Event is due to the:

- Death of covered employee (active employee and Direct Bill).
- Divorce from covered employee (active employee and Direct Bill).
- Covered employee choosing Medicare as primary carrier leaving dependents without health insurance coverage (active employees only), or

- Ceases to meet the SEHP's definition of eligible dependent, i.e., turns age 26 (active employee & Direct Bill):
    - The Qualified Beneficiary must notify the third-party COBRA administrator within 60 days of the Qualifying Event. If notice is not received within 60 days of the Qualifying Event, the Qualified Beneficiary will not be eligible for COBRA coverage. Because of this time limit, the completed Change Request must be entered into MAP as soon as possible.
    - An election by a covered employee or spouse to continue coverage will be deemed to be an election for coverage by any other Qualified Beneficiary. However, each Qualified Beneficiary has an individual right to elect COBRA coverage. Each Qualified Beneficiary may make a separate selection among the levels of coverage available.

E. TERMINATION OF COBRA COVERAGE

a. Non-payment or untimely payment of premiums
b. The employee or their dependent(s) become(s) covered, either as an employee or dependent, under another employer-provided medical plan
c. The employee or enrolled dependent(s) becomes eligible for Medicare. Termination includes all medical, prescription, dental, vision, and voluntary benefits coverage. However, if Medicare eligibility is due to ESRD, the individual may continue COBRA.
d. The State of Kansas no longer offers group health insurance to its employees.

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.

F. ADMINISTRATION

a. All SEHP active benefits will terminate the last day of the month in which the employee's COBRA Qualifying Event occurs unless the qualifying event occurs on the 1st day of the month, then benefits terminate on the 1st day of the month.
b. For all terminations, COBRA notices are generated by the SEHP's third-party COBRA administrator. COBRA notices are generated from the Termination requests entered in MAP by the NSE. If the Termination request is not entered into MAP, the member does not receive a COBRA notice. Prompt submission of requests is important.

c. COBRA coverage is not automatic. The member must complete the COBRA election form that accompanies the COBRA notification sent by the third-party COBRA administrator if they want to enroll in COBRA coverage. The member has 60 days from the date of the notice to return the COBRA election form to the third-party COBRA administrator.
d. If the member elects COBRA, COBRA coverage will begin the day after active SEHP coverage terminates.
e. COBRA notices are sent to the member at the last address in MAP. Therefore, it is very important at the time of termination that the correct address appears in MAP. Former employees should be reminded to update their mailing address information or leave forwarding instructions with the Postal Service if they change addresses.

G. COST OF BENEFITS - COBRA RATES

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

NOTE: COBRA premiums are billed monthly. For example:

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

For the current Plan Year COBRA rates:

APPEALS FOR EXCEPTION DUE TO NSE ERROR

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

Most policies use event date, date complete, and date received by the SEHP as the determining dates for timely notification. It is the responsibility of the NSE to ensure that appropriate requests are correctly completed, and the appropriate documentation is uploaded in MAP within the applicable timeframe.

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

A. Submit a Communication Form via MAP, appealing the denial or restriction that was due to NSE error. The Communication Form must include:
   - The name of the employee in question
   - Upload copies of documentation and other information provided by the employee.
   - The nature of the error; and
   - Any steps the NSE has taken to prevent a reoccurrence of the error.
   - A Communication Form is required for each employee. Acknowledgment of NSE error does not provide a blanket exception for all similar circumstances.
   - The appeal must be made by the NSE within 10 days following notification of a denial.
B. If the SEHP approves the appeal, the NSE may be fined up to $1,000 per incident.

FLEXIBLE SPENDING ACCOUNT PROGRAM

NonState Employer Groups that have opted to include Flexible Spending Accounts in their benefits offerings to employees.

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

FLEXIBLE SPENDING ACCOUNT OPTIONS

A. Health Care Flexible Spending Account (HC FSA) – allows participants to pay for qualified health expenses that are not otherwise reimbursable under the health plan, on a pre-tax basis. Eligible expenses are determined by IRS publication 502.
B. Dependent Care Flexible Spending Account (DC FSA) – allows participants to pay for qualified work-related daycare expenses on a pre-tax basis. Qualified DCARE FSA expenses are determined by Section 129 of the IRS.

C. Limited Purpose Flexible Spending Account (LP FSA) – allows participants to pay for qualified dental and vision expenses on a pre-tax basis. Qualified LP FSA expenses are determined by Section 129 of the IRS.
D. Mass Transit Flexible Spending Account – allows for reimbursement of qualified mass transit tickets or passes, or State of Kansas Vanpools.
E. Parking Flexible Spending Account – allows for reimbursement for parking associated with your daily commute to and from work.

TAX SAVINGS

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

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

EFFECTIVE DATE

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

CARRYOVER PROVISION

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

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

A. HC FSA to HC FSA – When carrying over funds from an HC FSA from the previous plan year to an HC FSA in the new plan year the carryover funds will be available immediately to reimburse claims incurred in

both the previous and new plan year. Claims with dates of service from the previous plan year can still be submitted for reimbursement during the run-out period, which is 120 days after the end of the plan year. Claims incurred during the new plan year will first be paid from any new plan year elections (if any) before being paid from any available Carryover funds.

B. HC FSA to LP FSA – When carrying over funds from an HC FSA to an LP FSA funds in the HC FSA as of the end of the previous plan year can reimburse expenses for previous plan years' medical, dental, and vision expenses until the end of the plan run-out period. The remaining funds from the previous year's HC FSA funds will not carry over to the new plan year until the run-out period has ended. At this time the funds from the Carryover may only be used for dental or vision expenses. Any dental or vision expenses incurred during the new plan year can be reimbursed immediately from the elected LP FSA or from the carryover when funds are available.

C. LP FSA to LP FSA – When carrying over funds from an LP FSA from the previous plan year to an LP FSA in the new plan year the carryover funds will be available immediately to reimburse claims incurred in both the previous and new plan years. Claims with dates of service from the previous plan year can still be submitted for reimbursement during the run-out period, which is 120 days after the end of the plan year. Claims incurred during the new plan year will first be paid from any new plan year elections (if any) before being paid from any available Carryover funds.

D. LP FSA to HC FSA – When carrying over funds from an LP FSA from the previous plan year to an HC FSA in the new plan year the carryover funds will be available immediately to reimburse claims incurred in both the previous and new plan years. Claims with dates of service from the previous plan year can still be submitted for reimbursement during the run-out period, which is 120 days after the end of the plan year. Claims incurred during the new plan year will first be paid from any new plan year elections (if any) before being paid from any available Carryover funds.

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

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

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

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

HEALTH SAVINGS ACCOUNT (HSA)

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

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

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

Members electing Plan C must make a minimum contribution of $50 per month, to receive the quarterly employer contributions. Members electing Plan N do not have a minimum per paycheck contribution, due to a reduced employer contribution. The HSA will be effective the 1st day of the month following the medical benefit effective date unless medical benefits are effective on the 1st.

The HSA employer contribution is made monthly. The HSA employer contribution amount is based on:

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

- The medical plan the member is enrolled in on the 1st day of each quarter.

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

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

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

HEALTH REIMBURSEMENT ACCOUNT (HRA)

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

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

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

This pertains to NonState Employer Groups that have opted to include Flexible Spending Accounts in their benefits offerings to employees.

A Limited Purpose (Limited Scope) FSA is an option for members who are enrolled in Plan C or Plan N with a Health Savings Account (HSA). The LP FSA works the same way a standard FSA does: pre-tax, “use it or lose it” elections, and expenses must occur within the plan year. The difference is that it limits what expenses are

eligible for reimbursement. With an LP FSA members can only submit claims for eligible dental and vision expenses, including:

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

FSA PARTICIPANTS: QUALIFIED RESERVIST DISTRIBUTIONS

NonState Employer Groups that have opted to include Flexible Spending Accounts in their benefits offerings to employees.

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

- The individual must be a “reservist”, as defined in 37 U.S.C. 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 the US
- Air Force Reserve

  Coast Guard Reserve
- Reserve Corps of the Public Health Service
- The participant is called to active duty for a period of 180 days or more or 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).

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

ACRONYM GLOSSARY

ACH – Automated Clearinghouse Network CHIP –Children's Health Insurance Program COBRA –Consolidated Omnibus Budget Reconciliation Act DOB – Date of Birth DOL – United States Government Department of Labor ESRD – End-Stage Renal Disease FMLA – Family Medical Leave Act FSA – Flexible Spending Account HC FSA – Health Care Flexible Spending Account HICN – Health Insurance Claim Number HIPAA – Health Insurance Portability and Accountability Act HCC – Health Care Commission HRA – Health Reimbursement Account HSA – Health Savings Account ID Cards – Identification Cards IRS – United States Government Internal Revenue Service ITIN – Individual Tax Identification Number K.A.R. – Kansas Administrative Regulation KPERS – Kansas Public Employees Retirement System KP&F – Kansas Police and Firemen's Retirement System K.S.A. – Kansas Statute Annotated LP FSA – Limited Purpose Flexible Spending Account LWOP – Leave Without Pay	MAP – Membership Administration Portal MHPAEA - Mental Health Parity and Addiction Equity Act MSP – Medicare Secondary Payer NMHPA - Newborns' and Mothers' Health Protection Act NSE – NonState Employer Group PPO – Preferred Provider Organization QHDHP – Qualified High Deductible Health Plan QMCSO – Qualified Medical Child Support Order SEHP – State Employee Health Plan SOK – State of Kansas SSN – Social Security Number TIN – Taxpayer's Identification Number TEFRA – Tax Equity and Fiscal Responsibility Act TPA – Third Party Administrator TTD – Temporary Total Disability USERRA – Uniformed Services Employment and Reemployment Rights Act WHCRA - Women's Health and Cancer Rights Act