Retiree User Guide

State Employee Health Plan

State Member Benefit Guidebook for

- Retirees

Kansas
Department of Administration
State Employee Health Plan

updated: Aug. 26, 2025

GENERAL HEALTH PLAN INFORMATION

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

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

Medical plan administrators include Aetna and Blue Cross Blue Shield of Kansas. CVS Caremark provides prescription coverage, Delta Dental provides dental coverage, and Surency provides voluntary prescription eyewear coverage.

SilverScript Rx coverage is available for Medicare Retirees.

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

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

IMPORTANT NOTE:

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

ANNUAL OPEN ENROLLMENT

Open Enrollment information will be posted on the SEHP website during the annual Open Enrollment period, October 15 - November 14. Members can elect, change, or waive benefits; add or drop a spouse or child(ren) from coverage. Elections made during Open Enrollment will be effective January 1 of the following plan year. If retirees do not wish to make any changes in their benefits, they do not need to submit elections, unless there is a vendor change for the following plan year.

NOTES:

PRE EXISTING CONDITIONS

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

REVISED OPEN ENROLLMENT ELECTIONS

A primary member may change their Open Enrollment elections anytime during the Open Enrollment period. Following the end of the Open Enrollment period, revised enrollment election requests in MAP will be accepted only if the primary member has a Qualifying Event or a 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.

SEHP will deny Change Requests submitted in MAP without the appropriate supporting documentation.

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.

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.

BENEFIT DESCRIPTIONS, CERTIFICATES, and BOOKLETS

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

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

PROVIDER LISTINGS

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

DIRECT BILL PROGRAM

Retirees will receive both information on the SEHP Direct Bill Program and a COBRA notice as required by law, when they terminate active employee benefits upon retirement. Active retirees should choose only one of these options to continue their coverage.

I. MEMBERS ELIGIBLE TO CONTINUE IN THE DIRECT BILL PROGRAM

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

A. Any former elected state official

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

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

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

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

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

CONDITIONS FOR DIRECT BILL MEMBERS

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

- The person was covered by the SEHP program on one of the following bases:
- The person was covered as an active member, as a COBRA member, or as a spouse immediately before the date that person ceased to be eligible for that type of coverage or when the individual became newly eligible for a class listed above.
- The person is a surviving spouse or eligible dependent of a person who was enrolled as an active or a Direct Bill member. The person was enrolled in the health care benefits program as a dependent when the primary member passed away.
- The agency must submit a request in MAP indicating that the member is retiring and wishes to continue with Direct Bill coverage. Active coverage will end on the last day of the month, in which an employee terminates employment, and Direct Bill coverage will begin on the first of the following month. If the member retires on the 1st day of the month, active benefits will terminate on the 1st, and Direct Bill will be effective on the 2nd.

MEMBER ONLY COVERAGE

I. Direct Bill coverage will begin on the first day of the month following the employees' last day of work, unless the termination occurs on the first day, in which case Direct Bill will be effective on the second day.

MEMBER AND SPOUSE COVERAGE OPTIONS

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

PAYMENT METHOD UNDER THE DIRECT BILL PROGRAM

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

II. RETIREMENT, SEHP BENEFITS, AND MEDICARE ELIGIBILITY

A. RETIREMENT:

When an employee retires, the employee needs to:

1. Notify their agency of their retirement date approximately 60 days before the retirement effective date.
2. Decide if they want to continue with the SEHP coverage or COBRA upon retirement.
3. If Medicare eligible, the primary member must be enrolled in Medicare Part A and Part B to enroll in a Medicare Direct Bill. If the member is enrolled only in Part A, the member must obtain from their agency a Medicare Part B memo (forms in MAP) to take to their local Social Security office to enroll in Medicare Part B.
4. If the member is electing one of the Kansas Senior Plans, they must indicate if they want to maintain the SEHP drug coverage. If the member does not keep the SEHP drug coverage, they need to obtain an Agency Medicare Memo Part B from their agency HR that indicates they have had creditable drug coverage before retirement.
5. Decide if they want to maintain SEHP dental coverage. If the member elects to opt out of dental coverage at retirement, they cannot re-enroll in it later.
6. If the employee waived dental coverage as an active member, dental coverage will not be an option when they retire. Members will not be able to enroll in dental coverage as retirees.
7. If medical coverage is dropped, dental and/or vision coverage can continue. The employee may drop medical coverage and still have dental and/or vision coverage. It is important to note that if medical or dental is dropped, they cannot add either later.
8. Upload a copy of all applicable Medicare cards or a letter from Social Security indicating their Medicare number and effective dates for Medicare Part A and B. Enrollment in the Medicare Direct Bill program cannot be completed without the Medicare information.
9. If dependent documentation has not previously been submitted to the SEHP, provide appropriate dependent documentation for any dependents to be included in their coverage.
10. If the Member does not elect Direct Bill nor COBRA, they cannot return to State coverage later.

NOTE: Retirement is considered a termination of employment, making the primary member and their covered dependents eligible to continue coverage under COBRA. The SEHP COBRA administrator will automatically send a COBRA Qualifying Event notice to the primary member and their dependents. The primary members and their dependents may continue their coverage under either the SEHP Direct Bill program or COBRA, but not both.

NOTE: If the retiree does not take Direct Bill or COBRA, they will NOT be able to return to State coverage later. Medical, dental, vision, and pharmacy Part D can only be waived/removed at open enrollment. If canceled at any other time of the year, all benefits will be canceled, and they will not be able to return to state coverage later.

REMINDERS:

- As of January 21, 2001, a person will not be eligible for Direct Bill coverage if they do not maintain continuous coverage with SEHP. This is in accordance with K.A.R. 108-1-1. If there is a break between the last day worked and the effective date of Direct Bill coverage, members can elect COBRA to maintain continuous coverage.
- Members must have continuous coverage under the SEHP to be eligible for the Direct Bill program. If continued coverage is desired, the Retirement request in MAP must be completed approximately 60 days before the employee's retirement to ensure continuous coverage between active employee coverage and Direct Bill coverage.
- The employee may change their medical plan at the time of retirement. Dependents may be dropped from coverage upon retirement; however, dependents may 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 first day of the month following the last day of the month in which the employee terminated/retired from employment. Unless the member retires on the first day, then the effective date will be the second.

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

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

Required information in the memo or letter is:

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

Split Account is required for the following situations:

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

If the primary member does not enroll in Direct Bill coverage, the non-Medicare spouses and dependents will be offered COBRA coverage. They are not eligible for Direct Bill.

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

NOTE: If a member has Member Only Dental coverage at retirement, the split dependent will be given a one-time opportunity to enroll in their own Dental coverage at the next Open Enrollment period. 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 a dependent child(ren) enrolled under their coverage, the surviving dependent child(ren) will be offered the option to continue coverage under the SEHP Direct Bill program and will receive a COBRA notice, due to the loss of dependent coverage. If Direct Bill is continued, the benefits will remain the same.

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 children set up as dependents under that new primary member. Once the child(ren) reaches the limited age of 26, coverage will terminate.

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

MAP CHANGE REQUESTS

A qualifying event does not allow changes to plan or vendors. Only coverage level changes can be made mid-year. After initial enrollment, plan and vendor changes can only be made during Open Enrollment.

All requests must be legible and submitted with appropriate documentation in English.

I. COMPLETING A MAP CHANGE REQUEST

Prepare Before Completing a MAP Change Request and ensure the following information is available:

- Username and password for retiree access to the MAP website
- Date of the retiree's qualifying event
- State of Kansas Employee ID (assigned by the HR office as active employee)
- Required documentation (e.g., proof of dependent status)

B. RETIREE INFORMATION

Provide demographic details, including:

- Full name
- Physical address
- Contact telephone number
- SSN or ITIN (for non-resident aliens)
- Gender
- Date of birth
- Valid retiree email address
- Marital status

C. ENROLLMENT CHANGE

NOTE: If the retiree drops Dental coverage when enrolling in Direct Bill, they will not be allowed to re-enroll in Dental later.

D. DEPENDENT INFORMATION (ADD/DROP DEPENDENT)

All changes must be submitted within 31 days of the qualifying event. Steps:

- Select the appropriate action (Add/Drop).
- Upload supporting documentation for each spouse and/or dependent, and enter the dependents:
- Full name
- SSN or ITIN
- Gender
- Date of birth (MM/DD/YYYY)
- Provide the dependent's address if it is different from the employees.

- Select coverage changes for Medical, Dental, and Voluntary Prescription Eyewear Coverage

The SEHP and/or Plan Administrator/carrier may request additional documentation to verify the relationship or dependency.

E. MEDICARE

If the retiree, spouse, and/or any dependent is eligible for Medicare and will be covered under SEHP, the following information is required:

- Full name (first, middle initial, last)
- Hospital (Part A) effective date
- Medical (Part B) effective date
- Medicare Claim Number (HICN)

Upload copies of all relevant Medicare cards to MAP.

MID YEAR ENROLLMENT CHANGES

APPLIES TO NON-MEDICARE ONLY

Individuals may be added or dropped during the Plan Year if all the following conditions are met:

A. The change results from one of the qualifying events.

- B. The request is submitted by the member within 31 days of the qualifying event through MAP.
- C. The change is consistent with the qualifying event and complies with HIPAA and IRS regulations.
- D. Supporting documentation is written, legible, completed in English, and submitted within the required deadline (e.g., marriage certificate, divorce decree, custody agreement).

SUPPORTING DOCUMENTATION REQUIRED:

- Upload the following in MAP as applicable:
- Marriage license (in English) – for spouse and stepchild eligibility
- Birth certificate or hospital birth announcement (in English) – for dependent children; must include full name of parent(s)
- Petition for adoption or placement agreement (in English)
- Legal custody or guardianship document (in English, issued by the court)
- Court order (in English) – for non-biological, step, or adopted children
- Certificate of birth + Dependent Grandchild Affidavit + current year's Federal tax return – for grandchildren
- Application for Coverage of Permanent and Totally Disabled Dependent Child + tax return – for children aged 26+
- Federal tax return (current year) – to verify spouse eligibility; income info may be redacted
- Form 1040/1040A: pages 1 & 2 with names, signatures, and dates
- Form 8879 (e-file): with name, signatures, date filed
- Divorce decree with judge's signature and court date stamp
- Military ID and privilege card (front and back with expiration date) – for Tricare verification
- Loss of other group health coverage – letter/certificate with names, employer, and termination date
- Gain of other group health coverage – letter/certificate with plan name, dependents, and effective date

NOTE: Gaining CHIP or marketplace coverage is not a valid reason to remove dependents mid-year

- Passport or I-94 form – for dependents entering the U.S.
- Death certificate, obituary, or document approved by legal counsel

IMPORTANT: To add a dependent, you must have a valid SSN or ITIN. If not provided, a Communication Form explaining the reason must be submitted in MAP.

Vendor Changes: A qualifying event does not allow for a change in plan or vendor. Only coverage levels can be adjusted mid-year. Plan/vendor changes are allowed during Open Enrollment only.

II. EFFECTIVE DATE OF COVERAGE

- Mid-year changes take effect on the first day of the month following the qualifying event.
- If the event occurs on the first day of a month, coverage is effective that same day.
- In case of death on the first day of a month, coverage ends on the last day of that month.

SPECIAL SITUATIONS:

- Changes due to Medicare eligibility follow Medicare-specific effective date rules.
- Coverage effective dates for newborns, adopted children, new spouses/stepchildren, or changes in legal custody follow the standard rule above.

QUALIFYING EVENTS INCLUDE:

1. A. Marriage – Add/drop dependents if added to the new spouse's employer plan.
    i. For common law marriage, submit a notarized Affidavit of Common Law Marriage + one of the following showing joint ownership:
        1. Bank statement
        2. Lease agreement
        3. Homeowners insurance
        4. Credit card or mortgage statement
        5. Tax return with both retiree and spouse's name (current year)
        6. Auto loan or brokerage account
2. Final divorce – Upload court-stamped decree with judge's signature. All benefit coverage ex-spouse will be terminated on the last day of the month when the divorce is final.
3. Birth or adoption – Add all eligible dependents. May drop others only if newly eligible elsewhere.
4. Change in legal custody – Submit court-stamped order.
5. Employment status changes – Full time to part time or vice versa, becoming benefits ineligible; affecting benefits.
6. Employment changes – Termination or retirement. (Retirees may change medical plans.)
7. Death of employee – Surviving dependents may elect Direct Bill coverage.
8. Cancellation due to non-payment – SEHP coverage ends.
9. Spouse/dependent open enrollment changes – If the employer plan changes significantly.
10. Military duty – Gain or loss of eligibility for military coverage.
11. Loss of COBRA eligibility – Not due to non-payment.
12. Gain/loss of VA benefits – Triggers a qualifying event.
13. Dependent turns 26 – Coverage ends on the last day of that month.
14. Medicare eligibility changes – Gaining or losing eligibility may prompt a coverage change.
15. Death of a spouse or dependent
16. Dependent loses group health coverage – Submit certificate of coverage with termination date.
17. Dependent moves to the U.S. – Select "Other" and explain in MAP.
18. CHIP coverage loss – Dependents losing CHIP can be added to SEHP.

NOTE: Gaining CHIP or Marketplace coverage is not a valid event for removing dependents mid year

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HEALTHQUEST PROGRAM

NON-MEDICARE RETIREES ONLY

This applies to retirees and spouses enrolled in SEHP Plans A, C, J, or N.

HealthQuest is the health and wellness program for Retirees. Services are available to non-Medicare retirees at no additional cost. There are two main program areas:

1. **WELLNESS OFFERINGS**

- Virtual care program
- Face-to-face and telephone coaching services for Lifestyle, Tobacco Cessation, and Condition Management
- Weight management program
- Wellness Challenges

2. **WHO IS ELIGIBLE TO USE WELLNESS SERVICES?**

- Eligible State of Kansas and participating Non-State Retirees enrolled in the SEHP.
- Retirees' spouses who are enrolled in the medical portion of the SEHP.
- Retirees do not earn points towards a premium discount

The telephone number for the HealthQuest program is (785) 783-4080 or online at www.HealthQuest.ks.gov.

IMPORTANT - PREMIUM REFUNDS DUE TO DEATH OF RETIREE MEMBER, SPOUSE, OR DEPENDENT DEATH

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

- If the SEHP is notified after 31 days but within 24 months of the date of death of a primary member, spouse, or dependent, a maximum of 12 months of paid premiums will be fully refunded.
- If the SEHP is notified 24 months after the date of death of a primary member, spouse, or dependent, the primary member or their authorized representative will not be eligible for any premium refund.
- Example: If a primary member's monthly premium payment is $200.00 per month and the SEHP is notified in writing in the 8th month after death, the primary member or their authorized representative would receive a premium refund of eight months of the actual monthly premium paid on behalf of by the primary member for a total refund of $1,600.

A death certificate, obituary, or funeral notice is required to terminate coverage.

HIPAA

I. HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT (HIPAA)

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

- Limit exclusions for preexisting conditions prohibit discrimination against employees and dependents based on their health status; and
- Guarantee renewability and availability of health coverage to certain employees and individuals.

A. SPECIAL ENROLLMENTS

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

Some examples where special enrollment situations may apply are:

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

B. NON-DISCRIMINATION REQUIREMENTS

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

C. OTHER APPLICATIONS OF HIPAA LAW

HIPAA provisions also apply to services under the following laws:

1. Women's Health and Cancer Rights Act (WHCRA), which provides protection to patients who choose to have breast reconstruction in connection with a mastectomy.
2. Mental Health Parity and Addiction Equity Act (MHPAEA), which generally prevents group health plans (and health insurance issuers) that provide mental health or substance use disorder (MH/SUD) benefits from imposing less favorable benefit limitations on those benefits than on medical/surgical benefits offered under the plan.

3. Newborns and Mothers' Health Protection Act (NMHPA) affect how long the member or beneficiary, and the newborn child are covered for a hospital stay following childbirth. For the mother or newborn child includes no restriction to less than 48 hours following a normal vaginal delivery or less than 96 hours following a cesarean. Nor is it required that a hospital obtain authorization from the medical plan for prescribing a length of stay not more than the above periods.
4. The Genetic Information Nondiscrimination Act of 2008 generally prohibits discrimination based on genetic information and the release of a member's genetic information.

D. PLAN DISCLOSURE REQUIREMENTS

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

1. Notify members and beneficiaries of any material reductions in covered services or benefits within 60 days of the change being adopted.
2. Disclose information about the role of insurance companies and health plans concerning the group health plan, specifically the name and address, to what extent benefits under the plan are under a contract, and the administrative services, such as paying claims.
3. Inform members and beneficiaries which DOL office they can contact for assistance or information on their rights under HIPAA, including HITECH; and 4) Inform members and beneficiaries that federal law prohibits the plan and health insurance issuer from limiting hospital stays for childbirth to less than 48 hours for normal deliveries and 96 hours for cesareans.

E. PLAN MEMBERS' RIGHTS

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

Office for Civil Rights

U.S. Department of Health & Human Services 200 Independence Ave, SW

Rm 509F, HHH Bldg.

Washington, D.C.

II. HIPAA ADMINISTRATIVE SIMPLIFICATION

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

identifiers for providers, health plans, and employers. It also addresses the security and privacy of health data. Adopting these standards improves the efficiency and effectiveness of the nation's health care system by encouraging the widespread use of electronic data interchange in health care.

A. PRIVACY REGULATIONS

The Privacy Rule (effective April 14, 2003) establishes national standards to protect individuals' medical records and other Personal Health Information (PHI) and applies it to health plans, healthcare clearinghouses, and those healthcare providers ("covered entities") that conduct certain healthcare transactions electronically. Under the Privacy Rule, the ways the individual's PHI can be used are limited and specified. The Rule and accompanying regulations apply to PHI on paper, in computers, or communicated orally.

Key provisions of these standards include:

1. Access to medical records.
2. Notice of privacy practices.
3. Limits on the use of personal medical information.
4. Prohibition on marketing and stronger state laws.
5. Confidential communications; and
6. Where to file complaints.

B. SECURITY REGULATIONS

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

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

D. SPECIAL NOTES:

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

THINGS TO CONSIDER

- SEHP cannot make recommendations on the coverage you choose. For Kansas residents, you can contact Senior Health Insurance Counseling for Kansas (SHICK) at 1-800-860-5260.
- The insurance that SEHP provides can be used anywhere in the United States.
- SEHP should be contacted directly to update any personal contact information, such as address, phone, email, and personal representative information.
- When you retire, you cannot continue your HSA through SEHP. You must contact the account vendor to become an individual consumer.

- When entering your ACH/billing information into your SEHP Member Portal and the system needs an ACH start date, please use the date that your benefits are effective. Contact SEHP for assistance in setting up your billing.
- If you are Medicare eligible, a copy of your Medicare card should be presented to SEHP, either by uploading to the SEHP Member Portal or by contacting SEHP for assistance.
- If a retiree is hired in a benefits-eligible position through a state agency or participating in the Non-State Employer Group, they will be given the option to continue retiree coverage or elect active employee benefits effective on the first day of the month following the hire date.
- When canceling Direct Bill benefits outside open enrollment, all coverage must be terminated. A written or typed letter with the verbiage of, “I would like to terminate all my State of Kansas Direct Bill benefits effective Month/Date/Year (effective date).
- Reaching age 65 is not considered a qualifying event for adding a spouse. If a retiree wishes to add a spouse, they will need to have a Mid Year Qualifying Event or wait to add them during Open Enrollment for the next plan year.
- It is encouraged to reach out to Medicare/Social Security Administration three months in advance of the retirement date to obtain Medicare Part A and B cards.
- Non-State retiree coverage will automatically terminate if the Non-State Employer Group terminates its contract.
- If enrolled in SilverScript, premiums are paid directly to SilverScript. You will receive a bill from SilverScript, and you will need to contact them to set up your payment option

DEFINITIONS

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

Retirees – Program to extend health coverage to:

- Retiring participating State of Kansas employees and participating non-state employees.
- Totally disabled former participating State of Kansas employees and participating non-state employees
- Surviving spouses and/or dependents of participating state employees and participating non-state employees are eligible under the provisions of K.A.R. 108-1-1
- Active participating state employees and participating non-state employees who were covered under the health plan immediately before going on approved Leave Without Pay
- Blind vendors
- Elected Officials

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

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

HealthQuest – A health and wellness program administered by the SEHP.

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

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

Member – An individual eligible for and actively participating in the health care benefits offered through the SEHP. This includes employees, spouses, children, retirees, and COBRA participants.

Membership Administration Portal (MAP) – Eligibility database for SEHP benefits.

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

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

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.

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

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

a dependent of another active primary member.

State Employee Health Plan (SEHP) – The state health care benefits plan 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.

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

ACRONYMS

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 HICN – Health Insurance Claim Number

HIPAA – Health Insurance Portability and Accountability Act

HCC – Health Care Commission ID Cards – Identification Cards

IRS – United States Government Internal Revenue Service

ITIN – Individual Tax Identification Number

K.A.R. – Kansas Administrative Regulation

KPERS – Kansas Public Employees Retirement System

K.S.A. – Kansas Statutes Annotated

NSE – Participating Non-State Employer Group

MAP – Membership Administration Portal

MHPAEA - Mental Health Parity and Addiction Equity Act

NMHPA - Newborns' and Mothers' Health Protection Act

PPO – Preferred Provider Organization

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

FAQ - Frequently Asked Questions

1. Appointment of personal representative form.

a. The appointment of a personal representative form gives permission to delegate individuals access to protected health information. This permission will allow the individual to speak and make decisions on your behalf.

b. The form can be found on MAP under the forms tab or at the back of this book

c. Once the form is completed, please submit to SEHP Direct Bill Membership Services at SEHPDirectBill@ks.gov or upload to your MAP portal.

2. How do I update my ACH if I change banks or bank accounts?

a. Option one: sign into your MAP portal and enter the new banking information under the billing tab,

b. Option two: Call 1-866-541-7100 for assistance.

3. Who do I notify of the death of a member or spouse?

a. Call 1-866-541-7100 or email SEHPDirectBill@ks.gov to notify of death; an obituary or death certificate is needed to terminate benefits.

b. Remember to contact KPERS: 1-785-296-6666 or online https://www.kspers.gov/

4. How do I update my email or home mailing address?

Call 1-866-541-7100, update in the MAP portal, or email SEHPDirectBill@ks.gov.

5. Can I use my HSA funds to pay for premiums?

No, you will need to talk to a tax preparer or contact Metlife.

6. How do I get SEHP a copy of my Medicare card?

Email a copy of the card to SEHPDirectBill@ks.gov.

7. When is Open Enrollment?

October 15 - November 14

8. Do I have to call or enroll at open enrollment if I am not changing anything?

No, except in the year that there is a vendor change.

9. If I do not use SEHP at retirement, can I enroll later?

No

10. Can I use my insurance card in other states across the U.S.?

Yes

MEDICARE RESOURCES

When you become eligible for Medicare, you will have multiple options both through the SEHP and on the open market. Below is information regarding Medicare Supplement and Medicare Advantage plans available on the open market, including guides to help you understand and compare your choices.

SEHP members are free to elect a plan from the open market. However, once a member opts out of the SEHP retiree Plan options for medical coverage they may not re-enroll at a later date.

A member may retain their dental coverage and voluntary prescription eyewear coverage through the SEHP even if they opt out of the medical plans.

- Read Medicare & You, the Official Medicare Handbook published by the US Department of Health & Human Services.
- Contact Senior Health Insurance Counseling for Kansas (SHICK) at 800-860-5260. SHICK is a free program offering seniors the opportunity to talk with trained volunteers and get answers about Medicare.
- Make the most of your Medicare by visiting Medicare.gov or by calling 1-800-MEDICARE (1-800-633-4227.)
- Review the Centers for Medicare & Medicaid Services website at https://www.cms.gov.
- Visit the Kansas Department of Insurance website https://insurance.kansas.gov/medicare.

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

State Employee Health Plan Contact Information:

Phone: 1-866-541-7100

Email: SEHPDirectBill@ks.gov

Website: https://sehp.healthbenefitsprogram.ks.gov/

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

STATE EMPLOYEE HEALTH PLAN (SEHP)
Appointment of Personal Representative

Member ID Number _____

Member Information		
Member, Spouse, or Dependent Names First name, Last name	**Mailing Address** STREET ADDRESS CITY, STATE, ZIP	**Phone Number** INCLUDING AREA CODE

Personal Representative Information			
Personal Representative Name First name, Last name	**Mailing Address** STREET ADDRESS CITY, STATE, ZIP	**Phone Number** INCLUDING AREA CODE	**Relationship to the Member**

I, the above-named member, hereby designate the above-named person(s) to act on my behalf or on behalf of my covered spouse and dependent(s).

I authorize my Personal Representative to act for me (and for my covered spouse and dependents, if named above,) in receiving any information that is (or would be) provided to me as a member of the SEHP, including but not limited to, any information that relates to my claim for coverage or benefits under the SEHP and any individual rights that I have regarding my protected health information under the Health Insurance Portability and Accountability Act (HIPAA).

Or alternatively,

I authorize my Personal Representative to act for me, my covered spouse, and dependent (if named above) in receiving protected health information to conduct the following functions on my behalf:

I understand that this designation is subject to approval by the SEHP. Once approved, it will remain in effect indefinitely or until I revoke it. I understand that I have the right to revoke this designation at any time by submitting a signed statement to that effect to the SEHP.

I certify that I have reviewed the SEHP's Policy for designation of Personal Representative.

Member's Signature: _____ **Date:** _____

Mail to:

SEHP Direct Bill Membership Services
109 SW 9th Street – Suite 600
Topeka, KS 66612
Email: sehpdirectbill@ks.gov

The SEHP may wish to use this paragraph to allow members and dependents to designate individuals to be personal representatives only for specific activities. The preamble to the privacy rules states that a personal representative must be treated as the individual only to the extent that PHI is relevant to the matters on which the personal representative is authorized to represent the individual. 65 Fed. Reg. 82500.

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