STATE EMPLOYEE HEALTH PLAN
ACTIVE NON-STATE EMPLOYEES BENEFITS GUIDEBOOK
PLAN YEAR 2010

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INTRODUCTION
STATE OF KANSAS
ACTIVE NON-STATE EMPLOYEE HEALTH PLAN GUIDE

This guide provides information to you on the State Employee Health Plan (SEHP). This guide should be read carefully and retained for reference. If there are additional questions, the employee should contact their Agency Human Resources Office.

NOTE: This guide contains information which is current as of May 1, 2009; however, benefit information is subject to change without notice.
http://www.khpa.ks.gov/sehp/2009_active_employees.html . Go to this website and click on the link that contains the information that you're looking for.

Note: The information in this guide is intended to summarize the benefits offered in language that is clear and easy to understand. Every effort has been made to ensure that this information is accurate. It is not intended to replace the legal plan document or contract which contains the complete provisions of a program. In case of any discrepancy between this guide and the legal plan document or contract, the legal plan document or contract will govern in all cases. An employee may review the legal plan document or contract upon request. The State of Kansas reserves the right to suspend, revoke or modify the benefit programs offered to employees. Information contained in this guide, in the State Employee Health Plan Administrative Manual and in the insurance provider's certificate/contract takes precedence over verbal information. Nothing in this guide shall be construed as a contract of employment between the State of Kansas and any employee, nor as a guarantee of any employee to be continued in the employment of the State, nor as a limitation on the right of the State to discharge any of its employees with or without cause.

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 general public (appointed by the Governor)

Generally, the SEHP bids and contracts with health plans for three-year periods. The contractual periods of the medical, prescription drug, dental and vision are staggered so that not all contracts come due the same year.

All SEHP medical plans are self insured. These include:

- Blue Cross Blue Shield (Plan A and Plan B),
- Coventry Health Care of Kansas (Plan A, Plan B and Plan C-Qualified High Deductible Health Plan with Health Savings Account),
- Preferred Health Systems (Plan A, Plan B and Plan C-Qualified High Deductible Health Plan with Health Savings Account)
- UMR, A UnitedHealthcare Company(Plan A, Plan B and Plan C-Qualified High Deductible Health Plan with Health Savings Account)
- The prescription drug program is self-insured with Caremark contracted as the prescription benefit manager.

Other health plan benefits available under the SEHP:

- The dental plan is also self-insured and administered by Delta Dental Plan of Kansas.
- The voluntary vision plan is fully insured by Superior Vision.

For each self-insured plan, the SEHP pays the plan provider an administrative fee per contract to process membership and claims. **The SEHP and plan members are directly responsible for the payment of all claims and utilization costs. SEHP rates are based on the amount spent on claims and the utilization costs.**

Definitions used in this Guidebook:

Co-Insurance (coinsurance) - A cost-sharing requirement that provides that the member will be responsible for payment of a portion or percentage of the costs of covered services. It is a cost of health care that the member is responsible for paying, according to a fixed percentage or amount. Coinsurance is a type of cost sharing where the member and the plan share payment of the approved charge for covered services in a specified ratio after payment of the deductible.

Co-Payment, Copayment - A cost-sharing arrangement in which the member pays a specified flat amount for a specific service (such as $40 for an office visit or $5 for each prescription drug). It does not vary with the cost of the service, unlike co-insurance which is based on a percentage of cost.

Deductibles – An amount that's required to be paid by the member before benefits become payable by the SEHP. Deductibles are usually expressed in terms of an "annual" amount.

EMPLOYEE ELIGIBILITY

According to provisions of K.A.R. 108-1-1, the classes of persons eligible to participate in the State Employee Health Plan shall be the following classes of persons:

- Any elected official of the state;
- Any other officer or employee of a state agency who meets both the following conditions:
- Works in one or more positions that together require at least 1,000 hours of work per year; and is in a position that is not temporary. An employee who works under employment customs at any regents institution requiring less than a full calendar year of service shall not be considered temporary;
- Any person engaged in a postgraduate residency-training program in medicine at the University of Kansas Medical Center or in a postgraduate residency or internship training program in veterinary medicine at Kansas State University, but not including student employees of a state institution of higher learning;
- Any person elected to a board position that requires less than 1,000 hours of work per year;
- Any person serving with the foster grandparent program;
- Persons participating under reduced service agreements outlined in K.S.A. 76-746, and amendments thereto;
- Any other class of individuals approved by the Kansas State Employees Health Care Commission, within the limitations set out in K.S.A. 75-6501, *et seq.*, and amendments thereto.

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

EMPLOYEE WAITING PERIOD

If you are in one of the groups listed above, you have 31 days from your first day of employment with the state to elect or waive SEHP coverage. If you enroll in the SEHP, your coverage will be effective the first day of the month following completion of a 60-day waiting period starting from your first day of employment. If you miss this deadline, the next opportunity you have to elect coverage will be at Open Enrollment.

Enrollment or Change forms submitted without the appropriate supporting documentation will be returned to your Agency with no action taken by the SEHP. The deadline for submitting the Forms will not be extended.

- If you are changing from a non-benefits eligible position to a benefits eligible position with no more than a 3 day break in employment, calendar days employed in the previous position will be applied towards meeting the 60-day waiting period.

- If you are returning to work and you were enrolled in the SEHP in the prior position and the break in service between positions is 3 calendar days or less, you can elect to have continuous SEHP coverage. A new Enrollment Form is not required.

- If you are hired by the State of Kansas and were previously enrolled in the SEHP through a participating non state entity employer in your prior position, you may have continuous group health insurance coverage if the break in service between positions is 3 calendar days or less. You must complete a new Enrollment Form.

- If you are returning to work, were previously enrolled in the SEHP, and the break in service between your termination and the rehire is between 4 and 30 calendar days, the 60-day waiting period does not apply. Coverage will be effective the 1st day of the month following your rehire date. There may be some situations where there may be a break in coverage. You must complete a new Enrollment Form.

- If you are returning to work and had continuous SEHP coverage, with either COBRA (Consolidated Omnibus Budget Reconciliation Act) or the Direct Bill Program; the 60-day waiting period shall not apply. The member must complete a new Enrollment Form.

- If a retiree previously enrolled in the SEHP benefits is returning to work and has had continuous coverage under a spouse's SEHP coverage, the 60-day waiting period shall not apply. The member must complete a new Enrollment Form.

- If a person was laid off from State service under K.S.A. 75-2948, the 60-day waiting period shall not apply if the member returns to a benefits eligible position with the State within 1 year from the date of layoff. The member must complete a new Enrollment Form.

Note: Student employee positions are not non-benefits eligible positions. Student employees are required to complete the 60-day waiting period when moving to a benefits eligible position.

Please visit your agency Human Resources office for more information.

Waiver of the Waiting Period

Under certain circumstances, the 60-day waiting period in K.A.R. 108-1-1 may be waived. **Before the prospective employee's acceptance of the position**, the Agency Head or designee must certify in writing, to the Director of the SEHP that the following 3 conditions exist and are met:

- You are not eligible for continuation of health insurance coverage under a prior insurance plan;

- The waiting period poses an obstacle to recruitment.
- That failure to grant a waiver would create a manifest injustice or an undue hardship on you.

The Agency head or designee must complete and submit a Request for Waiver of the 60-Day Waiting Period Form along with the written request for waiver, before you accept the position.

If the 60-day waiting period is waived, your part of the premium must initially be paid on an after-tax basis. You may change to the pre-tax premium option effective the 1st day of the month that your coverage would have become effective without the waiver. If you desire to change to the pre-tax option after this period of time, a Change Form must be submitted with the original Enrollment Form.

EFFECTIVE DATE OF COVERAGE

Your initial enrollment period for the SEHP is limited. You should complete an Enrollment Form within 31 days of your starting date in a benefits-eligible position. The effective date of your coverage will be the 1st day of the month following the completion of the waiting period, provided that the SEHP Membership Services receives the form within 41 days from your date of hire.

If your request for a waiver of the waiting period was approved (see prior section), the effective date of coverage is the 1st day of the month following your date of hire. If your date of hire is the 1st day of a month, your coverage will begin on that day.

If you are a current employee who is changing from a non-benefits eligible position to a benefits eligible position, and who have already served the 60-day waiting period, your enrollment period is 31 days from the date the you started working in the eligible position. SEHP Membership Services must receive your Enrollment Form within 10 days from the date you signed the Enrollment Form. Your effective date of coverage is the 1st day of the month following your starting date in the eligible position. If your starting date in the eligible position is on the 1st day of the month, your coverage will begin on that day.

If you were rehired and your break in service is 30 calendar days or less, your effective date of coverage is the 1st day of the month following your rehire date (if you had SEHP coverage in effect prior to your break in service). If your rehire date is the 1st day of the month, your coverage effective date will be the 1st day of that month. If you are rehired or reactivated within 30 days, you must enroll in the same coverage you previously had, unless you experience a qualifying event.

Corrected Enrollment Forms will be approved only if completed and received by the SEHP Membership Services before the initial coverage election has taken effect.

PRE-EXISTING CONDITIONS

The SEHP does not have a waiting period for pre-existing conditions. Certificates of Creditable Coverage from any other medical plan you were covered by are not required for enrollment.

WAIVER OF INSURANCE COVERAGE

If you elect to waive SEHP coverage, you must complete and sign an Enrollment Form, indicating that you wish to waive SEHP coverage. The Enrollment Form should be submitted during your enrollment period. If you do not return, or refuse to sign, the Enrollment Form, your employer will submit an Employer Waiver of Group Health Insurance Form to the SEHP.

FULL-TIME/PART-TIME STATUS

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

HEALTH PLAN SALARY RANGE

The Health Plan salary range is the range in which as of January 1 each year, your annual salary falls within. If you were newly hired during the Plan Year, the annual salary is as of the your date of hire. If you're a current employee with new benefits eligibility, your annual salary is as of the date of benefits eligibility.

Your contributions for SEHP coverage during the Plan Year are dependent upon your salary range as outlined below (if you're active in more than 1 eligible position, the annual salary range is based on the combined salary for all positions):

Annual Salary Ranges
Salary Range 1 = Less than $28,000
Salary Range 2 = $28,000 - $48,000
Salary Range 3 = More than $48,000

Your salary range isn't changed during the Plan Year unless your salary range changes due to changing from a full-time to a part-time position or from a part-time to a full-time position.

Prior to the beginning of a new Plan Year, the SEHP is responsible for updating your salary range. During the plan year, the SEHP will only change the salary tier for you if you change from Full-time to Part-time status or vice versa.

The Qualified High Deductible Health Plan deduction is not dependent on your salary range.

Tobacco Use Status Declaration

This section applies to all active members who are enrolled in SEHP Plans A, B, or C.

Active members that are non-tobacco users or active members who are tobacco users and are enrolled in an eligible plan who enroll in and complete the HealthQuest tobacco cessation program are eligible to participate in a premium discount of $20 per pay period.

Members are required to make an election regarding their tobacco use. There are 4 options for a member to elect:

Declare that they are not a tobacco user. This election allows the active member to participate in the premium discount of $20 each pay period. (For Direct Bill members, this election allows them to participate in the premium discount of $40 per month.) By selecting this option, the member affirmatively declares that they will not use tobacco, in any form, during the current plan year. If the member does use tobacco at any time during the plan year, this may constitute a fraudulent misrepresentation and may subject the member to penalties, which may include, but not limited to, elimination of the employer contribution to the member's health insurance premium, if such a contribution exists;

Declare that they are a tobacco user. Under this election there are 2 options for the member to choose from:

Declare that they use some form of tobacco and are willing to enroll and complete the HealthQuest tobacco cessation program prior to the end of the current plan year as a condition to obtaining the premium discount. If

they do not satisfactorily complete the HealthQuest tobacco cessation program, the member will lose the premium discount.

Declare that they use some form of tobacco but will not enroll in or complete the HealthQuest tobacco cessation program and therefore are not eligible for the premium discount. By making this election the member affirmatively declares that they are a tobacco user and choose not to participate in the non-tobacco user discount for the plan year.

Member chooses to not disclose their tobacco use status. By making this election, the member chooses not to disclose their status as it relates to tobacco use and as a result by not making a disclosure the member is choosing not to participate in the non-tobacco user discount for the plan year. No negative inferences shall be made of the member based on their decision not to disclose their status.

Before you submit an Enrollment, Change, or any other SEHP form, it is your responsibility to make sure that:

- You've completed the Form;
- You've signed the Form;
- You've included all documentation that is required in order to make the change.

DEPENDENT ELIGIBILITY

DEPENDENT DEFINITION

In addition to covering yourself, you can also elect coverage for your eligible dependents. Eligible dependents include:

- A lawful spouse. (Same gender marriages are not recognized under Kansas Law.) If you divorce, coverage for your former spouse and stepchild(ren) ends on the last day of the month of the date of the divorce.

Unmarried child(ren) or stepchild(ren). To be covered under the SEHP, the child or stepchild must:

1. be younger than 23 years of age;
2. be unmarried;
3. not file a joint tax return with another taxpayer;
4. receive more than 50% of his or her support from you (the member);
5. be a United States citizen, a United States national, or a legal resident of the United States, Canada or Mexico at some time during the tax year, and reside with you for more than 6 months of the year. The unmarried child is considered to reside with you when they are temporarily absent due to special circumstances such as illness, education, business, vacation or military service.

- The word "child" means in addition to your own or lawfully adopted child, any stepchild or a child for whom you have legal custody. If you are divorced from the natural parent of the stepchild, the child no longer qualifies as your stepchild, and is no longer eligible for SEHP coverage. As used in the preceding sentence, the term natural parent includes an adoptive parent.
- The child of a member's covered dependent child if such grandchild resides in the member's household and meets the criteria of section (B) (1) through (5) listed above. A Grandchild affidavit must be completed and submitted along with a copy of the grandchild's birth certificate.
- Your unmarried child who is 23 years of age or older, who is not capable of self support because of mental retardation or severe physical handicap which existed prior to attaining age 23, and who has maintained continuous group coverage as a dependent child prior to attaining age 23. Such child must receive more than 50% of his or her support from you. An Application for Coverage of Handicapped Dependent Child must be completed and submitted to SEHP

Membership Services. If approved for continued coverage, medical documentation may be periodically requested. Coverage will not be continued and will not be reinstated once the child is no longer incapacitated.

ADDITIONAL DEPENDENT INFORMATION

Children of divorced parents – You may cover your dependent children if they receive more than 50% of their support from one or both parents.

Grandchild – You may cover a grandchild if you have legal custody or have adopted the grandchild; or if the grandchild lives in your home, is the child of a covered dependent child, and you provides more than 50% of the grandchild's support. Special consideration may be given to a grandchild not living with you, if the parent is a college student.

Ex-Spouse - When you are divorced from your lawful spouse, the ex-spouse and subsequent stepchildren are no longer eligible to participate in the SEHP except as allowed under COBRA continuation coverage.

Dependents who are eligible Employees – If you are eligible for coverage in the SEHP, you are not eligible to be a covered dependent in the SEHP.

Dependents may not be covered in Duplicate – Eligible dependent children may not be covered by more than one SEHP member.

Dependents residing out-of-country - Your spouse who is not a U.S. citizen or who resides in another country is eligible for SEHP coverage only when you is newly eligible, when you're newly married or at Open Enrollment. You will not be allowed to add your spouse to coverage if the spouse moves to the United States during the Plan Year.

Dependent children who are not U.S. citizens and who reside in another country are not eligible for coverage until they move to the United States. You will be allowed to add the child(ren) to coverage if the child(ren) move to the United States, if added within 31 days of the move. If the dependent child(ren) later return to another country, coverage may not be dropped for the child(ren) until the next Open Enrollment period (unless enrolled on an after-tax basis).

Adopted child – You may cover an adopted child if the petition for adoption has been filed with the court, if you have a placement agreement for adoption, or if you have been granted legal custody of the child. Supporting documentation must be provided in English and must be submitted to the SEHP. Adopted children who are not U.S. citizens and who reside in another country are not eligible for coverage until they reside in the United States.

NOTE: The State of Kansas and the SEHP reserve the right to request documentation to support proof of dependency and/or residency. When enrolling dependent(s) for coverage with the SEHP, you must certify:

That your dependent(s) meet the requirements for dependent coverage for the year in which the dependent(s) are being enrolled.

You must also provide appropriate supporting documentation for each dependent (such as the birth certificate, adoption papers, marriage license, copy of current year's filed federal tax return, etc. – see additional information in this Guidebook).

Any attempt to enroll dependent(s) who do not meet the SEHP requirements will be considered fraud and will be subject to penalties as prescribed by law.

Note: Requests that are submitted without documentation or with incomplete documentation will be returned to the Agency with no action taken by the SEHP. The deadline for submitting the request will not be extended.

DEPENDENT'S EFFECTIVE DATE OF COVERAGE

Dependents shall become newly eligible on the later of:

- Your initial date of eligibility; or
- The 1st day of the month following the date the individual first becomes your dependent or becomes newly eligible for coverage according to the dependent definition. The newly eligible dependent must be added to your coverage within 31 days of the date you gain the new dependent or within 31 days of the date the dependent becomes newly eligible according to the dependent definition. The SEHP Membership Services must receive the Change Form and supporting documentation within 10 days of the date that you signed the Change Form.
- The 1st day of the month following the loss of Medicaid or State Children's Health Insurance Program (SCHIP) coverage. The newly eligible dependent must be added to coverage within 60 days of the date of the loss of Medicaid or SCHIP coverage. The SEHP must receive the Change Form and any supporting documentation within 10 days of the date the Change Form is signed by the member.

NEWLY ELIGIBLE DEPENDENTS

You must complete and sign all Enrollment or Change Forms adding newly eligible dependents within 31 days of the event that makes the dependent(s) newly eligible. The SEHP Membership Services must receive the form within 10 days of the date of your signature.

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

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

Supporting documentation is required (copy of the birth certificate, petition for adoption, marriage license, legal custody agreement, copy of current year's filed federal tax return, etc.) as proof of the qualifying event. Please see the section below that outlines in detail the documents that must be submitted to the SEHP. Requests that are submitted without documentation or with incomplete documentation will be returned to the Agency with no action taken by the SEHP. The deadline for submitting the forms will not be extended.

The following appropriate documentation is required to be submitted to the SEHP with the Enrollment or Change Form:

- Divorce decree (first and last page only of court document)
- Court order
- Petition for adoption or placement agreement
- Certificate of birth and dependent affidavit for children born to a covered dependent (grandchild)
- Legal custody or guardianship document issued by the court
- Notarized statement for dependents who no longer meet the 50% support requirement
- Handicapped child affidavit for covered dependent children over age 23

- Birth certificate or hospital birth announcement for newborns (in English)
- Marriage License in English (for proof of spouse eligibility)
- Copies of most current year's filed Federal tax return (for proof of marriage / spouse eligibility only) The pages needed from the current filed Federal tax returns depend on which Tax form was filed:
- Form 1040—pages 1 & 2 showing filer's name, spouse's name and both the filer's and spouse's signatures
- Form 1040A-- pages 1 & 2 showing filer's name, spouse's name and both the filer's and spouse's signatures
- A copy of a military ID and privilege card with the expiration date is acceptable as proof of coverage and to document the end of Tricare coverage.

Newborns or Adoptions

To add a newborn dependent to coverage, you must complete and sign a Change Form within **31 days** from the date of birth. SEHP Membership Services must receive the form within 10 days of the date of signature. For grandchildren, a copy of the birth certificate and a completed Dependent Grandchild Affidavit must be attached to the Change Form. No coverage will be provided for the newborn child until SEHP Membership Services has processed the Change Form and appropriate documentation.

NOTE: Kansas insurance code provides for 31 days of coverage for any newborn/adopted child of a member with any level of dependent coverage.

A Change Form must be completed on a timely basis (within 31 days from date of birth).

- If you currently have children or family coverage, the newly eligible dependent will be continuously covered starting with the date of birth. There will be no premium change.
- If you currently have spouse coverage, the newly eligible dependent will be covered for only the first 31 days from date of birth. There will be no premium change.
- If you have single coverage, the newly eligible dependent will not be covered.

In the case of adoption, the dependent must be added to your coverage 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 must be attached to the Change Form. SEHP Membership Services must receive the form and documentation within 10 days of the date of your signature. If the adoption is being handled through an adoption agency, they may require an adjustment period in your home prior to filing the petition for adoption. In this case, a copy of the adoption agency's placement letter must be attached to the Change Form and must indicate the date of placement as well as the length of the adjustment period.

When the adjustment period is over and the petition for adoption has been filed with the court, you must submit a copy of the petition for adoption in order to continue coverage for the dependent. If the dependent is removed from your home, or the petition for adoption is not filed, a Change Form must be submitted to remove the dependent from your coverage.

Your Agency should contact SEHP Membership Services for guidance if the dependent is being adopted and a petition for adoption is never filed in a U.S. court (which is sometimes the case with foreign adoptions).

Effective Date of Coverage

If the date of the filing for petition for adoption or placement in your home is within 31 days of the birth of the child, the coverage effective date is the date of birth provided that the SEHP Membership Services receives documentation within 41days of the birth of the child. 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.

If you add a newly eligible newborn or adopted dependent to coverage, you may add other eligible dependents to your coverage. The effective date of coverage for the newborn or adopted dependents will be the date of birth if a Change Form is completed within 31 days of the applicable child's birth. SEHP Membership Services must receive the form and documentation within 10 days of the date of your signature. The effective date of coverage for other eligible dependents, such as your spouse and/or other children or stepchildren of yours, will be the 1st day of the month following the birth, date of placement for adoption or date of petition for adoption.

Change in Employee Contribution

The change in coverage will be reflected in your contribution beginning the 1st of the month following the date of birth, date of petition for adoption or date of the placement agreement. If the date of birth, date of petition for adoption, or date of the placement agreement occurs on the 1st day of the month, the change in your contribution shall not take place until the 1st of the following month.

New Legal Custody/Guardianship Dependents (for dependents who are not natural or adopted children of the member)

If you are adding a newly eligible legal custody/guardianship dependent to coverage, you must complete a Change Form to add the dependent to coverage within 31 days of the date that the court issues a legal custody agreement. SEHP Membership Services must receive the Change Form within 10 days of the date you've signed the Change Form. A copy of the court order or legal custody agreement must be attached to the Change Form.

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 the 1st day of the month.

Your contributions will be due according to the dependent coverage effective date.

New Spouse or Stepchildren Due to Marriage

If you want to add other newly eligible dependents to coverage due to marriage, you must complete a Change Form adding the dependents to coverage within 31 days of the event (marriage). SEHP Membership Services must receive the appropriate Form along with appropriate supporting documentation within 10 days of the date you signed the Change Form.

The effective date of coverage will be the 1st day of the month following the date of marriage. If the marriage occurs on the 1st day of the month, the coverage effective date will be the 1st day of that month.

If you are adding a newly eligible spouse or stepchild(ren) to coverage, other eligible dependents may also be added to coverage, such as your other children. The effective date of coverage for these dependents will be the 1st day of the month following the date of marriage. Your contributions will be due according to the dependent coverage effective date.

If you have previously waived coverage, you've acquired a newly eligible dependent, (marriage, birth, adoption, etc…), and you want to elect SEHP coverage, you must complete a new Enrollment Form and submit it to the SEHP along with the appropriate documentation within 31 days of the date of the event. Coverage for you and your newly eligible dependent(s) will be effective the first of the month following the date of the qualifying event. In the case of a newborn, coverage for the newborn will be the date of birth, but your coverage will be

the first of the month preceding the newborn's date of birth. Any other dependents added as a result of this qualifying event will be effective the first of the month following the date of birth of the newborn.

ANNUAL OPEN ENROLLMENT PERIOD

Open Enrollment for SEHP coverage occurs annually during the month of October. When you enroll during the Open Enrollment period, you will have coverage effective the 1st day of the new Plan Year as outlined in the current Health Plan Summary/Open Enrollment booklet.

You must complete the Open Enrollment process to declare your Tobacco Use status, to change medical plans, add or drop coverage, add or drop dependents from coverage, or to change pretax payment status. You must complete an Enrollment form and submit it to the SEHP.

PRE-EXISTING CONDITIONS

The SEHP does not apply an additional waiting period for pre-existing conditions for you or your dependents that enroll in health coverage during the Open Enrollment period. Certificates of creditable coverage from other medical plans are not needed for Open Enrollment.

NEWLY ELIGIBLE MEMBERS

Newly eligible members who have completed their 60 day waiting period may enroll during their initial enrollment period for an effective date of coverage for the current Plan Year. In addition, during the month of October, the member may complete Open Enrollment and elect different coverage to be effective for the new Plan Year.

REVISED OPEN ENROLLMENT ELECTIONS

You may change your original Open Enrollment election during the Open Enrollment period. Following the end of the Open Enrollment period, revised Enrollment Forms will only be accepted if you have a qualifying event or family status change as listed in this Guidebook. You must complete a revised Enrollment form within 31 days of the qualifying event or family status change. The SEHP Membership Services must receive the completed Form within 10 days from the date you signed it. Requests that are submitted without documentation or with incomplete documentation will be returned to your Agency with no action taken by the SEHP. The deadline for submitting the Forms with documentation will not be extended.

IDENTIFICATION CARDS

Identification (ID) cards will be sent to you if you're newly enrolled or if you've made a coverage level change. If you are expecting but do not receive a new ID card by the end of December, you should contact the applicable carrier to request new ID cards be sent. Telephone numbers for the carriers are listed in the front of the Health Plan Open Enrollment booklet.

COST OF COVERAGE

Your contribution for the SEHP coverage is subject to change each Plan Year. Agency contributions are generally subject to change at the beginning of the fiscal year.

SEHP coverage is monthly and rates are based on semi-monthly payroll deduction periods. Coverage termination will be effective the 1st day of the month following termination of employment. Additional premiums are not collected if termination of employment is before the 2nd employee contribution is withheld.

NOTE: For current SEHP rates, refer to the Health Plan Open Enrollment booklet for the current Plan Year, available on the KHPA web site.

MID-YEAR ENROLLMENT CHANGES

ADDITION AND DELETION OF NON-NEWLY ELIGIBLE EMPLOYEES AND DEPENDENTS

Non-newly eligible employees and dependents are defined as:

Employees and/or dependents for which 31 days have passed since their initial eligibility for coverage.

Non-newly eligible employees and/or dependents may be added or dropped from the SEHP during the Plan Year but only if all of the following mid-year change requirements are met:

The change is a result of one of the events listed in this Guidebook;

You request the change within 31 calendar days of the event (by completing an Enrollment or Change Form) and received by SEHP Membership Services within 10 days of your signature;

The change in coverage is consistent with the event and complies with HIPAA regulations; and

Written documentation of the event is provided (divorce decree, death certificate, custody agreement, or statement from a spouse's employer on their letterhead).

Documentation - The following appropriate documentation is required to be submitted to the SEHP Membership Services with your Enrollment or Change Form:

1. Divorce decree (first and last page only of court document)
2. Court order
3. Petition for adoption or placement agreement
4. Certificate of birth and dependent affidavit for children born to a covered dependent (grandchild)
5. Legal custody or guardianship document issued by the court
6. Notarized statement for dependents who no longer meet the 50% support requirement
7. Handicapped child affidavit for covered dependent children over age 23.
8. Birth certificate or hospital birth announcement for newborns (in English)
9. Marriage License (in English) (for proof of spouse eligibility only)
10. Copies of most current year's filed Federal tax return (for proof of marriage/spouse eligibility only) The pages needed from the current filed Federal tax returns depend on which Tax form was filed:
    - Form 1040—pages 1 & 2 showing filer's name, spouse's name and both the filer's and spouse's signatures
    - Form 1040A-- pages 1 & 2 showing filer's name, spouse's name and both the filer's and spouse's signatures
11. A copy of a military ID and privilege card with the expiration date is acceptable as proof of coverage and to document the end of Tricare coverage.

Additions: If dependent medical coverage is added, then dependent dental coverage may be added at the same time. If dependent dental coverage is elected, the level of dependent dental coverage must match the dependent medical coverage level.

Vision coverage may be added during the Plan Year only for newly eligible employees and/or dependents. You cannot change from Basic to Enhanced vision coverage, or vice versa during the Plan Year.

If you have waived vision coverage, newly eligible dependents may not be added even if a qualifying event occurs.

Deletions: If you are enrolled on an after-tax basis, you may drop member or dependent coverage (both medical and dental) without restriction during the Plan Year. If you are enrolled on an after-tax basis, you may not change medical plans during the Plan Year.

Dependent dental coverage may not be dropped during the Plan Year unless dependent medical coverage is also dropped.

Vision coverage may not be dropped during the Plan Year unless due to an ineligible member and/or dependent. Even if you are enrolled on an after tax basis, vision coverage cannot be dropped during the Plan Year.

EFFECTIVE DATE OF COVERAGE

For mid-year enrollment changes, the effective date of coverage or change in coverage will generally be the 1st day of the month following the event (assuming all form requirements have been met). For events that occur on the 1st day of a month, the coverage effective date will be that day. However, if a death occurs on the 1st day of a month, the change effective date will be the 1st day of the following month.

The effective date of coverage is outlined in this Guidebook for newborns, adopted children, new spouses and/or new stepchildren, and changes in legal custody or guardianship of a dependent.

If you are enrolled on an after-tax basis and you are dropping member and/or dependent coverage, the effective date of change in coverage is the 1st day of the month following completion of the Change Form (assuming the Change Form is received by the SEHP Membership Services within 10 days of your signature). If the Change Form is completed on the 1st day of a month, the coverage effective date will be that day.

The effective date of coverage or change in coverage is outlined in this Guidebook for changes in Medicare eligibility.

MID-YEAR QUALIFYING EVENTS

PRETAX EVENTS

If you are enrolled on a pretax basis, and any addition or deletion to coverage will result in a change in employee contribution, there must be a qualifying event for the change to be approved. Enrollment changes must also be consistent with the event and must comply with HIPAA regulations. You may change pretax status only during Open Enrollment each year (unless the 60-day waiting period was waived for initial enrollment). The qualifying event must result in a gain/loss/change of coverage in an employer-sponsored group health insurance plan. This gain/loss/change can be for you, your spouse, or a dependent and can be under either the SEHP or a plan sponsored by your spouse or dependent's employer. The requested change of election must then correspond with the gain/loss/change of coverage, and must be confirmed with documentation in the form of a letter from the employer on the employer's letterhead. All changes must be requested within 31 days of the event.

If you are enrolled in the SEHP on a pretax basis, you may make mid-year additions and deletions from coverage based on the following events and subject to the requirements listed in this Guidebook:

Your marriage – you may add or drop entire family if the family is picked up under the new spouse's employer's plan because the entire family is now newly eligible. The entire family is not newly eligible for SEHP coverage if the spouse's employer covered unmarried domestic partners. If the marriage is a common law marriage, a notarized copy of The Affidavit of Common Law Marriage must be included with the Enrollment or Change Form.

Your final divorce (the first and last pages of the final divorce decree must be attached to the Enrollment or Change Form).

Birth or adoption of a dependent - may add entire family. May drop entire family only if the status change is due to a birth or adoption, and those family members are now newly eligible under some other employer's plan (see Chapter 3, Section IV).

Gain or loss of legal custody of a dependent.

Change from part-time to full-time or from full-time to part-time employment by your spouse or dependent that affects cost, benefit level, or benefit coverage for you, your spouse and/or dependents. Change from benefits eligible position to benefits ineligible position by you, your spouse or dependent. Termination or commencement of employment (includes retirement) of you, your spouse or dependent which affects benefits coverage for you, your spouse and/or dependents (you may change your medical plan at the time of retirement). Any employment status changes that affect eligibility.

Significant changes in the health insurance coverage of you, your spouse or dependent. Change of Network Status of a physician is not a qualifying event. You may make a mid-year change due to an Open Enrollment change made by a spouse or dependent on their health plan.

If you, your spouse or dependent are called to active military duty and/or gain or lose eligibility for military insurance.

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

Death of a spouse or dependent.

Dependent turning age 23 or marrying (coverage will end the last day of the month of the birthday or date of marriage). If the birth date or date of marriage is on the first day of a month, the coverage ending date for that dependent will be the last day of the preceding month.

If you, your spouse or dependent gain or lose government-sponsored medical card coverage. Terminating coverage is not allowable if you become covered under programs like SCHIP (State Children's Health Insurance Program) because these programs are not supposed to replace existing insurance. This may apply to other government card coverage.

If you, your spouse or dependent lose Medicare eligibility or become eligible for Medicare, and elect Medicare coverage as primary.

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).

Court Order requiring adding or dropping coverage for a dependent child.

Failing to meet the greater than 50% support requirement for a dependent child during the Plan Year. A notarized written statement from you must be attached to the Change Form, which states that the dependent does not receive more than 50% of their support from you. The date of event will be the date of completion of the Change Form and the effective date will be the first day of the following month. If the Change Form is completed on the first day of a month, the effective date will be that day. If approved and coverage is dropped for the dependent, the dependent cannot be added back to coverage during the Plan Year even with a qualifying event.

Children that change from non-dependent to dependent status during the Plan Year under SEHP guidelines can only be added back on to your coverage at Open Enrollment.

Dependent children losing eligibility/coverage under another group health insurance plan.

AFTER-TAX EVENTS

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

All events as listed under Pretax Events;

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

ACTIVE MILITARY DUTY

If you go on military duty - leave without pay, you may continue coverage for the next 30 days. Your Agency will continue to make the SEHP employer contribution for those 30 days. You must pay your premium (regular payroll deduction amount) to your Agency to continue your coverage during the 30 days following the effective date of the military leave without pay.

You may continue coverage in the SEHP beyond the 30 days leave without pay timeframe, but you must pay the full premium amount directly to the premium billing vendor as a direct bill participant. There will be no Agency contribution. An employee with spouse, children, or full family coverage may elect to drop themselves and keep their spouse and/or children covered in the SEHP. You must make the change within 30 days of the effective date of the military leave without pay. To continue SEHP coverage, a Change Form indicating LWOP must be completed and submitted to the SEHP Membership Services.

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

You and/or your dependents who elect to discontinue SEHP coverage and who have primary coverage provided by the military will be allowed to reenroll into the same SEHP plan and coverage when you return to active employee status.

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

The effective date of coverage may be either the first day of the month following your return from active military duty or the first day of the month in which you return to active employee status.

If you are qualified for and elect to participate in the military's transitional health benefit program, you will be allowed to reenter the SEHP without penalty when the transitional coverage terminates. You may be qualified

for up to 180-days of transitional health benefits.

The effective date of coverage may be either the first day of the month following termination of the military transitional health coverage or the first day of the month in which the military coverage terminates, whichever you choose.

Return from military leave policies also apply to dependents returning from military leave.

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

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

HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT (HIPAA)

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

1. limit exclusions for preexisting conditions;
2. prohibit discrimination against employees and dependents based on their health status; and
3. guarantee renewability and availability of health coverage to certain employees and individuals.

PRE-EXISTING CONDITION EXCLUSIONS

The SEHP does not have a waiting period for coverage of pre-existing conditions.

CREDITABLE COVERAGE

The group health plan is required to furnish a certificate of coverage automatically when coverage terminates either with the SEHP or when coverage is lost under COBRA continuation, as well as upon an individual's written request at any time while that person is covered by a plan or up to 24 months after coverage ceases. Plans are also required to use reasonable efforts to determine information needed to complete a certificate for a dependent. Creditable coverage is coverage under most health benefit programs, including employer or multiemployer group health plans, individual health insurance policies, COBRA continuation coverage, Medicare, Medicaid, and state and local government programs, including health coverage provided by SCHIP and by a foreign government. Certification will be sent to the individual or dependent at their last known address and will identify the covered person, the period of coverage, any waiting periods, and will include an educational statement to inform recipients of their HIPAA rights, and information about FMLA coordination. Also under the Trade Act of 2002, workers qualifying for the provisions of the Trade Act have a second opportunity to elect COBRA after an original qualifying event.

SPECIAL ENROLLMENTS

HIPAA requires that group health plans allow individuals to enroll without having to wait for late or open enrollment. These special enrollment periods are for individuals who previously declined coverage for themselves and their dependents. A special enrollment period can occur if: (1) a current employee or dependent with other health coverage loses eligibility for coverage, or (2) a person becomes a dependent through marriage, birth, adoption or placement for adoption. The employee needs to complete enrollment

within 31 days after their other coverage ends. Written documentation of the marriage, birth, adoption or placement for adoption must be provided. (Please refer to Chapter 3 and 10 for more information).
Some examples where special enrollment would apply are: 1) ceasing to be eligible under a plan due to cessation of dependent status (e.g. a child aging out of dependent coverage); 2) reaching a plan's lifetime limit on all benefits; 3) a plan ceasing to offer any benefits for a class of similarly situated individuals (e.g. all part-time workers); and 4) an employer of another plan stops contributions toward other coverage, even if the individual continues the other coverage by paying the amount that used to be paid by the employer.

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

OTHER APPLICATIONS OF HIPAA LAW
HIPAA provisions also apply to services under the following laws: 1) Women's Health and Cancer Rights Act (WHCRA) which provides protections to patients who choose to have breast reconstruction in connection with a mastectomy; 2) Mental Health Parity Act (MHPA) which prevents the group health plan from placing annual or lifetime dollar limits on mental health benefits that are lower - less favorable - than annual or lifetime dollar limits for medical and surgical benefits offered under the plan; and, 3) Newborns' and Mothers' Health Protection Act (NMHPA) which affects the amount of time the member or beneficiary and newborn child are covered for a hospital stay following childbirth. For the mother or newborn child, that includes no restriction to less than 48 hours following a normal vaginal delivery or less than 96 hours following a cesarean section. Nor is it required that a hospital obtain authorization from the medical plan for prescribing a length of stay not in excess of the above periods.

PLAN DISCLOSURE REQUIREMENTS
Under the Department of Labor's (DOL) rules governing plan disclosure requirements, group health plans must improve the summary plan descriptions and summaries of material modifications in the following ways: 1) Notify members and beneficiaries of any material reductions in covered services or benefits within 60 days of adoption of the change; 2) Disclose information about the role of insurance companies and health plans with respect to the group health plan, specifically the name and address, and to what extent benefits under the plan are under a contract, and the administrative services, such as paying claims; 3) Inform members and beneficiaries which DOL office they can contact for assistance or information on their rights under HIPAA; and 4) Inform members and beneficiaries that federal law prohibits the plan and health insurance issuer from limiting hospital stays for childbirth to less than 48 hours for normal deliveries and 96 hours for cesarean sections.

PLAN MEMBERS RIGHTS
Should you have questions about their rights under HIPAA, you may contact the following office:

U.S. Department of Labor
Employee Benefits Security Administration
City Center Square, 1100 Main Street
Kansas City, Missouri 64105
Telephone: 816-426-5131

You may also contact:

Division of Technical Assistance and Inquiries
Employee Benefits Security Administration
U.S. Department of Labor
200 Constitution Avenue NW
Washington, D.C. 20210

HIPAA ADMINISTRATIVE SIMPLIFICATION

The Administrative Simplification provisions of the HIPAA (Title II) require the Department of Health and Human Services to establish national standards for electronic health care transactions and national identifiers for providers, health plans, and employers. It also addresses the security and privacy of health data. Adopting these standards improves the efficiency and effectiveness of the nation's health care system by encouraging the widespread use of electronic data interchange in health care.

PRIVACY REGULATIONS

The privacy regulations (effective April 14, 2003) ensure a national floor of privacy protections for patients by limiting the ways that health plans, pharmacies, hospitals and other covered entities can use patients' personal medical information. The regulations protect medical records and other individually identifiable health information, whether it is on paper, in computers or communicated orally. Key provisions of these standards include: 1) Access to medical records; 2) Notice of privacy practices; 3) Limits on use of personal medical information; 4) Prohibition on marketing, and stronger state laws; 5) Confidential communications; and 6) Where to file complaints.

SECURITY REGULATIONS

The HIPAA Security requirements (effective April 20, 2005) ensure confidentiality of electronic protected health information that the health plan creates, receives, maintains or transmits.

WOMEN'S HEALTH AND CANCER RIGHTS ACT

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

A. Reconstruction of the breast on which the mastectomy was performed;
B. Surgery and reconstruction of the other breast to produce a symmetrical appearance; and
C. Prostheses and treatment of physical complications for all stages of a mastectomy, including lymphedema (swelling associated with the removal of lymph nodes). The deductible and coinsurance provisions applicable to these benefits are consistent with the deductible and coinsurance provisions governing other benefits provided by the State Employee Health Plan. Coverage will be provided in a manner determined from consultation with the attending physician and the patient.

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

CONTINUATION OF COVERAGE – DIRECT BILL PROGRAM

Members eligible to continue in the DIRECT BILL PROGRAM

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 former elected state official;
B. Any retired state officer or employee who is receiving retirement benefits under K.S.A. 74-4925,and amendments thereto, or from the Kansas Public Employees Retirement System (KPERS);
C. Any totally disabled former state officer or employee who is receiving benefits under K.S.A. 74-4927 and amendments thereto;
D. Any surviving spouse or dependent of a qualifying member in the SEHP;
E. Any person who is in a class listed as an active member in Section I, Chapter 2 and who is lawfully on leave without pay;

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

G. Any former "state officer" as they term is defined in K.S.A. 74-4911f or 74-4911h as stipulated in K.A.R. 108-1-1.

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

If you are eligible to continue coverage under the SEHP, you may pay your premiums by any of these methods:

- Bank draft.
- On line
- Telephone
- Check or money order

See your Human Resources staff to obtain the bank draft authorization form. Upon a new enrollment in the Direct Bill Program, you will also receive an authorization form from the Direct Bill Premium Billing Administrator,. Indicate that payment will be made by bank draft on the Change Form that designates retirement. Deductions from your bank account occur on approximately the 3rd of each month for coverage during that month. Check payments may be made only if your bank cannot process bank draft payments and a written exception request is made.

For additional information concerning the Direct Bill program, you or your Agency Human Resources Officer can contact:

Kansas Health Policy Authority
State Employee Health Plan
Membership Services
900 SW Jackson, Suite 900-N
Topeka, Kansas 66612-1220
Telephone: 1-866-541-7100 (Toll Free)
785-296-3226 (In Topeka)

CONTINUATION OF COVERAGE - COBRA

The federal COBRA law was enacted in 1986. The law requires that most employers sponsoring Group Health Insurance Plans offer employees and their families the opportunity for a temporary extension of health coverage at group rates in certain instances where coverage under the plan would otherwise end.

If you and your dependents that lose insurance coverage under the SEHP, you have the right to elect to continue coverage by paying the required premiums. (Under **COBRA**, if you're a retiree or are covered through the Direct Bill program, you also have the same continuation rights as active employees.). If you're a retiree and have chosen COBRA over the SEHP Direct Bill coverage and COBRA runs out, you may enroll in Direct Bill coverage

You, your spouse, and your dependents that are eligible to continue health insurance coverage are called **Qualified Beneficiaries**. The provisions under which you can continue coverage are called **Qualifying Events**. The number of months you can continue coverage is specified.

HEALTH COVERAGE TO BE CONTINUED

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

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

PROCEDURES TO BE FOLLOWED WHEN YOU EXPERIENCE A COBRA QUALIFYING EVENT

A. If the qualifying event is termination of employment (except for gross misconduct), the State must notify your medical plan that termination of insurance coverage has occurred. Because there is a time limit in which you can elect to continue coverage, your Agency must immediately enter terminations of employment in SHaRP (the state's personnel and payroll system) so that the SEHP Membership Services can cancel coverage.

B. If the qualifying event is the reduction of hours of work to less than 1,000 per year, the State must notify your medical plan that termination of insurance coverage has occurred. The Change Form has been designed so that this information can be recorded on the form. Because there is a time limit in which you can elect to continue coverage, the completed Forms must be immediately forwarded to the SEHP Membership Services.

C. If the qualifying event is because of 1) your death (active employee & Direct Bill); 2) Your divorce (active employee and Direct Bill); 3) You chooses Medicare as primary carrier leaving dependents without health insurance coverage (active employees ONLY); or 4) your dependent ceases to meet the SEHP's definition of dependent, i.e. turns age 23 or marries (active employee & Direct Bill), the qualified beneficiary must notify the benefits/personnel staff of your Agency **within 60 days** of the qualifying event. (Spouses and dependents of retirees should notify the SEHP **within 60 days** of the qualifying event). If notice is not received within 60 days of the qualifying event, the beneficiary will **not** be eligible for continuation coverage. Because of this time limit, the completed Change Forms must be transmitted immediately to the SEHP Membership Services.

D. Within 21 days of the SEHP Membership Services receiving notification of the qualifying event, the qualifying beneficiary will receive specific information, including a COBRA Enrollment Form setting forth the requirements for continuing insurance coverage, the plans available, and the applicable premium rates.

E. An election by you or your spouse to continue coverage will be deemed to be an election for coverage by any other qualifying beneficiary. However, each qualifying beneficiary has an individual right to select continuation coverage. Each beneficiary may make a separate selection among the levels of coverage available.

TERMINATION OF COVERAGE CONTINUATION

A. Nonpayment or untimely payment of premiums;

B. You or your dependent(s) become(s) covered, either as an employee or dependent, under another employer-provided medical plan which does not limit or exclude coverage for preexisting conditions (does **not** apply to the surviving spouse in qualifying event I);

C. You or enrolled dependent(s) become eligible for Medicare (has enrolled in the Medicare program). However, if Medicare eligibility is due to ESRD, the individual may continue on COBRA.
NOTE: **Only the person(s) eligible for Medicare coverage lose(s) COBRA Continuation benefits. Any other person(s) enrolled may continue for the duration of the COBRA eligibility period; or**

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

ADMINISTRATIVE ISSUES

A. SEHP benefits will generally terminate on the last day of the month in which the qualifying event occurs.
For routine terminations, COBRA letters are generated by the Third Party Administrator (TPA) following data entry of your termination action into SHaRP by the SEHP. All other COBRA letters are generated from Change Forms submitted by your agency. If the Change Form is not processed or the termination action is not entered into SHaRP, the qualified beneficiary does not receive a letter. Timeliness becomes a critical issue when completing and submitting forms.

B. COBRA continuation is not automatic - it is a choice that the qualified beneficiary must make. Also, the Change Form does not activate COBRA continuation status. The qualified beneficiary must complete the COBRA election form that accompanies the COBRA notification letter sent by the COBRA Administrator. The qualified beneficiary has 60 days from the date of the letter to return the COBRA continuation election form to the COBRA Administrator.

C. COBRA notification letters will be sent to the qualified beneficiary at their last known address. It is important at the time of termination that you make sure that your agency has your correct address. You should remember that if you move, that you leave forwarding instructions at the Post Office.

COST OF BENEFITS - COBRA CONTINUATION RATES

Any qualified beneficiary who elects to continue coverage under the plan must pay the full cost of that coverage (including **both** the share you paid as an active employee, and the share paid by the employer), **plus** any additional amounts allowed by law. At present, COBRA Continuation rates are 102% of total premium. Those beneficiaries who elect the 11-month extension of benefits due to disability will pay 150% of premium for the additional 11-months of coverage.

Please go to the KHPA web site for the current plan year COBRA rates.

RETIREES AND MEDICARE ELIGIBILITY

EMPLOYEES AND SPOUSES WHO ARE AGE 65 AT RETIREMENT

If you or your covered spouse is age 65 or over when you retire, you must apply for Medicare Part A and Part B if you do not currently have both Parts. The Social Security Administration requires that the SEHP provide you a memo or letter with health insurance information necessary to process the application for Medicare Part B coverage. When applying for Medicare Part B, you should present the memo or letter to the local Social Security Office.

Required information in the memo or letter is:

A. Statement that you are covered under the SEHP,
B. Date your coverage began,
C. Date your coverage ended or will end, and
D. Your spouse's name and Social Security Number if your spouse is covered by the SEHP.

Please note the letter or memo must be on your agency's letterhead.

RETIREMENT

When you retire from employment, you must indicate on a Change Form whether or not you wish to continue SEHP coverage through the Direct Bill program. You must have continuous coverage under the SEHP to be eligible for the Direct Bill program. If continued coverage is desired, the Change Form should be completed

90-days before your retirement in order to ensure continuous coverage between active employee coverage and Direct Bill coverage.

The effective date of change to the Direct Bill program will be the 1st day of the month following your last day in pay status. You will receive a bill for the 1st full month in retirement status if bank draft information is not received in time to get the automatic bank draft started. For the next month and as long as you're eligible, you are eligible to continue coverage under the SEHP and may pay your premiums by any of these methods:

- Bank draft.
- On line
- Telephone
- Check or money order

Deductions from your bank account will occur on approximately the 3rd of the month for that month's coverage (i.e. January 3rd for January's coverage).

You 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 only if there is a qualifying mid-year event. Qualified dependents may also be added to coverage during the next Open Enrollment period.

You may opt out of dental coverage at retirement or Open Enrollment. **NOTE: Once you opt out of dental coverage, you will not be able to re-enroll in dental coverage at a later date.**

Vision coverage may not be dropped during the plan year unless due to a dependent becoming ineligible or unless all coverage is terminated. If dependent medical coverage is dropped, dependent vision coverage can be dropped.

Important note: If you have retired after January 21, 2001, you do not have the option to re-enroll in the SEHP after you drop SEHP coverage. Retiring employees will be allowed to re-enroll only if they maintain continuous coverage under the SEHP as a dependent.

IF YOU ARE MEDICARE ELIGIBLE

As a Medicare eligible retiree or member, you have 6 additional medical plans from which to choose:

- Kansas Senior Plan C with SilverScript Part D
- Kansas Senior Plan C without drug coverage
- Coventry Advantra Freedom PPO with Coventry Part D
- Coventry Advantra PPO with Silverscript
- Humana PPO with Humana Part D
- Humana PPO with Silverscript

Information on these plans can be found in the Direct Bill Health Plan Summary.

IF YOU AND YOUR COVERED SPOUSE ARE BOTH MEDICARE ELIGIBLE

If you and your covered spouse are both Medicare eligible, you will have the same 6 additional options available as those listed above. When Medicare is an option, you and your spouse will be enrolled in separate plans.

SPLIT ENROLLMENT OPTION – EITHER YOU OR YOUR SPOUSE ARE MEDICARE ELIGIBLE, BUT NOT BOTH AT THE TIME OF THE YOUR RETIREMENT

The option exists for retirees with mixed eligibility (one of you is Medicare eligible and the other is not) to split their enrollment. With this option, the Medicare member would enroll in one of the Coventry Advantra Freedom or Humana Plans or in Kansas Senior Plan C with or without prescription drug coverage, while the non-Medicare member would be allowed to remain in one of the SEHP plans. If this option is elected, your agency will complete a Change Form indicating that you are retiring and wants to continue with SEHP Direct Bill coverage. On the form, you would indicate what coverage you want to enroll in and, under the spouse's information, would indicate what coverage your spouse will be enrolled in. Once this Change Form is received by the SEHP Membership Services, a form will be sent to your spouse for their signature, to verify the coverage they have elected.