



**STATE EMPLOYEE HEALTH PLAN  
ACTIVE EMPLOYEES BENEFITS GUIDEBOOK  
PLAN YEAR 2010**

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**INTRODUCTION  
STATE OF KANSAS  
ACTIVE 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. Go to this website and click on the link that contains the information that you're looking for: <http://www.khpa.ks.gov/sehp/default.htm>**

*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.
- Flexible Spending Accounts (Health care and Dependent care) administered by ASI Flex

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.

If your address changes, please be sure to let your Personnel or Human Resource staff know what your new address is. It's important that you maintain an accurate address so that you can receive health plan information timely.

## 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 with the State of Kansas. 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 service from State of Kansas employment, calendar days employed in the previous position will be applied towards meeting the 60-day waiting period.
- If you are returning to work for the State of Kansas 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 for the State of Kansas, 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 for the State of Kansas has 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 State of Kansas retiree is returning to work for the State of Kansas 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.

Your HealthyKIDS deduction (if applicable) is not dependent on your salary range.

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.

If your address changes, please be sure to let your Personnel or Human Resource staff know what your new address is. It's important that you maintain an accurate address so that you can receive health plan information timely.

## **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). If your address changes, please be sure to let your Personnel or Human Resource staff know what your new address is. It's important that you maintain an accurate address so that you can receive health plan information timely.**

**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 1<sup>st</sup> 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 41 days 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, change pretax payment status, or enroll/re-enroll in Flexible Spending Accounts.

Enrollment for the HealthyKIDS program is required each Open Enrollment period. You must complete and submit the HealthyKIDS application to the SEHP Membership Services.

If you're enrolled in the Qualified High Deductible Health Plan, you can change your Health Savings Account (HSA) contribution amount

Open Enrollment is completed via the Internet using the on-line Employee Self Service Center. Information concerning on-line enrollment and paper form exceptions is published prior to Open Enrollment. Enrollment Forms are used all other times during the year.

If you are on Leave Without Pay or Family Medical Leave Act, you will be sent Open Enrollment materials to be completed and submitted during the Open Enrollment period.

## **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.

You should utilize the Employee Self Service Center during the month of December to view and print your Open Enrollment Confirmation Statement. You should review the deductions taken on your 1st paycheck in January and report any discrepancies to your Agency Human Resources Officer within 15 days of the date of the paycheck. Any discrepancies reported after this time will require that you complete a Communications Form and submit it to the SEHP for review.

## **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.

## **EMPLOYEE RATES**

SEHP employee rates are based on the following criteria:

### **Full-time or part-time employment status of your position (see the previous description of status).**

If you're a full-time employee, your Agency contributes approximately 95% of the cost of single coverage and approximately 55% of the additional cost for dependent coverage.

If you're a part-time employee, your Agency contributes approximately 75% of the amount contributed for full-time employees.

### **Annual salary range of the employee's position**

Salary Range 1:	annual salary less than \$28,000
Salary Range 2:	annual salary from \$28,000 to \$48,000
Salary Range 3:	annual salary of \$48,000 or more

**Health (medical/prescription drug, dental and vision) plans selected.**

**Tobacco Use Status**

**Coverage level selected**

**HealthyKIDS eligibility**

**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.

Unpaid leave of absence by you, your spouse or dependent which affects the benefits coverage of you, your spouse and/or dependents. If you are rehired or reactivated within 30 days, you must return to the same plans and coverage levels unless you experience a qualifying event.

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.

## **PAID SABBATICAL LEAVE**

If you are enrolled in coverage on an after-tax basis, you may drop coverage while on paid sabbatical leave. If you are participating in the pretax premium option, your salary while on sabbatical leave must be reduced in order to drop or change coverage.

A Change Form must be completed indicating the date the sabbatical leave will begin, the expected duration of the leave, and whether coverage will be dropped or changed.

If you drop coverage due to paid sabbatical leave and returns to active status during the same Plan Year, you must come back into the same plan and the same, or a reduced, coverage level as they had before going on leave. No additions to coverage will be allowed unless due to a qualifying event.

If you return from sabbatical leave in a new Plan Year, you may enroll or change to any medical plan or coverage for which you are eligible.

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

If you reside outside of the U.S. for a sabbatical leave, you should pay for any needed medical, drug or dental services with your own funds. A receipt (in English) showing the type of service and cost at the current exchange rate must be obtained. This receipt may be submitted to the appropriate medical, dental, vision or prescription drug plan carrier for reimbursement following your return to the U.S.

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

## **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.

## **HealthyKIDS PROGRAM**

HealthyKIDS is a program that helps eligible state employees with their premium for children's health insurance coverage in the SEHP. SEHP members with eligible dependent children will have 90% of the premium for their covered children paid for by the state instead of the traditional 55%. The employee will pay for the remaining 10%. Employees may enroll in any of the available plan options. The state contribution will be based on the lowest cost Health Plan.

If you cannot qualify for Kansas Health Wave (Title 21) because you are a state employee, you may qualify for HealthyKIDS if your household size and income fall within the guidelines below. Current household gross income guidelines can be found on the KHPA web site. Income guidelines may change in May of each year.

If living in the same household, you should count yourself and your spouse. Also, count the children under 19 who live with you, including adoptive children and minors for whom you have legal custody.

During Open Enrollment, you would enroll in a health plan and coverage tier of their choice. If you believe that you may be eligible for HealthyKIDS, you should complete a HealthyKids application and submit it to HealthyKIDS, Landon State Office Building, 900 SW Jackson St., Rm 900-N, Topeka, KS 66612-1220.

**You may apply mid-year due to a qualifying event if that event affects your health insurance coverage.** The qualifying events are the same as those established for mid-year enrollment changes (See Chapter 10). You must apply within 31 days of the event.

The HealthyKIDS deduction will not be stopped mid-year because of an increase in income or stopped because of a dependent reaching the age of 19 during the year.

When you apply for HealthyKIDS, the application will be reviewed and a determination made on eligibility. You will receive a letter indicating if your application was approved or denied. The agency does not receive a copy of this letter. If you are approved, the SEHP will change your benefit program to reflect the approval and allow the discounted premiums.

The increase for the employer contribution will be effective:

- January 1<sup>st</sup> for Open Enrollment
- The date you become first eligible
- The effective date of the approved mid-year change

If you receive a denial letter, you may change your coverage tier, but not the medical plan (Example: You may go from Family coverage to Member and Spouse). An SEHP Change Form must be completed within 31 days of the denial letter. Please write "Denial of HealthyKIDS" on the Change Form.

**You must reapply for the HealthyKIDS program during open enrollment each year.**

## **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 MEMBER 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. Prosthesis 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 Agency. 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 the State of Kansas paid as 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 that the letter or memo must be on your agency's letterhead.

## RETIREMENT

When you retire from State of Kansas 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 these 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.

If your address changes before you retire, please let your Personnel or Human Resource staff know what your new address is. If your address changes after retirement, please let the SEHP know what your new address is. In both cases, it's important that you maintain an accurate address that you can receive health plan information timely.

## **HEALTHQUEST**

HealthQuest, the State of Kansas health and wellness program, is designed to enhance the health and wellness of employees and assist in the containment of health care costs. The Kansas State Employees Health Care Commission and KHPA jointly administer this program. Current programs and services are for benefits eligible State and Non State employees who are enrolled in the SEHP or who have waived coverage in the plan as well as retirees, spouses and dependents 18 years or older who are enrolled in the SEHP. For additional information on programs and services, visit the HealthQuest website at

<http://www.khpa.ks.gov/healthquest/default.htm>.

### **Health Screening Program**

HealthQuest offers free health screenings in locations across the state. With a simple finger stick test, eligible members can obtain important health information such as total cholesterol, HDL, LDL, total cholesterol to HDL ratio, triglycerides, glucose, blood pressure, height and weight.

### **Health Assessment**

The online health assessment tool helps eligible members take an active role in managing their health. Using test results obtained from their health screening, they may complete an online assessment and get a personalized action plan. They are eligible to receive a \$50 gift card for completing both steps - the health screening and assessment.

## **Health Coaching**

Through the HealthQuest health coaching service, eligible members have access to a toll-free nurseline 24 hours a day/7 days a week for any health related questions they may have. Phones are staffed by specially trained health care professionals such as registered nurses, dietitians and respiratory therapists. These health coaches provide information and support to help members make important decisions about their health, understand more about treatment choices and prepare for doctor appointments. The coaching service also provides condition/disease management for assistance in managing ongoing conditions such as asthma and diabetes. Additionally, eligible members may enroll in coaching programs for lifestyle changes such as tobacco cessation, weight and stress management.

## **Educational Services**

The monthly HealthQuest e-newsletter provides a wealth of health information covering nutrition, exercise, stress management, self-care and much more. Current and past issues of the newsletter are online at [http://www.khpa.ks.gov/healthquest/wellness\\_newsletter.html](http://www.khpa.ks.gov/healthquest/wellness_newsletter.html).

The HealthQuest blog helps more than 4,000 subscribers stay current about wellness topics. Blog posts include quotes, tips, articles, free resources, and participant stories. Visit the blog at <http://www.healthquestkansas.com>.

Your agency can request health promotion presentations on a variety of topics including stress management, self-care, exercise, healthy eating, and healthy aging. Printed materials such as brochures, posters and orientations packets for new hires are also available.

## **LIFELINE Employee Assistance Program**

LIFELINE, the State of Kansas employee assistance program, provides free, confidential help to any employee (or family member living in the same household) experiencing personal issues. LIFELINE counselors provide short-term counseling (up to four sessions per issue) for the concerns that affect most employees in today's hectic world. A few of the most common examples include:

- Marriage and relationship concerns
- Family and parenting questions
- Domestic violence
- Emotional and stress related issues
- Alcohol and drug problems
- Grief and loss
- Work related concerns

Other LIFELINE services available include:

- Legal Advice and Discounts - free telephonic consultation with an attorney and 25% discount if attorney is retained for resolution of the issue
- Personal Money Management Assistance and Information -free telephonic consultations with licensed professionals on a wide variety of financial services
- Eldercare Information and Referral - licensed geriatric care specialists provide assistance with appropriate care for aging parents; counseling for the stresses associated with care giving is available
- Childcare Information and Referral - receive personalized childcare search assistance from licensed daycare providers; counseling for parenting and other childcare concerns is available
- Grab-A-Cab Program - cab fare reimbursement for safe transportation home within your city (one request per six months, maximum of \$45 each)
- Life Coaching - programs on strengthening careers, building relationships, improving self-esteem and stress management (life coaching is for employees only)
- Monthly Messages - e-newsletter with tips on staying mentally healthy

LIFELINE can be accessed 24 hours a day by calling 1-800-284-7575. The calls and visits are completely confidential. For more information, visit <http://www.khpa.ks.gov/healthquest/lifeline.html>.

**It's important for you to know:**

- These programs are totally voluntary.
- These programs are completely confidential and are administered by a third party vendor. Your personal medical information is not shared with any State of Kansas agency.
- These programs are free to eligible members.

**WORKERS COMPENSATION – TEMPORARY TOTAL DISABILITY**

**Workers Compensation**

Workers Compensation provides medical and disability compensation to state employees for injuries/accidents that arise out of and during the course of state employment. Workers Compensation is administered by the State Self Insurance Fund (SSIF).

**What should an employee who is injured at work do?**

- You should immediately report any injury/accident to your supervisor.
- Your supervisor must complete the Employer's Report of Accident form K-WC 1101a (02/06 revision).
- You should seek medical treatment if necessary using the Corvel network of physicians which can be looked up on the KHPA / SSIF website. This does not mean your claim will be approved.
- You must communicate with your agency/department and the SSIF. The SSIF phone number is 785-296-2364.
- Shortly after reporting your injury, you will receive a letter from the Kansas Division of Workers Compensation containing Form K-WC15. If you want, you may complete and submit the form to your supervisor.
- A Mileage Form is available at the KHPA/SSIF website for your use in keeping track of your miles and may be submitted periodically. Mileage is paid at the current rate set by the Kansas Division of Workers Compensation for doctor visits over five (5) miles round trip in **your** vehicle.
- A Guideline for the Repair or Replacement of Eyeglasses, WC-00-A, explains the process for obtaining benefits and is available on the KHPA/SSIF web site. A Prescription Eyeglasses Replacement Form, WC-00 needs to be filled out and returned to SSIF should your prescription eyeglasses be damaged during the course of your work.

**What are the responsibilities of the agency when you are injured at work?**

- Direct you to receive medical care, if necessary. You will be referred to a Corvel physician network (see KHPA / SSIF website). You should go to the emergency room at a local hospital if you have a life threatening medical emergency.
- It is important to understand that when your agency directs you to seek medical care, this does not mean that your Workers Compensation claim will be approved. The SSIF adjuster will determine compensability of the claim.
- If a medical provider contacts your agency for authorization of medical care, they are to refer the provider to the State Self Insurance Fund at 785-296-2364.
- Your supervisor is to complete the Employer's Report of Accident form, Form 1101-A, and send it as soon as possible to the SSIF. It may either be mailed to: SSIF, 900 SW Jackson, Room 900, Landon State Office Building, Topeka, KS 66612, faxed to: 785-296-6995 or emailed to [wc1101a@khpa.ks.gov](mailto:wc1101a@khpa.ks.gov)
- Submission of the Employers Report of Accident does not mean that you have been approved for Workers Compensation. The SSIF will investigate your claim once they have received the Employers Report of Accident and determine compensability.
- Your agency will refer you to the KHPA website for information about Workers Compensation. If you don't have ready access to the website, your agency can print out the Information for Employees for

you. You may also call the SSIF at 785-296-2364 or the Division of Workers Compensation at 1-800-332-0353.

- If you receive medical care and are given work restrictions by your medical provider, your agency must determine if the restrictions can be accommodated. If you are missing work due to a work-related injury, you need to send your agency a copy of the work release or restrictions.
- It is important for you and your agency to keep the SSIF informed about any changes in your status. This includes changes in work restrictions, if you are missing work, or when you return to work.
- When you are eligible to receive Workers Compensation disability benefits, you may want to supplement it with vacation or sick leave. Your agency should contact the SSIF if they have questions about the payroll system adjustments.
- If you receive Workers Compensation, you are not eligible for Shared Leave for the same medical condition. If your agency has questions about Workers Compensation and how it interacts with the Family Medical Leave Act, please contact the SSIF.
- Please contact the SSIF whenever you or your agency has questions about any aspect of handling a work-related injury. The phone number is 785-296-2364 and the fax is 785-296-6995. If you know who the adjuster is for a particular claim, you may contact them directly.

### **Managed Care Facilities**

The SSIF has designated the Corvel Physician Network as the medical care providers for you when you're injured on the job. To receive authorized medical treatment, you must be seen at one these facilities. The Corvel network of physicians can be looked up on the KHPA / SSIF website.

### **WORKERS COMPENSATION – TEMPORARY TOTAL DISABILITY**

If you are receiving temporary total disability (TTD) payments from the SSIF, K.A.R. 1-9-4 and 1-9-5 define how you can use your accumulated sick and vacation leave as wage replacement for loss of work time and that you can be put on leave without pay at your request, but only if your accumulated sick and vacation leave is exhausted. Your vacation and sick leave should continue to accrue based upon your TTD payments from SSIF. Your SEHP coverage should be continued as an active employee member with Agency contribution. If you're on TTD, your agency will send you a letter informing you of this.

- A.** If you choose to be paid for their accrued leave and the amount of your paycheck is sufficient to take the SEHP deduction, benefits and deductions will continue unchanged.
- B.** If the employee chooses to be paid for accrued leave and their paycheck is insufficient to take the SEHP deduction, the Agency must inform the employee immediately following each pay period to submit a personal check to the agency to cover the cost of their SEHP deduction. The amount due must be paid before the next paycheck issue date. The Agency should then process an adjustment. If the employee fails to pay on the scheduled time frame, a SEHP Change Form marked "Cancellation due to Non-payment" must be submitted immediately to SEHP Membership Services. The employee will not be allowed to re-enroll in coverage until the employee returns to active work status or at Open Enrollment.
- C.** If the employee does not choose to be paid for their accrued leave, the Agency should contact the employee immediately following each semi-monthly deduction period to request a personal check be sent to the agency to cover their SEHP deduction. The employee must pay the amount due before the next paycheck issue date. The Agency must then process an adjustment.

Again, if the employee fails to pay according to these guidelines, an SEHP Change Form marked "Cancellation due to Non-payment" must be submitted immediately to SEHP Membership Services. The employee will not be allowed to re-enroll in coverage until the employee returns to active work status or at Open Enrollment.

## **QUALIFIED HIGH DEDUCTIBLE HEALTH PLAN (QHDHP)**

The Qualified High Deductible Health Plan (QHDHP) is a Preferred Provider Organization (PPO) with a Health Savings Account (HSA) feature. With the QHDHP-HSA, there are both network and non network pricing structures for health coverage. A QHDHP also provides broader nationwide services and there is an allowance for preventive care. Prescription drug coverage is included although there is a slightly different Preferred Drug list than offered with other plans.

When you choose dependent coverage, your entire family deductible must be met before claims are paid for any one individual. An exception to this is preventive care services up to the \$450 preventive care service allowance.

Prescription drugs are subject to the QHDHP deductible; the vendor ID card will carry the Caremark logo for purchase of medications at a pharmacy. The QHDHP preferred drug list applies, which is different from the preferred drug list of other health plans. In addition, the QHDHP preferred drug plan does not qualify as creditable with Medicare. In other words, if a Medicare eligible individual is enrolled in the QHDHP plan, they would incur a penalty when they enrolled in a Medicare Part D prescription drug plan.

## **HEALTH SAVINGS ACCOUNT (HSA)**

An HSA is a required part of the QHDHP with minimum and maximum allowable contributions. The purpose of the HSA is to allow members to put tax advantaged savings aside for future medical expenses. The savings may be used for certain premiums, copayments, coinsurance, deductibles or any medical expenses that are not covered by the QHDHP.

The HSA is owned by the member, administered by the HSA Bank, and can be funded up to the maximum amount determined by the U.S. Treasury Department each year. Members between 55 and 65 can make a "catch up" contribution as outlined in IRS Publication 969. The HSA account is portable and funds rollover from year to year.

New employees who enroll in the QHDHP must complete the SEHP Enrollment Form, the HSA Enrollment Form (see your Human Resources staff), and the HSA bank Enrollment Form (obtained from the HSA bank) within 31 days of their date of hire. The SEHP Enrollment Form and the HSA Enrollment Form should be returned to your Human Resources Office. The HSA bank Enrollment Form must be sent directly to the HSA bank. If the HSA bank Enrollment Form is not forwarded to the bank, you will not be able to access the HSA funds that have been deducted from their payroll warrants.

You may only change their HSA contribution during Open Enrollment, or if a qualifying event occurs mid-year. If no change is made, the same contribution will continue into the next Plan Year.

If you change from member only to member and dependent medical coverage or from member and dependent to member only medical coverage mid-year due to a qualifying event, you may also change the HSA contribution amount. In some cases, the contribution amount will have to change. Refer to the Health Savings Account Contribution Chart in the Health Plan Summary Booklet. Along with the SEHP Change Form, you must also complete the HSA Enrollment and Change Form. Even if you do not wish to change the deduction amount, the HSA Form must be completed and submitted to the SEHP.

**For more information concerning SEHP benefits, please contact your Agency Human Resources Office.**

## **FLEXIBLE SPENDING ACCOUNT (FSA) PROGRAM:**

### **General Information**

The FSA program is offered by the State of Kansas to benefits eligible employees and is an Internal Revenue Code (IRS) Section 125 plan. The FSA program allows you to pay for certain premiums, non-reimbursed health care expenses, and dependent daycare expenses with pretax dollars. You can save an estimated 25-40% in taxes on that portion of your salary that is used for these qualifying expenses.

### **Options**

The FSA Program offers three benefit plans:

#### **Pretax Premium Option**

An employee enrolled in the SEHP may elect to participate in the Pretax Premium Option. The pretax election must be indicated on an Enrollment Form, during the initial enrollment period or made on-line during Open Enrollment. Participation in the Pretax Premium Option reduces the amount of tax withheld from your pay and increases your take-home pay.

**Health Care Flexible Spending Account** - allows you to use pretax dollars to pay health care expenses allowed by the IRS but not reimbursed by medical, dental, prescription drug or vision insurance.

**Dependent Care Flexible Spending Account** - allows you to use pretax dollars to pay for work related daycare expenses.

### **Tax Savings**

Payment on a pretax basis means that you enter into an agreement with the State of Kansas to reduce your salary by the cost of SEHP coverage or by the amounts elected for either, or both Flexible Spending Accounts. Since your salary is reduced, you do not pay federal or state income taxes or Social Security taxes on these amounts. As a result, your take home pay will increase by the amount you don't pay in taxes for the pretax benefits selected.

### **Initial Enrollment**

All benefits eligible employees may elect to participate in the Flexible Spending Accounts even if they do not enroll in the SEHP.

The initial enrollment period for Flexible Spending Accounts is limited. Newly hired employees should submit a completed FSA Enrollment Form to your Agency Human Resources Office within 31 days of your date of hire or new benefits eligibility. If forms are not submitted within 31 days, you will not be allowed to enroll until the next Open Enrollment period unless you experience a mid-year qualifying event for Flexible Spending Accounts.

The effective date of coverage is the first day of the month following completion of a 60 day waiting period. The waiting period begins with the first day of work for the State of Kansas in a benefits eligible position. Time spent in a benefit ineligible position will be applied to the 60 day waiting period if there is not a break in service of more than three days when an employee moves from a benefits ineligible position to a benefits eligible position.

### **Annual Open Enrollment Period**

Employees electing to participate in either the Health Care or the Dependent Care Flexible Spending Account(s) for a new Plan Year must complete a new Flexible Spending Account enrollment form On-line during the annual Open Enrollment period. Open Enrollment is generally held during the month of October (1<sup>st</sup>-31<sup>st</sup>) each year. An employee who enrolls during the Open Enrollment period will have Flexible Spending Account coverage effective the first day of the new Plan Year as outlined in the Health Plan Summary Book.

## Mid-Year Changes

Because the FSA program is an IRS Section 125 plan, there are some restrictions imposed by the IRS regarding changes in coverage during the Plan Year. You cannot change your SEHP pretax coverage level or the amount placed in your Flexible Spending Accounts until Open Enrollment unless you experience a qualifying event. All changes must be requested within 31 calendar days of the qualifying event and must also include written documentation of the event. In addition, the requested change must be consistent with the event. If approved, all changes will be made on a “future-forward” prospective basis and will be effective as of the first day of the month following the date the approval is made, not the first of the month following the date of the event. A list of allowable status changes for each option of the FSA Program is included in the section for that option.

## The FSA program is not for everyone

If you will need additional flexibility to drop out of SEHP coverage during the year, the after-tax option may be better. If you are divorced and have children covered by court order or through an ex-spouse's employer, the after-tax option may offer more flexibility. If you do not have some predictable dependent care expenses or health care expenses that will not be reimbursed, you should not elect the Flexible Spending Accounts. Neither you nor your spouse may make contributions to a Health Care Savings Account (HSA) while you are participating in the health care flexible spending account.

## Questions

For more specific information, you should refer to the specific section in this guide that deals with each of the three options, or contact your Agency Human Resources Office.

## Status Changes

According to IRS regulations, if you are participating in the Pretax Premium Option and you request a change in their coverage that will change their premium amount, you must first experience an approved status change as listed in this guide. In addition, changes in the SEHP coverage **must be requested within 31 calendar days** of the qualifying event. The change in coverage will be effective the first day of the month following the approval of the request.

Supporting documentation of each qualifying event is required. Examples include copies of a marriage license, final divorce decree, birth or death certificate, custody agreement, adoption papers, statement from a spouse's employer or statement from the daycare provider. For more information, refer to the section on Qualifying Events.

## Waiver Option

If you do not want to participate in the Pretax Premium Option, and you want to pay for the cost of SEHP coverage on an after-tax basis, you can indicate this on the SEHP Enrollment Form or during the On-line Open Enrollment.

## FSA Enrollment Form and Options

The annual election for FSAs is the amount(s) selected on the FSA Enrollment Form for new hires and mid-year changes or on the FSA portion of the On-line Open Enrollment form. To complete the enrollment process for new hires and/or mid-year changes, the form must be given to your Human Resources Office. **A new enrollment must be completed each year during Open Enrollment even if no change is desired.**

You are responsible for reviewing the deductions on your first paycheck of a new Plan Year. If the deduction amounts are not correct, you should contact your Agency Human Resources Office within 14 days of the paycheck in order to make corrections. If corrections are not requested within 14 days of your first FSA payroll deduction, changes will not be considered.

## HEALTH CARE FLEXIBLE SPENDING ACCOUNT

The Health Care FSA can be used to pay for qualified medical, vision, prescription drug and dental expenses which are not reimbursed by health insurance. You determine how much money they want to set aside for non-reimbursed health care expenses during a particular Plan Year. You then make an annual election on the FSA portion of the on-line Open Enrollment portal or an FSA Enrollment Form for initial and mid-year enrollment, and that amount is withheld from your salary on a pretax basis. As you incur health care expenses, you request reimbursement from the account by filing claims with Application Software Inc (ASI). You will receive reimbursement of your eligible expenses by check or by direct deposit into your own checking or savings account.

### **NEW FOR PY 2010—Flexible Spending Account Debit Card**

New for PY2010, FSA participants will have the option of having a FSA Debit Card. There is a \$12 annual fee for use of this card that will be deducted from your first paycheck in 2010. The annual fee is not refundable if you elect to quit using the card. The FSA Debit Card will be issued through ASI Flex and can be used anywhere that has an IIAS (Information Inventory Approval System) in place or accepts credit cards and have a proper health care merchant category code. Such places include pharmacies (Walgreens, CVS, etc.), healthcare provider offices, some hospitals and major chain/grocery stores like Wal-Mart, Target, Dillon's, Hy-Vee, etc. Additional details are available at ASI's website.

You may not transfer money from one spending account into another spending account. Money from the Health Care Account cannot be used to pay for dependent daycare expenses, and money from the Dependent Care Account cannot be used to pay for health care expenses.

### **Eligible Expenses**

Except for insurance premiums and long-term care expenses, eligible expenses are generally those that would otherwise be deductible on a Federal income tax return. Refer to the current IRS Publication 502, or link to ASI's website ([www.asiflex.com](http://www.asiflex.com)) or through the SEHP website (<http://www.khpa.ks.gov/sehp/default.htm>) for further information on qualifying expenses. Publication 502 is not written for flexible spending accounts specifically but is intended as a reference. Please note that an expense is considered incurred and is eligible for reimbursement from the health care flexible spending account when the medical service that gives rise to the expense is provided and not the date you pay for it.

Some examples of eligible expenses for you and their dependents include the non-reimbursed portion of:

- Medical care expenses, such as deductibles and coinsurance;
- Dental care and orthodontia expenses;
- Prescription drug or insulin expenses;
- Treatment and procedures not covered by medical or dental insurance (excluding cosmetic surgery procedures);
- Vision care expenses, including exams, eyeglasses, and contact lenses;
- Hearing exams, hearing aids, and hearing aid batteries;
- Other health care expenses permitted by the IRS;
- Over-the-counter medicines used to treat an existing medical condition.

You may not use this account to pay health insurance premiums for any individual, group coverage, or long term care expenses, even though these expenses are considered tax deductible on their federal income tax return. The same expense cannot be submitted to both health insurance and a Health Care Account.

Participants of the Health Care FSA will be reimbursed only for expenses with dates of service between January 1st and December 31st of the Plan Year and through the grace period of March 15<sup>th</sup> of the following year. Participants of the Dependent Care FSA will be reimbursed for expenses with dates of service between

January 1<sup>st</sup> and December 31<sup>st</sup> of the Plan Year. There is no grace period for the Dependent Care FSA. If you enroll in the Health Care FSA after January 1 of a Plan Year, you will be reimbursed for only those expenses incurred on or after their effective date of participation in the account. An expense is considered incurred when the service that gives rise to the expense is provided, regardless of when you are billed for or pay for the expense.

### How Much to Deposit

To participate in the Health Care FSA, you must complete and submit an FSA Enrollment Form or enroll on-line during Open Enrollment. As of January 1, 2010 (amounts subject to change each Plan Year), the minimum and maximum pay period/annual amounts are:

#### Health Care Flexible Spending Account Minimum Maximum

24 deduction period employees / per deduction

24 deduction period employees / per year

\$ 8.00/ minimum per paycheck

\$192.00 / minimum annually

\$208.33 / maximum per paycheck

\$5,000.00 / maximum annually

16 deduction period (at regents) / deduction

16 deduction period (at regents) / year

\$12.00 / minimum per paycheck

\$192.00 / minimum annually

\$312.50 / maximum per paycheck

\$5,000.00 / maximum annually

If you and your spouse are both State of Kansas employees and eligible to participate, each may each deposit the maximum per year in a Health Care FSA. An eligible claim may only be submitted **to only one** account. Your annual Health Care FSA election will be divided by 24 semi-monthly deduction periods (or 16 for some regents) and deducted from 24 paychecks. New mid-year participants (new hires) will enroll with an annual election divided by the number of remaining deduction periods in the calendar year. Deductions per paycheck cannot exceed \$208.33.

### FSA Grace Period

In May 2005, the IRS modified its rules to permit a “grace period” immediately following each plan year during which unused funds may be used to pay for qualified expenses incurred during the grace period. The Health Care FSA plan has been modified to include a “grace period” through March 15th following the Plan Year. For the Health Care FSA, expenses eligible for reimbursement are those incurred from January 1, 2010 through March 15th, 2011. Claims for the Health Care FSA must be filed by April 30, 2011. Dependent Care FSA eligible expenses for 2010 are those incurred from January 1, 2010 through December 31<sup>st</sup>, 2010. There is no grace period for the Dependent Care FSA.

### Qualifying Events

According to federal tax regulations, once the Plan year begins, your Health Care Flexible Spending Account **cannot** change or stop until the next Open Enrollment period **unless** you experience one of the following qualifying events:

- Your marriage, divorce or court-approved legal separation;
- The birth or adoption of a dependent;
- The death of a spouse or dependent;
- The gain or loss of legal custody of a dependent;
- A dependent’s eligibility is affected due to reaching age 23 or marriage;

- A change in your employment status, your spouse or your dependent such as a change from a benefits eligible position to a benefits ineligible position, termination or commencement of your employment, your spouse's or dependent's which affects FSA coverage for you, your spouse and/or your dependent;
- An unpaid leave of absence by you, your spouse or dependent which affects the FSA coverage of you, your spouse and/or your dependent. If reactivated, you must step back into the same enrollment unless you experience a different qualifying event.
- If you leave or return from leave under the FMLA; you must return into the same election unless you experience a different qualifying event. All election changes must be requested within 31 calendar days of the event, must be consistent with the event, and must include supporting documentation of the event. An election change satisfies the requirements of the consistency rule only if the election change is because of and corresponds with the qualifying event that affects eligibility for coverage under an employer's plan. If you do not enroll in the Health Care FSA during Open Enrollment, or when you become eligible, you must wait to enroll during the next Open Enrollment period, unless you experience a qualifying event. A mid-year change in your annual maximum election applies to expenses incurred after the effective date of that change.

### **Ending the Account**

Health Care FSA coverage ends at the end of the month in which termination from State of Kansas employment occurs. If you terminate employment with the State of Kansas or stops making deposits following a change in status, you will face restrictions. You will have until April 30th following the end of the Plan Year to file claims that were incurred through the end of the month of your termination or status change. In addition, if you terminate employment, you may extend your period of coverage on the Health Care FSA on an after-tax basis by electing continuation of coverage under COBRA. If you are rehired by the State of Kansas in the same calendar year, you may not re-enroll until the next Open Enrollment period. If you're on FMLA leave, you may continue to participate in the Health Care FSA by making payments to the account on an after tax basis. Otherwise, you may reactivate the account upon return from FMLA leave.

### **Filing for Reimbursement**

You may file claims for reimbursement from your Health Care FSA at any time during the year by completing an ASI claim form. A welcome packet containing claim forms, information line instructions, a direct deposit Enrollment Form, e-mail notification information and a debit card application will be sent to you by ASI after Open-Enrollment. All forms may also be downloaded from the ASI website ([www.asiflex.com](http://www.asiflex.com) or link through <http://www.khpa.ks.gov/subject/benlink.htm> ). You must mail or fax the completed form and proof of expense to the address or fax number on the form. Proof of expense includes:

A written statement from an independent third party stating that the medical, dental, prescription drug or vision expense has been incurred. The written statement must clearly indicate the date the service was provided and the amount of the expense (such as a Blue Cross "Summary of Claims Processed" form); or

- If the service is not covered by insurance (such as eyeglasses or orthodontia), a written statement from the provider, such as an original invoice or contract for orthodontic expenses, indicating the patient's name, date and type of service, and amount of the expense. The IRS does not allow cancelled checks, statements of balance due or proof of payment as proof of expense.
- For prescription drugs, the proof of expense must also show the name of the drug being dispensed. In addition, the IRS will not allow advance reimbursement of future or projected expenses from the Health Care FSA (this includes future orthodontia expenses).

### **Reimbursement Payments**

An employee will be reimbursed daily for eligible health care expenses (for those participants that elected to have an FSA Debit Card, reimbursement can be instant). If you are enrolled in direct deposit and your claim is received by ASI for processing one day, then reimbursement to your account should be initiated on the next business day. A check or notice of direct deposit will be mailed to your home address, or if enrolled in email

notification, sent via the Internet. To enroll in direct deposit or e-mail notification, you should contact your Agency Human Resources Office or ASI.

- You may file claims until April 30th of the following year for eligible expenses incurred in the current Plan Year. **Any money remaining in your account after April 30th following the end of the Plan Year will be forfeited.**

### **How to Plan Ahead**

You should plan ahead for the effect of payroll reductions during participation in the Health Care FSA. Keep in mind, at the start of each year, there will be health care expenses as well as payroll deductions for the account.

### **Benefits of the Health Care Account**

A federal and state income tax deduction is available for health care expenses. It will be to your advantage to use the Health Care FSA for predictable medical expenses. Federal tax regulations do not allow you to take the deduction and use the Health Care FSA for the same eligible expenses. A comparison of the Health Care Account and the federal income tax deduction is shown below:

### **Health Care Spending Account Federal and State Income Tax Deduction**

- All expenses reimbursed through the account are on a pretax basis. Expenses are exempt from tax. You will not pay taxes on them at a later date.
- There is no Social Security tax on pay deposited to this account.
- Deposits through payroll deduction help budget for expected health care expenses during the year.
- Only expenses that exceed 7.5% of adjusted gross income are deductible, and only if deductions are itemized.
- Social Security tax is paid on health care expenses that are not paid through the FSA Health Care Spending Account, even if they can be deducted on federal and state income tax returns.

### **DEPENDENT CARE FLEXIBLE SPENDING ACCOUNT**

The Dependent Care FSA can be used to pay for your eligible **work-related dependent care (daycare) expenses. The Dependent Care FSA cannot be used to pay for health care expenses for your dependents.** You determine how much you will spend on dependent care during the year. These expenses must be employment-related, and are the amounts you will spend in order for you and/or your spouse to be employed. You then make an annual election on the FSA Enrollment Form or on-line during Open Enrollment and that amount is deducted from your paycheck on a pretax basis. As you incur dependent care expenses, you request reimbursement from the FSA account by filing claims (the FSA Debit Card is not available for the Dependent Care FSA). You will receive reimbursement for your eligible expenses by check or direct deposit. The money that is reimbursed has not been and will not be taxed. You may not transfer money from one FSA spending account into the other. Money from the Dependent Care FSA cannot be used to pay for health care expenses, and money from the Health Care FSA cannot be used to pay for dependent care expenses. You should not enroll prior to the birth of a child, in anticipation of daycare expenses for that child. No eligible daycare expenses can occur prior to the birth.

### **Who Can Use the Dependent Care FSA**

You may elect to participate in the Dependent Care Account if you are:

- Single;
- Married, and the dependent care expenses are necessary for both parents to work, or;
- Married and your spouse is either incapable of self-care, actively seeking employment, or is a full-time student at least 5 months during the year.

## Eligible Expenses

According to IRS regulations, eligible expenses for reimbursement are those expenses that are for the care and well being of your dependent child. The child must be under the age of 13 or the care must be for a disabled dependent of any age (such as a parent) that is incapable of self-care and spends at least 8 hours per day in your home. Camps in lieu of dependent care must be primarily for care of the dependent. Expenses for education, sports camps and overnight camps are not eligible except in extremely rare circumstances. Food and transportation expenses, when billed separately, are not eligible. (Please refer to the current IRS Publication 503 for further information on qualifying expenses. Publication 503 is not written specifically for flexible spending accounts and is used as a reference. Please note that expenses are eligible for reimbursement from the dependent care flexible spending account based on the date the dependent care is provided, not based on the date you pay for it.)

Eligible expenses include charges for:

- A licensed, certified or registered daycare facility or nursery school;
- An individual in your home (other than your spouse, your dependent child under age 19, or a housekeeper); or,
- An individual in your home (assuming all State requirements have been met). **This account may not be used to pay for a dependent's health care expenses.** If you are divorced, you must have more than 50% physical custody to use this account. You will be reimbursed only for daycare provided between January 1 and December 31 of the Plan Year for which you are enrolled. Expenses that were incurred in a prior year, although being paid for in the current Plan Year, are not eligible for reimbursement. If you enroll in the Dependent Care Account after January 1 of a Plan Year, you will be reimbursed for only those expenses incurred on or after your effective date of participation in the account.

## How Much to Deposit

To participate in the Dependent Care Flexible Spending Account, you must complete an FSA Enrollment Form or enroll on-line during Open Enrollment. The minimum and maximum (subject to change each Plan Year) pay period/annual amounts are:

### Dependent Care Flexible Spending Account Minimum Maximum

24 deduction period employees / deduction  
 24 deduction period employees / per year  
 \$16.00/ minimum per paycheck  
 \$384.00 / minimum annually  
 \$208.33\*/ maximum per paycheck  
 5,000.00\* / maximum annually  
 16 deduction period (at regents) / deduction  
 16 deduction period (at regents) / year  
 \$24.00/ minimum per paycheck  
 384.00 / minimum annually  
 \$312.50\*/ maximum per paycheck  
 5,000.00\* / maximum annually  
 \*Subject to tax filing status

If the employee is:	They may deposit up to:
Single	\$5,000 per year
Married, filing joint	\$5,000 per year
Married, filing separately	\$2,500 per year
Married, with a spouse who is disabled or a full-time student	\$2,400 per year for 1 dependent or up to \$4,800 per year for 2 or more dependents.

If you or your spouse earns less than the amounts shown, the maximum amount you may elect is the lesser of you or your spouse's income. If you and your spouse are both State of Kansas employees and are eligible for the Dependent Care FSA, you may deposit no more than the defined maximum deduction per year between your two accounts combined, subject to the income limitations already stated. Your annual Dependent Care FSA election will be divided by 24 deduction periods (or 16 for some Regents) and deducted from each semi-monthly paycheck (There is no deduction take on the third check of a month). New mid-year participants (new hires) will enroll with an annual election divided by the number of remaining deduction periods in the calendar year.

### **Grace Period**

There is no grace period for the Dependent Care FSA. Eligible expenses for reimbursement are those incurred from January 1, 2010 through December 31, 2010. Claims for 2010 dependent care expenses must be filed by April 30, 2011.

### **Qualifying Events**

According to federal tax regulations, once you are participating in the Dependent Care FSA, you cannot change the amount of money you put in their account or stop contributions until the next Open Enrollment period unless the employee experience one of the following qualifying events:

- Your marriage, divorce or court-approved legal separation;
- The birth or adoption of a dependent;
- The death of a spouse or dependent;
- A change in your employment status, your spouse, or your dependent such as a change from a benefits eligible position to a benefits ineligible position, termination or commencement of your employment, your spouse or dependent which affects FSA coverage for the employee, spouse and/or dependents;
- An unpaid leave of absence by you, your spouse or your dependent which affects the FSA coverage of you, your spouse and/or dependent. If reactivated, you may step back into the same enrollment unless you experience a qualifying event;
- Your leave or return from leave under the FMLA. Upon return from leave, you may step back into the same election unless you experience a qualifying event;
- A qualified dependent reaches the age of 13;
- A change in the employee's dependent care provider (including kindergarten)
- A significant increase or decrease in the current dependent care provider's rate (excludes relatives).

All changes must be requested within 31 calendar days of the event, must be consistent with the event, and must also include supporting documentation of the event. An election change satisfies the requirements of the consistency rule only if the election change is on account of and corresponds with a change in status that affects eligibility for coverage under an employer's plan. If an employee does not enroll in the Dependent Care Flexible Spending Account during Open Enrollment, or when they first become eligible, they must wait until the next Open Enrollment period to enroll, unless they experience a change in status.

### **Ending the Account**

If you terminate employment with the State of Kansas or stop making deposits due to a qualifying event, you until April 30th in the year following the end of the Plan Year to file claims which were incurred up to the end of the Plan Year. If you are rehired by the State of Kansas in the same calendar year, you may not reenroll until the next Open Enrollment period. If you return from a leave without pay, you may reenroll in the Dependent Care FSA.

## **Filing for Reimbursement**

You may file claims on your Dependent Care FSA at any time during the year by completing an FSA Reimbursement Form. After Open Enrollment, ASI will send you claim forms, information line instructions, a direct deposit Enrollment Form, and e-mail notification information. All forms may also be downloaded from the ASI website ([www.asiflex.com](http://www.asiflex.com)). You must mail or fax the completed form and proof of expense to the address or fax number on the form. Proof of expense includes:

- A receipt from the provider detailing the dates that dependent care services were provided and amount of the expense; and
- The Dependent Care provider's name, address, and Tax Identification Number or Social Security Number. The IRS does not allow cancelled checks as proof of expense or payment.

## **Reimbursement Payments**

You will be reimbursed for eligible dependent care expenses up to the balance currently on deposit in the your account. The IRS will not allow advance reimbursement of future or projected expenses from the Dependent Care FSA. Claims are processed within 24 hours following receipt. A check or notice of direct deposit will be mailed to your home address, or if direct deposit is activated, you have the option of receiving an e-mail notice. You may file claims until April 15th of the following year for eligible expenses incurred in the current Plan Year. **Any money remaining in your account after April 15th following the end of the Plan Year will be forfeited.**

## **How to Plan Ahead**

The first payroll deduction for Dependent Care FSA will be taken from the first paycheck of the Plan Year. You should plan ahead for the effect of payroll reductions during your participation in the Dependent Care FSA. At first, you will need to have a cushion of enough money to pay your expenses after payroll reductions to the account. The Dependent Care FSA deductions come out of the your pay. You pay expenses directly to your provider. Then, you submit a claim for reimbursement of expenses and you're reimbursed by ASI. Remember that no claim will be paid before the first paycheck of the Plan Year - when the account is funded.

## **Benefits of the Dependent Care Account**

Current tax laws offer both a federal and state income tax credit for eligible dependent care expenses paid on an after-tax basis. The tax credit is a percentage of your annual dependent care expenses based on your family's adjusted gross income. The maximum amount of expenses eligible for the tax credit is \$3,000 for one dependent and \$6,000 for two or more dependents. Any expense reimbursed through the Dependent Care Account reduces the amount of expenses eligible for the income tax credit. Generally, the Dependent Care Account offers greater tax savings if you are:

- Single and has an adjusted gross income over \$30,000; or,
- Married, filing jointly and your family's adjusted gross income over \$31,000. The above information is based on approximate calculations. It does not take into consideration any individual tax circumstances. Because this issue is complex, you may want to consult a tax advisor to find out whether the Dependent Care Flexible Spending Account or the income tax credit is better for their situation.

## WORKSHEET – HEALTH CARE FSA

Use this sheet to estimate your out-of-pocket expenses for the New Year. Consider any known factors that could impact these amounts. Remember you cannot change, increase or decrease your FSA contribution during the Plan Year, unless your status changes. When increasing the annual election for your FSA, you may only include expenses that are incurred after the effective date of the change of election.

Annual estimated expenses for medical services rendered in the upcoming Plan Year. Only use expenses **not reimbursed** by your medical, dental, and/or vision plans:

Medical expenses, such as:

- Deductibles and coinsurance \$ \_\_\_\_\_
- Routine physical exams \$ \_\_\_\_\_
- Well baby care \$ \_\_\_\_\_
- Prescriptions (Insulin, Birth Control, etc.) \$ \_\_\_\_\_
- Hearing aids or exams \$ \_\_\_\_\_
- Other eligible expenses\* \$ \_\_\_\_\_
- Dental expenses, such as:
  - Deductibles and coinsurance \$ \_\_\_\_\_
  - Routine check-ups \$ \_\_\_\_\_
  - Orthodontic (braces, etc.) -- paid only on a services \$ \_\_\_\_\_ rendered or monthly payment basis
- Vision care expenses, such as:
  - Exams \$ \_\_\_\_\_
  - Eyeglasses or contacts \$ \_\_\_\_\_
  - OTC Medicine and drugs (used to treat an existing medical condition) \$ \_\_\_\_\_

**Total Annual Estimated Health Care Expenses \$ \_\_\_\_\_**

\*Eligible expenses include most expenses considered deductible by the IRS for federal income tax purposes. See Eligible Expenses.

## DEPENDENT CARE FSA

Qualifying expenses are those incurred for the care and well being of your dependent in order for you to be gainfully employed.

- Annual payment to a child/dependent care facility or individual \$ \_\_\_\_\_
- Annual payment to other qualifying care providers \$ \_\_\_\_\_