Your Employee Benefits

2019

This document is current as of January 1, 2019.

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IMPORTANT NOTES:

The State of Minnesota expects to continue the State Employee Group Insurance Program (SEGIP) indefinitely. However, it reserves the right to change or discontinue all or any part of the insurance programs or benefits, consistent with the state's rights and obligations under the law and collective bargaining agreements. The State Employee Group Insurance Program is not liable for insurance plans that may become insolvent.

This document is a summary only. Please refer to each plan's summary of benefits/certificate of coverage for a complete description of all benefits and exclusions. You may view summaries and certificates on the SEGIP website at mn.gov/mmb/segip. If there is any difference between this document and any summary of benefits/certificate of coverage, the summary/certificate of benefits will govern.

Introduction to your benefits

The benefits available through the State Employee Group Insurance Program (SEGIP) are carefully negotiated by representatives of employee unions and the state. If you are not represented by a union, your employer may provide you with the same benefits that represented employees receive.

A broad base of programs have been developed to ensure the future health and security of you and/or your eligible family members. Employees who are eligible for benefits may enroll in the following insurance and flexible spending accounts (FSAs) benefits:

Basic Benefits

- employee medical insurance
- employee basic life insurance

Optional Benefits

- family medical insurance
- employee dental insurance
- family dental insurance
- supplemental employee life insurance
- spouse life insurance
- child life insurance
- employee accidental death and dismemberment insurance
- spouse accidental death and dismemberment insurance
- employee short-term disability insurance
- employee long-term disability insurance
- manager's income protection plan

Optional Pre-tax and Flexible Spending Accounts (FSAs)

- Health and Dental Premium Account
- Dependent Care Expense Account (day care)
- Medical/Dental Expense Account
- Transit Expense Accounts

The benefits available through SEGIP are provided through a governmental plan which is not subject to ERISA.

Access to Benefit Information

Personal Benefit Information

- state.mn.us/employee
- Use your 8 digit employee ID and password
- Select Sign-in, Benefits, Benefits Summary

SEGIP website

Information about all insurance benefits is available on the SEGIP website mn.gov/mmb/segip. If you need assistance to find a document or specific information, please call 651-355-0100 for help.

Medical and Dental plan materials

Each carrier administering claims in the State Employee Group Insurance Program (SEGIP) works with Minnesota Management and Budget (MMB) to prepare summaries and descriptions of the plans. Medical and dental provider networks can be found on the SEGIP website and on the websites of each carrier, found on the Insurance Contacts page.

Summaries of Benefits and Certificates of Coverage

Summaries of Benefits and Certificates of Coverage are legal documents that describe the plan benefits. They include much more detail about your plan and benefits than this document contains. All Summaries of Benefits and Certificates of Coverage are available on the SEGIP website .

Labor contracts and plans

Most state employees are covered by a labor contract (also called a collective bargaining agreement) or plan. These contracts and plans help define many of the key provisions of SEGIP. For more information about your benefits, check the contract or plan that covers your position. Most contracts and plans are available on the MMB home page mn.gov/mmb.

Flexible Spending Account (FSA) pre-tax benefits

A complete guide to enrollment and use of the SEGIP FSA benefit options is available online or upon request from 121 Benefits (the administrator of SEGIP FSA plans). Go to 121 Benefits homepage 121benefits.com or call 612-877-4321 or 1-800-300-1672.

Annual Open Enrollment materials

Each year, benefits-eligible employees are provided Open Enrollment materials via the SEGIP Newsletter or SEGIP brochure and the Open Enrollment tab of the SEGIP website .

Employee meetings

Employee meetings are held periodically to discuss changes in benefits, especially during the annual Open Enrollment. Watch for information posted prior to the annual Open Enrollment.

Financial and Administrative Services Agreements

Each insurance carrier or claims administrator participating in the State Employee Group Insurance Program signs a Financial and Administrative Services Agreement with the State. Versions of these agreements are

available for inspection at the offices of Minnesota Management and Budget/Employee Insurance, by calling for an appointment 651-355-0100. Consumers with hearing or speech difficulties can contact their preferred Telecommunications Relay Service.

Additional sources of information

Staff in your agency human resource office are trained to help direct you to appropriate resources on benefits available to you based on your employment status.

For other questions regarding rates, insurance billing, eligibility, coverage level, claims, or to answer basic questions, call SEGIP at 651-355-0100. Consumers with hearing or speech difficulties can contact their preferred Telecommunications Relay Service.

Medical coverage

Minnesota Advantage Health Plan is the medical benefits program for eligible state employees

State of Minnesota employees, retirees (under age 65), and eligible dependents who receive medical coverage under the State Employee Group Insurance Program (SEGIP) are enrolled in a medical benefits program called the Minnesota Advantage Health Plan (Advantage).

How does Advantage work?

Under Advantage, you share in the cost of most medical services by paying out-of-pocket costs through deductibles, office visit copays, and coinsurance. These amounts are determined by the cost level of the chosen primary care provider.

Health care providers participating in the Minnesota Advantage Health Plan have been placed into one of four cost levels, depending on the care system in which the provider participates and that care system's total cost of delivering medical care.

Copays, deductibles, and out-of-pocket maximums are lowest for providers in cost level 1, closely followed by cost level 2. The member responsibility for care delivered by providers in cost levels 3 and 4 is greater, due to these providers having higher costs of care.

Once you've reached your annual out-of-pocket maximum limit, the Advantage Plan will pay all remaining medical costs for eligible services for the rest of that year.

NOTE: Most employees can enroll in SEGIP's pre-tax flexible spending account (FSA), called the Medical/Dental Expense Account (MDEA), a program that will allow your predictable Out of Pocket (OOP) costs to be paid with pre-tax dollars you set aside through payroll deductions. If you have predictable OOP costs, making an MDEA election can minimize your health care costs. See the Optional Coverage Highlights section of this booklet or your Open Enrollment materials for details. If you are enrolled in the Advantage High Deductible Plan, or another high deductible plan, and have an accompanying Health Savings Account (HSA), you can enroll in an MDEA, however, you must enroll in a limited-purpose MDEA that only covers dental and vision expenses.

NOTE: Two state employees who are married to each other and enroll separately with the same medical carrier have an opportunity to combine out-of-pocket maximums. The out-of-pocket expenses, including the first-dollar deductible incurred by one spouse, can be applied to the family maximum and family deductible of the spouse who carries family coverage. In this situation, it is the employee's responsibility to notify their carrier when the out-of-pocket maximum and/or deductible have been met.

Advantage High Deductible Health Plan (HDHP)

SEGIP also offers a high deductible health plan, though state statute restricts enrollment to members of the Commissioner's Plan, Managerial Plan, and most unrepresented employees. The traditional Minnesota Advantage Health Plan will still be offered to these employees, but they will now have the option to choose the high deductible health plan with an accompanying Health Savings Account (HSA). See the SEGIP website at mn.gov/mmb/segip for more information about the HDHP.

Advantage Plan includes important features

The Advantage Plans have cost sharing features that will help you and the state to better control health care costs while maintaining flexibility in access to doctors and clinics. Advantage has some important notable features, including:

- Uniform comprehensive set of benefits across all carriers. There are some differences in the way the carriers administer certain benefits, such as with the treatment of infertility or transplant benefits.
- No copays or deductible for preventive care such as immunizations, well-child care, annual check-ups, etc.
- Most medical care is coordinated through your Primary Care Clinic (PCC) and you will generally need a referral to see a specialist.
- You may self-refer to certain specialists including obstetricians/gynecologists, chiropractors, and mental health/chemical dependency practitioners. You may also self-refer for routine eye exams. How you access this specialty care depends on your carrier and possibly your PCC.
- Family members may elect different PCCs (even in a different cost level), but must be covered under the same carrier as you, the employee/policy holder.
- You may change your PCC as often as monthly, even if it changes your cost level. Clinic changes are made by calling your carrier and are effective the first of the month following the date you request the change.
- Referrals to a specialist's office visit will be covered at the same cost level as your PCC.
- You must choose a carrier that is available in the county in which you live or work.
- You control your initial out-of-pocket costs with your selection of a PCC from one of four cost levels for yourself and/or covered dependents.
- The amount of cost sharing that will be paid when using medical services varies depending on the cost level of the PCC that is chosen. The PCCs in cost levels 1 and 2 provide the best value with the lowest possible out-of-pocket (OOP) maximum costs. The OOP maximum for cost level 3 and 4 are set higher because the cost to deliver care under these systems is higher than the costs in cost levels 1 and 2 clinics.

Advantage Prescription Drug Benefit

CVS Caremark® is the pharmacy benefit manager (PBM) for the Advantage Health Plans regardless of the carrier under which you enroll.

Your pharmacy benefit offers a high level of access to low cost, clinically effective medications. CVS Caremark has one drug formulary with three copay tiers. When you are prescribed formulary medications by your doctor, it will generally fall into one of these three tiers:

Tier 1: Includes mainly generic medications, but some brands. It is the best cost value for most drugs.

Tier 2: Includes preferred brand drugs and some generics; greater access to additional medication choices.

Tier 3: Includes more costly non-preferred brand drug options.

Although you will pay copays under one of these tiers, the Advantage prescription drug benefit features an out-of-pocket maximum. Once you or a covered family member has reached the out-of-pocket maximum, the plan will pay all remaining eligible expenses for that year.

You may have prescriptions filled at any pharmacy in the CVS Caremark network, but specialty drugs must be purchased through the CVS specialty network. Mail-order prescription service is also available for members filling maintenance medications. Mail-order or pick-up at a CVS pharmacy can provide a 90-day supply for two copays versus three. It is recommended (not required) that you set up an account at the CVS Caremark website at caremark.com once you have received your identification card to access important plan information.

How to find Primary Care Clinics (PCC) and clinic numbers

A list of participating clinics is available to help you make your PCC selection. This list includes your PCC number that you will need in order to enroll in medical insurance. To find the list, go to the SEGIP website at mn.gov/mmb/segip. Select Find a Clinic. As we approach Open Enrollment and the new plan year, additional information will be provided for the upcoming year.

The SEGIP website also provides links to more detailed online provider directories of the three Advantage Plan carriers: BlueCross BlueShield, HealthPartners, and PreferredOne.

For specific questions about clinics or access to specialists, call the carrier directly. The carriers' phone numbers are listed on the SEGIP website.

Convenience Care Clinics

Convenience care clinics are available in some areas with no member cost share, regardless of your cost level. The first dollar deductible is waived for participants in the Advantage Plan. Participants in the Advantage High Deductible Health Plan (HDHP) will have no cost share after they have met their deductibles. Convenience clinics provide a cost-effective alternative to emergency rooms, urgent care, and family practice clinics when used for simple illnesses, tests, and vaccinations. Each clinic is staffed by a certified family nurse practitioner or physician assistant who delivers the service in 10 to 15 minutes. Appointments are not required. Call your carrier for the most up to date information on in-network convenience care clinics and locations.

Online Care Benefit

This simple diagnostic tool provides access to a health care provider via the internet, regardless of your location or access to a certain care system. The benefit is designed to function like an in-network Convenience Care Clinic without the confines of office walls. The Online Care Benefit is provided without referrals, is not subject to the annual deductible, and is provided with no member cost share for participants in the Advantage Plan, regardless of your cost level. Participants in the Advantage High Deductible Health Plan will have no cost share after they have met their deductibles. You may access Doctor on Demand and/or Virtuwell if you are a member or BlueCross BlueShield or HealthPartners. You may access Virtuwell if you are a member of PreferredOne. To learn more about them or to use this benefit, visit: Doctor on Demand www.doctorondemand.com/bluecrossmn or Virtuwell www.virtuwell.com.

Out of Area Coverage

Emergency and Urgent Care Coverage

Employees and dependents (who reside in the service area) traveling out of the service area can receive out-of-area Emergency and Urgent Care benefit which is equivalent to the in-network Emergency Room and Urgent Care benefit. Each carrier offers a Preferred Provider Organization (PPO) through which all eligible employees and dependents are eligible to receive discounted services outside the State of Minnesota and the service area of the Minnesota Advantage Health Plan. Coverage is limited to urgent and emergency care for employees whose Permanent Residence is within the State of Minnesota and the service area of the Minnesota Advantage Health Plan.

The out-of-network Emergency and Urgent Care benefits for participants who permanently reside outside of the Advantage Plan service area will be administered consistent with their Point of Service benefit when they are in travel status.

Point of Service (POS)

The Point of Service (POS) benefit is available to employees, early retirees, former employees, former employees with disabilities, and COBRA enrollees whose permanent residence is outside the State of Minnesota and the service area of the Minnesota Advantage Health Plan. It is also available to employees temporarily residing outside Minnesota on temporary or paid leave (including sabbatical leave), all dependent children (including college students), and spouses and ex-spouses living out of area. The benefit schedule includes a $350 single/$700 family deductibles and 30% coinsurance paid up to the allowed amount. Members using this benefit may be responsible for the difference between the allowed amount and the billed charge. These employees and their dependents may receive provider discounts when they use the PPO of the carrier with whom they are enrolled. Parents of college students eligible for this benefit are asked to notify their carrier of their child's eligibility. Members eligible for this benefit will be asked to designate a Primary Care Clinic (PCC) within the service area, and when in-area, they are covered through the PCC at the cost level they have chosen.

Access for POS benefits must be requested by providing the permanent address outside the service area to SEGIP and by calling your carrier to request access to POS.

Employees who live and work out-of-area. Employees whose permanent residence and principal work location are outside the State of Minnesota and the service area of the Minnesota Advantage Health Plan may receive Cost Level 2 benefits in the area of their permanent residence if they obtain services from the PPO of the carrier with whom they are enrolled. If a PPO provider is not available in their area, they may receive Cost Level 2 benefits from any licensed provider in their area. If PPO provider is available but not used, coverage will be limited to POS benefits.

Married SEGIP Participants/Parent and dependent child employed by SEGIP

If both spouses work for the state or another organization participating in SEGIP, a spouse may be covered as a dependent by the other. If the employee's adult child (age 18 until 26) works for the state or another organization participating in SEGIP, the child may be covered as a dependent by the parent/employee. In either situation, the employee who will be covered as a dependent must waive coverage by completing the Waiver of Coverage Form within their initial eligibility period. Enrollment and dependent verification must be completed within the appropriate time periods. Also, only one state employee can cover any dependents they may have in common.

SEGIP Health Solutions

SEGIP Health Solutions improves the health and wellbeing of state employees, their families, and their workplaces. It draws on several strategies and resources to support health: health improvement services, wellness initiatives, health care cost management directives, and employee assistance programs. In SEGIP's ongoing commitment to create a healthy workplace, we provide the State of Wellbeing Program. As a state employee, you will have the opportunity to take advantage of innovative wellbeing programs and actively address your goals through the State of Wellbeing's four disciplines:

- cognitive wellbeing
- physical wellbeing
- social wellbeing
- economic wellbeing

Advantage Value for Diabetes

This pilot program aims to reduce health risks and promote effective management of diabetes. Adult participants diagnosed with type I or type II diabetes will receive high-value medical services associated with diabetes for reduced costs or no copays. Increasing the access to high-value services, including prescription medication and certain testing supplies, can reduce the risk of costly complications. There is no enrollment process, and reduced copays occur when visits, diabetic medications, or testing supplies are received. For more information, see the SEGIP Health Solutions Diabetes Management website at mn.gov/mmb/segip/health-solutions/employees/diabetes-management/.

Health Assessment

Employees in the Advantage Plan have an opportunity to take a health assessment as part of the State of Wellbeing program, powered by Virgin Pulse. If they choose to complete the health assessment during the annual Open Enrollment and agree to a follow-up call from a health professional, the employee and covered dependents will receive the lower office visit copay in each cost level. Employees hired (or becoming newly eligible) after Open Enrollment will be entitled to the lower of the two copays. Employees in the Advantage High Deductible Plan will receive a $500 single/$1,000 family incentive to their HSA if they complete the health assessment and agree to a follow-up call from a health professional.

Employee Assistance Program

The State's Employee Assistance Program (EAP) provides cost-free, confidential, professional assistance to help employees and families resolve work and personal issues. For more information, contact the Employee Assistance Program at 651-259-3840 or 800-657-3719 or www.mylifematters.com.

For More Information about Your Medical Benefits

BlueCross BlueShield

P.O. Box 64560
Saint Paul, MN 55164-1627
651-662-5090
888-878-0137 TTY
800-262-0819
www.bluecrossmn.com/segip
National PPO: Blue Card
800-810-2583

HealthPartners

8170 - 33rd Avenue South
P.O. Box 1309
Minneapolis, MN 55440-1309
952-883-7900
952-883- 5127 TTY
888-343-4404
www.healthpartners.com/segip
National PPO: CIGNA
888-343-4404

PreferredOne

P.O. Box 59212
Minneapolis, MN 55459
763-847-4477
763-847-4013 TTY
800-997-1750
www.preferredone.com/segip
MultiPlan PHCS (PPO)
800-922-4362 or
763-847-4477

2019 Minnesota Advantage Health Plan Schedule of Benefits

2019 Benefit Provision	Cost Level 1 - You Pay	Cost Level 2 - You Pay	Cost Level 3 - You Pay	Cost Level 4 - You Pay
A. Preventive Care Services • Routine medical exams, cancer screening • Child health preventive services, routine immunizations • Prenatal and postnatal care and exams • Adult immunizations • Routine eye and hearing exams	Nothing	Nothing	Nothing	Nothing
B. Annual First Dollar Deductible (single/family)	$150/300	$250/500	$550/1,100	$1,250/2,500
C. Office visits for Illness/Injury, for Outpatient Physical, Occupational or Speech Therapy, and Urgent Care • Outpatient visits in a physician's office • Chiropractic services • Outpatient mental health and chemical dependency • Urgent Care clinic visits (in & out of network)	$25/30*copay per visit Annual deductible applies	$ 30/35* copay per visit Annual deductible applies	$60/65* copay per visit Annual deductible applies	$80/85*copay per visit Annual deductible applies
D. In-network Convenience Clinics & Online Care (deductible waived)	Nothing	Nothing	Nothing	Nothing
E. Emergency Care (in or out-of-network) • Emergency care received in a hospital emergency room	$100 copay Annual deductible applies	$100 copay Annual deductible applies	$100 copay Annual deductible applies	25% coinsurance Annual deductible applies
F. Inpatient Hospital Copay (waived for admission to Center of Excellence)	$100 copay Annual deductible applies	$200 copay Annual deductible applies	$500 copay Annual deductible applies	25% coinsurance Annual deductible applies
G. Outpatient Surgery Copay	$60 copay Annual deductible applies	$120 copay Annual deductible applies	$250 copay Annual deductible applies	25% coinsurance Annual deductible applies
H. Hospice and Skilled Nursing Facility (deductible waived)	Nothing	Nothing	Nothing	Nothing
I. Prosthetics, Durable Medical Equipment	20% coinsurance Not subject to annual deductible	20% coinsurance Not subject to annual deductible	20% coinsurance Not subject to annual deductible	25% coinsurance Annual deductible applies
J. Lab (including allergy shots), **Pathology, and X-ray** (not included as part of preventive care and not subject to office visit or facility copayments)	5% coinsurance Annual deductible applies	5% coinsurance Annual deductible applies	20% coinsurance Annual deductible applies	25% coinsurance Annual deductible applies
K. MRI/CT Scans	5% coinsurance Annual deductible applies	10% coinsurance Annual deductible applies	20% coinsurance Annual deductible applies	25% coinsurance Annual deductible applies

L. Other expenses not covered in A-K above, including but not limited to:
• **Ambulance**
• **Home Health Care**
• **Outpatient Hospital Services (non-surgical)**
  • Radiation/chemotherapy
  • Dialysis
  • Day treatment for mental health and chemical dependency
  • Other diagnostic or treatment related outpatient services
	5% coinsurance
	Annual deductible applies
		5% coinsurance
		Annual deductible applies
			20% coinsurance
			Annual deductible applies
				25% coinsurance
				Annual deductible applies

M. Prescription Drugs 30-day supply of Tier 1, Tier 2, or Tier 3 prescription drugs, including insulin, or a 3-cycle supply of oral contraceptives Note: all Tier 1 generic and select branded oral contraceptives are covered at no cost.	$14/25/50	$14/25/50	$14/25/50	$14/25/50
N. Plan Maximum Out-of-Pocket Expense for Prescription Drugs (excludes PKU, Infertility) (single/family)	$800/1,600	$800/1,600	$800/1,600	$800/1,600
O. Plan Maximum Out-of-Pocket Expense (excluding prescription drugs) (single/family)	$1,200/2,400	$1,200/2,400	$1,600/3,200	$2,600/5,200

**Employees who complete the Health Assessment during Open Enrollment and agree to a health coaching call receive the lower office visit copayment for themselves and covered dependents. Employees hired after the close of Open Enrollment will automatically receive the lower copayment.*

This chart applies only to in-network coverage. Point-of-Service (POS), coverage is available only to members whose permanent residence is outside both the State of Minnesota and the Advantage plan's service area. This category includes employees temporarily residing outside Minnesota on temporary assignment or paid leave [including sabbatical]; and college students. It also applies to dependent children and spouses permanently residing outside the service area. Members enrolled in this category pay a $350 single or $700 family deductible and 30% coinsurance to the out-of-pocket maximum described in Section O above. Members pay the drug copayment described at Section M above to the out-of-pocket maximum described at Section N. This benefit must be requested.

The Advantage Plan offers a standard set of benefits regardless of the selected carrier. There are differences in how each carrier administers the benefits, including the transplant benefit, in the referral and diagnosis coding patterns of primary care clinics, and in the definition of Allowed Amount.

Revised September 5, 2018

2019 Advantage Health Plan Rates

100% Employer Contribution

Monthly Rates	Employee Coverage			Dependent Coverage			Family Coverage		
Health Plan	Total	State	Employee	Total	State	Employee	Total	State	Employee
Advantage BlueCross	649.72	617.24	32.48	1260.90	1071.76	189.14	1910.62	1689.00	221.62
Advantage HealthPartners	649.72	617.24	32.48	1260.90	1071.76	189.14	1910.62	1689.00	221.62
Advantage PreferredOne	649.72	617.24	32.48	1260.90	1071.76	189.14	1910.62	1689.00	221.62

75% Employer Contribution

Monthly Rates	Employee Coverage			Dependent Coverage			Family Coverage		
Health Plan	Total	State	Employee	Total	State	Employee	Total	State	Employee
Advantage BlueCross	649.72	462.94	186.78	1260.90	803.82	457.08	1910.62	1266.76	643.86
Advantage HealthPartners	649.72	462.94	186.78	1260.90	803.82	457.08	1910.62	1266.76	643.86
Advantage PreferredOne	649.72	462.94	186.78	1260.90	803.82	457.08	1910.62	1266.76	643.86

50% Employer Contribution

Monthly Rates	Employee Coverage			Dependent Coverage			Family Coverage		
Health Plan	Total	State	Employee	Total	State	Employee	Total	State	Employee
Advantage BlueCross	649.72	308.62	341.10	1260.90	535.88	725.02	1910.62	844.50	1066.12
Advantage HealthPartners	649.72	308.62	341.10	1260.90	535.88	725.02	1910.62	844.50	1066.12
Advantage PreferredOne	649.72	308.62	341.10	1260.90	535.88	725.02	1910.62	844.50	1066.12

0% Employer Contribution

Monthly Rates	Employee Coverage			Dependent Coverage			Family Coverage		
Health Plan	Total	State	Employee	Total	State	Employee	Total	State	Employee
Advantage BlueCross	649.72	0	649.72	1260.90	0	1260.90	1910.62	0	1910.62
Advantage HealthPartners	649.72	0	649.72	1260.90	0	1260.90	1910.62	0	1910.62
Advantage PreferredOne	649.72	0	649.72	1260.90	0	1260.90	1910.62	0	1910.62

MANAGEMENT AND BUDGET
STATE EMPLOYEE GROUP INSURANCE PROGRAM

Dental coverage

You have the option to purchase dental insurance for yourself and your dependents. Two dental plans are available through SEGIP. You may choose a dental plan that is available in the county where you live or work. You may enroll in, drop, or change dental plans every other year during the Open Enrollment period, or if you experience a qualifying life event (see page 23).

Important features

Both dental plans provide coverage for most conditions requiring dental diagnosis and treatment, including orthodontic treatment. To help you maintain good dental health, all plans also cover a broad range of preventive services, including:

- regular exams
- x-rays
- routine dental cleanings
- children's fluoride treatment

Benefits across both plans are similar, including the same annual maximum, but there are some differences in the way benefits are administered. For more detailed information, check your plan's Summary of Benefits.

Provider networks

Each dental plan has a network of dentists and preferred specialists through which you receive in-network care. You can access directories of dental clinics and dentists through links to each carrier. Links to the carriers can be found on the SEGIP website, mn.gov/mmb/segip. To ask specific questions about dental clinics, call the carrier directly. The carriers' customer service numbers are listed at the end of this section.

Predetermination of benefit

When services other than preventive care are recommended by your dentist, ask your dentist to submit a request for a predetermination of benefits to your carrier. This ensures that you understand the amount your carrier will pay and the amount that will be your responsibility.

For more information about dental insurance

HealthPartners State of Minnesota Dental Plan

8100 - 34th Avenue South
P.O. Box 1309
Minneapolis, MN 55440-1309
952-883-7900
952-883-5127 TTY
888-343-4404
www.healthpartners.com/segip

State Dental Plan (Delta Dental of Minnesota) Group 216

P.O. Box 330
Minneapolis, MN 55440-0330
651-406-5916
651-406-5923 TTY
800-553-9536
888-853-7570 TTY
www.deltadentalmn.org/segip

Dental Schedule of Benefits for 2019

Annual Maximum per person $2,000 (does not apply to Orthodontia).

Orthodontics Lifetime Maximum per person $2,400 (does not start over if you change dental plans).

	In-network Benefits	Out-of-network Benefits
Annual Deductible	$50 per person $150 per family	$125 per person

Diagnostic and preventive care (deductible does not apply)

Covered Services	In-network Benefits	Out-of-network Benefits
Preventive care; examinations, x-rays, oral hygiene & teeth cleaning	100% coverage	50% coverage of the allowed amount
Fluoride treatment (to age 19)	100% coverage	50% coverage of the allowed amount
Space maintainers	100% coverage	50% coverage of the allowed amount
Sealants	100% coverage	50% coverage of the allowed amount

Restorative care and prosthetics (deductible applies)

Covered Services	In-network Benefits	Out-of-network Benefits
Fillings (customary restorative materials)	80% coverage	50% coverage of the allowed amount
Oral surgery	80% coverage	50% coverage of the allowed amount
Periodontics (gum disease therapy)	80% coverage	50% coverage of the allowed amount
Endodontics (root canal therapy)	80% coverage	50% coverage of the allowed amount
Inlays and overlays	80% coverage	50% coverage of the allowed amount
Restorative crowns	80% coverage	50% coverage of the allowed amount
Implants	80% coverage	50% coverage of the allowed amount
Fixed or removable bridgework	80% coverage	50% coverage of the allowed amount
Full or partial dentures	80% coverage	50% coverage of the allowed amount
Dental relines or rebases	80% coverage	50% coverage of the allowed amount
Orthodontics	80% coverage (deductible does not apply)	50% coverage of the allowed amount (deductible does not apply)

Emergency services are covered at the same benefit level as non-emergency services.

See Summary of Benefits for specific plan limitations.

2019 Dental Plan Rates

100% Employer Contribution

Monthly Rates	Employee Coverage			Dependent Coverage			Family Coverage		
Health Plan	**Total**	**State**	**Employee**	**Total**	**State**	**Employee**	**Total**	**State**	**Employee**
State Dental Plan (Delta)	39.84	26.34	13.50	78.04	39.02	39.02	117.88	65.36	52.52
HealthPartners State of MN Dental Plan	39.84	26.34	13.50	78.04	39.02	39.02	117.88	65.36	52.52

75% Employer Contribution

Monthly Rates	Employee Coverage			Dependent Coverage			Family Coverage		
Health Plan	**Total**	**State**	**Employee**	**Total**	**State**	**Employee**	**Total**	**State**	**Employee**
State Dental Plan (Delta)	39.84	19.76	20.08	78.04	29.28	48.76	117.88	49.04	68.84
HealthPartners State of MN Dental Plan	39.84	19.76	20.08	78.04	29.28	48.76	117.88	49.04	68.84

50% Employer Contribution

Monthly Rates	Employee Coverage			Dependent Coverage			Family Coverage		
Health Plan	**Total**	**State**	**Employee**	**Total**	**State**	**Employee**	**Total**	**State**	**Employee**
State Dental Plan (Delta)	39.84	13.18	26.66	78.04	19.52	58.52	117.88	32.70	85.18
HealthPartners State of MN Dental Plan	39.84	13.18	26.66	78.04	19.52	58.52	117.88	32.70	85.18

0% Employer Contribution

Monthly Rates	Employee Coverage			Dependent Coverage			Family Coverage		
Health Plan	**Total**	**State**	**Employee**	**Total**	**State**	**Employee**	**Total**	**State**	**Employee**
State Dental Plan (Delta)	39.84	0	39.84	78.04	0	78.04	117.88	0	117.88
HealthPartners State of MN Dental Plan	39.84	0	39.84	78.04	0	78.04	117.88	0	117.88

MANAGEMENT AND BUDGET
STATE EMPLOYEE GROUP INSURANCE PROGRAM

2019 Disability Plans

Short-Term Disability Insurance

monthly benefit	semi monthly	monthly
300	2.31	4.62
400	3.08	6.16
500	3.85	7.70
600	4.62	9.24
700	5.39	10.78
800	6.16	12.32
900	6.93	13.86
1000	7.70	15.40
1100	8.47	16.94
1200	9.24	18.48
1300	10.01	20.02
1400	10.78	21.56
1500	11.55	23.10
1600	12.32	24.64
1700	13.09	26.18
1800	13.86	27.72
1900	14.63	29.26
2000	15.40	30.80
2100	16.17	32.34
2200	16.94	33.88
2300	17.71	35.42
2400	18.48	36.96
2500	19.25	38.50
2600	20.02	40.04
2700	20.79	41.58
2800	21.56	43.12
2900	22.33	44.66
3000	23.10	46.20
3100	23.87	47.74
3200	24.64	49.28
3300	25.41	50.82
3400	26.18	52.36
3500	26.95	53.90
3600	27.72	55.44
3700	28.49	56.98
3800	29.26	58.52
3900	30.03	60.06
4000	30.80	61.60
4100	31.57	63.14
4200	32.34	64.68
4300	33.11	66.22
4400	33.88	67.76
4500	34.65	69.30
4600	35.42	70.84
4700	36.19	72.38
4800	36.96	73.92
4900	37.73	75.46
5000	38.50	77.00

NOTE: You may enroll in short-term disability in amounts up to 2/3 of your gross monthly salary.

2019 Disability Plans

Long-term disability insurance

gross annual	salary	max monthly benefit from all sources	max monthly benefit payable	monthly cost	semi monthly cost
6,001	6,500	300	300	1.62	.81
6,501	7,000	350	350	1.89	.95
7,001	8,000	400	400	2.16	1.08
8,001	9,000	450	450	2.43	1.22
9,001	10,000	500	500	2.70	1.35
10,001	11,000	550	550	2.97	1.49
11,001	12,000	600	600	3.24	1.62
12,001	12,500	650	650	3.51	1.76
12,501	13,000	700	700	3.78	1.89
13,001	14,000	750	750	4.05	2.03
14,001	15,000	800	800	4.32	2.16
15,001	16,000	850	850	4.59	2.30
16,001	18,000	900	900	4.86	2.43
18,001	19,000	950	950	5.13	2.57
19,001	20,000	1,000	1,000	5.40	2.70
20,001	22,000	1,100	1,100	5.94	2.97
22,001	24,000	1,200	1,200	6.48	3.24
24,001	26,000	1,300	1,300	7.02	3.51
26,001	28,000	1,400	1,400	7.56	3.78
28,001	30,000	1,500	1,500	8.10	4.05
30,001	32,000	1,600	1,600	8.64	4.32
32,001	34,000	1,700	1,700	9.18	4.59
34,001	36,000	1,800	1,800	9.72	4.86
36,001	38,000	1,900	1,900	10.26	5.13
38,001	40,000	2,000	2,000	10.80	5.40
40,001	42,000	2,100	2,100	11.34	5.67
42,001	44,000	2,200	2,200	11.88	5.94
44,001	46,000	2,300	2,300	12.42	6.21
46,001	48,000	2,400	2,400	12.96	6.48
48,001	50,000	2,500	2,500	13.50	6.75
50,001	52,000	2,600	2,600	14.04	7.02
52,001	54,000	2,700	2,700	14.58	7.29
54,001	56,000	2,800	2,800	15.12	7.56
56,001	58,000	2,900	2,900	15.66	7.83
58,001	60,000	3,000	3,000	16.20	8.10
60,001	61,000	3,100	3,100	16.74	8.37
61,001	62,000	3,200	3,200	17.28	8.64
62,001	63,000	3,300	3,300	17.82	8.91
63,001	64,000	3,400	3,400	18.36	9.18
64,001	65,000	3,500	3,500	18.90	9.45

gross annual	salary	max monthly benefit from all sources	max monthly benefit payable	monthly cost	semi monthly cost
65,001	67,000	3,600	3,600	19.44	9.72
67,001	69,000	3,700	3,700	19.98	9.99
69,001	71,500	3,800	3,800	20.52	10.26
71,501	73,000	3,900	3,900	21.06	10.53
73,001	75,000	4,000	4,000	21.60	10.80
75,001	77,000	4,100	4,100	22.14	11.07
77,001	79,000	4,200	4,200	22.68	11.34
79,001	81,000	4,300	4,300	23.22	11.61
81,001	83,000	4,400	4,400	23.76	11.88
83,001	85,000	4,500	4,500	24.30	12.15
85,001	87,000	4,600	4,600	24.84	12.42
87,001	89,000	4,700	4,700	25.38	12.69
89,001	91,000	4,800	4,800	25.92	12.96
91,001	93,000	4,900	4,900	26.46	13.23
93,001	96,000	5,000	5,000	27.00	13.50
96,001	98,000	5,100	5,100	27.54	13.77
98,001	100,000	5,200	5,200	28.08	14.04
100,001	102,000	5,300	5,300	28.62	14.31
102,001	104,000	5,400	5,400	29.16	14.58
104,001	106,000	5,500	5,500	29.70	14.85
106,000	108,000	5,600	5,600	30.24	15.12
108,001	110,000	5,700	5,700	30.78	15.39
110,001	112,000	5,800	5,800	31.32	15.66
112,001	114,000	5,900	5,900	31.86	15.93
114,001	116,000	6,000	6,000	32.40	16.20
116,001	118,000	6,100	6,100	32.94	16.47
118,001	120,000	6,200	6,200	33.48	16.74
120,001	122,000	6,300	6,300	34.02	17.01
122,001	124,000	6,400	6,400	34.56	17.28
124,001	126,000	6,500	6,500	35.10	17.55
126,001	128,000	6,600	6,600	35.64	17.82
128,001	130,000	6,700	6,700	36.18	18.09
130,001	132,000	6,800	6,800	36.72	18.36
132,001	133,500	6,900	6,900	37.26	18.63
133,501	135,500	7,000	7,000	37.80	18.90

NOTE: The maximum benefit from all sources is the most you can expect to receive from all sources of disability income, including but not limited to, state disability retirement, workers' compensation, Social Security and any other income you may receive.

Flexible Spending Accounts (FSA) or pre-tax benefits

The Flexible Spending Account (FSA) benefits offered by SEGIP and administered by 121Benefits, can provide you with substantial tax savings by paying your SEGIP offered health and dental plan premiums, eligible dependent day care, out-of-pocket medical or dental, and transportation expenses with pre-tax dollars. Since your taxable income is reduced for Social Security, federal and state taxes, so are the taxes you pay.

The FSA benefits are available to employees paid through the State's Central Payroll. Employees of other organizations participating in SEGIP or paid through an independent payroll system may have similar benefits. Ask your Human Resources office about the availability of FSA plans.

It's important to understand how pre-tax plans work. One important rule to understand is the Internal Revenue Service's (IRS) "use or lose" rule. Because of the tax advantages of pre-tax benefits, contributions to the Dependent Care (daycare) Expense Account (DCEA) are forfeited if eligible expenses are not submitted by the deadline. Currently, the Medical/Dental Expense Account (MDEA) includes a $500 Carryover. This feature allows eligible participants to carryover up to $500 of unreimbursed money from their current year MDEA over to the next plan year. The carryover funds can be used for expenses in the next plan year. Any funds in excess of the allowed $500 carryover are subject to the "use or lose" rule. See the 121 Benefits website at www.121benefits.com/client-landing/state-of-minnesota for greater detail. Another important rule is that MDEA and DCEA elections cannot be changed without an IRS recognized status change. Be sure you understand these risks before you enroll in a pre-tax account.

Participation in the pre-tax benefits program has no effect on future state retirement pension benefits. Your retirement and disability benefits are figured based on your gross salary, not your reduced taxable salary. However, your Social Security benefits may be slightly reduced because you're paying less in Social Security (FICA) taxes.

Health and Dental Premium Account

The Health and Dental Premium Account (HDPA) allows you to pay your share of the Minnesota Advantage Health Plan and State Dental Plan or State of Minnesota HealthPartners Dental Plan premiums with pre-tax dollars if you are paid through the State's Central Payroll. The pre-tax premium account saves you money because your contributions for health and dental insurance are subtracted from your salary before federal, state, and Social Security taxes are calculated.

Dependent Care Expense Account

The Dependent Care (daycare) Expense Account (DCEA) allows you to pay for certain dependent care (daycare) expenses with pre-tax dollars. DCEA funds are for eligible daycare expenses for your qualified children up to age 13 or adult daycare for your qualified disabled spouse or other disabled dependent. The DCEA is for daycare expenses incurred while you are working or looking for work. The minimum election is $100 and the household federal maximum is $5,000 per tax year. There are special rules that apply depending upon your tax filing status. Consult your tax advisor. Remember, this account is for daycare expenses, not medical or dental expense for your dependents.

Medical/Dental Expense Account

The Medical/Dental Expense Account (MDEA) allows you to pay for certain out-of-pocket medical, dental, prescriptions, and vision expenses with pre-tax dollars for you, your spouse, and eligible dependents. The MDEA can be used to pay for health and dental plan deductibles, copays, coinsurance, and other expenses as defined by Internal Revenue Service (IRS) code that cannot be reimbursed from any other sources, such as another insurance plan. The MDEA cannot be used for premiums. Remember that the Minnesota Advantage Health Plan and dental plan premiums are automatically deducted pre-taxed. The minimum election is $100 and the current maximum is

$2,700 per plan year. If you lose your benefits eligibility, you can continue your MDEA participation on an after-tax basis by electing COBRA.

Enrollment in an MDEA is available each year during the annual Open Enrollment. Carefully plan your election, as your election cannot be changed unless you have a qualified life event.

Pre-tax Debit Cards

121 Benefits provides a Flexible Spending Account debit card that contains the value of your annual MDEA election and MDEA carryover amount and Health Reimbursement Arrangement (HRA) amounts (when applicable). You can use the debit card to pay for qualified medical expenses not covered by your health insurance. The debit card automatically deducts the costs of your eligible expenses from your MDEA balance (or HRA when applicable).

The IRS requires all MDEA and HRA claims be substantiated. If you use your debit card for payment, you may be asked to provide documentation. The unsubstantiated debit card transaction amount may be included on your W2 form as taxable income if the documentation is not provided when requested.

Limited Purpose MDEA and HRA

There are certain MDEA and HRA limitations if you, your spouse, or eligible dependent(s) participates in a Health Savings Account (HSA), which accompany a High Deductible Health Plan (HDHP). A limited purpose MDEA and HRA (if applicable) is an option for these employees. The limited purpose MDEA restricts what expenses are eligible for reimbursement. For more information, contact 121 Benefits prior to your MDEA enrollment.

The limited purpose MDEA works the same way a standard MDEA does – the difference is the limitation of expenses that are eligible for reimbursement. The limited purpose MDEA limits reimbursable expenses to vision, dental, or preventative medical expenses.

SEGIP members enrolled in the Advantage High Deductible Health Plan (HDHP), which is the high deductible health plan and elect an MDEA or have an HRA, should elect a limited purpose MDEA and a limited purpose HRA in order to avoid any adverse tax consequences. Additionally, SEGIP members covered by a spouse participating in a high deductible plan and HSA should elect a limited purpose MDEA in order to avoid tax consequences.

For more information, contact 121 Benefits prior to enrolling in your MDEA.

Transit Expense Accounts

The Transit Expense Account (TEA) allows you to use pre-tax dollars to pay for certain costs associated with your work-related commute. The Transit Expense Account-Parking (PKEA) covers out-of-pocket parking fees. The Transit Expense Account-Bus Pass/Vanpool (BVEA) covers out-of-pocket bus pass, light rail, or vanpool expenses. You may contribute up to the Federal/State maximum (see the administrator 121 Benefits's website for current annual/monthly limits).

You may enroll throughout the year and you may make monthly changes. Unlike the MDEA and DCEA, funds left in your account at the end of the year may be carried forward to the next year, provided you re-enroll in the plan for the next year either during the annual Open Enrollment or prior to the start of the new plan year. The minimum annual election is $50. **Note:** Reimbursement requests for vanpool or parking must be submitted within 180 days of the date the expense was incurred or paid.

The pre-tax debit card is the only way to access funds to purchase bus and light rail fares and passes. No other reimbursement method is allowed. Debit card purchases for bus and light rail fares and passes do not need follow up documentation.

STATE OF MINNESOTA
Flexible Spending Account
Medical/Dental Expense Account (MDEA)
Eligible Expense Worksheet

The Medical/Dental Expense Account (MDEA) allows an employee to set aside pre-tax dollars to pay for medical, dental, and vision expenses that are not paid by insurance, as well as eligible Over the Counter Drugs. You can include out-of-pocket expenses incurred by you, your spouse, and your qualified dependents.

The following is a partial list of eligible expenses. These include expenses related to the diagnosis, care, treatment, or prevention of disease. Eligible expenses are generally those permitted by Section 213(d) of the Internal Revenue Code.

Examples of Reimbursable Health Care Expenses

- Abortion – if legal
- Acupuncture
- Adoption – medical expenses incurred before adoption is finalized
- Alcoholism or drug dependency treatment and treatment centers
- Ambulance
- Artificial limbs and teeth
- Automobile modifications for physically handicapped person
- Birth control pills
- Blood pressure monitoring devices
- Body scan (ex: MRI, CT scan)
- Braille books and magazines – only amount paid ABOVE the cost of regular printed materials
- Breast pumps and related lactation supplies.
- Childbirth preparation classes for mother, **excludes** cost for "coach"
- Chiropractors
- Christian Science practitioners for specific medical care
- Contact lenses and contact lens solutions
- Contraceptives – including condoms
- Counseling – to treat a specific medical condition, **excludes** marriage counseling
- Crutches
- Deductible, coinsurance, and co-pay amounts if underlying expense is eligible
- Dental treatment, including dentures, orthodontia (braces and retainers), and occlusal guards to prevent teeth grinding
- Diabetic insulin, syringes and glucose monitoring equipment
- Diagnostic services
- Eye examination
- Eyeglasses, prescription sunglasses, reading glasses, and eyeglass cleaner
- Fertility treatments – if treatment impacts the participant or dependent of participant, includes shots, treatment, surgery, IVF, GIFT, ovulation monitor, fees for storage of sperm or embryo (*short-term; no longer than one year*)
- Flu shots
- Guide dog or other animal aide – purchase, training, and veterinary care of animal
- Hearing aids and batteries
- Home modifications to accommodate handicapped person
- Hospital services
- Immunizations
- Incontinence supplies
- Laboratory fees
- Language training for child with dyslexia or disabled child
- Laser eye surgery, radial keratotomy, LASIK, corneal ring segments
- Lead-based paint removal – to prevent a child, who has or has had lead poisoning from eating the paint, **excludes** cost of repainting
- Lodging for medical care – $50 per night for outpatient, essential medical care, up to $100 if companion required
- Mastectomy-related specialty bras
- Medic-alert bracelet or necklace (only to treat a medical condition)
- Medical conference admission and transportation to/from – expenses for admission and transportation to medical conference relating to chronic disease of participant or dependent, includes transportation to city where conference is held and local transportation to conference. Cost of meals and lodging is not allowed
- Medical information plan – expenses charged for storing and retrieving medical records from a computer data bank
- Medical monitoring and testing devices (ex: blood pressure monitor, glucose kits, etc.)
- Medical records charges
- Medical supplies – (ex: bandages, gauze, carpel tunnel wrist supports etc.) **excludes** personal comfort items
- Mental institution or special home-care for mentally ill or mentally disabled person who is unsafe when left alone
- Norplant insertion or removal
- Nursing services – nurse expenses, board and care for a specific medical condition, **excludes** nursing services for a healthy baby
- Nutritionist's professional expenses – if to treat a specific medical condition, **excludes** expense for general health
- Obstetrical expenses
- Organ transplants or donation
- Orthodontia
- Orthopedic shoes, only the cost over what normal shoes would cost
- Osteopathy
- Over-the-counter items (see the OTC Expense Worksheet for information about eligible OTC items)
- Oxygen and equipment
- Patterning exercises for a mentally disabled child
- Physical exams – excluding employment related physicals & sports physicals
- Pregnancy test (includes over-the-counter tests)
- Prescription medications – **excludes** medication to stimulate hair growth or prescriptions for cosmetic purposes
- Psychiatric care – includes cost of supporting mentally ill dependent at a special center which provides medical care
- Psychologist – medical care if to treat a specific medical condition
- Reconstructive surgery following mastectomy
- Screening tests (e.g. hearing, vision, cholesterol)
- Sleep deprivation testing and treatment
- Smoking cessation program – includes programs and prescription drugs
- Special schooling for physically or mentally handicapped – main reason for using school is its resources for relieving the disability
- Speech therapy
- Sterilization procedures
- Support or corrective devices (such as orthopedic shoes)
- Surgery to improve deformity from congenital abnormality, personal injury from accident or trauma, or disfiguring disease
- Taxes imposed on reimbursable medical care or products, along with shipping or handling fees

- Telephone – purchase and repair for special telephone equipment for hearing impaired person
- Television for hearing-impaired person – equipment which displays the audio part of TV programs (costs of specially equipped television that exceed the cost of regular models only)
- Transportation – expenses for essential medical care (18 cents per mile. Rate subject to IRS changes), parking and tolls
- Wheelchair – purchase, operation, and upkeep
- X-rays

Examples of Reimbursable Health Care Expenses that Require a Doctor's Note of Medical Condition

The following are examples of expenses that require a physician's letter of medical necessity. Please include, with claim, a physician's statement or prescription indicating the specific medical condition requiring the item or service being submitted for reimbursement, the specific items or services prescribed and the timeframe the items or services are to be used. Doctor's note is required each calendar year.

Remember: *All over-the-counter medications require a physician's prescription to be eligible for reimbursement (excluding diabetic insulin)*

- Air purifier
- Chelation (EDTA) therapy
- Chinese Herbal Doctor/herbs
- Ear plugs
- Exercise equipment
- Genetic testing - (if done to diagnose a medical condition)
- Health institute treatment
- Holistic or naturopathic remedies
- Learning disability (amount paid to special school or specially trained teacher for severe learning disability caused by mental or physical impairments)
- Massage therapy - for specific injury or trauma, **excludes** treatment to relieve stress. (Note must include medical condition, length of time treatment will be needed, and number of sessions during stated time.
- Vitamins (**excludes** multi or one a day vitamins)
- Weight loss program or drugs prescribed to induce weight loss
- Wigs –for a patient who has lost all of their hair from disease or treatment

Examples of Non-Reimbursable Health Care Expenses

- Air Conditioners (units or central air systems)
- Allergy treatment products and household improvements to treat allergies – examples – filters, pillows, and special vacuums –products that would be owned even without allergies
- Any charges incurred outside the plan year, even if paid for during the current plan year
- Baby-sitting, child care and nursing services for a healthy baby
- Cosmetic surgery, electrolysis, and/or hair transplants
- Cost of remedial classes for non-handicapped child
- Dance or ballet lessons for improvement of general health
- Diapers or diaper service unless for specific medical condition
- DNA collection and storage (very limited exceptions)
- Employment related physicals
- Fees/dues for exercise, fitness programs, athletic, or health club membership, even if prescribed by physician
- Finance or interest charges
- Funeral expenses
- Illegal operations or treatments
- Insurance premiums
- Laser hair removal, even when prescribed by a physician
- Marriage counseling
- Maternity clothes
- Mattresses
- Over the counter medications or vitamins for general well-being – even with physician's prescription
- Propecia and/or Rogaine – prescription drugs to stimulate hair growth
- Safety Glasses (unless lenses are prescribed)
- Sperm or embryo storage fees *(i.e. if longer than one year)*
- Student health fees
- Sunglass clips
- Swimming lessons for improvement of general health
- Teeth whitening
- TEFRA/Parental fees
- Veneers
- Warranty and protection plans
- Weight reduction program for general well being
- Whirlpools

Estimate Your Reimbursable Costs For:

Medical ______________________________ $ __________

______________________________ __________

______________________________ __________

Dental /Vision /OTC ______________________________ $ __________

______________________________ __________

Total estimated reimbursable health care expenses $ __________

Per paycheck amount

$ __________ / __________ = $ __________/paycheck

Total reimbursable expenses — Pay periods/year

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MANAGEMENT AND BUDGET
STATE EMPLOYEE GROUP INSURANCE PROGRAM

121 BENEFITS

Dependent Care Flexible Spending Account (FSA) Eligible Expense Worksheet

The Dependent Care FSA allows you to set aside pre-tax dollars to pay for daycare expenses for children under the age of 13 or for adult daycare for a disabled spouse or other disabled dependent. The primary purpose of the expense is to care for the dependent so the parent can work (or look for work). If you are married, your spouse must be working in a job for pay or actively seeking employment, or be a full-time student or be physically or mentally unable to care for himself/herself. The following is a list of allowable dependent care expenses. Expenses must be custodial in nature and **not** strictly educational.

Examples of Reimbursable Dependent Expenses

- Au pair Expenses – excludes airfare or fixed costs
- Amounts paid to a minor babysitter - unless babysitter is a (step)child of employee or spouse under age 19, or is claimed as a dependent by the employee or spouse
- Amounts paid to a relative of participant, e.g. parent grandparent
- Before and after school care or extended day programs
- Custodial or eldercare expenses – not eligible if expenses are attributable to medical services. Individual must spend at least 8 hours a day in participant's household
- Day camp (summer or holiday)
- Dependent Care Center
- FICA and FUTA taxes of daycare provider
- Nanny expenses
- Overnight care for night worker
- Pre-School/nursery school/Montessori (as long as the care is for pre-kindergarten expenses)
- Registration, application and agency fees
- Sick-child center
- Transportation expenses (if transportation is provided by the daycare provider)

Examples of Non-Reimbursable Dependent Care Expenses

- Clothing
- Custodial care for child age 13 or older
- Expenses paid to a child of participant – unless child is age 19 or older and not considered a dependent
- Expenses incurred while the participant and/or spouse is on a leave of absence.
- Kindergarten and beyond (educational expenses)
- Overnight camp expenses
- Tuition

Comparing the Dependent Care FSA to the Dependent Care Tax Credits

Due to the increasing complexity of the Federal and state tax codes, deciding which of these two options is most advantageous is a very complex issue. Generally, *the more taxable income a person has, the greater the likelihood that the Dependent Care FSA results in the greatest tax advantage*. But there are other factors to consider, such as the number of eligible dependents you have, or the amount of qualifying dependent care expenses you incur. If you have one eligible dependent, up to $3,000 of qualifying expenses may be used to calculate the credit; alternatively, you could set aside up to $5,000 in the Dependent Care FSA. If you have two or more eligible dependents, up to $6,000 of qualifying expenses may be used to calculate the credit, while you can still only set aside up to $5,000 in the *Dependent Care FSA*.

Additionally, these examples do not consider the effect of the Earned Income Tax Credit (EITC), which bases both eligibility for the credit and the calculation of the amount of the credit on your Adjusted Gross Income (AGI). Generally, families with AGI under $54,884 are eligible for the EITC. Because the Dependent Care FSA is a reduction in AGI, contributing to the Dependent Care FSA has the potential to increase the amount of EITC you could receive. If you are eligible for the EITC, this will have a significant impact on your choice.

There is no definite line at which a person should take the credit vs. contribute to the Dependent Care FSA; it is all based on your individual situation. You should consult your tax advisor to determine the best choice for you. Below are a few situations which highlight the complexity of the issue and touch on only a few of the factors to consider.

SITUATION 1
A married couple, 2 children, $80,000 in adjusted gross income, $24,000 standard deduction and $5,000 in dependent care expenses. The dependent care credits would result in a $1,000 reduction of tax, while contributing and paying these expenses through a Dependent Care FSA results in a $1,336 reduction of tax.

SITUATION 2
A single parent with 1 child, $30,000 in adjusted gross income, $12,000 in itemized deductions and $3,000 in dependent care expenses. The dependent care credits would result in an $823 reduction of tax, while contributing and paying these expenses through a Dependent Care FSA results in a $710 reduction of tax.

	Situation 1			Situation 2		
	No Dependent Care FSA or Credit	Dependent Care FSA	Credit	NO Dependent Care FSA or Credit	Dependent Care FSA	Credit
Adjusted Gross Income without Dependent Care FSA	$80,000	$80,000	$80,000	$30,000	$30,000	$30,000
Minus Dependent Care FSA Contribution	-	(5,000)	-	-	(3,000)	-
Adjusted Gross Income	80,000	75,000	80,000	30,000	27,000	30,000
Minus Deductions[1]	(24,000)	(24,000)	(24,000)	(12,000)	(12,000)	(12,000)
Minus Personal Exemptions[2]	(0)	(0)	(0)	(0)	(0)	(0)
Taxable Income	56,000	51,000	56,000	18,000	15,000	18,000
Federal Tax (Table A)	6,342	5,742	6,342	1,973	1,613	1,973
State Tax (Table B)	2,910	2,557	2,910	813	653	813
Minus FICA Tax Savings[3]	-	(383)	-	-	(230)	-
Total Taxes	9,252	7,916	9,252	2,786	2,036	2,786
Minus Child Tax Credit[4]	(4,000)	(4,000)	(4,000)	(1,973)	(1,613)	(1,163)
Minus Federal Dependent Care Credit[5]	-	-	(1,000)	-	-	(810)
Minus MN Dependent Care Credit[6]	-	-	-	-	-	(810)
Net Tax After Credits	**$5,252**	**$3,916**	**$4,252**	**$813**	**$423**	**$3**

1 - This is the greater of a taxpayer's total itemized deductions or standard deduction. Current standard deductions are: Married filing jointly and surviving spouse/domestic partner $24,000; Married filing separately $12,000; Head of Household $18,000; Single $12,000

2 - The personal exemption is currently suspended under the Tax Reform Act of 2017. The personal exemption will be available again starting January 1, 2026

3 - The Dependent Care FSA contribution is not subject to FICA taxes which are: Social Security tax of 6.2% on the first $128,400 of wages per taxpayer; Medicare Tax of 1.45% on all wages

4 - The child tax credit is a non-refundable Federal Credit of up to $2,000 per child in 2018. A refundable credit is also available, and is calculated using Form 8812. (See IRS Publication 972 for additional information)

5 - The Dependent Care Credit is a non-refundable federal credit computed on Form 2441 using both AGI and dependent care expenses. (Table C)

6 - The MN Dependent Care Credit is a refundable MN credit computed on MN Form M1CD using both AGI and the Federal Dependent Care Credit. (Table C)

Health Reimbursement Arrangement Account (HRA)
for Faculty and Administrators

The employer shall make a lump sum contribution of $800 to each insurance eligible faculty member's Health Reimbursement Arrangement (HRA) account and $800 to each administrator's HRA account, at the beginning of each calendar year.

The HRA account is administered by 121 Benefits.

The HRA account will reimburse faculty members / administrators for certain out of pocket medical and dental expenses. To receive reimbursement from the account, either complete the reimbursement form (available in the Employee Toolkit on the HR website, under Insurance-Forms), or use you Benny Card at the time of service and send your receipt to 121 Benefits

If you are a fixed term faculty member, HRA coverage will end when your insurance ends (generally August 31st), regardless of whether or not you return the following academic year. 121 Benefits will send you a COBRA notice. If you want to continue to have access to the HRA account through the end of the calendar year, complete the COBRA paperwork and choose the alternative COBRA option.

Payroll Deducted Account for Transit

Payroll Deducted Account for Transit expenses (PDA) are agency-provided parking agreements. These accounts allow you to pay for agency parking and bus pass expenses with pre-tax dollars. With these accounts, you do not need to submit reimbursement – your agency handles the deductions and reimbursements. If you have parking or bus pass deductions from your paycheck, you are automatically enrolled in the Payroll Deducted Account. Unless you have additional out-of-pocket transit expenses, do not enroll in the PKEA or BVEA in addition to the Payroll Deducted Account.

You must enroll each year in the Medical/Dental Expense Account, the Dependent Care (daycare) Expense Account, and the Transit Expense Accounts during Open Enrollment. The payroll-deducted premium and transit accounts continue from year to year.

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121 Benefits

730 2nd Avenue South, Suite 400
730 Building
Minneapolis, MN 55402-2466
(612) 877-4321
(800) 300-1672
(612) 877-4322 (fax)
www.121benefits.com/client-landing/state-of-minnesota/

Choosing your coverage as a new employee or newly eligible employee

If you are a new state employee and eligible for coverage under the State Employee Group Insurance Program (SEGIP), you must make decisions about your medical, dental, and other optional insurance coverage in addition to Flexible Spending Account or pre-tax benefits within your eligibility period which is your first 35 days. Newly insurance eligible employees (with greater than 35 days of employment) need to make these decisions within 30 days of becoming insurance-eligible.

If you are a full-time or part-time employee, you may be eligible (as defined by your collective bargaining agreement or plan) for insurance coverage.

An employee's eligibility is first determined by the terms of the applicable collective bargaining agreement or compensation plan. If an employee is not eligible based on the first determination, then the state and/or federal laws and regulations will be applied. Information on this criteria is found on the SEGIP website at mn.gov/mmb/segip or in the Summary of Benefits for the Minnesota Advantage Health Plan.

Applying for coverage as a new employee

You will be mailed enrollment materials about medical, dental, disability, and life insurance. Information about pre-tax benefits will be mailed if available through SEGIP. If your agency is not on state payroll, and your agency offers pre-tax benefits, contact them about enrollment as a new hire or newly eligible employee. Only those plans for which you are eligible will be listed on your enrollment form. Read all materials carefully.

The enrollment package will include:

- a worksheet listing your insurance options
- access to online directories for medical and dental selection
- directions for electronic enrollment using the MN State Employee Self Service website at http://www.state.mn.us/employee

If you are a new hire or are being rehired into state employment, your enrollment must be electronically completed within 35 days of your hire date. If you are rehired within 13 weeks (or 26 weeks in an educational institution) and you were previously eligible for a full employer contribution, your insurance eligibility changes because of your change in job status you will submit benefit elections via paper forms mailed to your home address. Your enrollment forms must be received by SEGIP within 30 days of the event (or within 30 days of the print date of your notification, whichever is later).

Effective date of coverage

You must make your insurance elections within 35 days of your hire date. You may enroll in family medical, employee or family dental, optional life, disability, accidental death and dismemberment, income protection, and pre-tax accounts within the first 35 days of your hire date. Most coverage will be effective 35 days after your date of hire on the 36th day of employment. However, coverage requiring evidence of insurability will be effective immediately after underwriting approval. Do not delay enrollment as this could result in a large retroactive deduction of your insurance premiums on your paycheck.

If you want to decline medical coverage and you receive the full employer contribution, you must submit the Waiver of Medical Coverage form within your eligibility period. You must also provide proof that you have other medical coverage that meets the IRS's Minimum Essential Coverage requirements.

The IRS defines Minimum Essential Coverage as a plan that will cover both hospital and medical costs. This includes, but is not limited to: employer sponsored plans, government sponsored programs, and plans in the individual market.

If you waive the medical insurance, you will not be able to enroll in the state employee coverage until the next Open Enrollment or upon a qualified life event.

In order to remain waived out of the medical coverage, each year you will need to provide an annual attestation during Open Enrollment confirming that you continue to have other medical coverage and that you do not want the state employee plan. If this annual attestation is not provided, you will be default enrolled into single medical insurance effective the first of the upcoming plan year.

Employees not eligible under their union contract or plan may be eligible under federal/state law if they are rehired in their previous control group within 13 weeks (26 weeks in educational institutions) of their previous employment (and had been eligible for the full employer contribution). Inquire with your HR office regarding benefits status affected by Employer Shared Responsibility.

Employees who are rehired within 30 days regardless of the control group, will have their previous elections reinstated.

Employees who become newly eligible for insurance must enroll (or waive medical, if eligible) within 30 days of the change in status. Most coverage will be effective the day of the status change. However, coverage requiring evidence of insurability will be effective immediately after underwriting approval and pre-tax accounts are effective based upon when SEGIP receives the enrollment form.

For medical and dental, you must be actively at work on the initial effective date of coverage, or coverage will be delayed until the first day you return to active payroll status. If you are not actively at work on the initial effective date of coverage due to your medical status, medical condition, disability, or the disability of your dependent, coverages shall not be delayed.

Coverage for your dependents will not be effective before your own coverage.

You must be working on the date your basic life, optional life, and disability coverages take effect. If you are on a scheduled vacation or semester break at that time, you will be deemed to be actively at work. Otherwise, coverage will be delayed until the first day when you return to work, following the initial 35 day eligibility period.

Requirement to verify dependent eligibility

You must verify the eligibility of a spouse or dependent before they may be covered on the state's medical, dental or life coverage. The Dependent Eligibility Chart for Medical and Dental Coverage details eligibility and it lists the documents required to validate your dependents. Be sure to include all of the requested documents. Your verification documentation must be in the SEGIP office within 30 days of the date of your enrollment submission.

To submit documents:

- Scan and email: segip.mmb@state.mn.us (only from another @state.mn.us email account, for security)
- Secure fax number: 651-296-5445
- Mailing address:
  SEGIP
  658 Cedar Street
  St. Paul, Minnesota 55155

Do not delay enrolling or submitting a change form because you are waiting to receive verification documents. Dependents not enrolled at this time will not be eligible for the coverage until either an Open Enrollment period or upon a qualified life event.

Default coverage

Employees eligible for a full employer contribution who fail to enroll or waive medical coverage within 35 days of their hire date will be automatically enrolled in basic life and employee-only medical coverage. Medical coverage will be selected by default in a cost level two clinic (or level one, if available) or in a service area that meets established access standards in the medical plan with the largest number of cost level one and two clinics in the county of the employee's residence (or work location if the employee's residence is outside the State of Minnesota) at the beginning of the insurance year. You will be unable to enroll dependents if your coverage is defaulted.

If an employee does not waive or elect their own medical carrier and PCC by their deadline or initial effective date, but was previously covered as a dependent immediately prior to their initial effective date, they will be defaulted to the medical carrier and PCC in which they were previously enrolled, per contract.

Medical Child Support Orders

Federal and state laws regarding medical child support seek to ensure that children who do not live with both of their legal parents have adequate medical and dental coverage.

If your agency is notified by a Department of Human Services office that there is an order to enroll any dependent child(ren), the order will be forwarded to Employee Insurance of Minnesota Management and Budget (MMB) along with your application for medical and dental insurance.

Even if an employee does not obey a court order, the state, as the employer, will proceed with the enrollment process. *Upon determination by an employer's medical plan administrator that a joint child is eligible to be covered under the medical plan, the employer and medical plan must enroll the joint child as a beneficiary in the medical plan. Once enrolled, premium deductions will be taken from the paycheck (this can occur on a retroactive basis).*

In such cases, dependent children must be enrolled in the same medical and dental plans in which the employee is enrolled. The employee may change carriers during Open Enrollment, but cannot cancel dependent insurance until after the time specified in the order or until a new Medical Child Support Order that qualifies to replace the previous court order is effective.

Changing coverage during Open Enrollment

You may make certain changes to your insurance benefits during the annual Open Enrollment period. This period is conducted according to your labor contract or plan.

During Open Enrollment you may:

- enroll or waive medical coverage
- add eligible dependents or remove dependents on medical coverage
- change medical carriers for yourself and dependents
- enroll in, cancel, or change dental carriers for yourself and dependents every other year
- enroll in or increase long-term disability (LTD) insurance
- reduce elimination period by one 30 day period for Manager's IPP
- enroll in the Dependent Care (daycare) Expense Account (DCEA), the Medical/Dental Expense Account (MDEA), and/or the Transit Expense Accounts (TEA).

In addition, you may be eligible to apply for some optional insurance benefits during the Open Enrollment period without providing evidence of insurability. These opportunities are generally announced prior to the annual Open Enrollment in which negotiations have been reached.

Effective dates for benefit changes

Most decisions you make during the annual Open Enrollment will take effect at the beginning of the new plan year.

For medical and dental, you must be actively at work on the initial annual Open Enrollment effective date of coverage, or coverage will be delayed until the first day you return to active payroll status. If you are not actively at work on the initial annual Open Enrollment effective date of coverage due to your health status, medical condition, or disability, or the disability of your dependent, coverages shall not be delayed.

Coverage for your dependents will not be effective before your own coverage.

In order for your optional life and disability coverage to take effect, you must be working. If you are on a scheduled vacation or semester break at that time, you will be deemed to be actively at work. Otherwise, coverage will be delayed until the first day when you return to work.

Important note: After you enroll on the MN Employee Self Service website, you will have an option to print or electronically save your Confirmation Statement. You should also review your paycheck and your online benefit summary on the MN Employee Self Service website at www.state.mn.us/employee to ensure the accuracy of the benefit and payroll deductions. If you note a discrepancy, immediately contact your insurance representative in your HR office or SEGIP at 651-355-0100.

Each year, benefits-eligible employees will be provided annual Open Enrollment notification. Materials that contain enrollment instructions and important information about SEGIP insurance options will be available on the SEGIP website at www.mn.gov/mmb/segip.

Changing coverage at other times

Generally, you may enroll or make changes in your medical and dental coverage only when you are first hired by the state or during the annual Open Enrollment. However, certain changes can be made at other times when you experience a qualified life event.

Your request to add or cancel coverage must be consistent with the life event that has taken place.

Notification

You are responsible for notifying SEGIP and your agency HR office if you experience a life event that could affect your benefits. In most cases, it is necessary to provide a third party's written verification of a life event. Failure to notify SEGIP of a life event that affects your coverage within the allowed time period will affect insurance benefits for you and all your dependents, such as loss of COBRA rights or personal responsibility for unpaid medical and/or dental claims. Benefit enrollment and cancellation forms must be received by SEGIP in Employee Insurance within the allowed timeframes. **Do not delay submission of forms if you are waiting for documentation.** Forms can be faxed to 651-296-5445 or scanned and emailed to : segip.mmb@state.mn.us (only email private data through another @state.mn.us account)

Adding, canceling and changing coverage

- Elections to **add or enroll in coverage** due to a qualified life event must be made **within 30 days of the event.**
    - **Exception**: if enrolling in coverage due to loss of Children's Health Insurance Program (CHIP), the application must be made within 60 days of the loss of CHIP coverage.
- Elections to **cancel coverage** due to life event must be made within **60 days of the event**.
    - **Exception**: Canceling or reducing MDEA/DCEA elections must be made **within 30 days** of the event.

These life events are:

a. A change in legal marital status, including marriage, death of a spouse, divorce (under certain circumstances) or annulment.

b. A change in number of dependents, including birth, death, adoption, and placement for adoption.

c. A change in employment status of the employee, or the employee's or retiree's spouse or dependent, including termination or commencement of employment, a strike or lockout, a commencement of or return from an unpaid leave of absence, a change in worksite, and a change in working conditions (including changing between part-time and full-time or hourly and salary) of the employee, the employee's spouse or dependent which results in a change in the benefits they receive under a cafeteria plan or medical or dental plan.

d. A dependent ceasing to satisfy eligibility requirements for medical and/or dental coverage due to attainment of age 26.

e. A carrier no longer being available due to a change in place of residence and/or work location of the employee, retiree or their spouse or dependent.

f. Significant cost or coverage changes (including coverage curtailment and the addition/or elimination of a benefit package).

g. Family Medical Leave Act (FMLA) leave.

h. Judgments, decrees or orders.

i. A change in coverage of a spouse or dependent under another employer's plan.

j. Open Enrollment under the plan of another employer for a spouse or dependent (limited to Open Enrollments with coverage effective dates other than January 1st of a new year).

k. Health Insurance Portability and Accountability Act (HIPAA) special enrollment rights for new dependents and in the case of loss of other group insurance coverage.

l. A COBRA-qualifying event.

m. Loss of coverage under the group health plan of a governmental or educational institution (a state's Children's Health Insurance Program (CHIP)*, medical care program of an Indian tribal government, state health benefits risk pool, or foreign government group health plan).

n. Entitlement to Medicare or Medicaid.

o. Any other situations in which the group health or dental plan is required by the applicable federal or state law to allow a change in coverage.

p. For those not eligible for the full employer contribution and have obtained a subsidy for coverage through MNsure or other Federal Exchange due to another qualified event (may only cancel medical insurance participation).

** See page 45 of this book.*

Your request to add or cancel insurance must be consistent with the life event that has taken place. For example: To change your medical carrier based on a change in place of residence, the change must impact access to coverage. Since the MN Advantage Plan provides coverage everywhere, except for parts of Houston County, Minnesota, when covered with PreferredOne, this life event only applies to employees who currently have PreferredOne and move into an area of Houston County, Minnesota, that does not have access to a Primary Care Clinic within the accepted proximity of their home or work location. If this situation occurs, the request to change carriers must be made within 30 days of their move into Houston County.

If you have questions about life events, please contact SEGIP.

Changes in optional benefits

You may change some optional benefits coverage at any time during the year. However, you may have to provide evidence of insurability to add or increase coverage. You may:

- apply for or increase optional life insurance coverage for yourself, your spouse, and your insurance-eligible children and/or grandchildren with evidence of insurability
- apply for or increase accidental death and dismemberment coverage for you and your spouse (no evidence required)
- apply for or increase short-term disability coverage with evidence of insurability
- decrease the managerial life insurance portion of Manager's IPP
- increase the life insurance portion of Manager's IPP (requires evidence of insurability)
- apply to decrease the eligibility period by greater than 30 days for disability coverage of Managers IPP
- decrease or terminate additional life insurance, accidental death and dismemberment insurance, short-term and long-term disability insurance coverages.

Changes in Pretax Accounts

You may increase, decrease, add or cancel the amounts, in your Dependent Care (daycare) Expense Account and your Medical/Dental Expense Account if a qualified life event occurs. See the Summary of Benefits found on the 121 Benefits website at www.121benefits.com/client-landing/state-of-minnesota for timeframes. You may change the amount you direct to the Transit Expense Account, without regard to life event, on a monthly basis.

Effective dates of benefits coverage

The effective date can vary, depending on the type of plan and the reason for the change in coverage.

Medical, dental, and life insurance coverage changes that do not require evidence of insurability will take effect on the day of the event, e.g., your marriage or birth/adoption. Dependent coverage must be secured by providing the required documents verifying dependent status. SEGIP requires proof of eligibility for newly enrolled spouse/dependents. Documents establishing eligibility will be requested within 30 days of enrolling in benefits. Enrollment will not be finalized without proof of eligibility. If you have questions regarding this, contact a SEGIP representative at 651-355-0100.

Coverage requiring evidence of insurability will be effective when approved by the insurance company.

For medical and dental, you must be actively at work on the initial effective date of coverage, or coverage will be delayed until the first day you return to active payroll status. If you are not actively at work on the initial effective date of coverage due to your health status, medical condition, or disability, or that of your dependent, coverages shall not be delayed.

Coverage for your dependents will not be effective before your own coverage.

You must be working on the date your optional life and disability coverages take effect. If you are on a scheduled vacation or semester break at that time, you will be deemed to be actively at work. Otherwise, coverage will be delayed until the first day when you return to work.

Medical Child Support Orders

Federal and state law regarding medical child support seeks to assure that children who don't live with both of their legal parents have adequate medical and dental coverage.

If you currently have a Medical Child Support Order (QMCSO) in force, you may change plans, but you cannot cancel dependent coverage.

Further, the expiration of the QMCSO is not a qualified event to drop the dependent. Once the QMCSO is removed, the dependents are subject to all rules of the plan.

If you are served with a Medical Child Support Order by the court at any time during your employment with the state, you must notify your agency HR office and Employee Insurance (SEGIP).

Even if an employee does not obey a court order, the state, as the employer, will proceed with the enrollment process. *Upon determination by an employer's health plan administrator that a joint child is eligible to be covered under the health plan, the employer and health plan must enroll the joint child as a beneficiary in the health plan. Once enrolled, premium deductions will be taken from the paycheck (this can occur on a retroactive basis).*

If you already have a dependent covered under your medical and dental coverage, your benefits carriers will be notified to also list any children shown in the court order as your dependents. If you do not currently have coverage for dependents, the premium payment for family coverage will automatically be deducted from your pay.

Important Information: Anytime you change a benefit, review your paycheck and your online benefit summary on the MN Employee Self Service website to ensure the accuracy of the benefit and the payroll deductions. If you note a discrepancy, immediately contact SEGIP and your agency HR office.

Continuation of your coverage

Continuation coverage provides you and your family the opportunity for a temporary extension of existing medical, dental, and life insurance coverage (at your expense) and your Medical/Dental Expense Account under certain circumstances when coverage would otherwise end.

In addition, if you obtained long-term care coverage for you, your spouse, and/or your parents prior to February 1, 2016, it is a portable benefit. This means you can retain the long-term care coverage by paying premiums directly to CNA without electing COBRA coverage.

If you lose your eligibility for coverage under certain circumstances, you and your dependents may have the right to continue:

- medical coverage
- dental coverage
- life insurance
- Medical/Dental Expense Account (on an after-tax basis)
- Health Reimbursement Arrangement (HRA)
- Long Term Care insurance

You may have a right to temporary extension of coverage under SEGIP (the Plan). The right to continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), as well as by certain state laws. Continuation coverage may become available to you and/or to qualified dependents who are covered under the Plan when you or they would otherwise lose group medical, dental, and life coverage, as well as participation in the Medical-Dental Expense Account. **This notice generally explains continuation coverage, when it may become available to you and your qualified dependents, and what you need to do to protect the right to continue. This notice gives only a summary of your continuation coverage rights.** For more information about your rights and obligations under the Plan and under federal law, you should either review the Plan's Summary of Benefits or Certificate of Coverage or get a copy of the Plan Document from the Plan Administrator.

The Plan Administrator is the state of Minnesota, Minnesota Management and Budget (MMB), Employee Insurance (SEGIP). The Plan Administrator is responsible for administering continuation coverage.

Continuation coverage for employees who retire or become disabled:

There are special rules for employees who become disabled or retire. It is your responsibility to contact your agency's Human Resources office and Employee Insurance (SEGIP) of Minnesota Management and Budget.

Continuing your coverage

Continuation coverage is a continuation of Plan coverage when coverage would otherwise end because of a life event known as a, "qualifying event."

In most cases, you have 60 days from the later of the date of the election notice is generated or the date on which coverage is due to end because of the qualified event. If you or a qualified dependent chooses to continue coverage, the full cost of coverage plus a two percent administrative fee based on the cost of your premium, from the date coverage is terminated, must be paid within 45 days of election. Specific qualifying events are listed later in this notice. Continuation coverage must be offered to each person who is a "qualified beneficiary." A qualified

beneficiary is someone who will lose coverage under the Plan because of a qualifying event. Depending on the type of qualifying event, employees, spouses of employees, and dependent children of employees may be qualified beneficiaries. Under the Plan, qualified beneficiaries who elect continuation coverage must pay premiums in full on a timely basis to continue coverage.

If you are an employee, you will become a qualified beneficiary if you will lose your coverage under the Plan because either one of the following qualifying events happens:

1. Your hours of employment are reduced
2. Your employment ends for reasons other than gross misconduct

If you are the spouse of an employee, you will become a qualified beneficiary if you will lose your coverage under the Plan because any of the following qualifying events happens:

1. Your spouse dies
2. Your spouse's hours of employment are reduced
3. Your spouse's employment ends for any reason other than gross misconduct
4. You become divorced from your spouse and have no children in common covered on the plan

Your dependent children will become qualified beneficiaries if they will lose coverage under the Plan because any of the following qualifying events happens:

1. The parent-employee dies
2. The parent-employee's hours of employment are reduced
3. The parent-employee's employment ends for reasons other than gross misconduct
4. The child stops being eligible for coverage under the plan as a dependent child

Sometimes, filing a proceeding in bankruptcy under Title 11 of the United States Code can be a qualifying event. If a proceeding in bankruptcy is filed with respect to the State of Minnesota, and that bankruptcy results in the loss of coverage of any retired employee covered under the Plan, the retired employee is a qualified beneficiary with respect to the bankruptcy. The retired employee's spouse, surviving spouse, and dependent children will also be qualified beneficiaries if bankruptcy results in the loss of their coverage under the Plan.

You must give notice of some qualifying events

For other qualifying events (divorce of the employee and spouse or a dependent child's losing eligibility for coverage as a dependent child), you must notify Employee Insurance of (SEGIP) no later than 60 days from the date of the qualifying event (the date on which the event occurs is day one). You must send this notice to: MMB - SEGIP, 658 Cedar Street, St. Paul, MN, 55155, fax 651-296-5445, or scan and email to the SEGIP at segip.mmb@state.mn.us (only email private data from another @state.mn.us account). If you do not properly notify SEGIP of these changes, you will jeopardize your ability or the ability of your dependents to elect continuation coverage.

How is continuation coverage provided?

Once SEGIP receives notice that a qualifying event has occurred, continuation coverage will be offered to each of the qualified beneficiaries if notice was given timely. Each qualified beneficiary will have an independent right to elect continuation coverage. Covered employees may elect continuation coverage on behalf of their spouses. Parents may elect continuation coverage on behalf of their children. For each qualified beneficiary who elects continuation coverage, that coverage will begin on the date that Plan coverage was lost.

Continuation coverage is a temporary continuation of coverage when:

- the qualifying event is a dependent child losing eligibility as a dependent child, divorce or annulment, continuation of medical and dental coverage lasts for up to 36 continuous months
- the initial qualifying event is the death of the employee, continuation of medical and dental coverage may last indefinitely
- the initial qualifying event is divorce, continuation of medical and dental coverage for the ex-spouse may last indefinitely
- the qualifying event is the end of employment or reduction of the employee's hours of employment, continuation coverage generally lasts for only up to a total of 18 consecutive months. This 18-month period of continuation coverage can be extended if a second qualifying event occurs
- the qualifying event is the end of employment or reduction of the employee's hours of employment and the employee became entitled to Medicare benefits less than 18 months before the qualifying event, continuation of medical and dental coverage for qualified beneficiaries other than the employee lasts up to 36 months after the date of Medicare entitlement. For example, if a covered employee becomes entitled to Medicare 8 months before the date on which his employment terminates, continuation coverage for his spouse and children can last up to 36 continuous months after the date of Medicare entitlement, which is equal to 28 months after the date of the qualifying event (36 months minus 8 months)

Continuation coverage will be terminated before the end of the maximum period if:

- any required premium is not paid in full and on time
- a qualified beneficiary becomes covered, after electing continuation coverage, under another group health plan that does not impose any pre-existing condition exclusion for a pre-existing condition of the qualified beneficiary
- the employer ceases to provide any group health plan for its employees

Continuation coverage may also be terminated for any reason the Plan would terminate coverage of a participant or beneficiary who is not receiving continuation coverage (such as fraud or misrepresentation).

Second qualifying events

1. Extension of 18-month period of continuation coverage

If you or a qualified beneficiary experiences another qualifying event while receiving 18 months of continuation coverage, your spouse and dependent children, who are qualified beneficiaries, in your family may gain additional months of medical and dental continuation coverage, up to a combined maximum of 36 months. Notice of the second qualifying event must be properly given in writing within allowed or established timeframes to SEGIP. This extension is available to the spouse and dependent children (who were qualified beneficiaries) if the employee or former employee dies, gets divorced, or if the dependent child stops being eligible under the Plan as a dependent child, but only if the event would have caused the spouse or dependent child to lose coverage under the Plan had the first qualifying event not occurred.

In all of these cases, you must make sure that SEGIP is notified of the second qualifying event no later than 60 days from the second qualifying event (the date on which the event occurs is counted as day one). This notice must be sent to: Minnesota Management and Budget, SEGIP, 658 Cedar Street, St. Paul, MN, 55155. You may also fax to 651-296-5445 or email to segip.mmb@state.mn.us.

2. Disability extension of 18-month period of continuation coverage

If you or a qualified dependent covered under the Plan is determined by the Social Security Administration to be disabled and you notify SEGIP in a timely fashion, you and your qualified dependents can receive up to an additional 11 months of medical and dental continuation coverage, for a total maximum of 29 months. The disability must start sometime prior to the 60th day of Continuation Coverage and must last at least until the end of the 18-month period of continuation coverage. You must notify SEGIP of the Social Security Administration's determination within 60 days of the date of the determination and before the end of the 18-month period of continuation coverage. This notice should be sent to: Minnesota Management and Budget, SEGIP, 658 Cedar Street, St. Paul, MN, 55155, fax 651-296-5445, or email to segip.mmb@state.mn.us (only email private data from another @state.mn.us account).

If you have questions

If you have questions about your continuation coverage, you should contact Minnesota Management and Budget, Employee Insurance at 651-355-0100, or you may also contact the nearest Regional or District Office of the U.S Department of Labor's Employee Benefits Security Administration (EBSA). Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website at www.dol.gov/ebsa or call their toll-free number at 1-866-444-3272.

You may also be able to buy coverage through the Health Insurance Marketplace. In the Marketplace, you could be eligible for a tax credit that lowers your monthly premiums and you can see what your premium, deductibles, and out-of-pocket costs will be before you make a decision to enroll. COBRA eligibility does not limit or exclude your eligibility for a health coverage tax credit through the Marketplace. For more information about health insurance options available through a Health Insurance Marketplace, visit MNsure webpage or Health Care website.

Continuation of Life Insurance

For **life insurance**, employees have the option to continue basic life, employee optional life, spouse optional life, and child life insurance in the event of termination of employment, layoff, or reduction in hours. Dependents do not have the right to continue life insurance on their own. All or any portion of the life insurance benefits in force at the time the qualifying event occurs may be continued at the employee's expense. The maximum period for continuation of life insurance is 18 months, or until covered by other group insurance, whichever is earlier.

Continuation of the Medical Dental Expense Account

For the **Medical Dental Expense Account**, you may continue participation by electing to continue coverage and continuing to contribute to the plan through monthly payments on an after-tax basis. Coverage will end on the earliest of the following dates:

- The end of the plan year, December 31
- The end of the period for which contribution is paid, if the required contribution is not paid on a timely basis
- The date the plan is terminated, if ever

For additional information about continuation of pre-tax accounts, please see the Plan Summary, available at the 121 Benefits website at www.121benefits.com/client-landing/state-of-minnesota.

Continuation of the Health Reimbursement Arrangement (HRA)

For the Minnesota State (formerly MnSCU), Health Reimbursement Arrangement (HRA) Plan, a dependent may continue participation by paying the required premium. The length of COBRA continuation depends upon the qualifying event:

- When the qualifying event is a dependent child losing eligibility as a dependent child, continuation lasts for up to 36 months
- When the qualifying event is the death of the employee or divorce or legal separation, continuation may last indefinitely
- When the qualifying event is termination from employment, then the continuation coverage runs for a period of 18 months following the date that coverage ended

Please contact the HRA administrator, 121 Benefits at www.121benefits.com/client-landing/state-of-minnesota, for additional information about COBRA continuation of the HRA Plan.

Keep your agency Human Resource office informed of address changes

In order to protect your rights and those of your qualified dependents, you must keep your address up to date. You may change your address by going to the My Personal Information section of the MN Employee Self Service website. Inform SEGIP of changes in address of qualified dependents, if their addresses are different from yours (such requests must be received in writing). Remember to inquire with SEGIP about Point-of-Service (POS), if you or dependents reside permanently outside the service area.

Dependent eligibility

Eligibility

The State Employee Group Insurance Program (SEGIP) determines the eligibility of state employees and dependents subject to collective bargaining agreements and compensation plans, which may change during a Benefit Year. The Claims Administrator (or carrier) agrees to accept the decisions of SEGIP as binding. If two or more employees have mutual dependents and both participate in the State Employee Group Insurance Program (SEGIP), only one of the employees may cover their mutual dependents.

For married SEGIP participants, if both spouses work for the state or another organization participating in SEGIP, a spouse may be covered as a dependent by the other. If the employees adult child (age 18 until 26) works for the state or another organization participating in SEGIP, the child may be covered as a dependent by the parent/employee. In either situation, the employee who will be covered as a dependent must waive coverage by completing the Waiver of Coverage Form within their initial eligibility period. Enrollment and dependent verification must be completed within the appropriate time periods. Also, only one state employee can cover any dependents they may have in common.

If an employee waived the medical insurance to be covered under another state employee, they will not be able to enroll in their own coverage again until an annual Open Enrollment or upon a qualified life event.

In order to remain a dependent under the other state employee's plan, the employee waiving medical coverage as a SEGIP participant must provide an annual attestation during Open Enrollment to confirm that they wish to continue to waive the coverage as an employee. If this annual attestation is not provided, the employee will be default enrolled into single medical insurance effective the first of the upcoming plan year.

Dependent Eligibility Verification

SEGIP requires you to submit legal documentation sufficient to prove the eligibility of your dependents including the appropriate SEGIP certification form for evaluation of eligibility. If you fail to provide sufficient documentation or knowingly provide false information as proof of eligibility, coverage will not be provided, and/or your dependents may be removed from the plan, and you may be required to reimburse the plan for claims the plan paid on behalf of the ineligible dependent during the period of ineligibility, and you may be subject to disciplinary action.

Eligible dependents include the following:

a) Spouse

The spouse of an eligible employee (if legally married under Minnesota law). For the purposes of medical and dental insurance coverage, if that spouse works full-time for an organization employing more than one hundred (100) people and elects to receive either credits or cash (1) in place of health insurance or health coverage or (2) in addition to a health plan with a seven hundred and fifty dollar ($750) or greater deductible through his/her employing organization, he/she is not eligible to be a covered dependent for the purposes of this Article. If both spouses work for the state or another organization participating in SEGIP, one working spouse may cover the other working spouse as a dependent.

b) Child

i) Dependent child: A dependent child is an eligible employee's child to age 26. "Dependent child" includes an employee's: (1) biological child, (2) child legally adopted by or placed for adoption with the employee, (3) stepchild, and (4) qualified foster child. For a stepchild to be considered a dependent child, the employee must be legally married to the child's legal parent. For a foster child to be considered a dependent child under

this plan, the foster child be placed with the employee or the employee's spouse by an authorized placement agency or by a judgment, decree or other court order; the employee and/or the employee's spouse must have full and permanent legal and physical custody.

ii) Coverage under only one plan: If the employee's child works for the state or another organization participating in the State's Group Insurance Program, the child may be covered as a dependent by the employee until the child reaches 26. If the child reaches age 26 while employed and covered by a SEGIP parent, the child must contact SEGIP no later than 30 days from the 26th birthday to enroll in their own insurance policy.

c) Grandchild

A dependent grandchild, to age twenty-five (25) is an eligible employee's unmarried dependent grandchild who: (a) is financially dependent upon the employee for principal support and maintenance and has resided with the employee continuously from birth or, (b) resides with the employee and is dependent upon the employee for principal support and maintenance, and the employee's unmarried child (the parent) is less than age nineteen (19). If a grandchild is legally adopted or placed in the legal custody (is a foster child) of the grandparent, they are covered as a dependent child under b) i).

d) Disabled Child

A disabled dependent child is an eligible employee's child or grandchild regardless of marital status, who was disabled prior to the limiting age or any other limiting term required for dependent coverage and who continues to be incapable of self-sustaining employment by reason of developmental disability, mental illness or disorder, or physical disability and is chiefly dependent upon the employee for support and maintenance, provided proof of such incapacity and dependency is furnished to the medical carrier by the employee or enrollee within 31 days of the child's attainment of the limiting age or any other limiting term required for dependent coverage. The disabled dependent is eligible to continue coverage as long as s/he continues to be disabled and dependent, unless coverage terminates under the contract.

e) Qualified Medical Child Support Order

A child who is required to be covered by a Qualified Medical Child Support Order (QMCSO or QMO) is considered an eligible dependent.

f) Child Coverage Limited to Coverage Under One Employee

If both parents work for the state or another organization participating in the State Employee Group Insurance Program, either parent, but not both, may cover the eligible dependent child or grandchild. This restriction also applies to two divorced or unmarried employees who share legal responsibility for their eligible dependent child or grandchild.

g) Other

Any person who is an eligible dependent under the employee's bargaining agreement or plan of employment or is required by federal or state law to be a covered dependent.

Dependent Eligibility Chart for Medical and Dental Coverage

Eligible Dependents	Definition of an Eligible Dependent	Required Documentation
Spouse	• Must be legally married under Minnesota law to an insurance eligible employee, ***and*** • Your spouse is not eligible if he/she works full-time for an employer (with more than 100 people) and elects to receive cash or credits (1) in place of health insurance, or (2) in addition to a health plan with a deductible of $750 or greater	1. Copy of your certified marriage certificate ***and*** 2. Copy of the front page for your most recent federal tax return confirming this dependent is your spouse OR a document dated within the last 60 days showing current relationship status such as a household bill. The document must include your spouse's name, the date and your mailing address. ***and*** 3. Completed Spouse/Former Spouse Certification Form
Former Spouse	• The divorce must occur while the employee is covered, ***and*** • Must have been covered on the employee's plan at the time of the divorce, ***and*** • May not have obtained other group coverage since the divorce, ***and*** • Not eligible if he/she works full-time for an employer (with more than 100 people) and elects to receive cash or credits (1) in place of health insurance, or (2) in exchange for a health plan with a deductible of $750 or greater	1. Copy of your divorce decree signed by a judge or court administrator ***and*** 2. Completed Spouse/Former Spouse Certification Form
Biological Children	• To age 26	1. Copy of your child's certified birth certificate naming you as the child's parent
Adopted children	• To age 26 if adopted ***or*** • To age 18 if placed with you for adoption	1. Final copy of your court documentation showing the names of both you (or your spouse) and the child confirming the adoption or 2. Copy of the child's certified birth certificate naming you (or your spouse) as the child's parent
Step Children	• To age 26 • You must be legally married to the child's parent	1. Copy of the child's certified birth certificate naming your spouse as the child's parent ***and*** 2. Copy of your certified marriage certificate and a current financial document naming both you and your spouse
Foster Children (ward, legal guardian, legal custody)	• To age 26 • Full and permanent legal and physical custody	1. Completed Foster Child Certification Form ***and*** 2. Final copy of court document showing your name (and/or your spouse) confirming the permanent custodial relationship ***and*** 3. Copy of the front page of your (or your spouse's) most recent federal tax return confirming this dependent is your (or your spouse's) tax dependent
Grandchildren	• To age 25 • Unmarried, dependent upon you for principal support and maintenance and lives with you; your child must be unmarried and less than age 19 ***or*** • Financially dependent upon you and has resided with you continuously from birth • *-OR-* • If you have legally adopted your grandchild or are the foster parent of your grandchild follow the eligibility rules for each above	1. Completed Grandchild Certification Form ***and*** 2. Copy of your grandchild's certified birth certificate, naming your (or your spouse's) child as your grandchild's parent ***and*** 3. Copy of your child's certified birth certificate naming you (or your spouse) as the parent ***and*** 4. Document dated within the last 6 months establishing this grandchild currently resides with you ***and*** 5. Copy of your most recent federal tax return listing this child as your (or your spouse's) tax dependent 6. If your grandchild has lived with you continuously from birth a copy of your federal tax return from the year this grandchild was born
Disabled Children	• Any age or marital status, includes dependent children incapable of self-sustaining employment by reason of developmental disability, mental illness or disorder, or physical disability, ***and*** • Chiefly dependent upon you for principal support and maintenance, ***and*** • You must provide proof of such incapacity and dependency annually as requested by your health plan administrator	1. Copy of the child's certified birth certificate naming you or your spouse as the child's parent, OR appropriate court order / adoption decree naming you as the child's legal guardian

Also covered: any other person required by state or federal law to be treated as a dependent for purpose of health care coverage.

Change in status or dependent eligibility: **It is your responsibility to notify SEGIP of any change in a dependent's status** (life event). Spouses and dependents losing eligibility may qualify for COBRA. An eligible spouse or dependent may be added within 30 days of a life event or during Open Enrollment. You must notify SEGIP within 60 days of your divorce from a covered spouse or if a covered dependent loses eligibility. After the 60-day period ends, continued failure to report a loss of eligibility may be considered fraud or intentional misrepresentation of a material fact and the employee may be liable for all claims paid by the Plan on behalf of such individuals and you may be subject to criminal penalties. Instances of fraud, intentional misrepresentation of a material fact or non-payment of premiums may result in the retroactive cancellation of coverage. Upon a 30-day notice, ineligible dependents may be dis-enrolled.

Annual notifications

Women's Health and Cancer Rights Act

Under the Federal Women's Health and Cancer Rights Act of 1998 You are entitled to the following services:

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 for physical complications during all stages of mastectomy, including swelling of the lymph glands (lymphedema).

Services are provided in a manner determined in consultation with the physician and patient. Coverage is provided on the same basis as any other Illness.

Family Medical Leave Act

In compliance with the Federal Family and Medical Leave Act (FMLA), and in accordance with state law and various collective bargaining or other labor agreements, the state of Minnesota will provide up to 12 weeks of unpaid, job-protected leave to eligible employees for certain family and medical reasons. While you are on family medical leave, you may be required to use other paid employee leave, such as sick leave and/or vacation leave. Use of Family Medical Leave runs concurrently with any paid leave you take.

You may take family and medical leave for:

- the birth and care of your newborn child
- the placement of a child for adoption or foster care in your home
- the care of a seriously ill spouse, child or parent
- a serious health condition that makes it impossible for you to perform your job

During this leave, you are entitled to continuation of the employee contribution for medical and dental coverage, but you are responsible for paying any part of the coverage premium that would regularly be deducted from your pay. **Failure to pay premiums timely will result in cancelation of coverage**. To be eligible for this leave, you must have worked for the state of Minnesota for at least one year and at least 1,250 hours during the 12 months immediately preceding your request. An employee is entitled to a total of 12 weeks of FMLA per fiscal year. For more information, contact your agency Human Resources office.

Medicare Part D Creditable Coverage

It has been determined that the prescription drug coverage offered through the Minnesota Advantage Health Plan is creditable. This means that the amount that the Advantage Plan expects to pay, on average, for prescription drugs is the same or more than what standard Medicare Part D prescription drug coverage will pay. This means that, if you are now eligible for Medicare Part D, but enroll at a future date, you will not pay extra for that coverage. An annual disclaimer is available to you on the SEGIP website.

Medical Data Privacy

Effective date: September 23, 2013
Reissue date: October 23, 2018

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

A. Introduction

The State of Minnesota and other participating employers sponsor a Plan and are required by federal law to provide You this Notice of the Plan's privacy practices and related legal duties and of Your rights in connection with the use and disclosure of Your protected health information (PHI). Carefully review this Notice to understand your individual rights and the ways that the Plan protects your privacy.

PHI is defined by the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") and its regulations (the "Privacy Rule"). PHI generally means individually identifiable health information that is created or received by a covered entity, including the Plan, in any form or media, including electronic, paper and oral. Individually identifiable health information includes demographic data, that relates to an individual's past, present or future physical or mental health or condition, the provision of health care to an individual, or the past, present, or future payment for the provision of health care to an individual, and that identifies the individual or for which there is a reasonable basis to believe it can be used to identify the individual. For purposes of the Plan and this Notice, PHI includes information related to the medical claims that are submitted to the Plan about You, and information about the payment of those claims.

While this Notice is in effect, the Plan must follow the privacy practice described. The Plan reserves the right to change its privacy practices and the terms of this Notice at any time, provided that applicable law permits such changes. The Plan also reserves the right to make such changes effective for all PHI that the Plan maintains, including information created or received before the changes were made.

This Notice applies to all PHI the Plan maintains. Your personal doctor or health care provider may have different policies or notices regarding the doctor's use and disclosure of Your medical information created in the doctor's office or clinic.

You may have additional rights under state law. State laws that provide greater privacy protection or broader privacy rights will continue to apply.

B. Health Plans covered by this Notice

This Notice describes the privacy practices of the group health plans listed here and together these plans are collectively referred to as the "Plan" for purposes of this Notice. Each of these plans is independent of one another. This Notice will apply to the extent that You participate in each separate plan. Minnesota Management & Budget / SEGIP contracts with internal and external entities to perform the work of each of these plans. In accordance with HIPAA, they may share PHI for the treatment, payment, and health care operations. Each entity is required to agree to additional terms and conditions to protect Your PHI.

Name of Plan	Plan Administrator	Claim Administrator
The Minnesota Advantage Health Plan	SEGIP	BlueCross BlueShield of Minnesota, BlueCross BlueShield of Minnesota PPO HealthPartners, HealthPartners PPO PreferredOne pharmacy benefit claims through CVS Caremark
The Advantage High Deductible Health Plan	SEGIP	BlueCross BlueShield of Minnesota, BlueCross BlueShield of Minnesota PPO HealthPartners, HealthPartners PPO PreferredOne pharmacy benefit claims through CVS Caremark
HealthPartners Dental Plan	SEGIP	HealthPartners
The State Dental Plan	SEGIP	Delta Dental
Flexible Benefits Accounts	SEGIP	121 Benefits LLC
Wellness Program	SEGIP	Virgin Pulse

C. The Plan's Rights and Obligations

1. The Plan is required by law to maintain the privacy of PHI.

2. The Plan is required by law to provide individuals with notice of the Plan's legal duties and privacy practices with respect to PHI.

3. The Plan is required to notify affected individuals of a breach of unsecured PHI.

4. The Plan is required to abide by the terms of the privacy practice described in this Notice. These privacy practices will remain in effect until the Plan replaces or modifies them.

5. The Plan reserves the right to change its privacy practices and the terms of this Notice at any time, provided that the change is permitted by law. The Plan reserves the right to have such a change affect all PHI it maintains, including PHI it received or created before the change. When the Plan makes a material change in its privacy practices, it will revise this Notice and post it at https://mn.gov/mmb/segip/ by the effective date of the material change and the Plan will provide the revised Notice, or information about the material change and how to obtain the revised Notice, in the next annual mailing to participants.

D. Uses and Disclosures of Your Protected Health Information

To protect the privacy of Your PHI, the Plan not only guards the physical security of Your PHI, but also limits the way Your PHI is used or disclosed to others. The Plan may use or disclose Your PHI in certain permissible ways, including the uses and disclosures described below. To the extent required by HIPAA,

only the minimum amount of Your PHI necessary to perform these tasks will be used or disclosed. The following categories describe the different ways that the Plan uses and discloses your PHI. Not every use or disclosure within category is listed, but all uses and disclosures fall into one of the following categories.

1. **Your authorization**. Except as outlined below, the Plan will not use or disclose Your PHI unless You have signed a form authorizing the use or disclosure. You may give the Plan written authorization to use your PHI or to disclose it to anyone for any purpose. You have the right to revoke that authorization in writing and the Plan will stop using or disclosing Your PHI in accordance with that authorization except to the extent that the Plan has taken action in reliance upon the authorization. In addition, the Plan is required to obtain Your authorization under the following circumstances:

    a. Psychotherapy Notes. Most uses and disclosures of psychotherapy notes will require Your authorization.

    b. Marketing. Uses and disclosures of PHI which result in the Plan receiving financial payment from a third party whose product or services is being marketed will require Your authorization.

    c. Sale of PHI. Disclosures that constitute a sale of PHI will require Your authorization.

2. **Payment.** The Plan may use and disclose PHI about You for all activities that are included within the definition of "payment" under the Privacy Rule, such as determining Your eligibility for Plan benefits, the eligibility of Your dependents, facilitating payment for treatment and health care services You receive, determining benefit responsibility under The Plan, coordinating benefits with other Plans, or determining medical necessity. The Plan will also provide Your PHI to the extent necessary to provide required coverage for Your former spouse. The definition of "payment" includes many more items, so please refer to the Privacy Rule for a complete list.

3. **Health care operations**. The Plan may use and disclose PHI about You for health care operations. These uses and disclosures are necessary to operate the Plan. This may include developing quality improvement programs, conducting pilot projects, developing new programs, as well as cost management purposes. The definition of "health care operation" includes many more items, so please refer to the Privacy Rule for a complete list.

    The Plan will not sell your PHI. The Plan will not set Your premium or conduct underwriting for Your coverage using Your PHI. The Plan will not use Your genetic information for underwriting purposes. Plan members are required to verify the eligibility of their dependents.

4. **Treatment**. The Plan does not provide treatment. The Plan may use or disclose PHI for treatment purposes. This includes helping providers coordinate your healthcare. For example, a doctor may contact The Plan to ensure You have coverage or, in an emergency situation, to learn who are Your other providers or to contact Your family members if You are unable to provide this information.

5. **Disclosures to the Plan Sponsor (Your Employer)**. The State of Minnesota, or your participating employer, is the Plan Sponsor. The Plan may disclose Your PHI to them to the extent necessary to administer the Plan. These disclosures may be made only to designated personnel at the administrative units of the Employer, usually the benefits department or Your Human Resources department, and will be limited to the disclosures necessary for Plan administration functions. Generally, this will include enrollment and billing information. These individuals will protect the privacy of Your PHI and will ensure that it is only used as described in this Notice and as permitted by law. Your PHI will not be used by the Employer for any employment-related actions or decisions or in connection with any other benefit plan offered by the Employer.

6. **Sponsored health plan programs**. The Plan may use or disclose Your PHI to a HIPAA-covered health care provider, health plan, or health care clearinghouse, in connection with their treatment, payment, or health care operations.

7. **Communications about product, service and benefits**. The Plan may use and disclose Your PHI to tell You about possible medical treatment options, programs, or alternatives, or to tell You about health related products or services, including payment or coverage for such products or services, that may be of interest to You, provided the Plan does not receive financial remuneration for making such communications. The Plan may also use Your PHI to contact You with information about benefits under the Plan, including certain communications about Plan networks, health plan changes, and services or products specifically related to a health condition You may have. The Plan may use and disclose Your PHI to contact You to provide reminders, such as annual check-ups, or information about treatment alternatives or other health related benefits and services that may be of interest to You.

8. **Communications with individuals involved in Your treatment and/or Plan payment**. Although the Plan will generally communicate directly with You about Your claims and other Plan related matters that involve Your PHI, there maybe instances when it is more appropriate to communicate about these matters with other individuals about Your health care or payment. This may include family, relatives, or close personal friends (or anyone else you may choose to designate).

   With Your authorization, the Plan may use or disclose Your PHI to a relative or other individual who You have identified as being involved in Your health care that is directly relevant to their involvement in these matters. If You are not present, the Plan's disclosure will be limited to the PHI that directly relates to the individual's involvement in Your health care. The Plan may also make such disclosures to these persons if: (i) You are given the opportunity to object to the disclosures and do not do so. This verbal permission will only cover a single encounter, and is not a substitute for a written authorization; or (ii) if the Plan reasonably infers from the circumstances that You do not object to disclose to these persons, such as if You are not present or are unable to give Your permission and the Plan determines (based on its professional judgment) that the use or disclosure is in Your best interest. The Plan will not need Your written authorization to disclose Your PHI when, for example, You are attempting to resolve a claims dispute with the Plan and You orally inform the Plan that Your spouse will call the Plan for additional discussion relevant to these matters. The Plan may also provide limited PHI to Your former spouse to the extent reasonably required to continue Your former spouse on Your Plan, including information related to cost, payment, benefits, and the coverage of any joint children.

   The Plan may also use or disclose your name, location, and general condition (or death) to notify, or help to notify, persons involved in Your care about Your situation. If You are incapacitated or in an emergency, the Plan may disclose Your PHI to persons it reasonably believes to be involved in Your care (or payment) if it determines that the disclosure is in Your best interest.

9. **Research**. The Plan may use or disclose PHI for research purposes, provided that the researcher follows certain procedures to protect Your privacy. To the extent it is required by State law, The Plan will obtain Your consent for a disclosure for research purposes.

10. **De-Identified Data**. The Plan may create a collection of information that can no longer be traced back to You. This information does not contain individually identifying information.

11. **Business Associates**. The Plan may disclose Your PHI to a "business associate." The Plan's business associates are the individuals and entities the Plan engages to perform various duties on behalf of the Plan, or to provide services to the Plan. For example, the Plan's business associates might provide claims management services or utilization reviews. Business associates are permitted to receive, create, maintain, use, or disclose PHI, but only as provided in the Privacy Rule, and only after agreeing in writing to appropriately safeguard Your PHI pursuant to a business associate agreement.

12. **Other Uses and Disclosures**. The Plan may make certain other uses and disclosures of Your PHI without Your authorization:

   a. The Plan may use or disclose Your PHI for any purpose required by federal, state, or local law. For example, The Plan may be required by law to use or disclose Your PHI to respond to a court order.

   b. The Plan may disclose Your PHI in the course of a judicial or administrative proceeding (for example, to respond to a subpoena or discovery request.)

   c. The Plan may use or disclose Your PHI for public health activities that are permitted or required by law, including reporting of disease, injury, birth and death, and for public health investigations.

   d. The Plan may disclose Your PHI to a public or private organization authorized to assist in disaster relief efforts. The Plan may use or disclose Your PHI to help notify a relative or other individual who is responsible for Your health care, of your location, general condition, or death. In such situations, if You are present and able to give Your verbal permission, the Plan will only use or disclose Your PHI with Your permission. This verbal permission will only cover a single encounter, and is not a substitute for a written authorization. If You are not present or are unable to give Your permission, the Plan will use or disclose Your PHI only if it determines (based on its professional judgment) that the use or disclosure is in Your best interest.

   e. The Plan may disclose Your PHI to a health oversight agency for activities authorized by law. The relevant agencies include governmental units that oversee or monitor the health care system, government benefit and regulatory programs, and compliance with civil rights laws. The relevant activities include conducting audits, investigations, or civil or criminal proceedings.

   f. Under limited circumstances (such as required reporting laws or in response to a grand jury subpoena), the Plan may disclose Your PHI to the appropriate law enforcement officials for law enforcement purposes.

   g. The Plan may disclose Your PHI to coroners, medical examiners, and funeral directors as necessary for them to carry out their duties. If You are an organ donor, the Plan may disclose Your PHI to organ procurement or organ, eye, or tissue transplantation organizations, as necessary to facilitate organ or tissue donation and transplantation.

   h. The Plan may use or disclose Your PHI to avert a serious threat to Your health or safety, or to the health and safety of others. Any such disclosure will be made to someone who would be able to help prevent the threat.

   i. The Plan may disclose Your PHI, if You are in the Armed Forces, for activities deemed necessary by appropriate military command authorities, for determination of benefit eligibility by the Department of Veterans Affairs, or to foreign military authorities if You are a member of that foreign military service. The Plan may disclose Your PHI to authorized federal officials for conducting national security and intelligence activities (including for the provision of protective services to the President of the United States) or to the Department of State to make medical suitability determinations. If You are an inmate at a correctional institution, then under certain circumstances the Plan may disclose Your PHI to the correctional institution.

   j. The Plan may disclose Your PHI to the extent necessary to comply with laws concerning workers' compensation or to comply with similar programs that are established by law and provide benefits for work-related injuries or illness.

k. The Plan may disclose Your PHI, consistent with applicable federal and state laws, if the Plan believes that You have been a victim of abuse, neglect, or domestic violence. Such disclosure will be made to the governmental entity or agency authorized to receive such information.

l. The Plan will disclose Your PHI to the Secretary of the Department of Health and Human Services, when required to do so, to enable the Secretary to investigate or determine the Plan's compliance with HIPAA and the Privacy Rule.

E. Your rights regarding Your Protected Health Information

You have the following rights relating to Your PHI:

1. **Right to access, inspect, and copy**. You have the right to look at or get copies of Your PHI maintained by the Plan that may be used to make decisions about Your Plan eligibility and benefits, with limited exceptions. The Plan may require You to make this request in writing to the Privacy Officer listed at the end of this Notice. Generally, the Plan will respond to Your request within 30 days after the Plan receives it; if more time is needed, the Plan will notify You within the original 30-day period. The Plan may deny Your request to inspect and copy in certain very limited circumstances. The Privacy Rule contains a few exceptions to Your right to inspect and copy Your PHI maintained by the Plan. You do not have the right to inspect or copy, among other things, psychotherapy notes or materials that are compiled in anticipation of litigation or similar proceedings. If Your written request is denied, You will receive written reasons for the denial and an explanation of any right to have the denial reviewed. If the information You request is maintained electronically, and You request an electronic copy, the Plan will provide a copy in the electronic form and format You request, if the information can be readily produced in that form and format; if the information cannot be readily produced in that form and format, the Plan will work with You to come to an agreement on form and format. If we cannot agree on an electronic form and format, the Plan will provide You with a paper copy. You have a right to choose to receive a copy of all or of only portions of your PHI. The Plan may charge a fee for copying or mailing Your PHI for You but may waive that charge depending on Your circumstances. If you make a request in advance, the Plan will provide You with an estimate of the cost of copying or mailing the requested information.

2. **Right to request an amendment of Your PHI**. If You believe that there is a mistake or missing information in a record of Your PHI held by the Plan or one of its vendors, You may request in writing, that the record be corrected or supplemented. You have the right to request an amendment for as long as the PHI is kept by or for the Plan. Your request must be in writing and must include a reason or explanation that supports Your request. The Plan, or someone on its behalf, will respond usually within 60 days of receiving Your request. The Plan may deny the request if it is not in writing, it is determined that the PHI is correct and complete, not part of the PHI kept by or for the Plan, not created by the Plan or its vendors, and/or not part of the Plan's or vendor's records (unless the person or entity that created the information is no longer available to make the amendment), or not part of the information which You would be permitted to inspect and copy. All denials will be made in writing. Any denial will include the reasons for denial and explain Your rights to have the request and denial, along with any statement in response that You provide, appended to Your PHI. If the Plan denies Your request for an amendment, You may file a written statement of disagreement, which the Plan may rebut in writing. The denial, statement of disagreement, and rebuttal will be included in any future disclosures of the relevant PHI. If Your request for amendment is approved, the Plan or the vendor, will change the PHI and inform You of the change and inform others that need to know about the change. If the Plan approve Your request, the Plan will include the amendment in any future disclosures of the relevant PHI.

3. **Right to request and receive an accounting of disclosures**. You have a right to receive a list of routine and non-routine disclosures that Plan has made of Your PHI. This right includes a list of when, to whom, for what purpose and what portion of your PHI has been released by the Plan and its vendors. This does not include a list of disclosures for treatment, payment, health care

operations, and certain other purposes (such as disclosures made for national security purposes, to law enforcement officials, or correctional facilities). If the PHI disclosed is not an "electronic health record," the accounting will include disclosures for the six (6) years prior to the date of your request. In this case, as noted above, the accounting is not required to include all disclosures. If the PHI disclosed is an "electronic health record," the accounting will include disclosures up to three (3) years before the date of Your request. Your request for the accounting must be made in writing. Your request must include the time frame that You would like the Plan to cover (this may be no more than six (6) years before the date of the request). You will normally receive a response to Your written disclosure for this accounting within 60 days after your request is received. There will be no charge for up to one such list each year but there may be a charge for more frequent requests. The Plan will notify You of the cost involved and You may choose to withdraw or modify Your request at that time before any costs are incurred.

4. **Right to request restrictions**. You have the right to request that the Plan restrict how it uses or discloses Your PHI for treatment, payment, or health care operations. You also have the right to request a limit on the PHI about You that the Plan discloses to someone who is involved in Your care or the payment of Your care, like a family member or friend. The Plan will consider Your request but generally is not legally bound to agree to the request for restriction. However, the Plan will comply with any restriction request if (1) except as otherwise required by law, the disclosure is to a health plan for purposes of carrying out payment or health care operations (and is not for purposes of carrying out treatment); and (2) the PHI pertains solely to a health care item or service for which You, or another person on Your behalf, has paid the health care provider or other covered entity involved in full. Your request must be in writing. In Your request, You must tell the Plan (1) what information You want to limit; (2) whether You want to limit the Plan's use, disclosure, or both; and (3) to whom You want the limits to apply, for example, disclosure to Your spouse. If the Plan does agree to Your restriction it must comply with the agreed to restriction, except for purposes of treating You in an medical emergency.

5. **Right to choose how the Plan contacts You**. You have the right to request that the Plan communicate with You about Your PHI by alternative means or to an alternative location. For example, you may request that the Plan only contact you at designated address or phone number. Your request must be in writing. In Your request, You must tell us how or where You wish to be contacted. The Plan will make a reasonable accommodation of Your request for confidential communication.

6. **Right to request a copy of this Notice in an alternative format**. You are entitled to receive a printed copy of this Notice at any time as well as a non-English translation. You may ask the Plan to give You a paper or electronic copy of this Notice at any time. Even if You have agreed to receive this Notice electronically, You are still entitled to a paper copy of this Notice. Contact the Plan using the information listed at the end of this Notice to obtain an alternative copy of this Notice.

F. Complaints

If You believe Your privacy rights have been violated, You may file a complaint with the Plan, or with the Secretary of the Department of Health and Human Services. To file a complaint with the Plan, send a

written complaint to the Privacy Officer listed at the end of this Notice. The Plan will not retaliate against You for filing a complaint, and You will not be penalized in any other way for filing a complaint.

G. Contact Information for questions

If You have questions about this Notice or would like more information about the Plan's privacy practices, please contact:

Privacy Officer
Minnesota Management & Budget / SEGIP
400 Centennial Office Building
658 Cedar Street
Saint Paul, Minnesota 55155
(651) 355-0100
segip.mmb@state.mn.us

Minnesota Management and Budget

NOTICE OF COLLECTION OF PRIVATE DATA
(September 2, 2017)

Minnesota Management and Budget (MMB) administers the State Employee Group Insurance Program (SEGIP). This notice explains why we are requesting the private data about You, Your spouse, and dependents, how we will use it, who will see it, Your obligation to provide the data, and the result of providing or not providing the requested data.

What data will we use?

We will use the data You provide us at this time, as well as data previously provided us, about You, Your spouse, and dependents. If You provide any data that is not necessary, we will not use it for any purpose.

Why we ask You for this data?

We ask for this data so that we can successfully administer employee group health benefits that are self-insured. This data is used to process Your request to add, change, or drop coverage for Yourself, Your spouse, or dependents. The requested data also helps us to determine eligibility, to identify, and to contact You and Your spouse and dependents. The data is used to administer programs, develop new programs, to determine if programs are properly managed and meet member needs, and to comply with federal and state laws and rules.

Do You have to answer the questions we ask?

You are not required to provide any of the data but certain data must be collected or we may be unable to administer the programs or provide You Your benefits.

What will happen if You do not answer the questions we ask?

If You do not provide the requested data, You, Your spouse, and dependent may not be approved to participate in a program or may lose coverage under the program or the participation may be delayed.

Who else may see this data about You and Your spouse and dependents?

We may give data about You, Your spouse, and dependents to the group health benefits that are self-insured and service providers You have chosen, as well as SEGIP's other contracted vendors, so that they may help administer the programs. We may also provide this data to the Legislative Auditor; the Department of Health; the Department of Commerce; and any law enforcement agency or other agency with the legal authority to have the data; and anyone authorized by a court order. In addition, the parents of a minor may see data on the minor unless there is a law, rule, court order, or other legally binding instrument that blocks the parent from that data.

How else may this data be used?

We can use or release this data only as stated in this notice or allowed under law unless You give us Your written permission to release the data for another purpose or to release it to another individual or entity. The data may also be used for another purpose if Congress or the Minnesota Legislature passes a law allowing or requiring us to release the data or to use it for another purpose.

Medicaid and the Children's Health Insurance Program (CHIP) Offer Free or Low-Cost Health Coverage to Children and Families

If You are eligible for health coverage through SEGIP, but are unable to afford the premiums, some States have premium assistance programs that can help pay for coverage. These States use funds from their Medicaid or CHIP programs to help people who are eligible for employer-sponsored health coverage, but need assistance in paying their health premiums.

If You or Your dependents are already enrolled in Medicaid or CHIP and You live in Minnesota, contact the Minnesota Medicaid office to find out if premium assistance is available. The telephone number is 800/657-3739; You may also go to the Minnesota Department of Human Services website at mn.gov/dhs/people-we-serve/children-and-families/health-care/health-care-programs/programs-and-services/families.jsp for more information about Health care coverage for families with children under 21. If You live in another state, dial 1-877-KIDS NOW or go to the Insure Kids Now Website at www.insurekidsnow.gov.

If You or Your dependents are NOT currently enrolled in Medicaid or CHIP, and You think You or any of Your dependents might be eligible for either of these programs, You can contact Your State Medicaid or CHIP office, or dial 1-877-KIDS NOW or access the Insure Kids Now Website to find out how to apply. If You qualify, You can ask if there is a program that might help You pay the premiums for the SEGIP Plan.

Once it is determined that You or Your dependents are eligible for premium assistance under Medicaid or CHIP, SEGIP is required to permit You and Your dependents to enroll in the Plan – as long as You and Your dependents are eligible, but not already enrolled in the SEGIP Plan. This is called a "special enrollment" opportunity, and You must request coverage within 60 days of being determined eligible for premium assistance. You must also notify SEGIP within 60 days if Your coverage or Your dependent's coverage terminates under Medicaid or CHIP due to loss of eligibility.

For more information, contact:

U.S. Department of Labor
Employee Benefits Security Administration
www.dol.gov/ebsa
1-866-444-EBSA (3272)

Minnesota
mn.gov/dhs
mn.gov/dhs/people-we-serve/children-and-families/health-care/health-care-programs/programs-and-services/families
Phone: 651-431-2670
1-800-657-3739

Wisconsin
www.dhs.wisconsin.gov/badgercareplus/index.htm
Phone: 1-800-362-3002

U.S. Department of Health and Human Services
Centers for Medicare and Medicaid Services
www.cms.hhs.gov
1-877-267-2323, Ext. 61565

Iowa
www.dhs.state.ia.us/hipp
Phone: 1-888-346-9562

North Dakota
www.nd.gov/dhs/services/medicalserv/medicaid
Phone: 1-800-755-260