Your Employee Benefits 2017

MANAGEMENT AND BUDGET
STATE EMPLOYEE GROUP INSURANCE PROGRAM

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IMPORTANT NOTES:

The State of Minnesota expects to continue the State Employee Group Insurance Program 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 certificate of coverage/summary of benefits for a complete description of all benefits and exclusions. You may view certificates and summaries on the www.mn.gov/mmb/segip. If there is any difference between this document and any certificate of coverage/summary of benefits, the certificate/summary 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. Benefits-eligible employees are eligible for 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
- additional 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.

Online access to benefits

Personal Benefit Information

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

SEGIP website

Information about all insurance benefits is available on the SEGIP website mn.gov/mmb/segip. Information is arranged by benefit, and audience after that.

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/or the carrier websites.

Certificates of Coverage and Summaries of Benefits

Certificates of Coverage and Summaries of Benefits are legal documents that describe the plan benefits provided by that carrier. They include much more detail about your plan and benefits than this document contains. All Certificates of Coverage and Summaries of Benefits are available through 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 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 homepage mn.gov/mmb.

Flexible Spending Accounts (FSA) Pre-tax Benefits

A complete guide to enrollment and use of SEGIP FSA benefit options is available on the internet or upon request from 121 Benefits (the administrator of SEGIP FSA plans). Go to 121 Benefits homepage www.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* 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 more information during the annual Open Enrollment.

Agreements

Each insurance carrier or claims administrator participating in the State Employee Group Insurance Program signs an agreement with the State. Versions of these agreements are available for inspection at the offices of Minnesota Management and Budget/Employee Insurance Division, by appointment at (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 all state employees

State of Minnesota employees, retirees (under age 65 and/or not Medicare eligible), and eligible dependents who receive medical coverage under the State Employees Group Insurance Program (SEGIP) are enrolled in a medical benefits program called the Minnesota Advantage Health Plan.

Advantage Plan includes important features

The Minnesota Advantage Health Plan has 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, for example, 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 plan 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.
- You may change your PCC as often as monthly, even if it changes your cost level. Clinic changes are effective the first of the month following the date you request the change by calling your carrier.
- 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 PCC’s 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

Navitus Health Solutions® 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. The Navitus plan 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 Navitus network. For a listing, go to the Navitus homepage www.navitus.com. You will need to set up an account at the Navitus website to access the drug formulary. Mail-order prescription service is also available for members filling maintenance medications.

Creditable coverage for prescription drugs

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.

How does Advantage work?

Under Advantage, you share in the cost of specific medical services by paying out-of-pocket costs through deductibles, office visit copays, and coinsurance.

Health care providers 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.

The amount of cost sharing that is paid when using health care services varies depending upon the cost level of the provider that you choose under your carrier.

Although you will pay out-of-pocket (OOP) costs under Advantage, cost levels one and two features the same low OOP maximum. The OOP maximum for cost level three and four are set higher, as the cost to deliver care under these systems is higher than costs in cost levels one and two clinics. Once you've reached your annual OOP 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 FSA or pre-tax flexible spending account (FSA) Medical/Dental Expense Account (MDEA), a program that will allow your predictable 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 expenses. See the Optional Coverage Highlights section of this booklet or your Open Enrollment materials for details.

NOTE: Two state employees who are married to each other and enroll 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. It is the employee's responsibility to notify their carrier when the out-of-pocket maximum and/or deductible have been met.

How to find Advantage Plan 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. To find the list, go to the SEGIP website mn.gov/mmb/segip. Click on the Medical and Dental tab. From here, you can select either New Hires or Current Employees. From either, select Choose Your Clinic. The current year's PCCs are found by clicking on Medical Clinics to Choose From. As we approach Open Enrollment and the new plan year, an additional tab with this information will appear in the top band of tabs.

The SEGIP website also provides links to more detailed online provider directories of the three Advantage Plan carriers: BlueCross BlueShield, HealthPartners, and PreferredOne. To access, go to SEGIP website, scroll to the bottom of the page and click on SEGIP Quick Links from the footer. Carrier Contacts is the first selection in the SEGIP Quick Links drop down menu.

For specific questions, call the carrier directly. The carriers' phone numbers are listed in this Carrier Contacts section.

Convenience Care Clinics

Convenience care clinics are available in some areas at a $10 copay level in all cost levels. The first dollar deductible is waived. 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. A list of convenience care clinics and locations are available on the SEGIP website or you may call your carrier's for the most up to date information.

Online Care Benefit

The Minnesota Advantage Plan also has an 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 the in-network Convenience Care Benefit without the confines of office walls. The Online Care Benefit is provided without referrals, is not subject to the annual deductible, and is provided at a $10.00 copay, regardless of your cost level. You may access Doctor on Demand and/or Virtuwell regardless of your carrier. To learn more about them or use this benefit visit: Doctor on Demand www.doctorondemand.com/bluecrossmn or Virtuwell www.virtuwell.com.

Centers of Excellence

Centers of Excellence are hospitals recognized for their success in transplantation and bariatric surgery. The inpatient copay (in Cost Level 1, 2 and 3) is waived if using a designated Center of Excellence for these surgeries. For detailed information and help in identifying a Center of Excellence, call the customer service number on the back of your Advantage Plan card.

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. Employees traveling out of Minnesota and the Advantage Plan service area may receive provider discounts when using the National Preferred Provider Organization (PPO) of the carrier in which they are enrolled.

Under Advantage, each carrier offers a National Preferred Provider Organization (PPO) available outside the Advantage Plan service area. Benefits in the National PPO vary depending on specific circumstances and the member's residence status. The out-of-network Emergency and Urgent Care benefits for participants who permanently reside in the Advantage Plan service area will be administered consistent with their Point of Service Benefit when they are in a travel status.

Point of Service (POS)

Point of Service (POS) coverage is available for members whose permanent residence is outside the state of Minnesota and outside the service areas of the carriers participating in Advantage. The POS benefit is also available to employees on temporary assignment, paid leave, (including sabbatical) and college students. It is also available to dependent children, including young adult dependents, and spouses permanently living out of area. Access to POS benefits must be requested by providing the permanent address outside the service area to SEGIP on the Point of Service Form (mn.gov/mmb/segip, Medical and Dental tab, Current Employees, Forms) **and** by calling your carrier to request access to Point of Service (POS) benefits. Benefits in the National PPO vary depending on specific circumstances and the member's status.

NOTE: The form and call must be done again if you change carriers during an Open Enrollment.

NOTE: Children who have lived out of area with an ex-spouse since 2003 will receive level 2 coverage with a national PPO provider. If a national PPO provider is not available a dependent may self-refer and receive level 2 benefits. This benefit applies if enrollment is continued with the same carrier.

Married SEGIP Participants/Parent and dependent child employed by SEGIP

Effective January 1, 2016, if both spouses work for the state or another organization participating in SEGIP, a spouse may be covered as a dependent by the other. Effective January 1, 2016, 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 Waive 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 dependents in common.

Advantage Consumer Directed Health Plan (ACDHP) – High Deductible Health Plan

During the 2007 legislative session, the legislature passed a bill providing that the State Employee Group Insurance Program (SEGIP) offer a high deductible health plan. It is available to Commissioner's Plan, Managerial Plan, and most unrepresented employees. The Minnesota Advantage Health Plan (Advantage) 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). This option is called the Advantage Consumer Directed Health Plan (ACDHP).

The ACDHP premium is based on the Advantage Plan. The employer contributes to the premium on the same basis as it contributes to Advantage (e.g., 95% of single premium, 85% for dependent premium). The employer will make a contribution to an HSA in the amount of $500 single and $1000 family. Employees who opted to participate in the Biometric Health Screening and who take the StayWell Health Assessment during Open Enrollment (and agreed to accept a coaching call) will gain additional funds for their 2017 HSA from the employer. New hires who were not eligible to participate in Open Enrollment will automatically be granted access to a portion of the additional HSA contribution, in accordance with their eligibility. Employee and employer contributions will be made on a pay period basis, and will be directed by MMB to the financial institution associated with the health plan administrator chosen. Changes to the contributions may be

announced during each year's Open Enrollment. The state will pay any applicable HSA administrative fees (not including investment fees, if any).

Health Assessment

Employees have an opportunity to take a health assessment administered by StayWell. 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.

Health Plan Options

Your Employee Benefits provides an overview of the plan options offered through SEGIP (referred to as medical plan or health plan). Your health plan options can change through collective bargaining agreements reached by management and labor unions. Throughout the term of union contracts, the Joint Labor-Management Committee on Health Plans discusses issues regarding your health benefits including rising health insurance costs and developing ways to evaluate the quality of health plans and promoting better labor-management relationships. If you have concerns about your health coverage, please share them with your union representative or agency HR office.

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
www.bluecrossmn.com/segip

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

2017 Minnesota Advantage Health Plan Schedule of Benefits

2016 - 17 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 and 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 and Online Care (deductible waived)	$10 copay	$10 copay	$10 copay	$10 copay
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	Nothing	Nothing	Nothing	Nothing
I. Prosthetics, Durable Medical Equipment	20% coinsurance	20% coinsurance	20% coinsurance	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 copays)	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, growth hormones) (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

**The level of the office visit copay for the employee and his or her family is dependent upon whether the employee has completed the Health Assessment in each Open Enrollment period, and agreed to accept a health coach call. Employees who have completed the Health Assessment and accept a health coaching call are entitled to the lower copay. Employees hired after the close of Open Enrollment will be entitled to the lower copay.*

This chart applies only to in-network coverage. Point-of-Service (POS), coverage is available only for members whose permanent residence is outside the State of Minnesota and outside the service areas of the health plans participating in Advantage. This category includes employees temporarily residing outside Minnesota on temporary assignment or paid leave [including sabbatical] and college students. It is also available to dependent children and spouses permanently residing outside the service area. These members 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 copay described at Section M above to the out-of-pocket maximum described at Section N. This benefit must be requested.

A standard set of benefits is offered in all SEGIP Advantage Plans. There are still some differences from plan to plan in the way that benefits, including the transplant benefit, are administered, in the referral and diagnosis coding patterns of primary care clinics, and in the definition of Allowed Amount. Beginning in 2016, benefits for palliative care and for the treatment of autism have been added, and are fully described in the Advantage Summary of Benefits.

Dental coverage

You have the option to purchase dental insurance as an employee 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 during the Open Enrollment period held **every other year**, or if you experience a qualifying life event (see page 22).

Important features

Both dental plans provide coverage for most conditions requiring dental diagnosis and treatment, including orthodontic treatment for children under age 19. 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 Certificate of Coverage.

Provider networks

Each dental plan has a network of dentists and, in some cases, preferred specialists through which you receive in-network care. The SEGIP website is available at: mn.gov/segip and offers more information on providers. You can access directories of dental clinics and dentists through links to each carrier. To ask specific questions about dental clinics, call the carrier directly. The carries' 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 plan. This ensures that you understand the amount your plan will pay and the amount that will be your responsibility.

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 an 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 Waive 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 dependents in common.

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 2016-2017

Annual Maximum per person (does not apply to Orthodontia) $1500.		
Covered Services	**In-network Benefits**	**Out-of-network Benefits**
Diagnostic and preventive care		
Preventive care; examinations, x-rays, oral hygiene and teeth cleaning	100% coverage (deductible does not apply)	50% coverage of the allowed amount (deductible does not apply)
Fluoride treatment (to age 19)	100% coverage (deductible does not apply)	50% coverage of the allowed amount (deductible does not apply)
Space maintainers	100% coverage (deductible does not apply)	50% coverage of the allowed amount (deductible does not apply)
Annual Deductible	**$50 per person** **$150 per family**	**$125 per person**
Restorative care and prosthetics		
Fillings (customary restorative materials)	80% coverage after deductible	50% coverage of the allowed amount after deductible
Sealants	80% coverage after deductible	50% coverage of the allowed amount after deductible
Oral surgery (simple extractions and root canals)	80% coverage after deductible	50% coverage of the allowed amount after deductible
Periodontics (gum disease therapy)	80% coverage after deductible	50% coverage of the allowed amount after deductible
Endodontics (root canal therapy)	80% coverage after deductible	50% coverage of the allowed amount after deductible
Inlays and overlays	80% coverage after deductible	50% coverage of the allowed amount after deductible
Restorative crowns	80% coverage after deductible	50% coverage of the allowed amount after deductible
Fixed or removable bridgework	50% coverage after deductible	50% coverage of the allowed amount after deductible
Full or partial dentures	50% coverage after deductible	50% coverage of the allowed amount after deductible
Dental relines or rebases	50% coverage after deductible	50% coverage of the allowed amount after deductible
Orthodontics - $2400 Lifetime Maximum (does not start over if you change dental plans)	50% coverage (deductible does not apply). Coverage is limited to dependents under age 19.	50% coverage of the allowed amount (deductible does not apply). Coverage is limited to dependents under age 19.

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

See Certificate of Coverage for specific plan details and limitations

Life insurance

The state offers basic life insurance in which you are automatically enrolled at the time you become a benefits-eligible employee of Minnesota state government or other organization that participates in SEGIP. We also offer additional life insurance for you, your spouse, and dependent children which you may purchase through SEGIP on an optional basis.

Basic Employee Life Insurance

- The state pays the full cost for benefits-eligible employees
- Benefit based on annual salary (consult your bargaining agreement)
- Maximum coverage allowed is $95,000

Manager's Life Insurance

If you are a manager, you choose an employer paid life insurance benefit option of:

- 1½ times your annual salary
- 2 times your annual salary

See your collective bargaining agreement or plan to determine the amount of your state-paid life insurance and your eligibility for employer-paid coverage.

Employees who are eligible to participate in SEGIP insurance but not eligible for an employer contribution may purchase basic life at their own expense.

Additional Life Insurance for yourself and your spouse

You may purchase additional term life insurance for yourself and your spouse. Generally you may purchase this insurance in increments of $5,000 up to a total of $500,000 each. The amount of coverage you can purchase may vary by collective bargaining agreements and plans.

Evidence of good health

Within 35 days of employment, new employees may apply for additional employee life insurance of up to two times their annual salary. (Newly benefits-eligible employees may apply within 30 days of becoming eligible.) This additional life insurance upon employment does not require evidence of insurability. New employees may also apply for $5,000 or $10,000 of additional life insurance for their spouse without evidence of insurability. If you get married after your employment begins, you may add $5,000 or $10,000 of spouse life insurance by submitting your application to SEGIP within 30 days of your marriage.

If amounts above two times your annual salary or amounts greater than $10,000 for spouse are desired, they may be requested by applying with evidence of insurability. Likewise, employees who did not enroll in optional life for themselves or spouse when initially eligible may obtain additional life if approved after submitting an application with evidence of insurability. If approved, the coverage is effective the date of the approval. Most additional employee or spouse life insurance requires satisfactory evidence of insurability. This involves completing a health questionnaire and may possibly require access to medical records or simplified physical exam. You will be notified if your coverage has been approved or denied.

The value of employee or spouse life insurance coverage automatically doubles in the event of an accidental death.

Child Life Insurance

You may purchase life insurance providing $10,000 of coverage for your eligible children as defined in the Certificate of Coverage. One child life insurance policy covers all of your dependent children, but not your spouse.

Child life coverage begins upon live birth and can be maintained through age 25 (ends at age 26). You may add child life insurance without evidence of insurability within 30 days of the birth of a child or the placement of a child for adoption.

If you enroll in any optional life insurance, the premium will be deducted from your paycheck.

Upon disability

If you become totally and permanently disabled before age 70, you may apply for a continuation of all your life insurance coverage currently in effect without further premium payments by contacting SEGIP at 651-355-0100. The waiver of premium may continue until age 70 is attained.

Upon retirement

If you meet the requirements as a retiree under your labor contract or plan or by statute and have carried additional employee and/or spouse life insurance for a minimum of five consecutive years immediately preceding your retirement date or age 65, whichever is later, you are eligible for a fully-paid post-retirement life insurance policy or policies. These policies are equal to 15 percent of the smallest amount of additional employee or spouse life insurance in effect during that five-year period. Each policy is separate and distinct; the amounts may not be combined to increase the amount of a single policy.

Employees who qualify for the post-retirement benefit and retire before age 65 must continue to pay their premiums at SEGIP rates until age 65 to remain eligible. Please note that this benefit is different from your right to continue life insurance for up to 18 months, which is explained later in this document (see “Continuation of your coverage”).

Accidental Death and Dismemberment Insurance

Accidental Death and Dismemberment (AD&D) insurance provides coverage for death or dismemberment due to an accident. This optional benefit is available to both you and your spouse.

You may purchase AD&D insurance in increments of $5,000 up to a total of $100,000 (up to $50,000 if you are 61 or older). You may also purchase up to a total of $25,000 worth of coverage for your spouse, but you may not have a greater dollar value of coverage for your spouse, than you have for yourself.

If you and your spouse or another family member are employed by the state, or another organization participating in the State Employee Group Insurance Program, none of the eligible members may cover the other as a dependent for Life or AD&D insurances as long as both are benefits eligible (can’t cover each other for life insurance). Also, only one state employee can cover dependents in common.

Beneficiary

Your group insurance provider, Securian (formerly Minnesota Life), provides a secure web site for electing, storing, and updating your beneficiary designations. This secure online service protects the privacy of your information while ensuring your beneficiary information is available when it’s needed.

New employees and newly-eligible employees will receive a letter with user instructions at their home from Securian.

You may change your beneficiary at any time. Beneficiary designations are maintained electronically and can be updated at any time online at the Life Benefits website at www.lifebenefits.com. If you do not name a beneficiary, the following priority list will determine who will receive your life insurance benefits:

1. Your surviving spouse
2. Your surviving children in equal shares
3. Your surviving parents in equal shares
4. Your estate

For plan details, premium rates, online documents, beneficiary information and much more go to:
www.lifebenefits.com/plandesign/statemn

The Life Suites, additional benefits available to employees with basic life are explained on this site as well. They include travel assistance, legacy planning, legal services, and beneficiary management online.

Ochs, Inc.

The servicing agent for Securian

400 Robert Street, Suite 1880
St. Paul, MN 55101-2016
(651) 665-3789
(800) 392-7295
www.lifebenefits.com/plandesign/statemn

Disability insurance

Two optional disability plans are available to most benefits-eligible employees:

- Short-Term disability (STD)
- Long-Term disability (LTD)

The amounts and terms of disability insurance described in this document apply to most employees but there may be some variations, depending upon the terms and conditions of your employment. If you are covered by the Income Protection Plan, special circumstances apply to you. Please see the section on, “Manager’s Income Protection Plan.”

The cost of short-term and long-term disability insurance is listed on the SEGIP Website. If you enroll in disability insurance, the premiums are deducted from your paycheck on a post-tax basis.

Short-Term Disability Insurance

Short-term disability insurance provides you with income when a non-work related injury, illness or pregnancy results in your total disability. Benefits will begin on the first day of a disability due to an accident or on the eighth day of a disability due to illness or pregnancy. Benefits will not be paid for any day you are not under the care of a physician. Benefits will not continue for more than 180 days for any one period of total disability. Benefits are not payable while you are eligible for workers’ compensation benefits.

You may purchase short-term disability insurance for monthly benefit amounts (income replacement) ranging from $300 to $5,000. Do not purchase more than the amount equal to two-thirds of your gross monthly salary; benefits paid will be capped at that amount. The cost of short-term disability insurance is based on the amount of the monthly benefit you elect.

New employees may purchase coverage within 35 days of becoming hired (if eligible for insurance), without providing evidence of insurability. Newly benefits-eligible employees may apply within 30 days of becoming eligible (provided they’ve worked more than 35 days). Benefits eligible employees may purchase or increase coverage at any time by providing evidence of insurability.

Long-Term Disability Insurance

Long-term disability (LTD) insurance provides you with income when an injury or illness results in your disability beyond 180 days. Benefits will begin on the 181st day of a total disability due to an injury, illness or pregnancy and are payable until your normal retirement age, as stated in the 1983 Social Security amendment, which is determined by your date of birth. If you are disabled after age 62, another age limit applies; see your insurance plan’s Certificate of Coverage available on the SEGIP Website.

New employees may enroll in LTD insurance within 35 days of employment or during an annual Open Enrollment. Newly benefits-eligible employees may elect within 30 days of becoming eligible (provided they’ve worked more than 35 days). You may purchase LTD coverage in monthly benefit amounts (income replacement) ranging from $300 to $7,000. Do not purchase more than the amount equal to approximately 60% of your monthly salary according to the rate guide available on the SEGIP website; paid benefits will be capped at that amount. The cost of LTD insurance is based on the amount of the monthly benefit you choose. Long Term Disability benefits are offset by other wage replacement benefits to which you may be entitled, such as those provided by Social Security Disability or Minnesota State Retirement Disability. The minimum benefit payable is $300 per month or 15 percent of the benefit amount purchased, whichever is greater. In no case would you collect more than you purchased.

Other sources of disability income.
Under some circumstances, you may be eligible for disability income through other sources, such as:

- retirement (including early retirement) or annuity benefits
- workers' compensation (including lump sum settlements)
- Social Security disability for yourself
- Social Security disability that your spouse or your children are entitled to as a result of your disability

Income from these sources will reduce the amount of benefits you receive under your LTD policy. Your Certificate of Coverage contains a list of possible income sources that may reduce your benefits.

Pre-existing medical condition. For the first 24 months of your LTD coverage, your policy will exclude coverage for any pre-existing medical condition. A pre-existing condition is defined as any disability which is caused by or results from any injury, illness or pregnancy which occurred was diagnosed, or for which you received medical care during the 12 months prior to the effective date of your long-term disability coverage.

If you have a pre-existing condition, your coverage must be in effect for 24 months before you may receive benefits for **that** particular condition. You may receive coverage for a disability unrelated to your pre-existing condition. If no pre-existing condition exists, the 24-month waiting period does not apply, and your disability will be covered according to the terms of your policy.

Manager's Income Protection Plan

Long-term disability and special basic life coverage are combined for employees covered by the Manager's Plan and certain employees covered in the Commissioner's Plan. These combined benefits are called the **Income Protection Plan (IPP)**.

The long-term disability portion of this benefit pays a percentage of your salary as a benefit. Under the IPP, you choose an elimination period which is an amount of time that must elapse before a benefit can be received following the onset of a disability. You may have the option to change your elimination period during the annual Open Enrollment or by providing evidence of insurability.

Current employees who become eligible for the Income Protection Plan may continue their short-term disability, if they had enrolled prior to becoming eligible for IPP if they choose. However, they may not increase the amount of coverage after IPP coverage begins. Current long-term disability cannot be continued. New employees who are eligible for IPP may not enroll in short-term disability or other long-term disability coverages. (This does not exclude Long Term Care Coverage).

Your IPP premium is based on which life insurance plan you choose, the elimination period you choose, and your monthly salary.

For information about disability insurance benefits you may contact the plan's customer service representative at:

The Hartford

The Hartford
Minneapolis Disability
P.O. Box 14305
Lexington, KY 40512-4305
Phone: (800) 752-9713
FAX: (877) 454-7217

STD Telephonic Claims

(800) 898-2458
Policy number 023458

Ochs, Inc. (servicing agent for The Hartford)

400 Robert Street, Suite 1880
St. Paul, MN 55101
(651) 665-3789
(800) 392-7295
http://ochsinc.com/MNOE/StateMNOE.html

Long-term care insurance

Long-term care insurance pays for a variety of services for participants who are unable to care for themselves due to an injury such as paralysis from a car accident, a chronic illness such as arthritis, an acute episode such as a stroke or a cognitive impairment like Alzheimer's.

Long-term care services may include assistance in the home or adult day care center with nursing or personal care activities or confinement in an assisted-living facility or nursing home.

Health insurance only pays for short periods of skilled long-term care while persons are recuperating. Long-term care insurance is meant to pick up where skilled long-term care becomes custodial.

Eligibility and underwriting

Group enrollments were discontinued as of February 1, 2016. Any group policies provided prior to February 1, 2016 will continue to be maintained and supported by CNA.

State Tax Credit

Minnesota residents may claim a tax credit for a portion of the long-term care insurance premiums paid. For further information please consult a tax professional or the Department of Revenue.

Portability

Since premiums are based on the age when a person enrolls, most covered participants do not switch insurers once they are enrolled. So, unlike most other coverages, long-term care insurance is portable. Participants may continue coverage if they retire or otherwise leave employment with the coverage and cost remaining the same for most of the options offered.

CNA Insurance

P.O. Box 13327
Pensacola, FL 32591
(800) 262-4580
Fax (866) 357-8479

Flexible Spending Accounts (FSA) or pre-tax benefits

The FSA benefits offered by SEGIP can provide you with substantial tax savings by paying your 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. By paying less in taxes, your net income may be greater.

The FSA benefits are available to employees paid through the State's Central Payroll. Employees of other organizations participating in SEGIP, 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 IRS "use or lose" rule. Because of the tax advantages of the pre-tax benefits, contributions to Dependent Care (daycare) pre-tax expense accounts that remain unclaimed by the end of a year will be forfeited. Currently, the Medical/Dental Expense Account (MDEA) includes a $500 Carryover. This added feature allows most participants to Carryover up to $500 of unreimbursed money from their current MDEA account 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 for greater detail. 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 health and dental premiums with pre-tax dollars. 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 deducted.

Dependent Day Care Expense Account

The Dependent Care (daycare) Expense Account (DCEA) allows you to pay for certain dependent care (day care) expenses with pre-tax dollars. You may use DCEA to pay for the care of children under age 13 who qualify as dependents on your income tax return (disabled family members or elderly parents who live with you). You may use your DCEA to pay for care that is necessary to allow you to work. You may deposit up to $5,000 per family per year ($2,500 per spouse if you and your spouse file taxes separately). This account is for "day care" type expenses, not medical/dental expense for your dependents. The minimum annual DCEA election is $100.

Medical/Dental Expense Account

The Medical/Dental Expense Account (MDEA) allows you to pay for certain unreimbursed medical and dental expenses with pre-tax dollars. You may use your MDEA 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, like another insurance plan. You may contribute up to the maximum allowed per IRS code of $2,600 per year to your MDEA. The minimum annual MDEA election is $100. If you lose your benefits eligibility, you may be eligible to continue your MDEA participation on an after-tax basis by electing COBRA.

Pre-tax Debit Cards

The Benny Card contains the value of your annual MDEA election 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 Benny Card automatically deducts the costs of your eligible expenses from your MDEA (or HRA when applicable).

Enrollment in an MDEA account during the annual Open Enrollment will allow you to take advantage of this convenient method for expense reimbursement.

Transit Expense Accounts

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

You may enroll at any time 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 transit or parking must be submitted within 180 days of the date the expense was incurred or paid.

Payroll Deducted Transit Accounts

These accounts allow you to pay for payroll-deducted parking and bus pass expenses with pre-tax dollars. If you have parking or bus pass deductions from your paycheck, you are automatically enrolled in 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.

Limited Purpose MDEA and HRA

A limited purpose MDEA is an option for employees who are enrolled in a Health Savings Account (HSA). The limited purpose MDEA works the same way a standard MDEA does: pre-tax, "use or lose" elections, and expenses must occur within the plan year. The difference is that it limits what expenses are eligible for reimbursement. In a limited purpose MDEA, you can only submit claims for eligible vision, dental or preventative medical expenses.

SEGIP members participating in the ACDHP (High Deductible Plan) are only eligible for a limited purpose MDEA. ACDHP (High Deductible Plan) participants must also classify their HRA as limited purpose. This also applies to SEGIP members that participate in an HRA. Additionally, SEGIP members covered by a spouse participating in a ACDHP and HSA with their employer are only eligible to participate in a limited purpose MDEA.

For more information about the pre-tax benefits and the Benny Card, contact your plan administrator:

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

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.

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 federal laws and regulations will be applied. Information on this criteria is found on the website at mn.gov/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 offers this benefit, 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 choices
- access to online directories for medical and dental selection
- directions for electronic enrollment using the MN State Employee Self Service website

Effective date of coverage

You must enroll in employee medical and basic life coverages within 35 days of your hire date. You may also 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 back deduction.

Employees rehired in their previous control group within thirteen weeks (26 in educational institutions) of their previous employment (and had been eligible for the full employer contribution) may be eligible for benefits on their date of rehire. 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 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.

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. Notwithstanding the foregoing, if you are not actively at work on the initial effective date of coverage due to your medical status, medical condition, or disability, or that of your dependent, as such terms are defined in Section 9802(a) of the Internal Revenue Code and the regulations related to that section, 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 on your enrollment submission.

- Scan and email: segip.mmb@state.mn.us
- 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.

If you are a New Hire or Rehire your enrollment must be electronically completed within 35 days of your becoming insurance eligible. If you are rehired within 13 weeks (or 26 in an educational institution) and you were previously eligible for a full employer contribution, you will submit benefit elections via paper forms mailed to your home address. If your insurance eligibility changes because of your change in job status, 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). If you do not enroll and you are eligible for a full employer contribution per contract, you will automatically be enrolled in employee only medical coverage and basic term life insurance. You will be unable to enroll dependents at this time.

Default coverage

Employees eligible for a full employer contribution, who fail to enroll 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 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. If an employee does not choose a health plan administrator and PCC by their initial effective date, but was previously covered as a dependent immediately prior to their initial effective date, they will be defaulted to the plan administrator 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 children, the order will be forwarded to the Employee Insurance Division 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 plans 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:

- add or cancel eligible dependents on medical coverage
- change medical plans for yourself and dependents
- enroll in, cancel, or change dental plans 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).

Part-time employees, who are eligible for a partial employer contribution, may also enroll in or cancel medical coverage (dental coverage every other year) for themselves and/or dependents during Open Enrollment. Employees who are only eligible for the full employer contribution due to the federal rules of Employer Shared Responsibility may also enroll or cancel medical coverage (dental every other year) for themselves or dependents.

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. Notwithstanding the foregoing, 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 that of your dependent, as such terms are defined in Section 9802(a) of the Internal Revenue Code and the regulations related to that section, coverages shall not be delayed.

Coverage may become effective on the first day you return to active payroll status.

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, in 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 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.

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 the Employee Insurance Division 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 the secure web email at: segip.mmb@state.mn.us.

Adding, canceling and changing coverage

You may add new dependents to your medical or dental coverage following the birth/adoption of a dependent child. Coverage will be effective on the day of the birth, adoption, and/or placement for adoption. Enroll immediately so you don't owe a large retroactive premium or experience problems having claims paid appropriately. A social security number is required to process enrollment, but do not delay submitting the required form, if you do not have your dependents social security number.

An eligible grandchild may be added on a limited basis (within 30 days).

- Any other election to **add coverage** due to a qualified dependent's life event must be made **within 30 days of the event.**

- Any election to **cancel coverage** due to life event must be made within **60 days of the event**.

  These life events are:

a. A change in legal marital status, including marriage, death of a spouse, divorce 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 change in place of residence and/or work location of the employee, retiree or their spouse or dependent and the current carrier is not available.
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 spouse or dependent.
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 41 of this book.*

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
- apply for or increase short-term disability coverage for yourself 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)
- decrease or terminate additional life insurance, accidental death and dismemberment insurance, short-term and long-term disability insurance, and long-term care coverage.

Changes in Pretax Accounts

You may increase, decrease, add or cancel the amounts, within the timeframes specified in the Summary of Benefits (www.121benefits.com) in your Dependent Care (daycare) Expense Account and your Medical/Dental Expense Account if a qualified life event occurs. 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, 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 representatives 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. Notwithstanding the foregoing, 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, as such terms are defined in Section 9802(a) of the Internal Revenue Code and the regulations related to that Section, 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 (QMO) in force, you may change plans, but you cannot cancel dependent coverage.

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

If you are served with Medical Child Support Order by the court at any time during your employment with the state, you must notify your agency HR office and the Employee Insurance Division (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 Plan Description 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 Division (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 Division (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, or

2. Your employment ends for any reason other than your 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 his or her gross misconduct; or

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 any reason other than their gross misconduct; or

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 the Employee Insurance Division of (SEGIP) within 60 days after the qualifying event occurs. You must send this notice to: Minnesota Management and Budget, SEGIP, 658 Cedar Street, St. Paul, MN, 55155 or fax (651) 296-5445 or scan and email to the SEGIP general mailbox at segip.mmb@state.mn.us . If you do not properly notify SEGIP of these changes, you will jeopardize your dependents' rights to continue 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 in a timely fashion. 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 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 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, or
- 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 your family experiences another qualifying event while receiving 18 months of continuation coverage, the spouse and dependent children in your family can gain additional months of medical and dental continuation coverage, up to a combined maximum of 36 months, if notice of the second qualifying event is properly given in writing within allowed or established timeframes to SEGIP. This extension is available to the spouse and dependent children 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 within 60 days of the second qualifying event. 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 would have to have started sometime during the continuation period and must last at least until the end of the 18-month period of continuation coverage. You must make sure that SEGIP is notified 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, or fax (651) 296-5445 or email to segip.mmb@state.mn.us.

If you have questions

If you have questions about your continuation coverage, you should contact the Employee Insurance Division at (651) 355-0100.

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 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, or
- The end of the period for which contribution is paid, if the required contribution is not paid on a timely basis; or
- The date the plan is terminated, if ever.

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

Continuation of the Health Reimbursement Arrangement (HRA)

For the 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 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 about Point-of-Service (POS).

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.

Dependent eligibility

Eligibility

The Employee Insurance Division of (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 Waive 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 dependents in common.

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) 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 thirty (30) 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 (QMSCO 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 for Medical and Dental Coverage State Employee Group Insurance Program (SEGIP)

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. Details are in Your Employee Benefits

Glossary of benefit terms

This section provides definitions of terms used throughout your benefits materials, such as your certificates of coverage and health plan materials. You may want to read these definitions before you begin exploring your benefit options. The definitions will help you understand your choices and the ways in which the plans work.

Allowed amount	A set amount which an insurance company or claims administrator (often referred to as a plan) agrees to pay for a particular service or product provided by a doctor or other health care provider. Under some plans, there may be a difference between the allowed amount and the health care provider's fee for a particular service or product. In some of these cases, you, as the covered person, are responsible for paying the difference.
Benefit	The rights of the covered person or beneficiary to either cash or services after meeting the eligibility requirements of a covered plan.
Beneficiary	A person named to receive any benefits provided by an insurance policy if the insured person dies. Also, a person designated by a plan participant or by the terms of an insurance plan, who is or may become entitled to a benefit.
Claims Administrator (or Carrier)	An organization, such as an insurance company or a third- party administrator that provides or administers programs that arrange for medical, dental, life or other benefit services. All of the companies that offer medical, dental, life, and optional benefits through the State Employee Group Insurance Program may also be called carriers.
Certificate of Coverage/Summary of Benefits	A document provided to plan participants describing details of coverage. Insured plans call this a certificate of coverage and self-insured plans call this a summary of benefits. These documents include much more detail than this document. Certificate of coverage and summary of benefits are available on line at the SEGIP website.
Continuation coverage	For some coverages each covered person and qualified beneficiary may have the option to pay for continued coverage under the plan if coverage would otherwise have ceased as a result of one of a number of qualifying events (described previously in this document). The length of time for which coverage may be continued depends on the qualifying event.
Conversion	A privilege given to covered persons to convert from group coverage to individual medical and life insurance policies, without evidence of good health.

Term	Definition
Coordination of benefits	A group of health plan provisions designed to eliminate duplicate payments and establish the sequence in which coverage will apply (primary and secondary) when a person is covered under two or more insurance or benefit plans. If you or any of your dependents have Medicare A or B due to age or disability, please report this information to your health plan. For employees who are actively at work their health plan must pay first (primary) on all claims. Your health claims administrator will then submit any remaining charges to Medicare for possible payment.
Copayment (Copay)	A flat dollar amount that is charged every time a service is provided. For example, under Advantage, members will be charged an office visit copay for most non-preventive visits to the doctor's office.
Coinsurance	This is a percentage of the cost that is charged for certain services after the deductible has been paid. For example, a coinsurance level of 20% means that the plan pays 80% of the costs, and the member pays the remaining 20% of the cost.
Deductible	An annual amount that must be paid once each year before the plan starts paying for certain services. For example, "$200 deductible" means that you will pay the first $200 per year for certain services before the plan will begin covering the cost of services.
Effective date	The date on which an insurance policy or plan coverage begins.
Evidence of good health/insurability	A statement or proof of a person's physical condition required by an insurance plan to determine if that person will be covered by the plan. This usually involves completing a questionnaire but may also include providing access to medical records or taking a physical exam.
ERISA	Employee Retirement Income Security Act. A federal law governing and guiding various employee sponsored health and/or benefit plans available through private employers. As a governmental plan, SEGIP is not subject to ERISA.
Formulary	A comprehensive list of preferred drugs selected on the basis of quality and efficacy by a professional committee of physicians and pharmacists. A drug formulary serves as a guide for the provider community by identifying which drugs are covered. It is updated regularly and includes brand name and generic drugs.
In-network	The group of medical or dental care providers with whom a plan has contracted to provide services to members of the plan. Networks may change during the year, so ask if a provider is still participating with your plan before you seek services.

Open Enrollment	The period during which participants in a benefit program, such as the State Employee Group Insurance Program, have an opportunity to choose among medical or dental plans being offered to them, or to change from one plan to another, or to enroll in the pre-tax benefit plans. The period when benefits-eligible employees and dependents may also obtain some optional insurance coverage without presenting evidence of insurability.
Out-of-pocket (OOP) cost	The defined limit of combined copays, deductibles, and co-insurance that an individual (or a family) will have to pay during a single insurance year. Under Advantage, members have an OOP maximum for prescription drug copays, and a separate OOP maximum for copays, deductibles, and co-insurance associated with medical services.
Pre-existing conditions	A physical or mental condition of an individual that existed prior to the beginning of the individual's coverage under a benefit plan. Under certain circumstances, pre-existing conditions may be excluded from coverage.
Preferred provider organization (PPO)	A dental or medical plan in which a limited network of providers contracts with a claims administrator to provide comprehensive medical or dental services. Providers agree to abide by specific quality-of-care standards and accept discounted payments for services in exchange for an increased number of patients.
Pre-tax benefits or Flexible Spending Accounts (FSA)	Programs which allow eligible employees to pay for certain medical, dental, dependent care expenses, and parking and bus pass/van pool expense with money that is deducted from their pay before it is taxed.
Primary care	Routine medical care normally provided in a doctor's office by a general internist, family or general practitioner, or pediatrician.
Provider	A doctor, therapist, chiropractor or other licensed medical or dental practitioner who provides health or dental services. A participating provider is one who contracts with a plan to provide services to members of the health or dental benefits plan.
Qualifying event	An event that may entitle a person to continue benefits coverage or make a change in contributions to a pre-tax account. Examples of qualifying events include termination of employment, reduction in work hours resulting in a reduction or loss of benefits, death of an insured employee, divorce or legal separation, or a dependent child's loss of dependent status.
Self-refer	When patients seek medical or dental services from providers without a referral from a designated primary care physician or clinic.

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.

Medical Data Privacy

Introduction

Recently, the federal Department of Health and Human Services adopted regulations governing the Plan's use and disclosure of Your health information. The regulations arose from the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"). While the Minnesota Advantage Health Plan ("the Plan") has always taken care to protect the privacy of Your health information, the new regulations require the Plan to adopt more formal procedures and to tell You about these procedures in this document. The information below discusses ways in which the Plan uses and discloses Your health information.

Under HIPAA, the Plan is required by law to take reasonable steps to ensure the privacy of Your personally identifiable health information and to tell You about:

1. The Plan's uses and disclosures of Protected Health Information ("PHI");
2. Your privacy rights with respect to Your PHI;
3. The Plan's duties with respect to Your PHI;
4. Your right to file a complaint with the Plan and the Secretary of the U.S. Department of Health and Human Services; and
5. The person or office to contact for further information about the Plan's privacy practices.

A. The Plan's Use and Disclosure of PHI

The Plan will use Protected Health Information ("PHI") to the extent of and according to the uses and disclosures allowed by the Medical Data Privacy Regulations ("Privacy Regulations") adopted under HIPAA, including for purposes related to Health Care Treatment, Payment, and Health Care Operations.

The Plan will enter into agreements with other entities known as "Business Associates" to perform some of these functions on behalf of the Plan. Each Business Associate will be allowed to use and disclose only the minimum amount of PHI needed to perform the Business Associate's duties on behalf of the Plan. The Plan's agreements with its Business Associates will also meet the other requirements of the Privacy Regulations.

Use of PHI for Treatment Purposes

Treatment includes the activities relating to providing, coordinating or managing health care and related services. It also includes but is not limited to consultations and referrals between one or more of Your Providers. As a health Plan, the Plan is generally not involved in Treatment situations but may, from time-to-time, release PHI to assist Providers in Your Treatment.

Use of PHI for Payment and Health Care Operations

Payment includes the Plan's activities to obtain premiums, contributions, self-payment, and other payments to determine or fulfill the Plan's responsibility for coverage and providing benefits under the Plan. It also includes the Plan obtaining reimbursement or providing reimbursement for providing health care that has been provided. These activities include but are not limited to the following:

1. Determining eligibility or coverage under the Plan;
2. Adjudicating claims for benefits (including claim appeals and other benefit payment disputes);
3. Subrogation;
4. Coordination of Benefits;
5. Establishing self-payments by persons covered under the Plan;
6. Billing and collection activities;
7. Claims management and related health care data processing, including auditing payments, investigating and resolving payment disputes and responding to covered persons' inquiries about payments;
8. Obtaining payment under stop-loss or similar reinsurance;
9. Reviewing whether claims are payable under the Plan, including whether they are Medically Necessary, Reasonable and Customary, or otherwise payable;
10. Reviewing coverage under the Plan, appropriateness of care, or justification of charges;
11. Utilization review, including precertification, preauthorization, concurrent review and retrospective reviews;
12. Disclosing to consumer reporting agencies certain information related to collecting contributions or reimbursement (the information that may be released is: name and address, date of birth, Social Security number, payment history, account number and name and address of the Provider and/or health Plan); and
13. Reimbursement to the Plan.

Health Care Operations can include any of the following activities. While the Plan does not currently use or release PHI for all of these activities, it may do so in the future to perform health care operations of the Plan:

1. Conducting quality assessment and improvement activities, including outcomes evaluation and development of clinical guidelines as long as general knowledge is not the primary purpose of these studies; population based activities relating to improving health or reducing health care costs, protocol

development, case management and care coordination, contacting health care Providers and patients with information about Treatment alternatives; and related functions that do not include Treatment;

2. Reviewing the competency or qualifications of health care professionals; evaluating Provider performance; accreditation, certification, licensing or credentialing activities;

3. Underwriting, premium rating and other activities relating to creating, renewing or replacing a health insurance contract (or reinsurance) or health benefits under the Plan;

4. Conducting or arranging for medical review, legal services, and auditing functions, including fraud and abuse detection and compliance programs;

5. Planning and development, such as conducting cost-management and planning related analyses relating to managing and operating the Plan (including Formulary development and administration, development or improvement of methods of payment or coverage policies); and

6. Management and general administrative activities of the Plan, including but not limited to:

    A. Managing activities related to implementing and complying with the Privacy Regulations;
    B. Resolving claim appeals and other internal grievances;
    C. Merging or consolidating the Plan with another Plan, including related due diligence; and
    D. As permitted under the Privacy Regulations, creating de-identified health information or a limited data set.

B. Other Uses and Disclosures of PHI

The Privacy Regulations permit certain other uses and disclosures of Your PHI. These include, for example, releasing PHI to personal representatives of deceased covered persons, releasing PHI for public health activities, releasing PHI for court proceedings, and releasing PHI for law enforcement and similar purposes. If the Plan releases PHI in any of these other permitted situations, it will do so according to the requirements of the Privacy Regulations.

The Privacy Regulations also permit the Plan to release PHI if it receives a valid authorization from You. If the Plan receives a valid authorization, the Plan will disclose PHI to the person or organization You authorize to receive the information. This may include, for example, releasing information to Your spouse, to the pension Plan, other retirement Plans, vacation Plan or similar Plan for the purposes related to administering those Plans.

C. Release of PHI to the Plan Sponsor

The Plan will disclose PHI to the Plan Sponsor. The Plan has received a certificate from the Plan Sponsor that the Plan documents, including this Summary of Benefits, have been amended to incorporate the following provisions.

The Plan Sponsor will receive and use PHI only for the Plan administration functions that the Plan Sponsor performs for the Plan. In addition, the Plan Sponsor will:

1. Not use or further disclose PHI other than as permitted or required by the Summary Plan Description or as required by law.
2. Ensure that any agents to whom the Plan Sponsor provides PHI received from the Plan, agree to the same restrictions and conditions that apply to the Plan Sponsor with respect to such PHI;

3. Not use or disclose PHI for employment-related actions and decisions unless authorized by the person who is the subject of the PHI;
4. Not use or disclose PHI in connection with any other benefit or employee benefit Plan of the Plan Sponsor unless authorized by the person who is the subject of the information;
5. Report to the Plan any PHI use or disclosure that is inconsistent with the allowed uses or disclosures of which it becomes aware;
6. Make PHI available to any person who is the subject of the information according to the Privacy Regulations' requirements;
7. Make PHI available for amendment and incorporate any amendments to PHI according to the requirements of the Privacy Regulations;
8. Make available the PHI required to provide an accounting of disclosures;
9. Make internal practices, books, and records relating to the use and disclosure of PHI received from the Plan available to the Secretary of Health and Human Services for the purposes of determining the Plan's compliance with the Privacy Regulations; and
10. If feasible, return or destroy all PHI received from the Plan that the Plan Sponsor maintains in any form, and retain no copies of the PHI when no longer needed for the purpose for which disclosure was made (or if return or destruction is not feasible, limit further uses and disclosures to those purposes that make the return or destruction infeasible).

D. Plan Sponsor Access to PHI for Plan Administration Functions

As required under the Privacy Regulations, the Plan will give access to PHI only to the following persons:

1. The Plan Sponsor. The Plan will release PHI to the Plan Sponsor, and the Plan Sponsor will be able to use PHI, for purposes of hearing and determining claim appeals; making other determinations concerning claims payments; assisting covered persons with eligibility and benefit issues; Plan benefit design; amending, modifying and terminating the Plan; and Plan management issues, including personal health records, health risk assessment, and health risk management.
2. The Plan Sponsor's agents, only to the extent reasonable to assist the Plan Sponsor in fulfilling their duties consistent with the above uses and disclosures of PHI.
3. The Plan Sponsor's employees, (e.g., staff Members of the Employee Insurance Division of Minnesota Management and Budget in the Billing and Enrollment, Benefits Services, or Purchasing units) only to the extent reasonable to assist the Plan Sponsor in fulfilling its duties consistent with the above uses and disclosures of PHI.

E. Noncompliance Issues

If the persons described above do not comply with this Summary of Benefits, the Plan Sponsor will provide a mechanism for resolving issues of noncompliance, including disciplinary sanctions.

F. Plan's Privacy Officer and Contact Person

As required by the Privacy Regulations, the Plan has named a Privacy Officer to oversee the Plan's compliance with the Privacy Regulations. The Plan has also named a Contact Person to help answer Your questions concerning the Privacy Regulations and Your PHI. You can also call the Contact Person if You have any complaints concerning the use or disclosure of Your PHI. If you have any questions or complaints concerning Your PHI, contact the Plan Administrator and ask to speak with the Plan's Contact Person.

G. Enrollment Information

Your election of employer-paid coverage, including health, dental, and life insurance, and the election of single or family coverage, is not PHI. Other enrollment information is only PHI as determined under state or federal law.

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 www.dhs.state.mn.us, and then click on "Health Care" then "Medical Assistance." 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)

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

Minnesota
mn.gov/dhs
Click on Health Care, then Medical Assistance
Phone: 651-431-2670
1-800-657-3739

Wisconsin
www.badgercareplus.org/pubs/p-10095.htm
Phone: 1-800-362-3002

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

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