Insurance Addendum

Insurance benefit provisions in effect plan years 2026 and 2027 for all State of Minnesota labor agreements and compensation plans

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Section 1. Amount of Employer Contribution. The Employer Contribution amounts and rules in effect on June 30, 2025 will continue through December 31, 2025.

A. **Contribution Formula - Health Coverage**.

1. **Employee Coverage.** For employee health coverage for the 2026 and 2027 plan years, the Employer contributes an amount equal to ninety-five percent (95%) of the employee-only premium of the Minnesota Advantage Health Plan (Advantage).
2. **Dependent Coverage.** For dependent health coverage for the 2026 and 2027 plan years, the Employer contributes an amount equal to eighty-five percent (85%) of the dependent premium of Advantage.

B. **Contribution Formula - Dental Coverage**.

1. **Employee Coverage.** For employee dental coverage, the Employer contributes seventy percent (70%) of the employee premium of the dental plan.
2. **Dependent Coverage.** For dependent dental coverage, the Employer contributes fifty percent (50%) of the dependent premium of the dental plan.

C. **Contribution Formula - Basic Life Coverage**. For employee basic life coverage and accidental death and dismemberment coverage, the Employer contributes one-hundred percent (100%) of the cost.

Section 2. Coverage Changes and Effective Dates.

A. **When Coverage May Be Chosen**.

1. **Newly Hired Employees.** All employees hired to an insurance eligible position must make their benefit elections by their initial effective date of coverage as defined in this Insurance Addendum, Section 2C. Insurance eligible employees will automatically be enrolled in basic life coverage. If employees eligible for a full Employer Contribution do not choose a health plan administrator and a primary care clinic by their initial effective date, and do not waive medical coverage, they will be enrolled in a Benefit Level Two clinic (or Level One, if available) that meets established access standards in the health plan with the largest number of Benefit Level One and Two clinics in the county of the employee's residence at the beginning of the insurance year. If an employee does not choose a health plan administrator and primary care clinic 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 primary care clinic in which they were previously enrolled.
2. **Eligibility Changes.** Employees who become eligible for a full Employer Contribution must make their benefit elections within thirty (30) calendar days of becoming eligible.

If employees do not choose a health plan administrator and a primary care clinic and do not waive coverage within this thirty (30) day timeframe, they will be enrolled in a Benefit Level Two clinic (or Level One, if available) that meets established access standards in the health plan with the largest number of Benefit Level One and Two clinics in the county of the employee's residence at the beginning of the insurance year.

If employees who become eligible for a partial Employer Contribution choose to enroll in insurance, they must do so within thirty (30) days of becoming eligible or during open enrollment.

An employee may change their health or dental plan if the employee changes to a new permanent work or residence location and the employee's current plan is no longer available. If the employee has family coverage and if the new residence location is outside of the current plan's service area, the employee shall be permitted to switch to a new plan administrator and new Benefit Level within thirty (30) days of the residence location change. The election change must be due to and correspond with the change in status. An employee who receives notification of a work location change between the end of an open enrollment period and the beginning of the next insurance year, may change their health or dental plan within thirty (30) days of the date of the relocation under the same provisions accorded during the last open enrollment period. An employee or retiree may also change health or dental plans in any other situation in which the Employer is required by the applicable federal or state law to allow a plan change.

3. **Waiving Medical Coverage.** Employees may choose to waive medical coverage. If an employee is eligible for the full employer contribution and desires to waive medical coverage, the employee must submit a Waiver of Medical Coverage form and provide proof of other coverage by the end of the employee's enrollment period. If an employee does not submit the form and proof by the end of the employee's enrollment period, the employee will be enrolled in medical coverage, with the next opportunity to waive coverage during Open Enrollment or upon a permitted Qualified Life Event. If an employee waives medical coverage, the employee can elect it again during the next Open Enrollment or midyear upon a permitted Qualified Life Event.

B. When Coverage May be Changed or Cancelled.

1. **Changes Due to a Life Event.** After the initial enrollment period and outside of any open enrollment period, an employee may elect to change health or dental coverage (including adding or canceling coverage) and any applicable employee contributions in the following situations (as long as allowed under the applicable provisions, regulations, and rules of the federal and state law in effect at the beginning of the plan year).

The request to change coverage must be consistent with a change in status that qualifies as a life event, and does not include changing health or dental plans, which may only be done under the terms of Section 2A above. Any election to add coverage must be made within thirty (30) days following the event, and any election to cancel coverage must be made within sixty (60) days following the event. (An employee and a retired employee may add dependent health or dental coverage following the birth of a child or dependent grandchild, or following the adoption of a child, without regard to the thirty (30) day limit.) These life events (for both employees and retirees) are:

a. A change in legal marital status, including marriage, death of a spouse, divorce, legal separation and 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 or retiree's spouse or dependent which results in a change in the benefits they receive under a cafeteria plan or a health or dental plan.

d. A dependent ceasing to satisfy eligibility requirements for coverage due to attainment of age or otherwise no longer meets the eligibility requirements under Section 2C of the Insurance Article (IFO and MSUAASF: Section B3; MSCF: Section 2, subd. 3).

e. A change in the place of residence of the employee, retiree or their spouse or dependent that is not in the health plan service administrator's service area.

f. Significant cost or coverage changes (including coverage curtailment and the addition 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.

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

2. **Canceling Dependent Coverage During Open Enrollment.** In addition to the above situations, dependent health or dependent dental coverage may also be cancelled for any reason during the open enrollment period that applies to each type of plan (as long as allowed under the applicable provisions, regulations and rules of the federal and state law in effect at the beginning of the plan year).

3. **Canceling Employee Coverage.** A part-time employee may also cancel employee coverage within sixty (60) days of when one of the life events set forth above occurs.

4. **Effective Date of Benefit Termination.** Medical, dental and life coverage termination will take effect on the first of the month following the loss of eligible employee or dependent status. Disability benefit coverage terminations will take effect on the day following loss of eligible employee status.

C. Effective Date of Coverage.

1. **Initial Effective Date**. The initial effective date of coverage under the Group Insurance Program is the thirtieth (30th) day following the employee's first day of employment, re-hire, or reinstatement with the State. The initial effective date of coverage for an employee whose eligibility has changed is the date of the change. An employee must be actively at work on the initial effective date of coverage, except that an employee who is on paid leave on the date State-paid life insurance benefits increase is also entitled to the increased life insurance coverage. In no event shall an employee's dependent's coverage become effective before the employee's coverage.

   If an employee is not actively at work due to employee or dependent health status or medical disability, medical and dental coverage will still take effect. (Life and disability coverage will be delayed until the employee returns to work.)

2. **Delays in Coverage Effective Date.**

   a. **Basic Life**. If an employee is not actively at work on the initial effective date of coverage, coverage will be effective on the first day of the employee's return to work. The effective date of a change in coverage is not delayed in the event that, on

the date the coverage change would be effective, an employee is on an unpaid leave of absence or layoff.

b. **Medical and Dental.** If an employee is not actively at work on the initial effective date of coverage due to a reason other than hospitalization or medical disability of the employee or dependent, medical and dental coverage will be effective on the first day of the employee's return to work.

The effective date of a change in coverage is not delayed in the event that, on the date the coverage change would be effective, an employee is on an unpaid leave of absence or layoff.

c. **Optional Life and Disability Coverages**. In order for coverage to become effective, the employee must be in active payroll status and not using sick leave on the first day following approval by the insurance company. If it is an open enrollment period, coverage may be applied for but will not become effective until the first day of the employee's return to work.

D. Open Enrollment.

1. **Frequency and Duration.** There shall be an open enrollment period for health and dental coverage in 2025 and 2026. Open enrollment periods shall last a minimum of fourteen (14) calendar days. Open enrollment changes become effective on January 1 in 2026 and 2027. Subject to a timely contract settlement, the Employer shall make open enrollment materials available to employees at least fourteen (14) days prior to the start of the open enrollment period.
2. **Eligibility to Participate.** An employee eligible to participate in the State Employee Group Insurance Program, as described in Sections 2A and 2B of the Insurance Article (IFO and MSUAASF: Section B1 and B2; MSCF: Section 2, subd. 1 and Section 2, subd. 2), may participate in open enrollment. In addition, a person in the following categories may, as allowed in section 2D1 of the Insurance Addendum above, make certain changes: (1) a former employee or dependent on continuation coverage, as described in Section 2D of the Insurance Article (IFO and MSUAASF: Section B4; MSCF: Section 2, subd. 4), may change plans or add coverage for health and/or dental plans on the same basis as active employees; and (2) an early retiree, prior to becoming eligible for Medicare, may change health and/or dental plans as agreed to for active employees, but may not add dependent coverage.
3. **Materials for Employee Choice**. Each year prior to open enrollment, the Appointing Authority will give eligible employees the information necessary to make open enrollment selections. Employees will be provided a statement of their current coverage each year of the contract.

E. **Coverage Selection Prior to Retirement.** An employee who retires and is eligible to continue insurance coverage as a retiree may change their health or dental plan during the sixty (60) calendar day period immediately preceding the date of retirement. The employee may not add dependent coverage during this period. The change takes effect on the first day of the month following the date of retirement.

Section 3. Basic Coverages.

A. Employee and Family Health Coverage.

1. **Minnesota Advantage Health Plan (Advantage).** The health coverage portion of the State Employee Group Insurance Program is provided through the Minnesota Advantage Health Plan (Advantage), a self-insured health plan offering four (4) Benefit Level options. Provider networks and claim administration are provided by multiple plan administrators. Coverage offered through Advantage is determined by Section 3A2 of the Insurance Addendum.

2. **Coverage Under the Minnesota Advantage Health Plan.** From July 1, 2025 through December 31, 2025, health coverage under the SEGIP will continue at the level in effect on June 30, 2025. Effective January 1, 2026, Advantage will cover eligible services subject to the copayments, deductibles and coinsurance coverage limits stated. Services provided through Advantage are subject to the managed care procedures and principles, including standards of medical necessity and appropriate practice, of the plan administrators. Coverage details are provided in the Advantage Summary of Benefits.

    a. **Benefit Options.** Employees must elect a plan administrator and primary care clinic. Those elections will determine the Benefit Level through Advantage. Enrolled dependents must elect a primary care clinic that is available through the plan administrator chosen by the employee.

        1) **Plan Administrator**. Employees must elect a plan administrator during their initial enrollment in Advantage and may change their plan administrator election only during the annual open enrollment and when permitted under Section 2 of the Insurance Addendum. Dependents must be enrolled through the same plan administrator as the employee.

        2) **Benefit Level.** The primary care clinics available through each plan administrator are assigned a Benefit Level. The Benefit Levels are outlined in the benefit chart below. Primary care clinics may be in different Benefit Levels for different plan administrators. Family members may be enrolled in clinics that are in different Benefits Levels. Employees and their dependents may change to clinics in different Benefit Levels during the annual open enrollment. Employees and their dependents may also elect to move to a clinic in a different Benefit Level within

the same plan administrator by calling their plan administrator, with changes typically effective the following day. Unless the individual has a referral from their primary care clinic, there are no benefits for services received from providers in Benefit Levels that are different from that of the primary care clinic in which the individual has enrolled.

3) **Primary Care Clinic**. Employees and each of their covered dependents must individually elect a primary care clinic within the network of providers offered by the plan administrator chosen by the employee. Employees and their dependents may elect to change clinics within their clinic's Benefit Level as often as the plan administrator permits and as outlined above.

4) **Advantage Benefit Chart for Services Incurred During Plan Years 2026 and 2027.**

2026 and 2027 Benefit Provision	**Benefit Level 1** Member pays:	**Benefit Level 2** Member pays:	**Benefit Level 3** Member pays:	**Benefit Level 4** Member pays:
MEDICAL SERVICES				
Deductible *Single/Family*	$250/$500	$400/$800	$750/$1,500	$1,500/$3,000
Copays for office visit and urgent care *No cost-sharing for preventive services*	$35	$40	$70	$90
Copays for mental health office visits *Deductible does not apply for levels 1 and 2*	$0	$0	$40	$60
Convenience clinics and online care *Deductible does not apply*	$0	$0	$0	$0
Copays for emergency room visit *Deductible does not apply*	$100	$125	$150	$350
Inpatient admission *Deductible applies first* *Costs waived for admission to Center of Excellence*	$100 copay	$200 copay	$500 copay	25% coinsurance
Outpatient surgery *Deductible applies first*	$60 copay	$120 copay	$250 copay	25% coinsurance
Coinsurance for MRI/CT scan services *Deductible applies first*	10%	15%	25%	30%
Coinsurance for services NOT subject to copays *Deductible applies first*	5%	5%	20%	25%
Coinsurance for lab, pathology and X-ray not included as part of preventive care and not subject to office visit or facility copayments *Deductible applies first*	10%	10%	20%	25%

2026 and 2027 Benefit Provision	**Benefit Level 1** Member pays:	**Benefit Level 2** Member pays:	**Benefit Level 3** Member pays:	**Benefit Level 4** Member pays:
Coinsurance for durable medical equipment *Deductible applies first*	20%	20%	20%	25%
Maximum non-Rx out-of-pocket limit *Single/Family*	$1,700/$3,400	$1,700/$3,400	$2,400/$4,800	$3,600/$7,200
PRESCRIPTION DRUGS (Rx)				
Copays for Rx *No deductible*	Tier 1: $18 Tier 2: $30 Tier 3: $55	Tier 1: $18 Tier 2: $30 Tier 3: $55	Tier 1: $18 Tier 2: $30 Tier 3: $55	Tier 1: $18 Tier 2: $30 Tier 3: $55
Maximum Rx out-of-pocket limit *Single/Family*	$1,050/$2,100	$1,050/$2,100	$1,050/$2,100	$1,050/$2,100

b. **Service Area**. The Minnesota Advantage Health Plan service area shall be comprised of all Minnesota counties as well as border communities, with the specific boundaries initially established by MMB and any changes thereafter mutually agreed to by the JLM.

c. **Services Received From, or Authorized By, a Primary Care Physician within the Primary Care Clinic.** Under Advantage, the health care services outlined in the benefits charts above shall be received from, or authorized by a primary care physician within the primary care clinic. Preventive care, as outlined in the Summary of Benefits, is covered at one hundred (100) percent for services received from or authorized by the primary care clinic. The primary care clinic shall be selected from approved clinics in accordance with the Advantage administrative procedures. Unless otherwise specified in 3A2 of the Insurance Addendum, services not received from, or authorized by, a primary care physician within the primary care clinic may not be covered. Unless the individual has a referral from their primary care clinic, there are no benefits for services received from providers in Benefit Levels that are different from that of the primary care clinic in which the individual has enrolled.

d. **In-Area Services Not Requiring Referral from a Primary Care Physician Within the Primary Care Clinic.**

1) **Routine Eye Exams**. Limited to one (1) routine examination per year for which no copay applies. Eye injury or illness at an in-network provider will be covered as an office visit based on the benefit level in which the individual is enrolled.

2) **Emergency Services and Urgent Care.** The emergency room copay applies to all outpatient emergency visits that do not result in hospital admission within twenty-four (24) hours.

3) **Obstetrics and Gynecological Care.** The deductible and coinsurance for services not subject to copays applies.

4) **Mental Health Care and Substance Use Disorder Treatment**.

5) **Chiropractic Care**.

For all services listed above apart from urgent care and emergency care, a provider must be in-network with the member's plan administrator for the service to be covered.

e. **Prescription Drugs.**

1) **Copayments and Annual Out-of-Pocket Maximums.**

For the first and second year of the contract:

Tier 1 Copayment: Eighteen dollar ($18) copayment per prescription or refill for a Tier 1 drug dispensed in a thirty (30) day supply.

Tier 2 Copayment: Thirty dollar ($30) copayment per prescription or refill for a Tier 2 drug dispensed in a thirty (30) day supply.

Tier 3 Copayment: Fifty-five dollar ($55) copayment per prescription or refill for a Tier 3 drug dispensed in a thirty (30) day supply.

Out of Pocket Maximum: There is an annual maximum eligible out-of-pocket expense limit for prescription drugs of one thousand and fifty dollars ($1,050) per person or two thousand one hundred dollars ($2,100) per family.

2) **Insulin**. Insulin will be treated as a prescription drug subject to a separate copay for each type prescribed.

3) **Brand Name Drugs.** If the subscriber chooses a brand name drug when a bioequivalent generic drug is available, the subscriber is required to pay the standard copayment plus the difference between the cost of the brand name drug and the generic. Amounts above the copay that an individual elects to pay for a brand name instead of a generic drug will not be credited toward the out-of-pocket maximum.

f. **Special Service Networks**. The following services must be received from special service network providers in order to be covered. All terms and conditions outlined in the Summary of Benefits apply.

1) Mental health services – inpatient or outpatient.
2) Chemical dependency services – inpatient and outpatient.
3) Chiropractic services.
4) Transplant coverage.
5) Cardiac services.
6) Home infusion therapy.
7) Hospice.
8) Fertility services.

g. **Individuals whose permanent residence and principal work location are outside the State of Minnesota and outside of the Advantage Plan's service area**. If these individuals use a provider within the plan administrator's national network, services will be covered at Benefit Level Two. If a national network provider is not available in their area, services will be covered at Benefit Level Two through any other provider available in their area. If a national network provider is available but not used, benefits will be covered at Benefit Level Three. All terms and conditions outlined in the Summary of Benefits will apply.

h. **Health Care Services Received Outside the Minnesota Advantage Health Plan's Service Area.** For covered services received by employees, former employees, and dependents outside of the Advantage service area, all care that is received within the national network of the member's plan administrator will be covered at Benefit Level Three, with a separate out-of-area deductible. Urgent care and emergency care will be covered at Benefit Level Three whether or not the providers are within the member's plan administrator's national network. All other out-of-area care must be received within the given plan administrator's national network to be covered by the plan. Referrals are not required for care received outside of the Advantage Plan's service area.

i. **Lifetime maximums and non-prescription out-of-pocket maximums.** Coverage under Advantage is not subject to a per person lifetime maximum.

   In the first and second years of the contract, coverage under Advantage is subject to a plan year, non-prescription drug, out-of-pocket maximum of one thousand seven hundred dollars ($1,700) per person or three thousand four hundred dollars ($3,400) per family for members whose primary care clinic is in Cost Level 1 or Cost Level 2; two thousand four hundred dollars ($2,400) per person or four thousand eight hundred dollars ($4,800) per family for members whose primary care clinic is in Cost Level 3; and three thousand six hundred dollars ($3,600) per person or seven

thousand two hundred dollars ($7,200) per family for members whose primary care clinic is in Cost Level 4.

j. **In-Network Convenience Clinics and Online Care**. Services received at in-network convenience clinics and online care are not subject to a copayment in each year of the Agreement. First dollar deductibles are waived for convenience clinic and online care visits. (Note that prescriptions received as a result of a visit are subject to the drug copayment and out-of-pocket maximums described above at 3A2e of the Insurance Addendum.)

3. **Benefit Level Two Health Care Network Determination**. Issues regarding the health care networks for the 2026 insurance year shall be negotiated in accordance with the following procedures:

   a. At least twelve (12) weeks prior to the open enrollment period for the 2026 insurance year the Employer shall meet and confer with the Joint Labor/Management Committee on Health Plans in an attempt to reach agreement on the Benefit Level Two health care networks.

   b. If no agreement is reached within five (5) working days, the Employer and the Joint Labor/Management Committee on behalf of all of the exclusive representatives shall submit a list of providers/provider groups in dispute to a mutually agreed upon neutral expert in health care delivery systems for final and binding resolution. The only providers/provider groups that may be submitted for resolution by this process are those for which, since the list for the 2025 insurance year was established, Benefit Level Two access has changed, or those that are intended to address specific problems caused by a reduction in Benefit Level Two access.

      Absent agreement on a neutral expert, the parties shall select an arbitrator from a list of five (5) arbitrators supplied by the Bureau of Mediation Services. The parties shall flip a coin to determine who strikes first. One-half (1/2) of the fees and expenses of the neutral shall be paid by the Employer and one-half (1/2) by the Exclusive Representatives. The parties shall select a neutral within five (5) working days after no agreement is reached, and a hearing shall be held within fourteen (14) working days of the selection of the neutral.

   c. The decision of the neutral shall be issued within two (2) working days after the hearing.

4. **Coordination with Workers' Compensation.** When an employee has incurred an on-the-job injury or an on-the-job disability and has filed a claim for workers' compensation,

medical costs connected with the injury or disability shall be paid by the employee's health plan, pursuant to M.S. 176.191, Subdivision 3.

5. **Health Promotion and Health Education**. Both parties to this Agreement recognize the value and importance of health promotion and health education programs. Such programs can assist employees and their dependents to maintain and enhance their health, and to make appropriate use of the health care system. To work toward these goals:

    a. **Develop Programs**.

        1) **Policy.** The Employer will develop and implement health promotion, health education programs, and other programs mutually agreed upon with the Joint Labor Management Committee on Health Plans, subject to the availability of resources. Each Appointing Authority will develop a health promotion and health education program consistent with the Minnesota Management and Budget policy. Upon request of any exclusive representative in an agency, the Appointing Authority shall jointly meet and confer with the exclusive representative(s) and may include other interested exclusive representatives. Agenda items shall include but are not limited to smoking cessation, weight loss, stress management, health education/self-care, and education on related benefits provided through the health plan administrators serving state employees.

        2) **Pilot Programs**. The Employer may develop voluntary pilot programs to test the acceptability of various risk management programs, programs that seek to control costs, programs that streamline the delivery of services, or that enhance services to members. Incentives for participation in such programs may include improvements to the benefits outlined in the Insurance Article and/or Insurance Addendum. Implementation of such pilot programs is subject to the review and approval of the Joint Labor-Management Committee on Health Plans.

    b. **Health Plan Specification**. The Employer will require health plans participating in the Group Insurance Program to develop and implement health promotion and health education programs for State employees and their dependents.

    c. **Employee Participation**. The Employer will assist employees' participation in health promotion and health education programs. Health promotion and health education programs that have been endorsed by the Employer (Minnesota Management and Budget) will be considered to be non-assigned job-related training pursuant to Administrative Procedure 21. Approval for this training is at

the discretion of the Appointing Authority and is contingent upon meeting staffing needs in the employee's absence and the availability of funds. Employees are eligible for release time, tuition reimbursement, or a pro rata combination of both. Employees may be reimbursed for up to one hundred (100) percent of tuition or registration costs upon successful completion of the program. Employees may be granted release time, including the travel time, in lieu of reimbursement.

6. **Post Retirement Health Care Benefit.** Employees who separate from State service and who, at the time of separation are insurance eligible and entitled to immediately receive an annuity under a State retirement program, shall be entitled to a contribution of two hundred fifty dollars ($250) to the Minnesota State Retirement System's (MSRS) Health Care Savings Plan. Employees who have a HCSP waiver on file shall receive a two hundred fifty dollars ($250) cash payment. If the employee separates due to death, the two hundred fifty dollars ($250) is paid in cash, not to the HCSP. An employee who becomes totally and permanently disabled on or after January 1, 2008, who receives a State disability benefit, and is eligible for a deferred annuity under a State retirement program is also eligible for the two hundred fifty dollar ($250) contribution to the MSRS Health Care Savings Plan. Employees are eligible for this benefit only once.

7. **Temporary plan changes due to a state or national emergency**.

   SEGIP and the unions recognize that certain natural disasters and other major emergencies may disrupt or seriously threaten to disrupt the State of Minnesota at a time when employees are especially needed to provide services. If the State or a federal government agency declares a state of emergency or otherwise invokes emergency authority by declaration, rules, regulations or similar official statements, the terms of the programs administered by SEGIP may be changed for the period of the declared emergency and for up to a 30 day run-out period.

   These changes may include changes to programs administered by SEGIP including but not limited to, benefit design, enrollment and eligibility, billing, and administration as well as waiver of out-of-network restrictions, changes to out of pocket costs, extension of time frames for enrollment and billing, and other protocols reasonably required to provide Members with access to benefits.

   These changes must be agreed to by both SEGIP and the Joint Labor Management Committee. Nothing in this provision prohibits SEGIP from making changes authorized or required under another authority including but not limited to a state or federal law, regulation, order, or rule without union agreement.

B. **Employee Life Coverage**.

1. **<u>Basic Life and Accidental Death and Dismemberment Coverage</u>**. The Employer agrees to provide and pay for the following term life coverage and accidental death and dismemberment coverage for all employees eligible for an Employer Contribution, as described in Section 3 of the Insurance Article (IFO, MSUAASF, and MSCF: Section C). Any premium paid by the State in excess of fifty thousand dollars ($50,000) coverage is subject to a tax liability in accord with Internal Revenue Service regulations. An employee may decline coverage in excess of fifty thousand dollars ($50,000) by filing a waiver in accord with Minnesota Management and Budget procedures. The basic life insurance policy will include an accelerated benefits agreement providing for payment of benefits prior to death if the insured has a terminal condition.

Employee's Annual Base Salary	**Group Life Insurance Coverage**	**Accidental Death and Dismemberment Principal Sum**
$0 - $20,000	$30,000	$30,000
$20,001 - $30,000	$40,000	$40,000
$30,001 - $40,000	$50,000	$50,000
$40,001 - $50,000	$60,000	$60,000
$50,001 - $60,000	$70,000	$70,000
$60,001 - $70,000	$80,000	$80,000
$70,001 - $80,000	$90,000	$90,000
$80,001 - $90,000	$100,000	$100,000
$90,001 - $100,000	$110,000	$110,000
$100,001 - $110,000	$120,000	$120,000
$110,001 - $120,000	$130,000	$130,000
$120,001 - $130,000	$140,000	$140,000
$130,001 - $140,000	$150,000	$150,000
$140,001 - $150,000	$160,000	$160,000
$150,001 - $160,000	$170,000	$170,000
$160,001 - $170,000	$180,000	$180,000
$170,001 - $180,000	$190,000	$190,000
Over $180,000	$200,000	$200,000

2. **<u>Extended Benefits</u>**. An employee who becomes totally disabled before age 70 shall be eligible for the extended benefit provisions of the life insurance policy until age 70. Employees who were disabled prior to July 1, 1983 and who have continuously received

benefits shall continue to receive such benefits under the terms of the policy in effect prior to July 1, 1983.

Section 4. Optional Coverages.

A. Employee and Family Dental Coverage.

1. **Coverage Under the State Dental Plan**. The State Dental Plan will provide the following coverage:

   a. **Copayments**. The State Dental Plan will cover allowable charges for the following services subject to the copayments and coverage limits stated. Higher out-of-pocket costs may apply to services obtained from dental care providers not in the State Dental Plan network. Services provided are subject to the dental plan administrators' managed care procedures and principles, including standards of dental necessity and appropriate practice. The plan shall cover general cleaning two (2) times per plan year and special cleanings (root or deep cleaning) as prescribed by the dentist. National Network benefits apply for members who see a dental provider outside of Minnesota that is in their dental plan administrator's national network but not the State Dental Plan network.

Service	State Dental Plan Network	National Network	Out-of-Network
Diagnostic/Preventive	100%	100%	50% after deductible
Fillings	80% after deductible	60% after deductible	50% after deductible
Endodontics	80% after deductible	60% after deductible	50% after deductible
Periodontics	80% after deductible	60% after deductible	50% after deductible
Oral Surgery	80% after deductible	60% after deductible	50% after deductible
Crowns	80% after deductible	60% after deductible	50% after deductible
Implants	80% after deductible	60% after deductible	50% after deductible
Prosthetics	80% after deductible	60% after deductible	50% after deductible

Service	State Dental Plan Network	National Network	Out-of-Network
Prosthetic Repairs	80% after deductible	60% after deductible	50% after deductible
Orthodontics	80% after deductible	60% after deductible	50% after deductible

b. **Deductible**. An annual deductible of fifty dollars ($50) per person and one hundred fifty dollars ($150) per family applies to State Dental Plan non-preventive services received from in-network providers. An annual deductible of one hundred dollars ($100) per person and three hundred ($300) per family applies to National Network non-preventive services received from national network providers outside the State Dental Plan network. An annual deductible of one hundred twenty-five dollars ($125) per person applies to State Dental Plan services received from out of network providers. The deductible must be satisfied before coverage begins.

c. **Annual Maximums**. State Dental Plan coverage is subject to a two thousand and two hundred dollar ($2200) annual maximum benefit payable (excluding orthodontia and preventive services) per person. "Annual" means per insurance year.

d. **Orthodontia Lifetime Maximum**. Orthodontia benefits are subject to a three thousand two hundred dollar ($3,200) lifetime maximum benefit. If an employee elects dental benefits on their own policy, dollars spent when the employee was a dependent of another policyholder shall not be applied toward the new policy's lifetime maximum.

B. Life Coverage.

1. **Employee.** An employee may purchase up to five hundred thousand dollars ($500,000) additional life insurance, in increments established by the Employer, subject to satisfactory evidence of insurability. A new employee may purchase up to two (2) times annual salary in optional employee life coverage by their initial effective date of coverage as defined in this Insurance Addendum, Section 2C without evidence of insurability. An individual may only be covered on one state sponsored life coverage policy. A retired employee who returns to state service with optional employee life coverage in place or who has already received a paid-up benefit are not eligible for optional employee life coverage. An employee who becomes eligible for insurance may purchase up to two (2) times annual salary in optional employee life coverage without evidence of insurability within thirty (30) days of the initial effective date as defined in this Insurance Addendum.

2. **Spouse.** An employee may purchase up to five hundred thousand dollars ($500,000) life insurance coverage for their spouse in increments established by the Employer, subject to satisfactory evidence of insurability. An individual may only be covered on one state sponsored life coverage policy. A retired employee who returns to state services with optional spouse life coverage in place or who has already received a paid-up benefit is not eligible for optional spouse life coverage. A new employee may purchase either five thousand dollars ($5,000) or ten thousand dollars ($10,000) in optional spouse life coverage by their initial effective date of coverage as defined in this Insurance Addendum, Section 2C without evidence of insurability. An employee who becomes eligible for insurance may purchase either five thousand dollars ($5,000) or ten thousand dollars ($10,000) in optional spouse coverage without evidence of insurability within thirty (30) days of the initial effective date as defined in this Insurance Addendum.
3. **Children/Grandchildren**. An employee may purchase life insurance in the amount of ten thousand dollars ($10,000) as a package for all eligible children/grandchildren (as defined in Section 2C2 and 2C3 of the Insurance Article (IFO and MSUAASF: Section B3b and B3c; MSCF: Section 2, subd. 3B and Section 2, subd. 3C)). An individual may only be covered on one policy, by one employee participating in the State Employee Group Insurance Program. For a new employee, child/grandchild coverage requires evidence of insurability if application is made after the initial effective date of coverage as defined in this Insurance Addendum, Section 2C. An employee who becomes eligible for insurance may purchase child/grandchild coverage without evidence of insurability if application is made within thirty (30) days of the initial effective date as defined in this Insurance Addendum. Child/grandchild coverage commences immediately from the moment of live birth up to age twenty-six (26).
4. **Accelerated Life.** The additional employee, spouse and child life insurance policies will include an accelerated benefits agreement providing for payment of benefits prior to death if the insured has a terminal condition.
5. **Waiver of Premium.** In the event an employee becomes totally disabled before age seventy (70), there shall be a waiver of premium for all life insurance coverage that the employee had at the time of disability.
6. **Paid Up Life Policy**. At age sixty-five (65) or the date of retirement, an employee who has carried optional employee life insurance for the five (5) consecutive years immediately preceding the date of the employee's retirement or age sixty-five (65), whichever is later, shall receive a post-retirement paid-up life insurance policy in an amount equal to twenty (20) percent of the smallest amount of optional employee life insurance in force during that five (5) year period. The employee's post-retirement

death benefit shall be effective as of the date of the employee's retirement or the employee age sixty-five (65), whichever is later. Employees who retire prior to age sixty-five (65) must be immediately eligible to receive a state retirement annuity and must continue their optional employee life insurance to age sixty-five (65) in order to remain eligible for the employee post-retirement death benefit.

An employee who has carried optional spouse life insurance for the five (5) consecutive years immediately preceding the date of the employee's retirement or spouse age sixty-five (65), whichever is later, shall receive a post-retirement paid-up life insurance policy in an amount equal to twenty (20) percent of the smallest amount of optional spouse life insurance in force during that five (5) year period. The spouse post-retirement death benefit shall be effective as of the date of the employee's retirement or spouse age sixty-five (65), whichever is later. The employee must continue the full amount of optional spouse life insurance to the date of the employee's retirement or spouse age sixty-five (65), whichever is later, in order to remain eligible for the spouse post-retirement death benefit.

Each policy remains separate and distinct, and amounts may not be combined for the purpose of increasing the amount of a single policy.

C. **Disability Coverage**.

1. **Short-Term Disability Coverage.** An employee may purchase short-term disability coverage that provides benefits of from three hundred dollars ($300) to five thousand dollars ($5,000) per month, up to two-thirds (2/3) of an employee's salary, for up to one hundred eighty (180) days during total disability due to a non-occupational accident or a non-occupational sickness. Benefits are paid from the first day of a disabling injury or from the eighth day of a disabling sickness. For a new employee, coverage applied for by the initial effective date of coverage as defined in this Insurance Addendum, Section 2C does not require evidence of insurability. For an employee who becomes eligible for insurance, coverage applied for within thirty (30) days of the initial effective date does not require evidence of insurability. An employee who is insurance eligible and moves from a temporary position to a permanent position will be allowed to enroll in short-term disability coverage within thirty (30) days of the event without providing evidence of insurability. A short-term disability open enrollment will be offered every five years.
2. **Long-Term Disability Coverage.** New employees may enroll in long-term disability insurance by their initial effective date of coverage. Employees who become eligible for insurance may enroll in long-term disability insurance within thirty (30) days of their initial effective date as defined in this Insurance Addendum, Section 2C. An employee who is insurance eligible and moves from a temporary position to a permanent position will be allowed to enroll in long-term disability coverage within thirty (30) days of the

event without providing evidence of insurability. The terms are the same as for employees who wish to add/increase during the annual open enrollment. During open enrollment only, an employee may purchase long-term disability coverage that provides benefits of from three hundred dollars ($300) to seven thousand dollars ($7,000) per month, based on the employee's salary, commencing on the 181st calendar day of total disability, and not subject to evidence of insurability but with a limited term pre-existing condition exclusion. Employees should be aware that other wage replacement benefits, as described in the certificate of coverage (i.e., Social Security Disability, Minnesota State Retirement Disability, etc.), may result in a reduction of the monthly benefit levels purchased. In any event, the minimum is the greater of three hundred dollars ($300) or fifteen (15) percent of the amount purchased. The minimum benefit will not be reduced by any other wage replacement benefit. In the event that the employee becomes totally disabled before age seventy (70), the premiums on this benefit shall be waived.

3. **Disability Coverage Subcommittee**. A subcommittee of the Joint Labor Management Committee on Health Plans (JLM) will be created to review disability plan options to conform with and complement the Minnesota Paid Leave Law. The JLM must agree to changes that modify or change the disability coverage provisions.

D. **Accidental Death and Dismemberment Coverage.** An employee may purchase accidental death and dismemberment coverage that provides principal sum benefits in amounts ranging from five thousand dollars ($5,000) to two hundred thousand dollars ($200,000). Payment is made only for accidental bodily injury or death and may vary, depending upon the extent of dismemberment. An employee may also purchase from five thousand dollars ($5,000) to twenty-five thousand dollars ($25,000) in coverage for their spouse, but not in excess of the amount carried by the employee.

E. **Vision Coverage.** Under the life of this agreement, an optional and fully employee-paid vision benefit will be available pursuant to contract parameters with the State’s vision vendor.

F. **Voluntary Legal Services Coverage.** Under the life of this agreement, an optional and fully employee-paid legal services benefit will be available pursuant to contract parameters with the State’s vendor for disability insurance.

G. **Continuation of Optional Coverages During Unpaid Leave or Layoff.** An employee who takes an unpaid leave of absence or who is laid off may discontinue premium payments on optional policies during the period of leave or layoff. If the employee returns within one (1) year, the employee shall be permitted to pick up all optionals held

prior to the leave or layoff. For purposes of reinstating such optional coverages, the following limitations shall be applicable.

For the first twenty-four (24) months of long-term disability coverage after such a period of leave or layoff during which long-term disability coverage was discontinued, any such disability coverage shall exclude coverage for pre-existing conditions. For disability purposes, a pre-existing condition is defined as any disability which is caused by, or results from, any injury, sickness or pregnancy which occurred, was diagnosed, or for which medical care was received during the period of leave or layoff. In addition, any pre-existing condition limitations that would have been in effect under the policy but for the discontinuance of coverage shall continue to apply as provided in the policy.

The limitations set forth above do not apply to leaves that qualify under the Family Medical Leave Act (FMLA).