Your Employee Benefits

2022

This document is current as of January 1, 2022.
IMPORTANT NOTES:
The State of Minnesota expects to continue the State Employee Group Insurance Program (SEGIP) indefinitely. However, it reserves the right to change or discontinue all or any part of the insurance programs or benefits, consistent with the state’s rights and obligations under the law and collective bargaining agreements. The State Employee Group Insurance Program is not liable for insurance plans that may become insolvent.

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

The benefits available through SEGIP are provided through a governmental plan which is not subject to ERISA.
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 has 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
- employee vision care plan
- family vision care plan
- supplemental employee life insurance
- spouse life insurance
- child life insurance
- employee accidental death and dismemberment insurance
- spouse accidental death and dismemberment insurance
- employee short-term disability insurance
- employee long-term disability insurance
- manager’s income protection plan

Optional Pretax and Flexible Spending Accounts (FSAs)

- Health and Dental Premium Account
- Dependent Care Expense Account (day care)
- Medical/Dental Expense Account
- Transit Expense Accounts (work-related parking and mass transit)

Access to Benefit Information

Personal Benefit Information

- [mn.gov/selfservice](http://mn.gov/selfservice)
- Use your 8-digit employee ID and password
- Click Sign-in, Self Service, Benefits, Benefits Summary
SEGIP website

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

Medical and Dental plan materials

Each claim administrator that administers 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 or on the websites of each claim administrator.

Summaries of Benefits and Certificates of Coverage

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

Labor contracts and plans

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

Flexible Spending Account (FSA) pretax benefits

A complete guide to enrollment and uses of the SEGIP FSA benefit options is available online or upon request from the administrator of the SEGIP FSA plans, Benefit Resource (formerly 121 Benefits). Go to the BRI webpage www.BenefitResource.com/state-of-minnesota or call (612) 877-4321 or 1-800-300-1672.

Annual Open Enrollment information

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

Employee meetings

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

Financial and Administrative Services Agreements

Each insurance carrier or claim administrator participating in the State Employee Group Insurance Program signs a Financial and Administrative Services Agreement with the State. Versions of these agreements are available for inspection at the offices of Minnesota Management and Budget/Employee Insurance by 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 eligible state employees

State of Minnesota employees, retirees (under age 65), 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.

How does Advantage work?

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

Primary care clinics participating in the Advantage Health Plan have been placed into one of four cost levels, depending on the care system in which the primary care clinic participates and that care system’s total cost of delivering medical care.

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

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

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

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

**Advantage High Deductible Health Plan (HDHP)**

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

**Advantage Plan includes important features**

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

- Uniform comprehensive set of benefits across all claim administrators. There are some differences in the way the claim administrators administer certain benefits, such as with the treatment of infertility or transplant benefits.
- No copays or deductible for preventive care such as immunizations, well-childcare, annual check-ups, etc.
- You must select a Primary Care Clinic and most medical care is coordinated through your Primary Care Clinic (PCC); you will generally need a referral to see a specialist. The Advantage Plan does not cover out-of-network services not referred by your PCC.
- 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 claim administrator and possibly your PCC.
- Family members may elect different PCCs (even in a different cost level) but must be covered under the same claim administrator as you, the employee/policy holder.
- You may change your PCC as often as your claim administrator allows, even if it changes your cost level. Clinic changes are made by calling your claim administrator and can be effective the same day you call.
- Referrals to a specialist’s office visit will be covered at the same cost level as your PCC.
- You must choose a claim administrator that is available in the county in which you live or work.
- You control your initial out-of-pocket costs with your selection of a PCC from one of four cost levels for yourself and/or covered dependents.
- The amount of cost sharing that will be paid when using medical services varies depending on the cost level of the PCC that is chosen. The PCCs in cost levels 1 and 2 provide the best value with the lowest possible out-of-pocket (OOP) maximum costs. The OOP maximum for cost level 3 and 4 are set higher because the cost to deliver care under these systems is higher than the costs in cost levels 1 and 2 clinics.
**Advantage Prescription Drug Benefit**

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

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

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

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

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

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

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

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

A list of primary care clinics that participate in the Minnesota Advantage Health Plan is available on the SEGIP website at [mn.gov/mmb/segip](http://mn.gov/mmb/segip). On this site, click on Find a Clinic. This list includes the PCC number that you will need to enroll. As we approach Open Enrollment and the new plan year, additional information will be provided for the upcoming year.

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

For specific questions about clinics or access to specialists, call the claim administrator directly. The claim administrators’ phone numbers are listed on the SEGIP website.

**Convenience Care Clinics**

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

This simple diagnostic tool provides access to a health care provider via the internet, regardless of your location or access to a certain care system. The benefit is designed to function like the in-network Convenience Care Clinic 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 with no member cost share for participants in the Advantage Plan, regardless of your PCC’s cost level. Participants in the Advantage High Deductible Health Plan will have no cost share after they have met their deductibles. You may access Doctor on Demand and/or Virtuwell if you are a member of BlueCross BlueShield or HealthPartners. You may access Virtuwell or MDLive if you are a member of PreferredOne. To learn more about them or to use this benefit, visit: Doctor on Demand doctorondemand.com/bluecrossmn; Virtuwell virtuwell.com or MDLive mdlive.com/preferredone

Out of Area Coverage

Emergency and Urgent Care Coverage

Employees and dependents (who reside in the service area) traveling out of the service area receive the same Emergency and Urgent Care benefit as if they were in the service area. Each claim administrator offers a Preferred Provider Organization (PPO) through which all eligible employees and dependents are eligible to receive discounted services outside the State of Minnesota and the service area of the Minnesota Advantage Health Plan. Coverage is limited to urgent and emergency care for employees whose Permanent Residence is within the service area of the Minnesota Advantage Health Plan. The out-of-network Emergency and Urgent Care benefits for participants who permanently reside outside of the Advantage Plan service area will be administered consistent with their Point of Service benefit when they are in travel status.

Point of Service (POS)

The POS benefit is available to Minnesota Advantage Health Plan participants whose permanent residence is outside the State of Minnesota and the service area of the Minnesota Advantage Health Plan. It is also available to those participants temporarily residing outside of Minnesota and the Advantage Plan’s service area such as college students, spouses, ex-spouses, and employees on sabbatical leave. The benefit schedule includes a $350 single/$700 family Deductibles and 30% Coinsurance paid up to the Allowed Amount. Members using this benefit may be responsible for the difference between the Allowed Amount and the billed charge. These participants may receive Provider discounts when they use the PPO of the claim administrator with whom they are enrolled. Members eligible for this benefit will be asked to designate a Primary Care Clinic within the Advantage Plan service area, and when in-area, they are covered at the cost level of the PCC they have chosen.

Access for Point of Service (POS) benefits must be requested ahead of seeking services by completing the Immediate Point of Service Request form found on SEGIP’s website and submitting that form to SEGIP. SEGIP will contact your claim administrator with this information. Retroactive POS changes are not allowed.
**Employees who live and work out-of-area**

Employees whose Permanent Residence and principal work location are outside the State of Minnesota and the service area of the Minnesota Advantage Health Plan may receive Cost Level 2 benefits in the area of their Permanent Residence if they obtain services from the PPO of the claim administrator with whom they are enrolled. If a PPO Provider is not available in their area, they may receive Cost Level 2 benefits from any licensed PCC in their area. If a PPO Provider is available but not used, coverage will be limited to point-of-service benefits ($350/$700 Deductibles, 30% Coinsurance).

**Married SEGIP Participants/Parent and dependent child Participating in SEGIP**

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

**SEGIP Health and Well-being Program**

SEGIP has an ongoing commitment to improve the health and well-being of state employees, their families, and their workplaces. It draws on strategies and resources to support health through health improvement services, wellness initiatives, health care cost management, and employee assistance programs. As a state employee, you are encouraged to take advantage of this innovative program.

**Employee Assistance Program**

The State’s Employee Assistance Program (EAP) provides cost-free, confidential, professional consultation and resources that 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 mn.gov/mmb/segip/health-and-wellbeing/eap

**Advantage Value for Diabetes**

This program aims to reduce health risks and promote effective management of diabetes. Advantage members and their eligible dependents diagnosed with type I or type II diabetes will receive high-value medical services associated with diabetes for reduced costs or no copays. Increasing the access to high-value services, including prescription medication and certain testing supplies, can reduce the risk of costly complications. There is no enrollment process, and reduced copays occur when visits or diabetic medications or testing supplies are received. Advantage High Deductible Health Plan members are not eligible. For more information, see the SEGIP website mn.gov/mmb/segip/health-and-wellbeing/diabetes/advantage-value.jsp
**Omada**

This health benefit is available at no cost to employees and their adult family members who are at risk for Type 2 diabetes and enrolled in the Advantage Health Plan. Learn more about program criteria and eligibility [mn.gov/mmb/segip/health-and-wellbeing/diabetes/omada.jsp](http://mn.gov/mmb/segip/health-and-wellbeing/diabetes/omada.jsp)

**Well-being Incentive**

See the SEGIP Health and Well-being web page at [mn.gov/mmb/segip/health-and-wellbeing](http://mn.gov/mmb/segip/health-and-wellbeing) for more information.

**For More Information About Your Medical Benefits**

<table>
<thead>
<tr>
<th>BlueCross BlueShield</th>
<th>HealthPartners</th>
<th>PreferredOne</th>
</tr>
</thead>
<tbody>
<tr>
<td>P.O. Box 64560</td>
<td>P.O. Box 1309</td>
<td>P.O. Box 59212</td>
</tr>
<tr>
<td>Saint Paul, MN 55164-1627</td>
<td>Minneapolis, MN 55440-1309</td>
<td>Minneapolis, MN 55459</td>
</tr>
<tr>
<td>(888) 878-0137 TTY</td>
<td>(952) 883-7900</td>
<td>(763) 847-4477</td>
</tr>
<tr>
<td>(800) 262-0819</td>
<td>(952) 883-5127 TTY</td>
<td>(763) 847-4013 TTY</td>
</tr>
<tr>
<td><a href="http://bluecrossmn.com/segip">bluecrossmn.com/segip</a></td>
<td>(888) 343-4404</td>
<td>(800) 997-1750</td>
</tr>
<tr>
<td>National PPO: Blue Card</td>
<td><a href="http://healthpartners.com/segip">healthpartners.com/segip</a></td>
<td><a href="http://preferredone.com/segip">preferredone.com/segip</a></td>
</tr>
<tr>
<td>(800) 810-2583</td>
<td>National PPO: CIGNA</td>
<td>Aetna Signature Administrators</td>
</tr>
<tr>
<td></td>
<td>(888) 343-4404</td>
<td>(800) 997-1750 or</td>
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<td></td>
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<td>(763) 847-4477</td>
</tr>
</tbody>
</table>
### 2022 Minnesota Advantage Health Plan Schedule of Benefits

<table>
<thead>
<tr>
<th>2022 Benefit Provision</th>
<th>Cost Level 1 - You Pay</th>
<th>Cost Level 2 - You Pay</th>
<th>Cost Level 3 - You Pay</th>
<th>Cost Level 4 - You Pay</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>A. Preventive Care Services</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Routine medical exams, cancer screening</td>
<td></td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>• Child health preventive services, routine immunizations</td>
<td></td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>• Prenatal and postnatal care and exams</td>
<td></td>
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<tr>
<td>• Adult immunizations</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Routine eye and hearing exams</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>B. Annual First Dollar Deductible</strong> (single/family)</td>
<td>$250 / 500</td>
<td>$400 / 800</td>
<td>$750 / 1,500</td>
<td>$1,500 / 3,000</td>
</tr>
<tr>
<td><strong>C. Office visits for Illness/Injury, for Outpatient Physical, Occupational or Speech Therapy, and Urgent Care</strong></td>
<td>$35 copay per visit Annual deductible applies</td>
<td>$40 copay per visit Annual deductible applies</td>
<td>$70 copay per visit Annual deductible applies</td>
<td>$90 copay per visit Annual deductible applies</td>
</tr>
<tr>
<td>• Outpatient visits in a physician’s office</td>
<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>• Chiropractic services</td>
<td></td>
<td></td>
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<td></td>
</tr>
<tr>
<td>• Outpatient mental health and chemical dependency</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Urgent Care clinic visits (in &amp; out of network)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>D. In-network Convenience Clinics &amp; OnlineCare (deductible waived)</strong></td>
<td>$0 copay</td>
<td>$0 copay</td>
<td>$0 copay</td>
<td>$0 copay</td>
</tr>
<tr>
<td><strong>E. Emergency Care (in or out of network)</strong></td>
<td>$100 copay not subject to deductible</td>
<td>$125 copay not subject to deductible</td>
<td>$150 copay not subject to deductible</td>
<td>$350 copay not subject to deductible</td>
</tr>
<tr>
<td>• Emergency care received in a hospital emergency room</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>F. Inpatient Hospital Copay (waived for admission to Center of Excellence)</strong></td>
<td>$100 copay Annual deductible applies</td>
<td>$200 copay Annual deductible applies</td>
<td>$500 copay Annual deductible applies</td>
<td>25% coinsurance Annual deductible applies</td>
</tr>
<tr>
<td><strong>G. Outpatient Surgery Copay</strong></td>
<td>$60 copay Annual deductible applies</td>
<td>$120 copay Annual deductible applies</td>
<td>$250 copay Annual deductible applies</td>
<td>25% coinsurance Annual deductible applies</td>
</tr>
<tr>
<td><strong>H. Hospice and Skilled Nursing Facility</strong></td>
<td>Nothing</td>
<td>Nothing</td>
<td>Nothing</td>
<td>Nothing</td>
</tr>
<tr>
<td><strong>I. Prosthetics, Durable Medical Equipment</strong></td>
<td>20% coinsurance</td>
<td>20% coinsurance</td>
<td>20% coinsurance</td>
<td>25% coinsurance Annual deductible applies</td>
</tr>
<tr>
<td>Section</td>
<td>Description</td>
<td>10% coinsurance</td>
<td>15% coinsurance</td>
<td>20% coinsurance</td>
</tr>
<tr>
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</tr>
<tr>
<td>J. Lab</td>
<td>(including allergy shots), Pathology, and X-ray (not included as part of preventive care and not subject to office visit or facility copayments)</td>
<td>Annual deductible applies</td>
<td>Annual deductible applies</td>
<td>Annual deductible applies</td>
</tr>
<tr>
<td>K. MRI/CT Scans</td>
<td>Annual deductible applies</td>
<td>Annual deductible applies</td>
<td>Annual deductible applies</td>
<td>Annual deductible applies</td>
</tr>
<tr>
<td>L. Other expenses not covered in A-K above, including but not limited to:</td>
<td>5% coinsurance</td>
<td>5% coinsurance</td>
<td>20% coinsurance</td>
<td>25% coinsurance</td>
</tr>
<tr>
<td>• Ambulance</td>
<td>Annual deductible applies</td>
<td>Annual deductible applies</td>
<td>Annual deductible applies</td>
<td>Annual deductible applies</td>
</tr>
<tr>
<td>• Home Health Care</td>
<td>Annual deductible applies</td>
<td>Annual deductible applies</td>
<td>Annual deductible applies</td>
<td>Annual deductible applies</td>
</tr>
<tr>
<td>• Outpatient Hospital Services (non-surgical)</td>
<td>Annual deductible applies</td>
<td>Annual deductible applies</td>
<td>Annual deductible applies</td>
<td>Annual deductible applies</td>
</tr>
<tr>
<td>• Radiation/chemotherapy</td>
<td>Annual deductible applies</td>
<td>Annual deductible applies</td>
<td>Annual deductible applies</td>
<td>Annual deductible applies</td>
</tr>
<tr>
<td>• Dialysis</td>
<td>Annual deductible applies</td>
<td>Annual deductible applies</td>
<td>Annual deductible applies</td>
<td>Annual deductible applies</td>
</tr>
<tr>
<td>• Day treatment for mental health and chemical dependency</td>
<td>Annual deductible applies</td>
<td>Annual deductible applies</td>
<td>Annual deductible applies</td>
<td>Annual deductible applies</td>
</tr>
<tr>
<td>• Other diagnostic or treatment related outpatient services</td>
<td>Annual deductible applies</td>
<td>Annual deductible applies</td>
<td>Annual deductible applies</td>
<td>Annual deductible applies</td>
</tr>
<tr>
<td>M. Prescription Drugs</td>
<td>30-day supply of Tier 1, Tier 2, or Tier 3 prescription drugs, including insulin, or a 3-cycle supply of oral contraceptives</td>
<td>$18 / 30 / 55</td>
<td>$18 / 30 / 55</td>
<td>$18 / 30 / 55</td>
</tr>
<tr>
<td></td>
<td>Note: all Tier 1 generic and select branded oral contraceptives are covered at no cost.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>N. Plan Maximum Out-of-Pocket Expense for Prescription Drugs (excludes PKU, Infertility, growth hormones) (single/family)</td>
<td>$1,050 / 2,100</td>
<td>$1,050 / 2,100</td>
<td>$1,050 / 2,100</td>
<td>$1,050 / 2,100</td>
</tr>
<tr>
<td>O. Plan Maximum Out-of-Pocket Expense (excluding prescription drugs) (single/family)</td>
<td>$1,700 / 3,400</td>
<td>$1,700 / 3,400</td>
<td>$2,400 / 4,800</td>
<td>$3,600 / 7,200</td>
</tr>
</tbody>
</table>

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

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

You have the option to purchase dental insurance for yourself and your dependents. Two dental administrators are available through SEGIP’s State Dental Plan. You may choose a dental provider that is available in the county where you live or work.

Important features

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

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

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

Provider networks

Each dental administrator has a network of dentists and, in some cases, preferred specialists through which you receive in-network care. You can access directories of dental clinics and dentists through links to each dental administrator. Links to the dental administrators can be found on the SEGIP website, mn.gov/mmb/segip. To ask specific questions about dental clinics, call the administrator directly. The administrators’ 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 claim administrator. This ensures that you understand the amount your claim administrator will pay and the amount that will be your responsibility.

For more information about the State Dental insurance:

**HealthPartners**
P.O. Box 1309
Minneapolis, MN 55440-1309
(952) 883-7900
(952) 883-5127 TTY
(888) 343-4404
[healthpartners.com/segip](http://healthpartners.com/segip)

**Delta Dental of Minnesota**
*(Group 216)*
P.O. Box 330
Minneapolis, MN 55440-0330
(651) 406-5916 (800) 406-5923 TTY
(800) 553-9536
(888) 853-7570 TTY
[ deltadentalmn.org/segip](http://deltadentalmn.org/segip)
### 2022-23 Dental Schedule of Benefits

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

**Orthodontics Lifetime Maximum** per person $3,000 (does not start over if you change dental plans).

<table>
<thead>
<tr>
<th></th>
<th>In-network Benefits</th>
<th>Out-of-network Benefits</th>
</tr>
</thead>
<tbody>
<tr>
<td>Annual Deductible</td>
<td>$50 per person</td>
<td>$150 per family</td>
</tr>
<tr>
<td></td>
<td>$125 per person</td>
<td></td>
</tr>
</tbody>
</table>

**Diagnostic and preventive care** (deductible does not apply)

<table>
<thead>
<tr>
<th>Covered Services</th>
<th>In-network Benefits</th>
<th>Out-of-network Benefits</th>
</tr>
</thead>
<tbody>
<tr>
<td>Examinations, oral hygiene &amp; teeth cleaning</td>
<td>100% coverage</td>
<td>50% coverage of the allowed amount</td>
</tr>
<tr>
<td>Fluoride treatment (to age 19)</td>
<td>100% coverage</td>
<td>50% coverage of the allowed amount</td>
</tr>
<tr>
<td>Space maintainers</td>
<td>100% coverage</td>
<td>50% coverage of the allowed amount</td>
</tr>
<tr>
<td>Sealants</td>
<td>100% coverage</td>
<td>50% coverage of the allowed amount</td>
</tr>
</tbody>
</table>

**Restorative care and prosthetics** (deductible applies)

<table>
<thead>
<tr>
<th>Covered Services</th>
<th>In-network Benefits</th>
<th>Out-of-network Benefits</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fillings (customary restorative materials)</td>
<td>80% coverage</td>
<td>50% coverage of the allowed amount</td>
</tr>
<tr>
<td>Oral surgery</td>
<td>80% coverage</td>
<td>50% coverage of the allowed amount</td>
</tr>
<tr>
<td>Periodontics (gum disease therapy)</td>
<td>80% coverage</td>
<td>50% coverage of the allowed amount</td>
</tr>
<tr>
<td>Endodontics (root canal therapy)</td>
<td>80% coverage</td>
<td>50% coverage of the allowed amount</td>
</tr>
<tr>
<td>Inlays and overlays</td>
<td>80% coverage</td>
<td>50% coverage of the allowed amount</td>
</tr>
<tr>
<td>Restorative crowns</td>
<td>80% coverage</td>
<td>50% coverage of the allowed amount</td>
</tr>
<tr>
<td>Dental Implants</td>
<td>80% coverage</td>
<td>50% coverage of the allowed amount</td>
</tr>
<tr>
<td>Fixed or removable bridgework</td>
<td>80% coverage</td>
<td>50% coverage of the allowed amount</td>
</tr>
<tr>
<td>Full or partial dentures</td>
<td>80% coverage</td>
<td>50% coverage of the allowed amount</td>
</tr>
<tr>
<td>Dental relines or rebases</td>
<td>80% coverage</td>
<td>50% coverage of the allowed amount</td>
</tr>
<tr>
<td>Orthodontics (deductible coverage applies)</td>
<td>80% coverage</td>
<td>50% coverage of the allowed amount</td>
</tr>
</tbody>
</table>

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

See Summary of Benefits for specific plan limitations.
Vision plan

The Blue Cross Vision plan, partnered with Davis Vision, is optional and designed to supplement your family’s medical coverage. It’s available to benefits eligible employees, whether you’re enrolled in the state’s Minnesota Advantage Health Plan or are covered elsewhere. Minnesota Advantage Health Plan members may select the Blue Cross Vision plan no matter which plan administrator you are enrolled in for your medical coverage including, BlueCross BlueShield, HealthPartners, and PreferredOne. While our medical plan covers your eye exam, the Blue Cross Vision plan helps cover the costs of eyeglasses or contact lenses and offers discounts on LASIK and more. The vision plan uses the Davis Vision network of retailers and independent provider offices.

Blue Cross Vision administered by Davis Vision.

Bluecrossmn.com/segip-vision
Vision Plan Provider Finder: bluecrossmn.com/findaneyedoctor
1-888-921-1192

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 another 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. Your collective bargaining agreement or Plan provides information about the amount of state-paid life insurance and eligibility for employer-paid coverage.

Basic Employee Life Insurance

- The state pays the full cost of basic life insurance for benefits-eligible employees receiving an employer contribution towards insurance
- Benefit based on annual salary (consult your bargaining agreement or Plan)
- Maximum coverage allowed is $95,000

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

Manager’s Life Insurance

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

- 1½ times your annual salary, or
- 2 times your annual salary

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

New employees may apply within 30 days of employment for supplemental employee life insurance of up to two times their annual salary. Newly benefits-eligible employees may apply within 30 days of becoming eligible. This supplemental 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 the date of your marriage (the 30 days includes the date of marriage).

If amounts above two times your annual salary or amounts greater than $10,000 for spouse are desired, coverage may be requested by applying with evidence of insurability. Likewise, employees who did not enroll in supplemental life for themselves or spouse life 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 supplemental employee life 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 that provides $10,000 of coverage for your eligible children as defined in the Certificate of Coverage. One child life insurance policy covers all 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 as a new employee, a newly benefits-eligible employee, or within 30 days of the birth of a child or the placement of a child for adoption.

Life Insurance 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.

Life Insurance upon retirement

If you meet the requirements as a retiree under your labor contract or plan or by statute and have carried supplemental employee life 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 supplemental 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 $200,000 (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.

**NOTE:** 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 (also known as Minnesota Life), provides a secure website for electing, storing, and updating your beneficiary designations. This secure online site 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 from Securian with user instructions mailed to their home address.

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 lifebenefits.com/plandesign/statemn. 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

LifeStyle Benefits are additional benefits available to employees with basic life. These additional benefits include travel assistance, legacy planning, legal services, and beneficiary management services.

For plan details, premium rates, online documents, beneficiary information, and much more are available through:

**Ochs, Inc.**

**The servicing agent for Securian**

400 Robert Street, Suite 1880
St. Paul, MN 55101-2016
(651) 665-3789
(800) 392-7295
ochsinc.com/stmn
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 the Manager’s Income Protection Plan below.

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 (STD) 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. You may purchase amounts less than or 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 30 days of hire date (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 30 days). Benefits eligible employees may apply to 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 30 days of employment or during an annual Open Enrollment. Newly benefits-eligible employees may elect within 30 days of becoming benefits eligible (provided they’ve worked more than 30 days). You may purchase LTD coverage in monthly benefit amounts (income replacement) ranging from $300 to $7,000. You may purchase amounts less than or 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. However, they may not increase the amount of short-term disability 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.

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
Flexible Spending Accounts (FSA) or pretax benefits

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

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

It’s important to understand how pretax plans work. One important rule to understand is the Internal Revenue Service’s (IRS) “use or lose” rule. Because of the tax advantages of pretax benefits, contributions to the Dependent Care (daycare) Expense Account (DCEA) are forfeited if eligible expenses are not submitted for reimbursement by the deadline. Currently, the Medical/Dental Expense Account (MDEA) includes a $Carryover. For the plan year 2021 into 2022, this feature allows eligible participants to carryover unreimbursed money from their 2021 MDEA over to the 2022 plan year. The carryover funds can be used for expenses in the next plan year. For plan year 2022 into 2023, the allowed carryover amount will be $570 for those who qualify. Any funds in excess of the allowed $570 carryover are subject to the “use or lose” rule. See the BRI website (formerly 121 Benefits) at www.BenefitResource.com/state-of-minnesota for greater detail. Another important rule is that MDEA and DCEA elections cannot be changed without an IRS recognized status change. Be sure you understand these risks before you enroll in a pretax account.

Participation in the pretax benefits program has no effect on future state retirement pension benefits. Your retirement and disability benefits are figured based on your gross salary, not your reduced taxable salary.

However, your Social Security benefits may be slightly reduced because you’re paying less in Social Security (FICA) taxes.

Health and Dental Premium Account

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

The Dependent Care (daycare) Expense Account (DCEA) allows you to pay for certain dependent care (daycare) expenses with pretax dollars. DCEA funds are for eligible daycare expenses for your qualified children up to age 13 or adult daycare for your qualified disabled spouse or other disabled dependent. The DCEA is for daycare expenses incurred while you are working or looking for work. The minimum election is $100, and the household federal maximum is $5,000 per tax year. There are special rules that apply depending upon your tax filing status. Consult your tax advisor. Remember, this account is for “day care” type expenses, not medical or dental expense for your dependents. Remember that the DCEA does not have a carryover feature for the 2022 into 2023 plan year.

**Medical/Dental Expense Account**

The Medical/Dental Expense Account (MDEA) allows you to pay for certain out-of-pocket medical, dental, prescriptions, and vision expenses with pretax dollars for you, your spouse, and eligible dependents. The MDEA can be used to pay for health and dental plan deductibles, copays, coinsurance, and other expenses as defined by Internal Revenue Service (IRS) code that cannot be reimbursed from any other sources, such as another insurance plan. The MDEA cannot be used for premiums. Remember that the Minnesota Advantage Health Plan and dental plan premiums are automatically deducted pretaxed. The minimum election is $100, and the 2022 maximum is $2,850 per plan year. If you lose your benefits eligibility, you can continue your MDEA participation on an after-tax basis by electing COBRA continuation.

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

**Pretax Debit Cards**

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

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

**Limited Purpose MDEA and HRA**

There are certain MDEA and HRA limitations if you, your spouse, or eligible dependent(s) participates in a Health Savings Account (HSA), which accompany a High Deductible Health Plan (HDHP). A limited purpose MDEA and HRA (if applicable) is an option for these employees. The limited purpose MDEA restricts what expenses are eligible for reimbursement. For more information, contact BRI (formerly 121 Benefits) prior to your MDEA enrollment.
The limited purpose MDEA works the same way a general purpose MDEA does – the difference is the limitation of expenses that are eligible for reimbursement. The limited purpose MDEA limits reimbursable expenses to vision, dental, or preventative medical expenses.

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

For more information about the pretax benefits and the debit card, contact BRI prior to your MDEA enrollment.

Transit Expense Accounts

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

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

The pretax debit card is the only way to access funds to purchase bus and light rail fares and passes. No other reimbursement method is allowed. Debit card purchases for bus and light rail fares and passes do not need follow up documentation. The pretax debit card can also be used to pay for your work-related parking expenses with certain vendors. If the debit card is used for parking with an approved vendor, follow-up documentation is not required.

Payroll Deducted Account for Transit

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

You must enroll each year in the Medical/Dental Expense Account, the Dependent Care (daycare) Expense Account, and the Transit Expense Accounts during Open Enrollment. The payroll-deducted premium and payroll deducted transit accounts continue from year to year.
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 pretax benefits within your enrollment period which is your first 30 days after hire. Newly insurance eligible employees (with greater than 30 days of employment) need to make these decisions within 30 days of becoming insurance eligible.

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

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

Applying for coverage as a new employee

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

The enrollment package will include:

- a worksheet listing your insurance options
- access to online directories for medical and dental selection
- directions for electronic enrollment using the MN State Employee Self Service website

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

You must make your insurance elections within 30 days of your hire date. You may enroll in family medical, employee or family dental, optional life, disability, accidental death and dismemberment, income protection, and pretax accounts within the first 30 days of your hire date. However, coverage requiring evidence of insurability will be effective immediately after underwriting approval. Do not delay enrolling as this could result in a large retroactive deduction of your insurance premiums on your paycheck.

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

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

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

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

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

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

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

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

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

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 enrollment period.

**Requirement to verify dependent eligibility**

You must verify the eligibility of a newly enrolled 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 the requested documents. SEGIP must receive your verification documentation within 30 days of the date of your enrollment submission. SEGIP determines eligibility and submission of forms is not a guarantee of coverage.

To submit documents:

- **Scan and email forms** to segip.mmb@state.mn.us. SAVE the sent confirmation for your records.
- **Fax forms** to our secure fax line at (651) 797-1313 and save a confirmation showing receipt by SEGIP for your records.
- **Mail forms** to:
  
  Minnesota Management and Budget/SEGIP  
  400 Centennial Building  
  658 Cedar Street  
  St. Paul, MN 55155

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

**Default coverage**

Employees eligible for a full employer contribution who fail to either enroll or waive medical coverage within 30 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 medical claim administrator 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 and you will be placed in a cost level two clinic (or level one, if available) You will be unable to enroll dependents until the annual Open Enrollment period if your coverage is defaulted.

If an employee does not waive or elect their own medical claim administrator and PCC by their deadline or initial effective date but was previously covered as a dependent immediately prior to their initial effective date, they will be defaulted to the medical claim 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 child(ren), the order will be forwarded to Employee Insurance of Minnesota Management and Budget (MMB) along with your application for medical and dental insurance.

Even if an employee does not obey a court order, the state, as the employer, will proceed with the enrollment process. Upon determination by an employer's medical claim 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 employee’s paycheck (this can occur on a retroactive basis).

In such cases, dependent children must be enrolled in the same medical plan and claim administrator and dental plans in which the employee is enrolled. The employee may change their claim administrator 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.

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.

During Open Enrollment you may:

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

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

**Effective dates for benefit changes**

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

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

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

Important note: After you enroll on the MN Employee Self Service website, you will have an option to print or electronically save your Confirmation Statement. You should also review your paycheck and your online benefit summary on the MN Employee Self Service website 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. Adjustments to your elections cannot be made outside of the established Open Enrollment period. Please carefully make your selections and follow the online instructions.

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.

NOTE: 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. SEGIP must receive benefit enrollment and cancellation forms within the allowed timeframes. Do not delay submission of forms if you are waiting for documentation. Forms can be faxed to (651) 797-1313 or scanned and emailed to segip.mmb@state.mn.us (only email private data through another @state.mn.us account)

Adding, canceling, and changing coverage

- SEGIP must receive elections to add or enroll in coverage due to a qualified life event within 30 days of the event. Exception: if enrolling in coverage due to loss of Children’s Health Insurance Program (CHIP), SEGIP must receive the application within 60 days of the loss of CHIP coverage.
- SEGIP must receive elections to cancel coverage due to life event within 60 days of the event. Exception: SEGIP must receive requests to cancel or reduce MDEA/DCEA elections within 30 days of the event.
These life events are:

a. A change in legal marital status, including marriage, death of a spouse, divorce (under certain circumstances) or annulment.
b. A change in number of dependents, including birth, death, adoption, and placement for adoption.
c. A change in employment status of the employee, or the employee’s or retiree’s spouse or dependent, including termination or commencement of employment, a strike or lockout, a commencement of or return from an unpaid leave of absence, a change in worksite, and a change in working conditions (including changing between part-time and full-time or hourly and salary) of the employee, the employee’s spouse or dependent which results in a change in the benefits they receive under a cafeteria plan or medical or dental plan.
d. A dependent ceasing to satisfy eligibility requirements for medical and/or dental coverage due to attainment of age 26.
e. A claim administrator no longer being available due to a change in place of residence and/or work location of the employee, retiree or their spouse or dependent.
f. Significant cost or coverage changes (including coverage curtailment and the addition/or elimination of a benefit package).
g. Family Medical Leave Act (FMLA) leave.
h. Judgments, decrees, or orders.
i. A change in coverage of a spouse or dependent under another employer’s plan.
j. Open Enrollment under the plan of another employer for a spouse or dependent (limited to Open Enrollments with coverage effective dates other than January 1st of a new year).
k. Health Insurance Portability and Accountability Act (HIPAA) special enrollment rights for new dependents and in the case of loss of other group insurance coverage.
l. A COBRA-qualifying event.
m. Loss of coverage under the group health plan of a governmental or educational institution (a state’s Children’s Health Insurance Program (CHIP)*, medical care program of an Indian tribal government, state health benefits risk pool, or foreign government group health plan).
n. Gain or Loss of Medicare, Medicaid, or Medical Assistance.
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 51 of this book.

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

Changes in optional benefits

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

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

Changes in Pretax Accounts

You may increase, decrease, add or cancel the amounts, within the timeframes specified in the Summary of Benefits (benefitresource.com/state-of-minnesota) 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, if necessary.

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

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

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

Coverage for your dependents will not be effective before your own coverage.
You must be working on the date your optional life and disability coverages take effect. If you are on a scheduled vacation or semester break at that time, you will be deemed to be actively at work. Otherwise, coverage will be delayed until the first day when you return to work.

**Medical Child Support Orders**

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

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

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

If you are served with a Medical Child Support Order by the court at any time during your employment with the state, you must notify your agency HR office and 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 claim 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 employee’s paycheck (this can occur on a retroactive basis).

If you already have a dependent covered under your medical and dental coverage, your benefits claim administrator 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, vision, life insurance coverage, and your Medical/Dental Expense Account (at your expense) 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 the following coverages on an after-tax basis:
• medical coverage
• dental coverage
• vision coverage
• life insurance
• Medical/Dental Expense Account
• 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, vision, and life coverage, as well as participation in the Medical/Dental Expense Account. This notice generally explains continuation coverage, when it may become available to you and your qualified dependents, and what you need to do to protect the right to continue. This notice gives only a summary of your continuation coverage rights. For more information about your rights and obligations under the Plan and under federal law, you should either review the Plan’s Summary of Benefits or Certificate of Coverage or get a copy of the Plan Document from the Plan Administrator.

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

**Continuation coverage for employees who retire or become disabled**

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

**Continuing your coverage**

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

In most cases, you have 60 days from the later of the date 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 reasons other than gross misconduct.

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

1. Your spouse dies;
2. Your spouse’s hours of employment are reduced;
3. Your spouse’s employment ends for any reason other than gross misconduct; 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 reasons other than 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 SEGIP no later than 60 days from the date of the qualifying event (the date on which the event occurs is day one). You must send this notice to: MMB - SEGIP, 658 Cedar Street, St. Paul, MN, 55155 or fax (651) 797-1313 or scan and email to SEGIP at segip.mmb@state.mn.us (only email private data from another @state.mn.us account). If you do not properly notify SEGIP of these changes, you will jeopardize your ability or the ability of your dependents to elect continuation coverage.

**How is continuation coverage provided?**

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

Continuation coverage is a temporary continuation of coverage when:

- the qualifying event is a dependent child losing eligibility as a dependent child, divorce or annulment, continuation of medical and dental coverage lasts for up to 36 continuous months.
• the initial qualifying event is the death of the employee, continuation of medical and dental coverage may last indefinitely.

• the initial qualifying event is divorce, continuation of medical and dental coverage for the ex-spouse may last indefinitely.

• the qualifying event is the end of employment or reduction of the employee’s hours of employment, continuation coverage generally lasts for only up to a total of 18 consecutive months. This 18-month period of continuation coverage can be extended if a second qualifying event occurs.

• the qualifying event is the end of employment or reduction of the employee’s hours of employment and the employee became entitled to Medicare benefits less than 18 months before the qualifying event, continuation of medical and dental coverage for qualified beneficiaries other than the employee lasts up to 36 months after the date of Medicare entitlement. For example, if a covered employee becomes entitled to Medicare 8 months before the date on which his employment terminates, continuation coverage for his spouse and children can last up to 36 continuous months after the date of Medicare entitlement, which is equal to 28 months after the date of the qualifying event (36 months minus 8 months).

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

• any required premium is not paid in full and on time,

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

In all these cases, you must make sure that SEGIP is notified of the second qualifying event no later than 60 days from the second qualifying event (the date on which the event occurs is counted as day one). This notice must be sent to Minnesota Management and Budget, SEGIP, 658 Cedar Street, St. Paul, MN, 55155. You may also fax to (651) 797-1313 or email to segip.mmb@state.mn.us.
2. **Disability extension of 18-month period of continuation coverage**

If you or a qualified dependent covered under the Plan is determined by the Social Security Administration to be disabled and you notify SEGIP in a timely fashion, you and your qualified dependents can receive up to an additional 11 months of medical and dental continuation coverage, for a total maximum of 29 months. The disability must start sometime prior to the 60th day of Continuation Coverage and must last at least until the end of the 18-month period of continuation coverage. You must notify SEGIP of the Social Security Administration’s determination within 60 days of the date of the determination and before the end of the 18-month period of continuation coverage. This notice should be sent to Minnesota Management and Budget, SEGIP, 658 Cedar Street, St. Paul, MN, 55155, or fax (651) 797-1313 or email to segip.mmb@state.mn.us (only email private data from another @state.mn.us account).

**If you have questions**

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

You may also be able to buy coverage through the Health Insurance Marketplace. In the Marketplace, you could be eligible for a tax credit that lowers your monthly premiums, and you can see what your premium, deductibles, and out-of-pocket costs will be before you decide 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 another group insurance, whichever is earlier.

**Continuation of the Medical Dental Expense Account**

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

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

For additional information about continuation of pretax accounts, please see the Plan Summary, available at the BRI website (BenefitResource.com/state-of-minnesota)
Continuation of the Health Reimbursement Arrangement (HRA)

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

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

Please contact the HRA administrator, BRI (BenefitResource.com/state-of-minnesota) for additional information about COBRA continuation of the HRA Plan.

Keep your agency Human Resource office informed of address changes

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

Dependent eligibility

Eligibility

The State Employee Group Insurance Program (SEGIP) determines the eligibility of state employees and dependents subject to collective bargaining agreements and compensation plans, which may change during a Benefit Year. The claim administrator 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 employee’s adult child (age 18 until 26) works for the state or another organization participating in SEGIP, the child may be covered as a dependent by the parent/employee. In either situation, the employee who will be covered as a dependent must waive coverage by completing the Waiver of Coverage form within their initial eligibility period. Enrollment and dependent verification must be completed within the appropriate time periods. Also, only one state employee can cover dependents in common.

If an employee waived the medical insurance to be covered under another state employee, they will not be able to enroll in their own coverage again until an annual Open Enrollment or upon a qualified life event.
In order to remain a dependent under the other state employee’s plan, the employee waiving medical coverage as a SEGIP participant must provide an annual attestation during Open Enrollment to confirm that they wish to continue to waive the coverage as an employee. If this annual attestation is not provided, the employee will be default enrolled into single medical insurance effective the first of the upcoming plan year.

**Dependent Eligibility Verification**

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

*Eligible dependents include the following:*

a) **Spouse**

The spouse of an eligible employee (if legally married under Minnesota Law). For the purposes of medical and dental insurance coverage, if that spouse works full-time for an organization employing more than one hundred (100) people and (1) elects to receive either credits or cash in place of health insurance or health coverage or towards some other benefit in place of health insurance, and (2) is enrolled in a high deductible medical insurance plan (as defined by the IRS) that includes a contribution to a health savings account (HSA) through their employing organization, then they are not eligible to be a covered dependent for the purposes of this Article.

If both spouses work for the state or another organization participating in SEGIP, one working spouse may cover the other working spouse as a dependent.

b) **Child**

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

A dependent child with a disability 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 claim administrator by the employee or enrollee within 31 days of the child’s attainment of the limiting age or any other limiting term required for dependent coverage. The dependent with a disability is eligible to continue coverage as long as they continue to be disabled and dependent unless coverage terminates under the contract.

e) Qualified Medical Child Support Order

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

f) Child Coverage Limited to Coverage Under One Employee

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

g) Other

Any person who is an eligible dependent under the employee’s bargaining agreement or plan of employment or is required by federal or state law to be a covered dependent.
<table>
<thead>
<tr>
<th>Eligible Dependents</th>
<th>Definition of an Eligible Dependent</th>
<th>Required Documentation</th>
</tr>
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<tbody>
<tr>
<td>Spouse</td>
<td>• Must be legally married under Minnesota law to an insurance eligible employee, <strong>and</strong>&lt;br&gt;• Your spouse is not eligible if they work full-time for an employer (with more than 100 people) and (1) elects to receive either credits or cash in place of health insurance or health coverage or towards some other benefit in place of health insurance.&lt;br&gt;• Your spouse is also not eligible if enrolled in a high deductible medical insurance plan (as defined by the IRS) that includes a contribution to a health savings account (HSA) through their employing organization.</td>
<td>1. Copy of your certified marriage certificate <strong>and</strong>&lt;br&gt;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. <strong>and</strong>&lt;br&gt;3. Completed Spouse/Former Spouse Certification Form</td>
</tr>
<tr>
<td>Former Spouse</td>
<td>• The divorce must occur while the employee is covered, <strong>and</strong>&lt;br&gt;• Must have been covered on the employee's plan at the time of the divorce, <strong>and</strong>&lt;br&gt;• May not have obtained other group coverage since the divorce, <strong>and</strong>&lt;br&gt;• Not eligible if they work full-time for an employer (with more than 100 people) and (1) elects to receive either credits or cash in place of health insurance or health coverage or towards some other benefit in place of health insurance.&lt;br&gt;• In addition, also not eligible if enrolled in a high deductible medical insurance plan (as defined by the IRS) that includes a contribution to a health savings account (HSA) through their employing organization.</td>
<td>1. Copy of your divorce decree signed by a judge or court administrator <strong>and</strong>&lt;br&gt;2. Completed Spouse/Former Spouse Certification Form</td>
</tr>
<tr>
<td>Biological Children</td>
<td>• To age 26&lt;br&gt;1. Copy of your child’s certified birth certificate naming you as the child’s parent</td>
<td></td>
</tr>
<tr>
<td>Adopted children</td>
<td>• To age 26 if adopted <strong>or</strong>&lt;br&gt;• To age 18 if placed with you for adoption</td>
<td>1. Final copy of your court documentation showing the names of both you (or your spouse) and the child confirming the adoption <strong>or</strong>&lt;br&gt;2. Copy of the child’s certified birth certificate naming you (or your spouse) as the child’s parent</td>
</tr>
<tr>
<td>Stepchildren</td>
<td>• To age 26&lt;br&gt;• You must be legally married to the child’s parent</td>
<td>1. Copy of the child’s certified birth certificate naming your spouse as the child’s parent <strong>and</strong>&lt;br&gt;2. Copy of your certified marriage certificate and a current financial document naming both you and your spouse</td>
</tr>
<tr>
<td>Foster Children (ward, legal guardian, legal custody)</td>
<td>• To age 26&lt;br&gt;• Full and permanent legal and physical custody</td>
<td>1. Completed Foster Child Certification Form <strong>and</strong>&lt;br&gt;2. Final copy of court document showing your name (and/or your spouse) confirming the permanent custodial relationship <strong>and</strong>&lt;br&gt;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</td>
</tr>
</tbody>
</table>
### Eligible Dependents

<table>
<thead>
<tr>
<th>Definition of an Eligible Dependent</th>
<th>Required Documentation</th>
</tr>
</thead>
<tbody>
<tr>
<td>• To age 25</td>
<td>1. Completed Grandchild Certification Form and</td>
</tr>
<tr>
<td>• Unmarried, dependent upon you for principal support and maintenance and lives with you; your child must be unmarried less than age 19 or</td>
<td></td>
</tr>
<tr>
<td>• Financially dependent upon you and has resided with you continuously from birth</td>
<td>2. Copy of your grandchild’s certified birth certificate, naming your (or your spouse’s) child as your grandchild’s parent and</td>
</tr>
<tr>
<td>• -OR-</td>
<td>3. Copy of your child’s certified birth certificate naming you (or your spouse’s) as the parent and</td>
</tr>
<tr>
<td>• If you have legally adopted your grandchild or are the foster parent of your grandchild follow the eligibility rules for each above</td>
<td>4. Document dated within the last 6 months establishing this grandchild currently resides with you and</td>
</tr>
<tr>
<td></td>
<td>5. Copy of your most recent federal tax return listing this child as your (or your spouse’s) tax dependent</td>
</tr>
<tr>
<td></td>
<td>6. If your grandchild has lived with you continuously from birth</td>
</tr>
<tr>
<td></td>
<td>a copy of your federal tax return from the year this grandchild was born</td>
</tr>
<tr>
<td>Grandchildren</td>
<td></td>
</tr>
<tr>
<td>Child(ren) with a disability</td>
<td></td>
</tr>
<tr>
<td>• Any age or marital status, includes dependent children incapacitated by reason of developmental disability, mental illness or disorder, or physical disability, and</td>
<td></td>
</tr>
<tr>
<td>• Chiefly dependent upon you for principal support and maintenance, and</td>
<td></td>
</tr>
<tr>
<td>• You must provide proof of such incapacity and dependency annually as requested by your health plan administrator</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
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<tr>
<td>Also covered: any other person required by state or federal law to be treated as a dependent for purpose of health care coverage.</td>
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</tbody>
</table>

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

Women’s Health and Cancer Rights Act

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

- reconstruction of the breast on which the mastectomy was performed;
- surgery and reconstruction of the other breast to produce a symmetrical appearance; and
- prosthesis and treatment for physical complications during all stages of mastectomy, including swelling of the lymph glands (lymphedema).

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

Family Medical Leave Act

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

You may take family and medical leave for:

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

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

Medicare Part D Creditable Coverage

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

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

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

A. Introduction

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

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

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

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

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

B. Health Plans covered by this Notice

This Notice describes the privacy practices of the group health plans listed here and together these plans are collectively referred to as the “Plan” for purposes of this Notice. Each of these plans is independent of one another. This Notice will apply to the extent that You participate in each separate plan. Minnesota Management and Budget / SEGIP contracts with internal and external entities to perform the work of each of these plans. In accordance with HIPAA, they may share PHI for the treatment, payment, and health care operations. Each entity is required to agree to additional terms and conditions to protect Your PHI.
<table>
<thead>
<tr>
<th>Name of Plan</th>
<th>Plan Administrator</th>
<th>Claim Administrator</th>
</tr>
</thead>
<tbody>
<tr>
<td>The Minnesota Advantage Health Plan</td>
<td>SEGIP</td>
<td>BlueCross BlueShield of Minnesota, BlueCross BlueShield of Minnesota PPO HealthPartners, HealthPartners PPO PreferredOne pharmacy benefit claims through CVS Caremark</td>
</tr>
<tr>
<td>The Minnesota Advantage High Deductible Health Plan (HDHP)</td>
<td>SEGIP</td>
<td>BlueCross BlueShield of Minnesota, BlueCross BlueShield of Minnesota PPO HealthPartners, HealthPartners PPO PreferredOne pharmacy benefit claims through CVS Caremark</td>
</tr>
<tr>
<td>State Dental Plan</td>
<td>SEGIP</td>
<td>HealthPartners Dental Delta Dental of MN – GRP 216</td>
</tr>
<tr>
<td>Flexible Benefits Accounts</td>
<td>SEGIP</td>
<td>Benefit Resource, Inc.</td>
</tr>
<tr>
<td>Wellness Program</td>
<td>SEGIP</td>
<td>Virgin Pulse</td>
</tr>
<tr>
<td>Vision Plan</td>
<td>SEGIP</td>
<td>Blue Cross Vision</td>
</tr>
</tbody>
</table>

C. The Plan’s Rights and Obligations

1. The Plan is required by law to maintain the privacy of PHI.
2. The Plan is required by law to provide individuals with notice of the Plan’s legal duties and privacy practices with respect to PHI.
3. The Plan is required to notify affected individuals of a breach of unsecured PHI.
4. The Plan is required to abide by the terms of the privacy practice described in this Notice. These privacy practices will remain in effect until the Plan replaces or modifies them.
5. The Plan reserves the right to change its privacy practices and the terms of this Notice at any time, provided that the change is permitted by law. The Plan reserves the right to have such a change affect all PHI it maintains, including PHI it received or created before the change. When the Plan makes a material change in its privacy practices, it will revise this Notice and post it at mn.gov/mmb/segip by the effective date of the material change and the Plan will provide the revised Notice, or information about the material change and how to obtain the revised Notice, in the next annual mailing to participants.
D. Uses and Disclosures of Your Protected Health Information

To protect the privacy of Your PHI, the Plan not only guards the physical security of Your PHI, but also limits the way Your PHI is used or disclosed to others. The Plan may use or disclose Your PHI in certain permissible ways, including the uses and disclosures described below. To the extent required by HIPAA, only the minimum amount of Your PHI necessary to perform these tasks will be used or disclosed. The following categories describe the different ways that the Plan uses and discloses your PHI. Not every use or disclosure within category is listed, but all uses and disclosures fall into one of the following categories.

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

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

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

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

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

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

4. **Treatment.** The Plan does not provide treatment. The Plan may use or disclose PHI for treatment purposes. This includes helping providers coordinate your healthcare. For example, a doctor may contact The Plan to ensure You have coverage or, in an emergency situation, to learn who are Your other providers or to contact Your family members if You are unable to provide this information.
5. **Disclosures to the Plan Sponsor (Your Employer).** The State of Minnesota, or your participating employer, is the Plan Sponsor. The Plan may disclose Your PHI to them to the extent necessary to administer the Plan. These disclosures may be made only to designated personnel at the administrative units of the Employer, usually the benefits department or Your Human Resources department, and will be limited to the disclosures necessary for Plan administration functions. Generally, this will include enrollment and billing information. These individuals will protect the privacy of Your PHI and will ensure that it is only used as described in this Notice and as permitted by law. Your PHI will not be used by the Employer for any employment-related actions or decisions or in connection with any other benefit plan offered by the Employer.

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

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

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

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

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

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

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

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

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

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

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

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

   e. The Plan may disclose Your PHI to a health oversight agency for activities authorized by law. The relevant agencies include governmental units that oversee or monitor the health care system, government benefit and regulatory programs, and compliance with civil rights laws. The relevant activities include conducting audits, investigations, or civil or criminal proceedings.
f. Under limited circumstances (such as required reporting laws or in response to a grand jury subpoena), the Plan may disclose Your PHI to the appropriate law enforcement officials for law enforcement purposes.

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

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

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

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

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

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

E. Your rights regarding Your Protected Health Information

You have the following rights relating to Your PHI:

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

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

3. **Right to request and receive an accounting of disclosures.** You have a right to receive a list of routine and
non-routine disclosures that Plan has made of Your PHI. This right includes a list of when, to whom, for
what purpose and what portion of your PHI has been released by the Plan and its vendors. This does not
include a list of disclosures for treatment, payment, health care operations, and certain other purposes
(such as disclosures made for national security purposes, to law enforcement officials, or correctional
facilities). If the PHI disclosed is not an “electronic health record,” the accounting will include disclosures
for the six (6) years prior to the date of your request. In this case, as noted above, the accounting is not
required to include all disclosures. If the PHI disclosed is an “electronic health record,” the accounting will
include disclosures up to three (3) years before the date of Your request. Your request for the accounting
must be made in writing. Your request must include the time frame that You would like the Plan to cover
(this may be no more than six (6) years before the date of the request). You will normally receive a
response to Your written disclosure for this accounting within 60 days after your request is received.
There will be no charge for up to one such list each year but there may be a charge for more frequent
requests. The Plan will notify You of the cost involved and You may choose to withdraw or modify Your
request at that time before any costs are incurred.
4. **Right to request restrictions.** You have the right to request that the Plan restrict how it uses or discloses Your PHI for treatment, payment, or health care operations. You also have the right to request a limit on the PHI about You that the Plan discloses to someone who is involved in Your care or the payment of Your care, like a family member or friend. The Plan will consider Your request but generally is not legally bound to agree to the request for restriction. However, the Plan will comply with any restriction request if (1) except as otherwise required by law, the disclosure is to a health plan for purposes of carrying out payment or health care operations (and is not for purposes of carrying out treatment); and (2) the PHI pertains solely to a health care item or service for which You, or another person on Your behalf, has paid the health care provider or other covered entity involved in full. Your request must be in writing. In Your request, You must tell the Plan (1) what information You want to limit; (2) whether You want to limit the Plan’s use, disclosure, or both; and (3) to whom You want the limits to apply, for example, disclosure to Your spouse. If the Plan does agree to Your restriction it must comply with the agreed to restriction, except for purposes of treating You in a medical emergency.

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

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

F. **Complaints**

If You believe Your privacy rights have been violated, You may file a complaint with the Plan, or with the Secretary of the Department of Health and Human Services. To file a complaint with the Plan, send a written complaint to the Privacy Officer listed at the end of this Notice. The Plan will not retaliate against You for filing a complaint, and You will not be penalized in any other way for filing a complaint.

G. **Contact Information for questions**

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

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

(September 2, 2017)

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

What data will we use?

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

Why we ask You for this data?

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

Do You have to answer the questions we ask?

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

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

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

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

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

How else may this data be used?

We can use or release this data only as stated in this notice or allowed under law unless You give us Your written permission to release the data for another purpose or to release it to another individual or entity. The data may also be used for another purpose if Congress or the Minnesota Legislature passes a law allowing or requiring us to release the data or to use it for another purpose.
Medicaid and the Children’s Health Insurance Program (CHIP) Offer Free or Low-Cost Health Coverage to Children and Families

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

If You or Your dependents are already enrolled in Medicaid or CHIP and You live in Minnesota, contact the Minnesota Medicaid office to find out if premium assistance is available. The telephone number is 800/657-3739; You may also go to https://mn.gov/dhs/people-we-serve/children-and-families/health-care/health-care-programs/programs-and-services/families.jsp. If You live in another state, dial 1-877-KIDS NOW or go to the Insure Kids Now Website at 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
dol.gov/agencies/ebsa
1-866-487-2365

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

Minnesota
Mn.gov/dhs/people-we-serve
651-431-2670
1-800-657-3739

Iowa
dhs.iowa.gov
1-800-972-2017

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

North Dakota
nd.gov/dhs
1-800-755-2604