
STATE OF MINNESOTA

FLEXIBLE BENEFITS AND TRANSIT EXPENSE PLAN



2017 Plan Year Summary

MINNESOTA MANAGEMENT & BUDGET DEPARTMENT
AND 121 BENEFITS

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Acronyms	
COBRA	Consolidated Omnibus Budget Reconciliation Act
DCEA	Dependent Care (Daycare) Expense Account
EIC	Earned Income Credit
EID	Employee Insurance Division
ESR	Employer Shared Responsibility
FMLA	Family Medical Leave Act
HDBA	Health/Dental Premium Account
HIPAA	Health Insurance Portability and Accountability Act
HRA	Health Reimbursement Account
HSA	Health Savings Account
HR	Agency Human Resources Representative
IRS	Internal Revenue Service
MDEA	Medical/Dental Expense Account
MMB	Minnesota Management & Budget Department
OTC	Over-The-Counter
PDA	Payroll Deduction Account
SEGIP	State Employee Group Insurance Program
TEA	Transit Expense Account
TEP	Transit Expense Plan

Introduction

What are the Flexible Benefits and Transit Expense Plans?

The State of Minnesota Flexible Benefits Plan is comprised of the following accounts:

- ◆ The Health and Dental Premium Account (HDP), which covers employee paid portions of health and dental premiums through the State Employee Group Insurance Program (SEGIP).
- ◆ Health Savings Account (HSA), which covers employee pre-tax salary contributions.
- ◆ The Medical/Dental Expense Account (MDEA), which covers eligible out-of-pocket medical, dental, vision, and over-the-counter medical expenses.
- ◆ The Dependent Care Expense Account (DCEA), which covers dependent care (daycare) expenses for qualifying dependents.

The Transit Expense Plan is comprised of the following accounts:

- ◆ The Transit Expense Plan (TEP), which covers both the Transit Expense Account for Parking (TEA-Parking) and the Bus Pass/Vanpool (TEA-Bus Pass/Vanpool) and the Payroll Deduction Account (PDA).

These accounts are administered through the Minnesota Management & Budget Department. This booklet is intended to provide a description of the Flexible Benefits Plan and the Transit Expense Plan. If you have any questions regarding these benefits, contact your Human Resource Office (HR), 121 Benefits at (612) 877-4321 or (800) 300-1672, or the State Employee Group Insurance Program (SEGIP) at (651) 355-0100.

Internal Revenue Code Section 125 governs the Flexible Benefits Plan and Internal Revenue Code Section 132 governs the Transit Expense Plan. Both of these plans are administered to comply with strict IRS regulations. The Employer's ability to offer these Plans to its employees depends upon the appropriate administration of the Plans.

Who is eligible for the plan?

Insurance-eligible employees of the State of Minnesota (as defined by your collective bargaining agreement or plan) are eligible to participate in the HDP, MDEA, DCEA, and TEA. Employees do not need to be insurance-eligible to be enrolled in the PDA. Employees whose insurance follows either the Manager's Plan or the Commissioner's Plan are eligible to enroll in the HSA. Those employees electing the HSA must also participate in the Advantage Consumer Directed Health Plan (ACDHP).

Effective July 1, 2015, participants enrolled in an MDEA will continue the account in the event of a layoff pursuant to a State or federal government shutdown. Upon returning to work, any contribution amounts not taken during the layoff will be caught up within the next feasible pay checks that occur within the same tax year. If a participant does not have enough funds to cover the deductions, the contributions will need to be submitted out of the participant's personal funds.

New employees who are insurance eligible must enroll in the MDEA and DCEA within 35 days of their employment, re-hire, or reinstatement. Coverage is effective on the 36th day of employment. Employees who become insurance eligible mid-year must enroll within 30 days of becoming eligible. Coverage is effective on the eligibility date or the first day of the pay period in which the form was received by SEGIP, whichever is later.

If you do not enroll during your new employee enrollment period for MDEA and DCEA, federal regulations require that you wait until an Open Enrollment period (usually during the month of November) for the next opportunity to participate (except for situations where you incur a “status change”). If you sign up for the plan during Open Enrollment **AND** you are on payroll on January 1, you will be able to start using the plan on January 1. If you are on an unpaid FMLA leave of absence at the start of the year and had elected an MDEA, you can begin your participation in the MDEA on January 1 by paying your MDEA premium on billing (see the **What happens if I take a leave of absence?** section).

What if I work less than a full calendar year?

If you anticipate dropping off the payroll at any time during the calendar year, you should take special care to understand how that change will affect your participation in the plan. Employees who work at educational institutions and have summers off are given special consideration under the federal guidelines. Other employees who have a portion of the year off payroll (seasonal employees) have different rules to consider. Consult with SEGIP, 121 Benefits, or your HR to understand your particular situation before enrolling.

Will my enrollment in this program automatically continue from year to year?

You are automatically enrolled in the HDEA and PDA unless you instruct SEGIP otherwise. However, for the MDEA, DCEA, and TEA **you must enroll during Open Enrollment for each plan year in which you wish to participate.**

What is the purpose of the flexible benefits and transit expense plan?

Getting the most from your paycheck—that is the idea behind the State’s Flexible Benefits Plan and Transit Expense Plan. These plans allow you to pay for the employee-paid portions of your health and dental premiums for SEGIP¹ plans, as well as certain medical, dental, dependent care (daycare) and transit out-of-pocket expenses, with money that is sheltered from taxes by deducting the funds from your pay before it is taxed. Since less of your pay is taxed, you should come out ahead at the end of the year. ***Certain rules and guidelines apply to each benefit, so be sure you fully understand the programs before you choose to participate.***

¹ SEGIP stands for “State Employee Group Insurance Program.”

Are there any risks involved in participating in this plan?

YES! UNDER CERTAIN CIRCUMSTANCES, YOU RISK FORFEITING PART OR ALL OF THE MONEY YOU HAVE CONTRIBUTED. In general, you will forfeit money if you do not incur enough eligible expenses to cover your contributions or if you fail to file a **complete** reimbursement request by the final deadline of the plan year. This risk of forfeiture is required by federal regulations. For more information on the forfeiture risk, see the applicable sections for the MDEA, DCEA and TEA. Under some circumstances, participants may carry over to the next plan year any unused balance in their MDEA of \$500 or less. Please see the section titled **If I have money left in my account at the end of the year, can it carry forward into the next year?**

What period does the plan cover?

This booklet is a summary of the plan as of January 1, 2017. The plan year runs January 1 through December 31. Generally, employees enroll during Open Enrollment prior to the beginning of the plan year. Employees who enroll or end their participation during the plan year due to a status change have a shorter period of coverage. An employee's period of coverage differs depending upon the type of account. For further information, see the applicable sections for the MDEA, DCEA, and TEA.

Does this plan affect my benefits from other employer benefit programs that are based on my pay?

No. All benefits from your pay-related benefit plans are based on your gross pay without regard to any salary deduction amounts under this plan.

Does this booklet describe both plans?

This booklet is a description of plan features for the Flexible Benefit Plan and Transit Expense Plan.

What if I have questions about the plan?

SEGIP, a 121 Benefits customer service representative, or your HR can help you if you have specific questions about the plan. You may also wish to consult with your tax advisor.

Would converting part of my pay to the Flexible Benefits Plan or Transit Expense Plan cause my Social Security Benefits to be reduced?

Your Social Security benefits could be affected if your taxable earnings are less than the Social Security maximum covered wages (\$118,500 in 2015). The laws affecting Social Security taxes and benefits are constantly changing, so it is difficult to predict how anyone might be affected. The decision becomes one of whether the current overall tax savings are more valuable to you than a possible reduction in Social Security benefits in the future.

Health and Dental Premium Account

As an active employee on payroll, the Health and Dental Premium Account (HDP) allows you to pay your share of MN Advantage Health Plan and State Dental Plan or State of Minnesota HealthPartners Dental Plan premiums for yourself and your qualified dependents with pre-tax dollars. You are automatically enrolled in this program when you sign up for insurance and all enrollment arrangements are made by your employer. No forms are necessary unless you choose to waive your right to this benefit and pay your premiums on a post-tax basis.

How do I take advantage of the savings?

Premiums you pay for your employer-sponsored health and/or dental insurance will be automatically deducted from your paycheck before taxes unless you waive your right to this benefit and choose after-tax premiums. You can elect to have your portion of the premiums taken after-tax by filling out a Premium Account Mid-year Change in Participation form, available on SEGIP's website (www.mn.gov/mmb/segip).

If you choose to waive pre-tax payment of your health and dental insurance premiums, the waiver will be effective until you choose to revoke it during an Open Enrollment period or following a status change (for more information about status changes, please see the section titled **What status changes allow a mid-year election change to my HDP?**).

Are dependents covered under the HDP?

Your eligibility to pay the premiums for a dependent on a pre-tax basis depends on whether or not your dependent qualifies as a dependent under Section 152 of the Internal Revenue Code and under your collective bargaining agreement or plan of employment.

You can cover your portion of eligible dependent premiums in the HDP if he or she qualifies as a dependent under Section 152 of the Internal Revenue Code by meeting *one of* the criteria listed below. In addition, dependent children, up through the end of the month in which they turn 26 are also considered eligible dependents for health insurance purposes. A child is a biological child, stepchild, foster child, adopted child, or a child placed with you for adoption.

To be considered as a dependent under Section 152, the individual must be either a "qualifying child" or a "qualifying relative." A qualifying child is an individual who meets one of the following criteria:

- Will be less than 19 years of age during the entire calendar year(s) in which coverage is provided; or
- Will be less than 24 years of age during the entire calendar year(s) in which coverage is provided and is a regular full-time student (for more information on full-time student status); or
- Is permanently and totally disabled

In addition, the following criteria must apply:

- The individual resides with you.
- The individual provides 50% or less of his/her own support.
- The individual is one of the following:
 - your child (biological, stepchild, adopted child, or child placed for adoption); or
 - your sibling (brother, sister, stepbrother, or stepsister); or
 - a descendent of your child or sibling (e.g., grandchild, great grandchild, niece, nephew).
- The individual is a citizen, national, or resident of the United States, or a resident of Canada or Mexico. (Special rules apply to adopted children.)
- The individual is younger than you.

A Qualifying Relative is an individual who meets at least one of the following criteria:

Resides with you and is part of your household; or

- Is related to you as your child, descendent of a child, sibling, parent, parent's ancestor (e.g., grandparent), step parent, niece, nephew, uncle, aunt, or in-law (son, daughter, father, mother, brother, or sister).

In addition, the following criteria must apply:

- The individual receives more than 50% of his/her support from you.
- The individual does not satisfy the requirements of Qualifying Child with respect to any individual.
- The individual is a citizen, national, or resident of the United States, or a resident of Canada or Mexico.

If during the year your dependent ceases to be a dependent, you must immediately discontinue the HDPA for your dependent.

Are there any general guidelines as to whether pre-tax premiums through this plan are better than tax deductions or tax credits on my tax return?

If you pay your premiums on a pre-tax basis through the plan, you save federal taxes, and in some situations state taxes.

How are premiums for my employer-sponsored health and/or dental insurance handled?

Your portion of the premiums for the employer-sponsored health and/or dental insurance will be withheld from your paycheck before taxes are deducted, resulting in less taxes and more income for you. For example, a single employee, Terry, makes \$28,000 per year. Terry's portion of the employer-sponsored health plan premium of \$75 per month (\$900 per year) is automatically paid through the premium account.

Sample Annual Tax Savings Comparison Single - 1 Exemption	Without the Plan	With the Plan
Gross salary	28,000	28,000
Pre-tax premiums paid	-	(900)
Adjusted gross income	28,000	27,100
Estimated income tax (2016 Federal and State)	(3,128)	(2,945)
Social Security (FICA) tax	(2,142)	(2,073)
Spendable income	22,730	22,082
Health care premiums paid after tax	(900)	-
Spendable income after taxes and health care premiums	21,830	22,082

Using this account to pay health plan premiums on a pre-tax basis increases Terry's spendable income by \$252 a year.

Can I change my HDBA election?

You can change your participation in the HDBA each year during Open Enrollment. In addition, federal regulations allow you to make a change mid-year if you experience certain changes in status.

What status changes allow a mid-year election change to my HDBA?

According to federal rules, a status change is a change in one or more of the following categories that affect your eligibility for insurance coverage:

- Change in employee's legal marital status
 - Marriage
 - Divorce, legal separation, annulment, death of spouse
- Change in number of employee's dependents
 - Birth, adoption, or placement for adoption
 - Death of dependent
- Change in employment status of employee, spouse, or dependent *that affects insurance eligibility*
 - Part-time to full-time
 - Hourly to salary
 - Unpaid leave²
 - Family Medical Leave Act (FMLA) leave
 - Termination and rehire within 30 days (prior HDBA elections at termination are reinstated unless another event has occurred that allows a change)
 - Termination and rehire after 30 days (employee can make new HDBA elections)
 - Commencement or termination of employment by employee, spouse or dependent that triggers insurance eligibility

² In most occurrences unpaid leaves will be treated like unpaid FMLA leaves for purposes of administration.

- Event causing employee's dependent to satisfy or cease to satisfy *insurance eligibility requirements*
 - Attaining a specified age
 - Becoming single or getting married
 - Becoming or ceasing to be a student
- Change in place of residence of employee, spouse or dependent
 - If underlying insurance eligibility change occurs
- Significant cost change under spouse's plan
- Judgments, decrees or orders
- Entitlement to Medicare or Medicaid
- Significant curtailment of coverage or loss of coverage under another benefit package option; e.g., when there is an overall reduction in coverage, generally *not the loss of one physician in a network*
- Addition or significant improvement of benefit package option
- Change in coverage of spouse or dependent under other employer's plan
- Open Enrollment under plan of another employer
- Loss of Other Insurance Coverage
- Health Insurance Portability and Accountability Act (HIPAA) special enrollment rights
The group health plan has special HIPAA enrollment periods for certain individuals. These individuals include those who are eligible for coverage but did not enroll due to a pre-existing coverage under another health plan during Open Enrollment and individuals who become dependents through marriage, birth, adoption, or placement for adoption.
- COBRA event
- Loss of coverage under group health plan of governmental or educational institution (state's children's health insurance program, medical care program of an Indian tribal government, state health benefits risk pool, or foreign government group health plan)
You must request enrollment within 60 days in these situations.
- Qualified Medical Child Support Orders
In certain circumstances you may be able to enroll a child in the Plan if the Plan receives a Qualified Medical Child Support Order (QMCSO) and/or National Medical Support Notice.
- The Plan has been amended to allow participants to change their elections to make salary reduction contributions to purchase group medical coverage in the following situations:
 - (a) If you have made an election to pay for group medical coverage through the Plan, you may *revoke* that payment election if the following conditions are satisfied:
 - (i) You have been in an employment status under which you were reasonably expected to average at least thirty (30) hours of service per week;
 - (ii) You have experienced a change in employment status such that after that change you will reasonably be expected to average less than thirty (30) hours of service per week (but you nevertheless will remain eligible for group medical coverage);

(iii) You cancel your group medical coverage in accordance with the requirements of that plan; and

(iv) You represent to the State of Minnesota that you, and any related individuals who were also enrolled in the group medical coverage, have enrolled or intend to enroll in other medical coverage that provides minimum essential coverage and that other coverage will be effective no later than the first day of the second month following the month in which your group medical coverage under the Employer's plan ends.

(b) If you have made an election to pay for group medical coverage through the Plan, you may **revoke** that payment election if the following conditions are satisfied:

(i) You are eligible to enroll in a qualified health plan through the Marketplace (i.e., a public exchange) via a special enrollment period (in accordance with the Marketplace's enrollment rules) **OR** you seek to enroll in a qualified health plan through the Marketplace during the Marketplace's annual open enrollment period;

(ii) You cancel your group medical coverage in accordance with the requirements of that Plan; and

(iii) You represent to the State of Minnesota that you, and any related individuals who were also enrolled in the group medical coverage, have enrolled or intend to enroll in a qualified health plan through the Marketplace and your Marketplace coverage will be effective no later than the day immediately following the last day for which the State of Minnesota's group medical coverage was effective (i.e., you will not have a break in coverage).

(c) If you have made an election to pay for group medical coverage through the Plan, you may **reduce** that payment election if the following conditions are satisfied:

(i) Your spouse and/or dependents are eligible to enroll in a qualified health plan through the Marketplace via a special enrollment period (in accordance with the Marketplace's enrollment rules) **OR** your spouse and/or dependents seek to enroll in a qualified health plan through the Marketplace during the Marketplace's annual open enrollment period; and

(ii) You cancel group medical coverage (in accordance with the requirements of that plan) for your spouse and/or dependents who are enrolling in a qualified health plan through the Marketplace; and

(iii) You request a reduction in your premium payment election corresponding to the premium reduction caused by the cancellation of coverage for your spouse and/or dependents who are enrolling in a qualified health plan through the Marketplace; and

(iv) You represent to the State of Minnesota that your spouse and/or dependents have enrolled or intend to enroll in a qualified health plan through the Marketplace and their Marketplace coverage will be effective no later than the day immediately following the last day for which their group medical coverage under the State of Minnesota's plan was effective (i.e., they will not have a break in coverage).

Unless they conflict with the provisions described above, the Plan's general rules regarding election changes as described in the Summary, including the rule regarding the prospective effective date of an election change, shall remain in full force and effect. Furthermore, the State of Minnesota will administer these new election change rules in accordance with all applicable guidance issued by the Internal Revenue Service.

If you have a status change and want to change your HDPA election, please contact SEGIP or see your HR. In most situations, you must return the applicable form within 30 days of the event. Coverage under the HDPA for marriage is effective no earlier than the marriage date. Coverage under the HDPA for birth, adoption, or placement of adoption is effective retroactive to the date of birth, adoption, or placement for adoption if enrollment occurs within 30 days of the birth or adoption.

Health Savings Accounts

The Plan includes the establishment of a Health Savings Account (HSA). Employees whose insurance follows either the Manager's Plan or the Commissioner's Plan are eligible to enroll in the HSA. However, in order to participate in the HSA, employees must elect the Advantage Consumer-Directed Health Plan (ACDHP) as their medical insurance plan. The HSA will be credited with contributions made by both yourself and the State and payments made on your behalf will reduce the available balance in the account. Once this plan is elected, contributions are directed to the HSA that is established in your name at a financial institution selected by your health insurance administrator.

Any balance remaining in your HSA at the end of the Plan Year is carried forward and can be used for eligible expenses in a subsequent Plan Year. The HSA is employee owned and it goes with you if you retire or otherwise leave State employment. In addition, you may modify your election to either begin to contribute or adjust the amount being contributed to the HSA at any time as long as the change is effective prospectively (i.e., after the request for the change is received). The Plan Administrator may place additional restrictions on the election of HSA contributions.

Medical/Dental Expense Account

The Medical/Dental Expense Account (MDEA) allows you to pay for certain unreimbursed medical, dental, vision, and over-the-counter expenses with up to \$2,600 of pre-tax dollars. You participate in the program by enrolling during Open Enrollment. New employees must enroll within 35 days of their employment, re-hire, or reinstatement, or within 35 days of the print date of their enrollment packet. Employees who become insurance eligible mid-year must enroll within 30 days of becoming eligible or within 30 days of the print date of their enrollment packet. You must enroll each year during Open Enrollment for each plan year in which you wish to participate. **There is a minimum annual enrollment amount of \$100 in the MDEA.**

When you enroll in this account, you must decide how much of your wages for the year you wish to contribute to this account to pay for medical, dental, vision or over-the-counter expenses that would otherwise be paid out of your pocket. These expenses may be for your spouse and other tax-qualified dependents as well as for yourself. **Plan your amount carefully since the amount elected is an irrevocable election for the plan year.**

The funds you contribute to the MDEA will be deducted before taxes, and will be deducted in equal semi-monthly amounts from the first two paychecks you receive in a month throughout the year. When there is a third paycheck in a month, no deduction is taken.

As you incur eligible medical, dental, vision, and over-the-counter expenses for yourself, your spouse, and your qualified dependents, you can either use your debit card to instantly pay for eligible expenses or submit a claim for reimbursement by filling out a *Reimbursement Request Form* or completing the form on-line at www.121benefits.com. A reimbursement check will be mailed to your home or deposited directly in your bank account if you have signed up for direct deposit. (For specific information on reimbursements, see the section titled **How do I submit requests for reimbursement?**)

What dependents are covered under the MDEA?

You may cover expenses for eligible dependents in the MDEA if he or she qualifies as a dependent under Section 152 of the Internal Revenue Code by meeting *one of* the criteria listed below. In addition, expenses for dependent children, up through the calendar year in which they turn 26, can also be submitted for reimbursement. A child is a biological child, stepchild, foster child, adopted child, or a child placed with you for adoption.

To be considered as a dependent under Section 152, the individual must be either a “qualifying child” or a “qualifying relative.” A qualifying child is an individual who meets one of the following criteria:

- Will be less than 19 years of age during the entire calendar year(s) in which coverage is provided; or

- Will be less than 24 years of age during the entire calendar year(s) in which coverage is provided and is a regular full-time student (for more information on full-time student status, see the attached page); or
- Is permanently and totally disabled

In addition, the following criteria must apply:

- The individual resides with you.
- The individual provides 50% or less of his/her own support.
- The individual is one of the following:
 - your child (biological, stepchild, adopted child, or child placed for adoption); or
 - your sibling (brother, sister, stepbrother, or stepsister); or
 - a descendent of your child or sibling (e.g., grandchild, great grandchild, niece, nephew).
- The individual is a citizen, national, or resident of the United States, or a resident of Canada or Mexico. (Special rules apply to adopted children.)
- The individual is younger than you.

A Qualifying Relative is an individual who meets at least one of the following criteria:

- Resides with you and is part of your household; or
- Is related to you as your child, descendent of a child, sibling, parent, parent's ancestor (e.g., grandparent), stepparent, niece, nephew, uncle, aunt, or in-law (son, daughter, father, mother, brother, or sister).

In addition, the following criteria must apply:

- The individual receives more than 50% of his/her support from you.
- The individual does not satisfy the requirements of qualifying child with respect to any individual.
- The individual is a citizen, national, or resident of the United States, or a resident of Canada or Mexico.

If during the year your dependent ceases to be a dependent, you must immediately discontinue requesting MDEA reimbursements for your dependent.

Special rule for divorced parents

If both parents together provide more than 50% of his or her support, the individual can qualify as a dependent.

What expenses qualify for pre-tax reimbursement under the MDEA?

This account enables you to be reimbursed for eligible out-of-pocket medical, dental, vision, and over-the-counter expenses incurred by you and your tax qualified dependents. Eligible expenses are *generally* those permitted by Section 213(d) of the Internal Revenue Code; that is, expenses which would qualify as a deductible expense on your income tax return. Remember that not all items listed in Section 213(d) are reimbursable under the MDEA (e.g. insurance premiums). In addition, the following conditions must apply:

- You cannot be reimbursed for the expense by **any** insurance plan or in **any** other manner
- You cannot deduct the expense on your income tax return
- You cannot be reimbursed for long-term care expenses
- You cannot be reimbursed for the cost of other health care coverage
- The expense must be incurred during your period of coverage

Here are some examples of expenses that may be reimbursed from your MDEA:

Deductibles and co-payments (not premiums) from SEGIP medical or dental plans	
Orthopedic shoes/arch supports	Orthodontia and other dental expenses
Hearing aids	Transportation expenses for medical care
Chiropractic services	Nursing care
Chemical dependency services	Medical equipment and supplies
Prescription drugs	Wheelchairs
Ambulance service	Prescription eyeglasses or contact lenses
Psychiatric care	Contact lens cleaning solutions and supplies
Over-the-counter drugs to treat a medical condition	

The following expenses are specifically excluded from reimbursement:

- Air Conditioners (wall units or central air systems)
- Whirlpools
- Gym Memberships
- Veneers

Please see the *MDEA Worksheet* and the list of *Over-The-Counter Drugs* at www.121benefits.com.

Guidelines Effective January 1, 2011. Federal Health Care Reform changed how and what type of over-the-counter (OTC) drugs can be reimbursed through the MDEA. The MDEA will not reimburse OTC medicine (except insulin) without a prescription. This change did not impact the eligibility for reimbursement of OTC supplies (e.g., saline solution or bandages) and these continue to be eligible under the MDEA.

When is an expense incurred?

You incur an expense on the date that the service is received or product is ordered, not when you receive or pay the bill or receive the product. An exception to this rule is for advance payments for orthodontia before the services are provided. These payments can be reimbursed only when the advance payments are made in order to receive the services.

What is my period of coverage?

If you enroll during Open Enrollment, your period of coverage under the MDEA begins on January 1 if you are on payroll and not on an unpaid leave of absence. If you are on an unpaid FMLA leave of absence *and* elected MDEA at Open Enrollment *and* have elected *and* paid your January premium, your period of coverage will begin January 1. If you enroll mid-year, your period of coverage begins on the event date or the date you enroll, whichever is later. The IRS prohibits retroactive enrollments. Your period of coverage continues through the calendar year if you continue participation in the plan. If you terminate participation prior to the end of the plan year, your period of coverage ends on your termination date.

Are insurance premiums eligible for pre-tax reimbursement under this account?

No. Insurance premiums are not eligible for reimbursement from the MDEA. Remember that health and dental premiums deducted from your check are already taken pre-tax through the HDPA. The IRS prohibits insurance premiums from being reimbursed through an MDEA.

A special note about parental fees

These are expenses paid for health insurance coverage for a disabled child. The rules of the plan prohibit reimbursement of these fees from the MDEA.

Can I change the amount I am contributing to the MDEA during the year?

Generally, no—you cannot begin, stop, or change your election during the year. The election you make during Open Enrollment is irrevocable and you must decide at that time how much you wish to contribute to your MDEA for the upcoming year. However, there are some exceptions to this irrevocability rule specified in the federal regulations that allow a change or mid-year enrollment.

What status changes allow mid-year election changes?

According to federal rules, a status change occurs when a change in one or more of the following categories **affects eligibility for insurance coverage**:

- Change in employee's legal marital status
 - Marriage
 - Divorce, legal separation, annulment, death of spouse
- Change in number of employee's dependents
 - Birth, adoption, or placement for adoption
 - Death of dependent

- Change in employment status of employee, spouse, or dependent that affects insurance eligibility
 - Part-time to full-time
 - Hourly to salary
- Unpaid leave³
 - Return to work from unpaid leave of absence (If an MDEA election was made prior to the commencement of your unpaid leave of absence and you continued and paid your MDEA while on the unpaid leave, that original election is reinstated upon your return to work unless another status change occurred allowing an election change.)
- Termination and rehire within 30 days (The original MDEA election amount at time of termination is reinstated.)
- Termination and rehire after 30 days – employee can make new elections (The new election cannot be less than the amount the employee had contributed through payroll contributions nor less than the amount the employee had been reimbursed for eligible expenses.)
- Commencement or termination of employment by employee, spouse or dependent that triggers insurance eligibility (terminated employee may not decrease election). Coverage is revoked unless COBRA is elected.
- Event causing employee's dependent to satisfy or cease to satisfy eligibility requirements
- Attaining a specified age
- Family Medical Leave Act (FMLA) leave
- Judgments, decrees or orders
- Entitlement to Medicare or Medicaid (not Medical Assistance)

Important qualification: You may use the status change as a reason to start or adjust your contribution amount during the year if, and only if, the mid-year election change is consistent with the status change that affects eligibility for insurance coverage under the plan.

If you have an employment change that affects your insurance benefits eligibility through SEGIP, an enrollment form will be sent to you by SEGIP. If you have any other status change (e.g., marriage, birth), you can obtain a *Change in Participation Form* at www.121benefits.com. You must submit the completed form(s) to SEGIP within 30 days of the status change (30 days includes the date of the event) or, if applicable, 30 days from the print date of the enrollment paperwork. Because of payroll system limitations, SEGIP must receive election changes by December 1, 2017. **You can only make changes prospectively (going forward from the date of the event), and the change is effective on the first day of the pay period in which the form was received.**

For example, if you elect \$1,000 effective on January 1 and on June 1 get married and increase your election by \$500, you will now have a total election of \$1,500. The additional \$500 can only be used for expenses incurred from June 1 through

³ Unpaid leaves will be treated like FMLA leaves for purposes of administration.

December 31. If the status change allows a reduction in your MDEA election, your new election amount cannot be less than the amount you have been reimbursed through the plan or contributed to the plan.

Your first check to reflect the change in deductions depends, in part, on when the enrollment or change form is received by SEGIP. The effective date is the date of event or the first day of the pay period in which the form was received, whichever is later. Consult with SEGIP and review your paystub when making a change to be sure the enrollment amount is correct.

What about mid-year enrollment for new employees?

New employees who are insurance eligible must enroll within 35 days from the date of employment, re-hire, reinstatement, or from the date of your paperwork, if applicable. Employees who become insurance eligible mid-year must enroll within 30 days of becoming eligible or within 30 days from the date of the paperwork, if applicable.

How do I submit requests for reimbursement?

Eligible MDEA expenses can be reimbursed by (1) entering reimbursement requests on-line at the 121 Benefits' website, (2) completing the paper Reimbursement Request Form, or (3) using your flexible spending account debit card (the Benny card) for automatic payment at participating vendors (remember to keep receipts!).

The first option is to enter your reimbursement request online. After entering the request online, the documentation to substantiate the request can then be uploaded to the 121 Benefits' website or faxed or mailed to 121 Benefits (see below for what is acceptable documentation). All on-line claims entry must be completed, and documentation uploaded and/or sent or postmarked to 121 Benefits by the 2017 plan year deadline of February 28, 2018.

If you do not upload the documentation to the website, after checking your documents for accuracy and legibility, fax or mail them to 121 Benefits. **Be sure to keep copies of all documents submitted.** This will ensure you have adequate records to support your claim in the event of an IRS inquiry, or should your envelope be lost in the mail. **Be sure to submit all necessary documentation by February 28, 2018, which is the 2017 plan year deadline.**

If you prefer, the second option for receiving reimbursement for your eligible MDEA expenses is to complete a *Reimbursement Request Form*. *Be sure to complete the form in its entirety, making sure to sign and date it before submitting the form either via fax or mail.* Attach a statement from the provider indicating the date the service was provided, a description of the service, and the charge for the service (see below for what is acceptable documentation). Reimbursement forms are available on 121 Benefits' website (www.121benefits.com).

If you submit requests for reimbursements either on-line or using the reimbursement form, expenses will be reimbursed to you weekly. Reimbursement requests received by noon on Friday will be processed by the following Friday. If you do not receive reimbursement within two weeks of submitting your request and you have not been notified of the denial of your claim, contact 121 Benefits at (612) 877-4321 or (800) 300-1672.

The third way to access funds is to use your flexible spending account debit card (Benny card). The debit card will reimburse up to the available MDEA balance, including any carried over funds, if applicable. When the card is used, the merchant is paid the full amount of the charge (not to exceed the account balance) and your MDEA is reduced by the same amount. When you use your debit card for reimbursement, you are certifying that the debit card is being used only for eligible medical expenses for yourself and/or your eligible dependents and that the expenses paid with the card have not been and will not be reimbursed by another health plan. **You should not use the debit card to pay for expenses whose date of service is from a previous plan year, regardless of the billing date by the provider.** If you do so in error, please contact 121 Benefits Customer Service at (612) 877-4321 or toll free (800) 300-1672 for assistance.

Using the Flexible Spending Account debit card correctly

You must acquire and retain documentation for any expense paid with the debit card (e.g. itemized invoices or Explanation of Benefits statements) in case you are asked to verify the expense (per IRS Regulations). The advantage to the debit card is that you do not have to pay out of pocket and then wait for reimbursement. It does not eliminate the IRS requirement for documentation and does not make the process paperless. If you use your flexible spending account debit card for an eligible purchase and later return that item, the merchant should return the amount to that debit card. If the merchant does not credit your debit card but rather refunds you directly, you are responsible for the overpayment.

Providing debit card transaction substantiation

If 121 Benefits requires additional information regarding a debit card purchase, 121 Benefits will send you a letter requesting additional information. You will have 30 days to respond to 121 Benefits' request. If 121 Benefits does not receive a response from this first inquiry, a second request will be sent to you. You will be given an additional 14 days to respond to 121 benefits' second request. If you do not respond to this second request, your debit card will be de-activated. To have the debit card reactivated, you must respond to 121 Benefits' letter and supply the requested information. Note: **do not** submit debit card documentation on a reimbursement request form. This form is only to be used for expenses that have not previously been reimbursed from the account.

If the requested information is not provided to 121 Benefits by the timeframes described above, you will need to either repay the amount of that debit card transaction or submit a

substitute claim to offset the amount. If it is not repaid or a substitute claim is not received, the amount will be included as taxable income on your W-2 form.

In addition, if your card is on hold for a debit card transaction and you submit a manual claim for reimbursement, your claim will automatically be used to offset the transaction for which the card is on hold (as long as the on hold transaction and the date of service on the manual claim occurred in the same plan year).

Acceptable documentation

Acceptable documentation is an itemized receipt or Explanation of Benefits (EOB) that reflects the actual date of service, description of service, and patient portion of the charges.

Please note that the following **are not** sufficient forms of documentation for most expenses: cancelled checks, copies of checks, cash register/credit card receipts, credit card statements, predetermination or estimate of insurance benefits forms, balance forward statements, and balance due statements. Cash register/credit card receipts are permissible for standard medical copay amounts and over-the-counter items as long as the provider's name, dollar amount and over-the-counter item description (if applicable) is listed on the receipt.

Should you lose your card, if it is stolen or if you need additional cards for dependents, there is a \$10.00 replacement fee for a set of two cards. This amount is deducted from your MDEA. You can also order cards (\$10.00 fee for a set of two cards) online in a dependent's name.

Over-the-Counter (OTC) Medicines

Federal Health Care Reform changed how reimbursement can be made for eligible over-the-counter (OTC) medicines. Effective January 1, 2011 the MDEA will no longer reimburse over-the-counter (OTC) medicines without a prescription. The debit card will work only in certain situations for over-the-counter prescriptions. There are three types of merchants at which the debit card can be used to purchase OTC drugs and medicines:

1. At 90% pharmacies with after-the-fact substantiation;
2. At drug stores, pharmacies, non-health care merchants that have pharmacies, and mail order or web-based merchants that sell prescription drugs if the requirements described below are satisfied; and
3. At vendors having healthcare related merchant codes (other than merchants described in #2).

When purchasing a prescribed OTC drug or medicine with the debit card from a merchant described in #2 the following conditions must be satisfied:

1. The cardholder must present the prescription to the pharmacist;

2. The pharmacist must assign a prescription number and dispense the OTC drug or medicine in accordance with applicable law;
3. The pharmacy must retain a record of the transaction, including the patient name on the prescription, prescription number, date, and the amount of the purchase;
4. The pharmacy's records must be accessible by the employer, agent, and/or flexible benefits vendor;
5. The debit card system must not allow OTC drugs or medicines without a prescription number; and
6. The debit card system must meet current IRS requirements which limit the use of the debit card to only tax-qualified medical care expenses.

If these requirements are met, the debit card transaction will be considered fully substantiated at the time and point-of-sale. If these requirements are not met, then the debit card cannot be used to purchase an OTC drug or medicine from a merchant described in #2 unless the merchant is a 90% pharmacy and the expense is substantiated by submission of claim documentation after the purchase has been made.

Other over-the-counter medicine reimbursements must be made using either the paper reimbursement form or by completing the on-line request for reimbursement through the 121 Benefits' website. A copy of the doctor's prescription must accompany either method.

How are expenses paid through the MDEA?

When you incur an eligible medical, dental, vision, or over-the-counter expense and submit the claim to 121 Benefits, payment will be deducted from your account.

The plan will pay the lesser of:

- The amount of the expense you are submitting, or
- The total amount you have elected to contribute to your MDEA for the year (plus applicable carry over funds), reduced by any previous claims paid from the account during the plan year.

Is there a minimum reimbursement request amount?

If you are submitting requests for reimbursement either on-line or using the reimbursement form, there is a minimum reimbursement amount of \$50.00. The debit card has no minimum reimbursement amount. This minimum does not apply to reimbursements on or after December 31 for the plan year just ended. **There is no need to wait until the end of the year to submit reimbursement requests.** The entire amount for which you enrolled is available from the first day of your participation during the plan year.

Can I get cash out of my account for reasons other than expense reimbursement?

No. Under federal rules, you can only get money out of the account for reimbursement of eligible expenses. In addition, amounts deposited in one account cannot be used to reimburse expenses from another account.

What is the last date I can submit a request for reimbursement?

The deadline for submitting reimbursement requests towards the 2017 plan year, whether submitted by mail, fax, online, or in person is **February 28, 2018**. **All reimbursement requests must be entered with documentation uploaded and/or paper claims successfully faxed or postmarked by this date.** Requests for reimbursement postmarked or faxes received after the deadline will not be processed. If submitting your reimbursement request on the 121 Benefits' website, after completing and submitting the reimbursement request online, follow the directions to fax or mail in your documentation. Be sure to keep a copy of your online confirmation of submission. **All necessary documentation must be submitted to 121 Benefits by the 2017 plan year deadline of February 28, 2018.**

Important Note: Over the history of the program, we have seen a few participants forfeit money because their final reimbursement request was lost in the mail. **The United States Postal Service does not guarantee delivery of first class mail. If you are submitting a reimbursement request close to the deadline, you may wish to send it via fax or certified mail to protect your investment.**

If I have money left in my account at the end of the year, can it carry forward into the next year?

Possibly. In accordance with recent IRS regulations, effective with the 2014 plan year, the MDEA includes a carryover feature. The IRS allows up to \$500 to carry over to the 2018 plan year. If you are an active participant in the 2017 MDEA plan on December 31, 2017 and contributed your full election amount, up to \$500 of unreimbursed money will carry over from your 2017 MDEA to be used in 2018. If your 2017 plan year balance is greater than \$500, any funds remaining in the 2017 account over the \$500 after the end of the run-out period on February 28, 2018 will be forfeited.

Should I be concerned about forfeiting money if I cannot claim it?

You should be fully informed of the rules and regulations so that your risk of forfeiture is minimized. In addition, estimating your expenses carefully should help you avoid forfeitures. However, even if you forfeit money, you still may come out ahead. For example, if you would otherwise pay 30 percent in federal, state, and social security taxes, it is fair to say that you save 30 percent on any expenses you pay with pre-tax dollars through this plan. Therefore, if you deposit \$1,000 into your account and you forfeit \$100, you are still \$200 ahead because you have saved approximately \$300 in taxes.

What happens to forfeited money?

IRS rules allow forfeited funds to be used by the employer to help offset the expense of administering the plan. 121 Benefits, the administration firm, does not profit from forfeitures.

What if I terminate employment during the year and still have money left in my account?

If you terminate employment during the year, your period of coverage under the MDEA will end on your termination date. Expenses incurred only during your period of coverage can continue to be submitted for reimbursement until the final filing deadline of the plan year. Expenses incurred after your termination date will not be reimbursed unless you elect to make additional contributions to your account on an after-tax basis.

Federal regulations (COBRA), allow you to continue participation in the MDEA by electing to continue contributions to the plan through monthly payments, on an after-tax basis. You will receive notification of your right to continue and how to make the appropriate election upon termination of employment.

What rules apply if I choose to continue participating in the MDEA after ending my employment with the State of Minnesota?

1. You must be qualified. The following people qualify for continuation:

- An employee (and any covered dependents) whose coverage would otherwise end due to: (1) termination of employment for a reason other than gross misconduct, or (2) a discontinuance of the employee's pay, or (3) reduced hours
- An employee's surviving spouse and/or children, whose coverage would otherwise end due to the employee's death, divorce or children who lose their dependent status.

Exception: Continuation is not available to any employee, spouse, or dependent who as of the date of the status change has "overspent" the MDEA. An account is overspent when more dollars have been reimbursed than have been deducted from a participant's paycheck as of the status change.

2. You must pay the monthly cost. A person who elects continuation will be required to pay the entire cost of the continued coverage. A 2 percent surcharge may be added to each monthly contribution to help defray the administrative expenses.

3. Your continuation period is limited. Continued coverage will end on the earliest of the following dates:

- a. For qualified persons described above, the end of the plan year, December 31, (see exception below) or
- b. The end of the period for which a contribution is paid, if the required contribution is not paid on a timely basis; or
- c. The date this plan is terminated, if ever.

Exception: If you have elected to continue your coverage through the end of the year in which your employment ends, AND contributed the full election amount for the year in which you terminated, and have funds remaining in your account as of January 1 of the year following your termination, you may carryover up to \$500 of the remaining balance to the following plan year. These carried over funds may be used on dates of service within the

new plan year. In this situation, your continuation period may extend up to 18 months following your date of termination, or until the funds are depleted whichever occurs earliest.

4. Your employer will notify you. The employer must give qualified persons written notice of their continuation rights, obligations, and costs.

5. You have a limited time to decide. The period during which continuation coverage may be elected (1) must be within 60 days of the date of the qualifying event or the date of the initial notification letter, whichever is later, and (2) may not end earlier than 60 days after the coverage ends due to a qualifying event and after the qualified beneficiary receives notice of his or her continuation rights. Failure to return the election form within the stated 60-day period will result in termination of participation. The initial contribution will include the cost of coverage retroactive to the date of the status change and is payable at the time of election.

If an election is made after the status change, and within the enrollment period, the plan shall permit payment for continuation of coverage during the period preceding the election to be made within 45 days of the date of the election.

For more information concerning all of the preceding conditions, check with your HR. Should your employer become aware that any of these conditions apply to you or your tax qualified dependents, you will receive information about your rights, the cost of coverage, and other continuation matters.

Please see the end of this section for the **Formal COBRA Notice for MDEA Participants**.

What happens if I take a leave of absence or a voluntary reduction of hours?

If during the leave of absence you continue to receive regular pay, sick pay, or vacation pay from the State of Minnesota, your contributions to and coverage under the MDEA will continue.

If during the leave of absence you do not receive pay from the State of Minnesota and you want to continue your participation in the MDEA, you must elect to continue your participation. You will receive an enrollment form from SEGIP and will have 60 days to complete and return the form. Continuation will be on an after-tax basis and you will receive a monthly bill from SEGIP.

When you return to work, you can reinstate your election amount or change it due to a qualified status change. The event of returning to work is not a qualifying reason to make a change in your election. The election change must be consistent with the status change. Your deductions will be adjusted to reflect the new amount. **When you return from an unpaid leave and continued your MDEA while on unpaid leave by paying the invoices, your original election amount will be automatically reinstated and pre-tax deductions**

will begin. If you had a qualified status change and wish to change your MDEA election upon returning to work, you must complete a Change of Participation Form to adjust your election. This form must be received by SEGIP within 30 days of your return to work date.

If you did not continue your MDEA while on unpaid leave, you must complete a Change in Participation form to re-enroll in the MDEA. The Change in Participation form must be submitted within 30 days (counting your return to work date) of your return to work date OR within 30 days of the print date of your return to work paperwork. If you do not re-enroll, your period of coverage in which you can claim expenses will terminate on the date your unpaid leave started. If you continued and paid for part of the time you were on unpaid leave, your period of coverage will end at the end of the month in which you have paid. If full contributions were made while out on leave, you will have continuous coverage. MDEA payments while you are on unpaid leave are billed and paid on a monthly basis only.

If you did not continue your MDEA while on unpaid leave, your effective date will be the date you returned to work or the first day of the pay period in which the form was signed and returned to SEGIP, whichever is later. If you wish to change your election amount due to a status change, your deductions will be adjusted to reflect the new election amount.

However, if you did not continue your MDEA while on leave, you will have two separate periods of coverage during the calendar year and expenses incurred during the uncovered period (the period of your unpaid leave) will not be eligible for reimbursement. Contact 121 Benefits, SEGIP, or your HR for more information.

I have been called to active military duty. Are there any special rules for those called to active duty?

The Heroes Earnings Assistance and Relief Tax (HEART) Act added special rules for unused MDEA balances for individuals called to active duty called a Qualified Reservist Distribution (QRD). The plan can make a cash distribution to eligible employees of all or any portion of their MDEA balance. The individual must have been called to active duty for at least 180 days.

The amount that can be disbursed is the amount contributed, less any amounts already reimbursed. Requests for QRDs must be submitted to SEGIP no later than December 31, 2017. The distribution is taxable to you and will be reflected in your W-2. Every attempt to report the distribution in the W-2 of the calendar year of your request will be made.

What will happen to my MDEA when I retire?

When you retire, you can choose to continue your MDEA until the end of the year, or terminate your participation at the time you retire. If you decide to end your MDEA at retirement, your period of coverage will end on your retirement date and any unclaimed funds will be forfeited. You cannot change your annual election amount at this time, and once you have retired, you cannot enroll during Open Enrollment for the following year.

If you want to extend your participation in the MDEA when you retire

In order to avoid forfeiture of money that you have already contributed to your MDEA, you have two options: 1. You can authorize the employer to take one **aggregated pre-tax (lump sum) deduction** from your final or final full paycheck, or 2. You can elect and pay **COBRA continuation payments** until you can submit expenses for the election amount. In either case, extending your period of coverage will give you more time to incur eligible expenses, thus providing you with more opportunity to claim reimbursements from your account. If you elect to either take a lump sum deduction or pay COBRA payments through the balance of the plan year in which you retire, you may be eligible to have up to \$500 of the unused balance in your account carry over to the new plan year. In this situation, the funds may be used on dates of service up to 18 months following your retirement date, or until the funds are depleted whichever occurs earliest.

1. Aggregated Deduction

Authorizing the employer to make an aggregated deduction for the remaining amount to pay up your account in full will enable you to extend your period of coverage until the end of the plan year. Contact SEGIP one month prior to your retirement for instructions on sending a written notice authorizing an aggregated deduction. This amount will be taken as a pretax payroll deduction. A payment other than payroll deduction is not permissible.

2. COBRA Continuation of Coverage

Electing COBRA continuation will allow you to continue making payments to your MDEA on an after-tax basis to extend your period of coverage. Your period of coverage would continue on a monthly basis until continuation payments are stopped or until the end of the plan year, whichever comes first. You will receive a *Notice of Continuation Rights* from SEGIP. Your monthly contribution may be assessed a 2 percent surcharge to defray administrative expenses. (See the section titled **Formal COBRA Notice for MDEA Participants** for more information.)

Phased Retirement, Annuitant

There are special MDEA enrollment and deduction options for employees working under the Annuitant Program (AEP) or retiring under the Phased Retirement Program.

If you are working under any of these programs, you can elect to accelerate your MDEA payroll deductions over the number of pay periods for which you will be working during the plan year (January 1 to December 31). Choosing this option allows you to have MDEA coverage through the end of the plan year.

If you request accelerated MDEA deductions, you should enroll for the MDEA during Open Enrollment using a paper enrollment form. On the form, note both the program under which

you are employed (Phased Retirement or AEP) and the number of pay periods you will be employed during the plan year.

If you do not choose the above option and wish to have your period of coverage extended during the plan year when you are not working, you must continue your MDEA on COBRA and contribute towards the MDEA on a post-tax basis for the period of the plan year you are off payroll.

Regardless of the option you select, your period of coverage under the MDEA will not begin until you begin working in any given plan year.

If you had requested accelerated deductions and there is a break in your work period during the plan year, you will need to re-enroll in the MDEA upon your return to work by completing a Change in Participation form (marking the form as Phased Retirement or AEP) within 30 days of your return to work. Accelerated deductions will be reinstated. If you fail to re-enroll upon your return from work break, your coverage will terminate retroactive to when your work break began. Please call SEGIP or your HR if you have questions regarding these deductions.

If you choose to terminate your MDEA

If you decide to terminate your account, your last day of coverage is your retirement date. If you have not incurred enough expenses to meet or exceed the balance remaining in your account, those funds will be forfeited. Expenses incurred after the period of coverage has ended are not eligible for reimbursement. (Even if you have contributed money and not used it, you cannot be reimbursed for a claim that takes place after your coverage period.) To avoid forfeiture, you should consider continuing to participate in the account by authorizing an aggregated deduction or electing COBRA continuation of coverage payments (see preceding information).

Are pre-tax reimbursements through this plan better than tax deductions or tax credits on my tax return?

On your federal tax return, only your uninsured medical, dental and vision expenses in excess of 10 percent of your adjusted gross income are deductible. However, under the MDEA, up to \$2,600 of your uninsured medical, dental, vision and over-the-counter expenses can be paid with pre-tax dollars. In addition, under current law, you don't pay Social Security taxes on dollars directed to your MDEA. Therefore, if you expect to incur uninsured medical and dental expenses, paying for them through the MDEA is likely to be more advantageous than taking a deduction for those expenses on your tax return.

Who is responsible if I get reimbursed by this plan and also get reimbursed from another source and/or claim a reimbursed expense on my tax return?

You are. Duplications of reimbursements, attempts to take tax credits or deductions for reimbursed expenses, and/or filing erroneous claims constitute tax fraud, and you personally

will incur any penalties. Your employer does not monitor your personal income tax and other financial affairs, and will not attempt to do so. You should maintain adequate records to support your claims in the event of inquiry by the IRS and keep copies of all documentation sent to the plan administration firm.

What is the order of reimbursement if I have the State HRA or the Minnesota State HRA?

The State HRA will be exhausted first, then the MDEA, followed by the Minnesota State HRA, if applicable. There is a monthly administrative fee of \$2.67 that will be deducted from your State HRA balance, if applicable. Only one fee is charged if an individual has two State HRA accounts with a balance.

My spouse has a High Deductible Health Plan (HDHP) and wants to contribute to an HSA. Can I enroll in MDEA and maintain my spouse's eligibility in the HSA?

The MDEA is considered a Low Deductible Health Plan (LDHP). HSA rules require that in order to be eligible to contribute to an HSA, the individual cannot have an LDHP including an HRA or an MDEA. You can elect to have your MDEA or HRA account be limited to dental or vision expenses. This Limited MDEA or HRA allows your spouse to still maintain HSA eligibility. If you want to change your MDEA or HRA to a Limited Account contact 121 Benefits and complete the MDEA/HRA to Limited Account Change Request Form (located on 121 Benefits' website) to make this change. Note that you can only change your MDEA to a Limited MDEA during each year's Open Enrollment or prior to the start of the new plan year, but you can change your HRA to a Limited HRA at any time during the year if your spouse is enrolling in a high deductible health plan and wants to contribute to an HSA. You can change your HRA to general purpose during the year if your spouse has had a change and is no longer in a high deductible health plan and will no longer contribute to an HSA; but you cannot change your Limited MDEA to general purpose during the year. Please call 121 Benefits for details.

In addition, if your eligible dependent is employed elsewhere and is eligible to contribute to an HSA and their expenses could potentially be submitted under your or your spouse's MDEA or HRA that is not limited to dental or vision expenses through the end of the year they turn 26, your dependent is not eligible to make or receive HSA contributions.

Formal COBRA Notice for MDEA Participants

Under federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), certain employees and their families covered under this Plan will be entitled to the opportunity to elect a temporary extension of MDEA coverage (called "COBRA continuation coverage") when coverage under the Plan would otherwise end. This notice is intended to inform Plan Participants and beneficiaries, in summary fashion, of their rights and obligations under the continuation coverage provisions of COBRA, as amended and reflected in final and proposed regulations published by the Department of the Treasury. This notice is intended to reflect the law and does not grant or take away any rights under the law.

The Plan Administrator or its designee is responsible for administering COBRA continuation coverage. Complete instructions on COBRA, as well as election forms and other information, will be provided by the Plan Administrator or its designee to Plan Participants who become Qualified Beneficiaries under COBRA.

1. What is COBRA Continuation Coverage?

COBRA continuation coverage is the temporary extension of group plan coverage that must be offered to certain Plan Participants and their eligible family members (called "Qualified Beneficiaries") at group rates. The right to COBRA continuation coverage is triggered by the occurrence of a life event that results in the loss of coverage under the terms of the Plan (the "Qualifying Event"). The coverage must be identical to the coverage that the Qualified Beneficiary had immediately before the Qualifying Event, or if the coverage has been changed, the coverage must be identical to the coverage provided to similarly situated active employees who have not experienced a Qualifying Event (in other words, similarly situated non-COBRA beneficiaries).

2. Who Can Become a Qualified Beneficiary?

In general, a Qualified Beneficiary can be:

(a) Any individual who, on the day before a Qualifying Event, is covered under a Plan by virtue of being on that day either a covered Employee, the Spouse of a covered Employee, or a Dependent child of a covered Employee. If, however, an individual is denied or not offered coverage under the Plan under circumstances in which the denial or failure to offer constitutes a violation of applicable law, then the individual will be considered to have had the coverage and will be considered a Qualified Beneficiary if that individual experiences a Qualifying Event.

(b) Any child who is born to or placed for adoption with a covered Employee during a period of COBRA continuation coverage, and any individual who is covered by the Plan as an alternate recipient under a qualified medical support order. If, however, an individual is denied or not offered coverage under the Plan under circumstances in which the denial or failure to offer constitutes a violation of applicable law, then the individual

will be considered to have had the coverage and will be considered a Qualified Beneficiary if that individual experiences a Qualifying Event.

The term "covered Employee" includes any individual who is provided coverage under the Plan due to his or her performance of services for the employer sponsoring the Plan.

An individual is not a Qualified Beneficiary if the individual's status as a covered Employee is attributable to a period in which the individual was a nonresident alien who received from the individual's Employer no earned income that constituted income from sources within the United States. If, on account of the preceding reason, an individual is not a Qualified Beneficiary, then a Spouse or Dependent child of the individual will also not be considered a Qualified Beneficiary by virtue of the relationship to the individual.

Each Qualified Beneficiary (including a child who is born to or placed for adoption with a covered Employee during a period of COBRA continuation coverage) must be offered the opportunity to make an independent election to receive COBRA continuation coverage.

3. What is a Qualifying Event?

A Qualifying Event is any of the following if the Plan provided that the Plan participant would lose coverage (i.e., cease to be covered under the same terms and conditions as in effect immediately before the Qualifying Event) in the absence of COBRA continuation coverage:

- (a) The death of a covered Employee.
- (b) The termination (other than by reason of the Employee's gross misconduct), or reduction of hours, of a covered Employee's employment.
- (c) The divorce or legal separation of a covered Employee from the Employee's Spouse.
- (d) A covered Employee's enrollment in any part of the Medicare program.
- (e) A Dependent child's ceasing to satisfy the Plan's requirements for a Dependent child (for example, attainment of the maximum age for dependency under the Plan).

If the Qualifying Event causes the covered Employee, or the covered Spouse or a Dependent child of the covered Employee, to cease to be covered under the Plan under the same terms and conditions as in effect immediately before the Qualifying Event (or in the case of the bankruptcy of the Employer, any substantial elimination of coverage under the Plan occurring within 12 months before or after the date the bankruptcy

proceeding commences), the persons losing such coverage become Qualified Beneficiaries under COBRA if all the other conditions of the COBRA are also met. For example, any increase in contribution that must be paid by a covered Employee, or the Spouse, or a Dependent child of the covered Employee, for coverage under the Plan that results from the occurrence of one of the events listed above is a loss of coverage.

4. What is the Procedure for Obtaining COBRA Continuation Coverage?

The Plan has conditioned the availability of COBRA continuation coverage upon the timely election of such coverage. An election is timely if it is made during the election period.

In the case of an individual who is not a Qualified Beneficiary and who is receiving coverage under the Plan solely because of the individual's relationship to a Qualified Beneficiary, if the Plan's obligation to make COBRA continuation coverage available to the Qualified Beneficiary ceases, the Plan is not obligated to make coverage available to the individual who is not a Qualified Beneficiary.

If Timely Payment is made to the Plan in an amount that is not significantly less than the amount the Plan requires to be paid for a period of coverage, then the amount paid will be deemed to satisfy the Plan's requirement for the amount to be paid, unless the Plan notifies the Qualified Beneficiary of the amount of the deficiency and grants a reasonable period of time for payment of the deficiency to be made. A "reasonable period of time" is 30 days after the notice is provided. A shortfall in a Timely Payment is not significant if it is no greater than the lesser of \$50 or 10% of the required amount.

5. What is the Election Period and How Long Must It Last?

The election period is the time period within which the Qualified Beneficiary can elect COBRA continuation coverage under the Plan. The election period must begin no later than the date the Qualified Beneficiary would lose coverage on account of the Qualifying Event and must not end before the date that is 60 days after the later of the date the Qualified Beneficiary would lose coverage on account of the Qualifying Event or the date notice is provided to the Qualified Beneficiary of her or his right to elect COBRA continuation coverage.

Note: If a covered employee who has been terminated or experienced a reduction of hours qualifies for a trade readjustment allowance or alternative trade adjustment assistance under a federal law called the Trade Act of 2002, and the employee and his or her covered dependents have not elected COBRA coverage within the normal election period, a second opportunity to elect COBRA coverage will be made available for themselves and certain family members, but only within a limited period of 60 days or less and only during the six months immediately after their group health plan coverage ended. Any person who qualifies or thinks that he or she and/or his or her family

members may qualify for assistance under this special provision should contact the Plan Administrator or its designee for further information.

6. Is a Covered Employee or Qualified Beneficiary Responsible for Informing the Plan Administrator of the Occurrence of a Qualifying Event?

The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Plan Administrator or its designee has been timely notified that a Qualifying Event has occurred. The employer (if the employer is not the Plan Administrator) will notify the Plan Administrator or its designee of the Qualifying Event within 30 days following the date coverage ends when the Qualifying Event is:

- (a) the end of employment or reduction of hours of employment,
- (b) death of the employee,
- (c) commencement of a proceeding in bankruptcy with respect to the employer, or
- (d) enrollment of the employee in any part of Medicare,

IMPORTANT:

For the other Qualifying Events (divorce or legal separation of the employee and spouse or a dependent child's losing eligibility for coverage as a dependent child), you or someone on your behalf must notify the Plan Administrator or its designee in writing within 60 days after the Qualifying Event occurs, using the procedures specified below. If these procedures are not followed or if the notice is not provided in writing to the Plan Administrator or its designee during the 60-day notice period, any spouse or dependent child who loses coverage will not be offered the option to elect continuation coverage. You must send this notice to the Plan Administrator.

NOTICE PROCEDURES:

Any notice that you provide must be ***in writing***. Oral notice, including notice by telephone, is not acceptable. You must mail, fax or hand-deliver your notice to the person, department or firm listed below, at the following address:

Minnesota Management & Budget
SEGIP
400 Centennial Office Building
658 Cedar Street
St. Paul, MN 55155

If mailed, your notice must be postmarked no later than the last day of the required notice period. Any notice you provide must state:

- the **name of the plan or plans** under which you lost or are losing coverage,
- the **name and address of the employee** covered under the plan,
- the **name(s) and address(es) of the Qualified Beneficiary(ies)**, and
- the **Qualifying Event** and the **date** it happened.

If the Qualifying Event is a **divorce or legal separation**, your notice must include **a copy of the divorce decree or the legal separation agreement**.

Be aware that there are other notice requirements in other contexts, for example, in order to qualify for a disability extension.

Once the Plan Administrator or its designee receives ***timely notice*** that a Qualifying Event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. Each Qualified Beneficiary will have an independent right to elect COBRA continuation coverage. Covered employees may elect COBRA continuation coverage for their spouses, and parents may elect COBRA continuation coverage on behalf of their children. For each Qualified Beneficiary who elects COBRA continuation coverage, COBRA continuation coverage will begin on the date that plan coverage would otherwise have been lost. If you or your spouse or dependent children do not elect continuation coverage within the 60-day election period described above, the right to elect continuation coverage will be lost.

7. Is a Waiver Before the End of the Election Period Effective to End a Qualified Beneficiary's Election Rights?

If, during the election period, a Qualified Beneficiary waives COBRA continuation coverage, the waiver can be revoked at any time before the end of the election period. Revocation of the waiver is an election of COBRA continuation coverage. However, if a waiver is later revoked, coverage need not be provided retroactively (that is, from the date of the loss of coverage until the waiver is revoked). Waivers and revocations of waivers are considered made on the date they are sent to the Plan Administrator or its designee, as applicable.

8. When May a Qualified Beneficiary's COBRA Continuation Coverage be Terminated?

During the election period, a Qualified Beneficiary may waive COBRA continuation coverage. Except for an interruption of coverage in connection with a waiver, COBRA continuation coverage that has been elected for a Qualified Beneficiary must extend for at least the period beginning on the date of the Qualifying Event and ending not before the earliest of the following dates:

- (a) The last day of the applicable maximum coverage period.
- (b) The first day for which Timely Payment is not made to the Plan with respect to the Qualified Beneficiary.
- (c) The date upon which the Employer ceases to provide any health plan reimbursement account (MDEA) to any employee.

The Plan can terminate for cause the coverage of a Qualified Beneficiary on the same basis that the Plan terminates for cause the coverage of similarly situated non-COBRA beneficiaries, for example, for the submission of a fraudulent claim.

In the case of an individual who is not a Qualified Beneficiary and who is receiving coverage under the Plan solely because of the individual's relationship to a Qualified Beneficiary, if the Plan's obligation to make COBRA continuation coverage available to the Qualified Beneficiary ceases, the Plan is not obligated to make coverage available to the individual who is not a Qualified Beneficiary.

9. What Are the Maximum Coverage Periods for COBRA Continuation Coverage?

COBRA Continuation Coverage may extend up to 18 months. If you elect to continue coverage AND make all contributions for the plan year in which the Qualifying Event occurred AND have funds remaining in your account at the end of this plan year, the maximum coverage period for COBRA Continuation is 18 months after the Qualifying Event.

10. Does the Plan Require Payment for COBRA Continuation Coverage?

For any period of COBRA continuation coverage under the Plan, qualified beneficiaries who elect COBRA continuation coverage may be required to pay up to 102% of the applicable premium and up to 150% of the applicable premium for any expanded period of COBRA continuation coverage covering a disabled Qualified Beneficiary due to a disability extension. Your Plan Administrator will inform you of the cost. The Plan will terminate a Qualified Beneficiary's COBRA continuation coverage as of the first day of any period for which timely payment is not made.

11. Must the Plan Allow Payment for COBRA Continuation Coverage to be Made in Other Than Monthly Installments?

Yes. The Plan is also permitted to allow for payment at other intervals.

12. What is Timely Payment for payment for COBRA Continuation Coverage?

Timely Payment means a payment made no later than 30 days after the first day of the coverage period. Payment that is made to the Plan by a later date is also considered Timely Payment if either under the terms of the Plan, covered employees or Qualified Beneficiaries are allowed until that later date to pay for their coverage for the period or under the terms of an arrangement between the Employer and the entity that provides Plan benefits on the Employer's behalf, the Employer is allowed until that later date to pay for coverage of similarly situated non-COBRA beneficiaries for the period.

Notwithstanding the above paragraph, the Plan does not require payment for any period of COBRA continuation coverage for a Qualified Beneficiary earlier than 45 days after the date on which the election of COBRA continuation coverage is made for that Qualified Beneficiary. Payment is considered made on the date on which it is postmarked to the Plan.

If Timely Payment is made to the Plan in an amount that is not significantly less than the amount the Plan requires to be paid for a period of coverage, then the amount paid will be deemed to satisfy the Plan's requirement for the amount to be paid, unless the Plan notifies the Qualified Beneficiary of the amount of the deficiency and grants a reasonable period of time for payment of the deficiency to be made. A "reasonable period of time" is 30 days after the notice is provided. A shortfall in a Timely Payment is not significant if it is no greater than the lesser of \$50 or 10% of the required amount.

13. How is My Participation in the Medical/Dental Expense Account Affected?

You can elect to continue your participation in the MDEA for the remainder of the Plan Year, subject to the following conditions. You may only continue to participate in the MDEA if you have contributed more money than you have taken out in claims. For example, if you elected to contribute an annual amount of \$500 and, at the time you terminate employment, you have contributed \$300 but only claimed \$150, you may elect to continue coverage under the MDEA. If you elect to continue coverage, then you would be able to continue to receive your health care reimbursements up to the \$500. However, you must continue to pay for the coverage, just as the money has been taken out of your paycheck, but on an after-tax basis. The Plan can also charge you an extra amount (as explained above) to provide this benefit.

If You Have Questions

If you have questions about your COBRA continuation coverage, you should contact the Plan Administrator or its designee or you may contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA). Addresses

and phone numbers of Regional and District EBSA Offices are available through EBSA's website at www.dol.gov/ebsa.

KEEP YOUR PLAN ADMINISTRATOR INFORMED OF ADDRESS CHANGES

In order to protect your family's rights, you should keep the Plan Administrator informed of any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the Plan Administrator or its designee.

Dependent Care (Daycare) Expense Account

The Dependent Care Expense Account (DCEA) allows you to pay for certain dependent care (daycare) expenses with up to \$5,000 of pre-tax dollars. You participate in this program by enrolling during Open Enrollment. New employees must enroll within 35 days of employment, re-hire or reinstatement or within 35 days of the print date of their enrollment packet. Employees who become insurance eligible mid-year must enroll within 30 days of becoming eligible or within 30 days of the print date of their enrollment packet. **You must enroll each year during Open Enrollment for each plan year in which you wish to participate.**

Important Note: The DCEA is for daycare type expenses. It does **not** cover medical or dental expenses for your tax-qualified dependents. Unreimbursed medical/dental expenses for your tax qualified dependents fall under the Medical/Dental Expense Account (MDEA).

Special rules apply to children of divorced or separated parents and to married parents who are filing separate income tax returns. Persons in either of these circumstances should obtain the instructions to IRS Form 2441 and consult their tax advisor.

When you enroll in the DCEA, you decide how much of your wages you wish to direct to this account to pay your dependent care (daycare) expenses while you are at work. There is a \$5,000 **family maximum** per tax year. The amount you contribute to the DCEA will be deducted in equal semi-monthly amounts from the first two paychecks you receive in a month throughout the year. When there is a third paycheck in a month, no deduction is taken. **There is a minimum annual enrollment amount of \$100 in the DCEA.**

As you incur eligible dependent care (daycare) expenses, fill out a *Reimbursement Request Form* (found on 121 Benefits' website, www.121benefits.com), itemize your expenses including the name and Tax ID# of your dependent care provider (or social security number for an in-home provider), and have the provider sign the form or receipt and either enter the information online, scan and upload the documentation or fax or mail it to 121 Benefits. A reimbursement check will be mailed to your home or deposited directly in your bank account if you have signed up for direct deposit. (See the section titled **How do I submit requests for reimbursement?**)

Who is a qualified dependent under the DCEA?

A qualified dependent would include **either:**

- Your dependent (including adopted) children who are under age 13 and with respect to whom the participant is entitled to a tax deduction under Internal Revenue Code Section 152(a)(1); **or**
- Your spouse and/or dependents who are physically or mentally unable to care for themselves and who regularly spend at least eight hours per day in your household.

In addition, a qualified dependent must meet both of the following conditions:

1. Your home is the dependent’s “principal abode” for more than one half of the year.

Special rule for child of divorced or separated custodial parent. The child of a divorced or separated employee who has custody (more than 50% of the time) of the child is treated as a qualifying child of the employee.

2. He or she must be a citizen or resident of the United States or a resident of Canada or Mexico.

The qualified dependent cannot be the qualified dependent of any other taxpayer in the taxable year.

How much would the plan’s tax savings increase my take-home pay?

Let’s say a married employee, Pat, files jointly, and has a salary of \$44,000 per year with two children. Pat’s spouse also works and earns an annual salary of \$38,000. Pat elects to contribute a total of \$5,000 per year (\$208.33 from each of 24 paychecks) to her DCEA. And, let’s say Pat gets reimbursed for expenses equal to the amount Pat contributes during the year. The chart below illustrates Pat’s savings under the plan.

Sample Annual Tax Savings Comparison		
	Without the Plan	With the Plan
Gross salary	\$ 82,000	\$ 82,000
Pre-tax Dependent Care contribution	-	(5,000)
Adjusted gross income	82,000	77,000
Estimated income tax (federal and MN based on 2016 rates)	(10,178)	(9,075)
Social Security (FICA) tax	(6,273)	(5,891)
Spendable income	65,549	62,034
Dependent care expenses paid after tax	(5,000)	-
Spendable income after taxes and dependent care expenses	60,549	62,034

Using the plan to pay dependent care (daycare) expenses on a pre-tax basis increases Pat’s spendable pay by \$1,485 per year. However, please note that without the plan, Pat would be eligible for a dependent care credit on her income tax return, and the tax advantages of the credit may outweigh the tax advantages of being reimbursed for dependent care expenses on a tax-free basis under this plan. See IRS Publication 503 *Child and Dependent Care Expenses* and/or consult with your tax advisor.

What dependent care (daycare) expenses qualify?

The expenses must be necessary to permit you to be gainfully employed. If you are married, your spouse must be working in a job for pay or actively seeking employment, or be a full-time student, or be physically or mentally unable to care for himself/herself.

Expenses incurred while you are on paid leave, such as maternity leave, may be eligible for reimbursement under the plan if you are physically unable to care for your children while on such a leave.

The cost associated with kindergarten is generally not allowable since it is educational. Summer programs may be eligible for reimbursement under the plan as long as they are for custodial care. In general, if the institution providing the services documents them as *education*, they are not eligible. (A tuition charge on a bill will be deemed an educational expense.) If the institution provides you with documentation separating educational from other expenses, the child care expenses will be eligible. Be sure to consult with 121 Benefits if you have any questions about this issue. The cost of schooling for first grade or higher is not eligible for reimbursement under the plan. However, the cost of care provided before and after school is eligible.

If you have a regular dependent care (daycare) arrangement where you must pay a set weekly amount, even if you or your dependent are on vacation or are ill and your dependent is not receiving care, you may include those payments as an eligible expense under the plan. Expenses incurred for summer day camps are eligible as long as they are custodial in nature and not educational. Summer camp expenses involving any overnight stays are not eligible.

Only eligible expenses you incur during the plan year can be reimbursed.

When should I start, or increase contributions to, my DCEA for an expected baby?

This is an important question. If you or your spouse is pregnant during the Open Enrollment period, or if you or your spouse is a new hire, it is best *not* to include anticipated expenses for the child in your election. This holds true for an adoption as well. **Wait to enroll in, or increase contributions to, a DCEA when the mother returns to work or the adoption takes place.**

Often times, parents find that their needs and plans change in unanticipated ways after the birth of a baby or adoption. For example, the mother may not return to work as soon as expected. If this happens to you, and deductions are already coming out of your check, you may not be able to change your election and may end up forfeiting money. Call 121 Benefits or talk to your HR if you have questions about this.

When is an expense incurred?

You “incur” an expense on the date that the service is received, not when you receive or pay the bill.

What is my period of coverage?

If you enroll during Open Enrollment, your period of coverage under the DCEA begins on January 1 if you are on payroll and not on an unpaid leave of absence. If you enroll mid-year, your period of coverage begins on the event date or the first day of the pay period in

which the form is signed and received by SEGIP, whichever is later. Your period of coverage ends on December 31 whether or not your deductions continue until the end of the year.

What is the maximum amount of dependent care expenses that may be reimbursed through the DCEA?

The calendar year maximum for this plan is \$5,000 in dependent care (daycare) expenses for one or more dependents. This is a family maximum set by the IRS, so if your spouse also participates in a dependent care expense account, your \$5,000 maximum must be reduced by your spouse's dependent care contribution for the year.

If you are married and you and your spouse file separate federal income tax returns, not more than \$2,500 of dependent care expense reimbursements for services provided during the year will be exempt from your tax. Any excess must be declared on your tax return as taxable income.

If you are married, reimbursements from your DCEA that exceed the earnings of the lower-paid spouse for the year must be reported as taxable income for that year. For example, if you receive \$3,600 of dependent care reimbursements for expenses for services provided during a year and your spouse only earned \$3,000 that year, the \$600 excess must be declared as taxable income. This will be reported when you file your tax returns using Forms 1040 and 2441.

For income tax purposes, the statement you receive each time you get a reimbursement check from the plan will show the amount you actually received from your DCEA for expenses incurred during the year.

If your spouse has no earnings or low earnings for the year because he or she is a full-time student, or physically or mentally unable to care for him or herself, you may still qualify for daycare reimbursements. Your spouse will be considered to earn \$250 per month if you have one dependent receiving daycare and \$500 per month if you have two or more dependents receiving daycare for each month your spouse is a full-time student or is incapable of self-care.

Expenses that your spouse incurs while actively seeking employment are considered expenses that enable him or her to be gainfully employed. However, because of the statutory earned income limits, if your spouse does not find a job and has no earned income for the year, you may not qualify to receive reimbursements. And, if your spouse has worked for part of the year, the maximum income exclusion under the DCEA may be reduced as a result of your spouse's lack of earnings.

Here is an example: Let's say John is married to Susan, both of whom have full time jobs. John earns \$60,000 per year, while Susan makes \$35,000. They have always used John's

employer (i.e. The State) to reimburse dependent care expenses for their child. A couple of months into the new year, Susan is laid off. She looks for a new job but is not able to secure employment. At the end of the year, her earned income is only \$2,500. However, during the year, John and Susan incurred \$3,000 in child-care expenses while Susan was seeking employment and preparing resumes, contacting employers, going to job fairs, etc... Although John's DCEA allows him to be reimbursed for expenses incurred while actively looking for work, the statutory income limit nevertheless limits the amount that can be reimbursed to \$2,500.

In order to have your dependent care (daycare) expenses reimbursed on a tax-exempt basis from this plan, you will have to give the name, address, and taxpayer identification number of your provider to the IRS when you file your federal income tax form. This requirement also applies if you are taking a dependent care credit on your personal tax return.

Who qualifies as a provider of daycare?

Daycare centers and private daycare providers in your home or outside of your home qualify as a provider of daycare.

If you pay your own child to provide daycare services while you are at work, the expense will not qualify unless the child you pay is at least age 19 and you do not claim the child as a dependent on your income tax return.

If you use a daycare center that provides care for more than six individuals (excluding individuals who reside at the daycare center), the center must be licensed and comply with all applicable state and local regulations.

Can I change the amount I am contributing to my DCEA during the year?

Generally, no—you may not begin, stop, or change your contribution amount during the year. You must decide during Open Enrollment how much you wish to direct to your DCEA during the coming year. However, there are some specified status changes in the federal regulations that allow changes or mid-year enrollment status changes. Otherwise, flexible benefit enrollments are irrevocable during the plan year.

What status changes allow mid-year adjustments to my participation?

According to federal rules, a status change occurs when a change in one or more of the following categories affects eligibility for insurance coverage as described below:

- Change in employee's legal marital status
 - Marriage
 - Divorce, legal separation, annulment, death of spouse
- Change in number of employee's dependents
 - Birth, adoption, or placement for adoption
 - Death of dependent

- Change in employment status of employee, spouse, or dependent that affects eligibility
 - Part-time to full-time
 - Hourly to salary
 - Unpaid leave⁴
 - Termination and rehire within 30 days (amount of election at the time of termination must be reinstated unless another event has occurred that allows a change)
 - Termination and rehire after 30 days – employee may make new elections (the new election cannot be less than the amount the employee had contributed through payroll contributions nor less than the amount the employee had been reimbursed for eligible expenses)
 - Commencement or termination of employment by employee, spouse, or dependent that triggers insurance eligibility
- Event causing employee's dependent to satisfy or cease to satisfy dependent eligibility requirements
 - Attaining a specified age
 - Becoming single or getting married
 - Becoming or ceasing to be a student
- Family Medical Leave Act (FMLA) leave
- Significant dependent care cost increase or decrease – **Note:** No change can be made when the cost increase or decrease is imposed by a dependent care provider who is a blood relative of the employee.
- Addition or elimination of dependent care account through spouse's plan
- Change in coverage of spouse or dependent under other employer's plan (dependent care account)

If you have an employment change that affects your insurance benefits eligibility through SEGIP, an enrollment form will be sent to you by SEGIP. If you have any other kind of status change, you must obtain a *Change in Participation Form* from www.121benefits.com. You must submit the completed form(s) to SEGIP within 30 (the 30 days includes the event date) days of the status change date. Because of payroll system limitations, election changes must be received by SEGIP by December 1, 2016. You can only make changes prospectively (going forward from the date of the event).

Your first check to reflect the change in deductions depends, in part, on when the change form gets to SEGIP. The effective date is the date of the event or the first day of the payroll period in which the form was received, whichever is later. Consult with SEGIP or your HR and check your pay stub when making a change to be sure the enrollment amount is correct.

What about mid-year enrollment for new employees?

New employees who are insurance eligible must enroll within 35 days of employment, re-hire, or reinstatement. Employees who become insurance eligible must enroll within 30 days

⁴ Unpaid leaves will be treated like FMLA leaves for purposes of administration.

of becoming eligible. The effective date of coverage is prospective. Retroactive enrollment is prohibited.

How do I submit requests for reimbursement?

Eligible DCEA expenses can be reimbursed by (1) entering a reimbursement request on-line at the 121 Benefits' website or (2) completing the Reimbursement Request Form located on 121 Benefits' website, www.121benefits.com.

Enter your reimbursement request online and either upload the documentation to their website or fax or mail the documentation to 121 Benefits. If you do not upload the documentation to the website, after checking your documents for accuracy and legibility, fax or mail them to 121 Benefits. Be sure to keep copies of all documents submitted. All on-line claims entry must be submitted, and documentation uploaded and/or sent or postmarked to 121 Benefits by the 2017 plan year deadline of February 28, 2018.

If you prefer, you may receive reimbursement for your eligible DCEA expenses by completing a *Reimbursement Request Form*. *Be sure to complete the form in its entirety, making sure to sign and date it before submitting the form.* Have the provider complete the *Provider Signature* section of the form or attach an itemized statement from the provider. The Reimbursement Request Form along with documentation can be faxed or mailed to 121 Benefits.

Be sure to keep copies of all documents submitted. This will ensure you have adequate records to support your claim in the event of an IRS inquiry, or should your envelope be lost in the mail.

Be sure to submit all necessary documentation so that it is postmarked or received by fax by February 28, 2018 which is the 2017 plan year deadline.

You cannot be reimbursed for daycare expenses until after expenses have been incurred (after the end of the week or month for which you are submitting expenses). Reimbursements will be made weekly. Reimbursement requests received by Friday at noon will be processed by the following Friday.

What is the last date I can submit requests for reimbursement?

Your final reimbursement request for expenses incurred during the 2017 plan year ***must be postmarked or received by fax on or before February 28, 2018.*** Requests for reimbursement postmarked or faxes received after the deadline will not be processed and any **money remaining in your account will be forfeited** as required by federal law.

Important Notice: Over the history of the program we have seen a few participants forfeit money because their final reimbursement request was lost in the mail. The United States Postal Service does not guarantee delivery of first class mail. If you are submitting a

reimbursement request close to the deadline, you may wish to send it via certified mail or fax to protect your investment.

How are dependent care expenses paid through the DCEA?

When you incur an eligible dependent care expense and submit the claim to 121 Benefits, you will be reimbursed from your account.

The plan will pay the lesser of:

- The amount of the expense you are submitting, or
- The total amount that has been contributed to your DCEA to date, reduced by any previous claims paid from the account during the plan year.

If there is not enough money in your DCEA to pay all the expenses you have submitted during a payment period, the excess expenses will be carried forward and paid from the deposits you make in subsequent periods. Remember that in the months of the year when employees receive a third paycheck, there are no deductions taken from the third check.

Can dependent care expenses be paid with the debit card?

No, the debit card may only be used to pay for eligible expenses of the MDEA.

Is there a minimum reimbursement request amount?

There is a minimum reimbursement amount of \$50.00. This minimum does not apply to reimbursements on or after December 31st for the plan year just ended. **There is no need to wait until the end of the year to submit reimbursement requests.**

Can I get cash out of my account for reasons other than expense reimbursement?

No. Under federal rules, you may only get money out of the account for reimbursement of eligible expenses. Also, amounts deposited in one account cannot be used to reimburse expenses from another account.

If I have money left in my account at the end of the year, can I carry it forward into the next year?

No. Expenses incurred during one plan year cannot be reimbursed with money contributed in another plan year. Furthermore, according to federal law, any funds remaining in your account at the close of the plan year will be forfeited. (See the section titled **What is the last date I can submit a request for reimbursement?** for more detail regarding the final deadline.)

Should I be concerned about forfeiting money if I can't claim it?

You should be fully informed of the rules and regulations so that your risk of forfeiture is minimized. In addition, estimating your expenses carefully should help you avoid forfeitures. However, even if you forfeit money, you still may come out ahead. For example, if you would otherwise pay a total of 30 percent in federal, state, and social security taxes, it's fair to say that you save 30 percent on any expenses you pay with pre-tax dollars

through this plan. Therefore, if you deposit \$1,000 into your account and you forfeit \$100, you're still \$200 ahead because you've saved approximately \$300 in taxes.

What happens to forfeited money?

Forfeited money is used by your employer to help offset the expense of administering the plan. 121 Benefits, the administration firm, does not profit from forfeitures.

What if I terminate employment during the year and still have money left in my account?

If you terminate employment while participating in a DCEA and you have money in your account, you may continue to submit reimbursement requests for eligible expenses until the final deadline of the plan year, whether they were incurred before or after your termination date. (You may not, however, be reimbursed for expenses incurred before the beginning of your period of coverage.) No new contributions may be made to the account. Any money remaining in the account after the last processing cycle will be forfeited.

What will happen to my DCEA when I retire?

If you have money in your account when you retire, you will be able to continue to submit expenses for reimbursement for the remainder of the plan year, even after you are off payroll. Your contributions will cease with your last paycheck, but your period of coverage will continue until December 31. Once you have retired, you cannot enroll during Open Enrollment for the following year.

What happens if I take a leave of absence?

If during the leave of absence you continue to receive regular pay, sick pay or vacation pay from the State of Minnesota, your contributions to and coverage under the DCEA will continue. You may discontinue DCEA contributions during the leave if your dependent care expenses during that time would not qualify for reimbursement. To discontinue DCEA contributions during your paid leave, please complete a Change in Participation form found on the 121 Benefits' website.

If during the leave of absence you do not receive pay from the State of Minnesota, your participation under the plan will be terminated. Therefore, your contributions under the DCEA will cease, but you may continue to submit eligible expenses, as long as the expenses were incurred while you were at work.

Anytime you return from an unpaid leave, you must complete a Change in Participation Form to re-enroll in the DCEA.

You may resume your participation in the DCEA by submitting the Change in Participation Form within 30 days of returning to work or within 30 days of your status change (the 30 days includes your return to work date or your status change date). At this time, you will be able to change your election amount, if necessary. Please see the section titled **What status changes allow mid-year adjustments to my participation?** for more information on changes to participation. Call SEGIP, 121 Benefits, or your HR with questions.

Are there any general guidelines as to whether pre-tax reimbursements through this plan are better than tax deductions or tax credits on my tax return?

Due to the increasing complexity of the federal and state tax codes, deciding which of these two options is most advantageous is a very complex issue. Generally, *the more taxable income a person has, the greater the likelihood that the DCEA will result in the greatest tax advantage.* However, there are other factors to consider, such as the number of eligible dependents you have, or the amount of qualifying dependent care expenses you incur. If you have one eligible dependent, up to \$3,000 of qualifying expenses may be used to calculate the credit, alternatively, you could set aside up to \$5,000 in the DCEA. If you have two or more eligible dependents, up to \$6,000 of qualifying expenses may be used to calculate the credit, while you can still only set aside up to \$5,000 in the DCEA. See the *DCEA Worksheet* located at 121 Benefits' website.

Your own tax advisors should be consulted to help you determine whether the tax credit or paying dependent care expenses through the plan on a pre-tax basis is better for you. Your employer is not permitted to give advice about personal income tax matters.

A detailed explanation of how dependent care expenses may be used for federal tax credit purposes can be found in IRS Publication 503. You can obtain a copy of this publication from your local IRS office, the library or perhaps from your accountant or tax preparer.

What is the federal dependent care tax credit? Can I use it as well as this plan for dependent care expenses?

This tax credit is a percentage of your eligible dependent daycare expenses, up to \$3,000 per year for one dependent and \$6,000 for two or more dependents. The actual percentage depends on your income level. The credit is 35 percent of eligible expenses at \$15,000 of adjusted gross income, and reduces by 1 percent for each \$2,000 of additional income, to 20 percent at adjusted gross incomes exceeding \$43,000. The maximum combined Federal and State tax credit ranges between \$600 and \$1,770 for one dependent and between \$1,200 and \$3,540 for two or more.

You may not receive reimbursement under this plan for a dependent daycare expense and receive a tax credit for the same expense. In addition, the dollar limit on the amount of eligible expenses you can use to figure the tax credit (\$3,000 or \$6,000 as applicable) must be reduced dollar-for-dollar by reimbursements under the plan. If you have two or more dependents and your daycare costs are over \$5,000 you may be eligible for a partial tax credit, in addition to participating in the DCEA. The amount available to determine the credit could be an additional \$1,000. (See example below.)

For example, assume you have one dependent child. You put \$2,000 in your DCEA, but you actually incur \$3,400 of eligible dependent care expenses during the year. First, you will have received a full reimbursement of \$2,000 from the plan if you submit eligible claims

timely. You may also claim a dependent care tax credit for an additional \$1,000 on your personal federal tax return for the year. Why not for \$1,400? Because you've already received reimbursement of \$2,000, and the maximum amount available for determining the tax credit for one child is \$3,000.

Let's see an example for two dependent children. You put \$5,000 in your DCEA, but you actually incur \$7,500 of eligible dependent care expenses during the year. First you will have received a full reimbursement of \$5,000 from the Plan. You may also claim a dependent care credit for an additional \$1,000 on your personal Federal tax return for the year. Why not for \$2,500? Because you've already received reimbursement of \$5,000, and the maximum amount available for determining the tax credit for two or more children is \$6,000.

Earned income tax credits are available to lower income tax payers with dependent children. There are three possible federal tax credits: the child tax credit, dependent care credit and earned income credit.

What about earned income tax credits (EIC)?

Earned income tax credits are available to lower income tax payers. Under current law, three different credit amounts apply, depending on whether the taxpayer has one, two or more, or no qualifying children.

For 2016, the credits are determined as follows:

For an eligible individual with:	The maximum credit available is:	The credit reduces for earned income above:	The credit becomes zero when earned income reaches:
1 qualifying child	\$3,373	\$23,740	\$44,846
2 qualifying children	\$5,572	\$23,740	\$50,198
3 or more qualifying children	\$6,269	\$23,740	\$53,505
No qualifying children	\$506	\$13,820	\$20,430

Participating in the DCEA can affect the amount of your earned income credit. For more information about EIC see IRS Publication 596.

Who is responsible if I get reimbursed by this plan and also get reimbursed from another source and/or claim a reimbursed expense on my tax return?

You are. Duplications of reimbursements, attempts to take tax credits or deductions for reimbursed expenses, and/or filing erroneous claims constitute tax fraud, and you personally will incur any penalties. Your employer does not have the means to monitor your personal income tax and other financial affairs, and will not attempt to do so. You should maintain adequate records to support your claims in the event of inquiry by the IRS and keep copies of all documentation sent to the plan administration firm.

Transit Expense Plan

The Transit Expense Plan is another way to get the most money from your paycheck. The plan allows you to pay for qualified work-related transportation expenses with money that is sheltered from taxes by deducting the funds from your pay before it is taxed. Since less of your pay is taxed, you should come out ahead at the end of the year. Certain rules and guidelines apply, so be sure you fully understand the program before you choose to participate.

The Transit Expense Plan has three components: the Payroll Deduction Account (PDA) and two accounts through the Transit Expense Accounts (TEA) - one for parking and one for mass transit (e.g., bus pass, vanpool, light rail).

- The PDA is for parking and bus pass expenses and is paid directly through your agency's payroll deduction. This account is explained in further detail in the Payroll Deduction section.
- The TEA-Parking is for out-of-pocket parking fees not paid through your PDA. This account is explained in further detail in the Transit Expense Account section.
- The TEA-Bus Pass/Vanpool is for out-of-pocket bus pass, vanpool, or light rail expenses not paid through your PDA. This account is explained in further detail in the Transit Expense Account section.

The PDA is administered by the employee's agency. Claims processing for the TEAs are administered by 121 Benefits.

Who is eligible for the plan?

Any State of Minnesota employee who has transit expenses deducted from payroll through their agency is eligible to participate in the PDA. Only insurance eligible employees of the State of Minnesota (as defined by your collective bargaining agreement or plan) are eligible to participate in the TEAs.

Will my enrollment in this program automatically continue from year to year?

You are automatically enrolled in the PDA unless you instruct your agency otherwise. If you want your TEA period of coverage to begin January 1, you must enroll either during each Open Enrollment or enroll prior to the start of the plan year.

If you have a balance in your TEA for parking and/or bus pass/vanpool and want that balance to carry forward to the new plan year, you must enroll during Open Enrollment or enroll prior to the start of the plan year.

What if I work less than the full calendar year?

You will still be able to take advantage of the pre-tax savings if you do not work year-round. The **monthly election option** will work well for you if you are employed at an educational institution and have summers off or if you are a seasonal employee. If you

anticipate dropping off the payroll at any time during the calendar year, you should consider making a monthly election rather than yearly election. See the additional information under the Transit Expense Accounts heading.

Are there any risks involved in participating in this plan?

There are strict IRS rules and regulations, and deadlines must be met. If you terminate employment, you could forfeit money if you do not incur enough eligible expenses to cover your contributions. This risk of forfeiture is required by federal regulations. If you terminate employment, you can **continue to submit expenses incurred during your State employment for 180 days from the date on which the expense was incurred or paid, or through February 28, 2018, the end of the run-out period, whichever occurs first.**

If you stop your contributions, you can continue to submit eligible expenses to cover your contributions. The expenses must be submitted within 180 days from the date on which the expense was incurred or paid, or through February 28, 2018, the end of the run-out period, whichever occurs first.

If you continue participation in the plan through December 31, 2017, you can submit expenses incurred in 2017 for 180 days from the date on which the expense was incurred or paid, or through February 28, 2018, the end of the run-out period, whichever comes first. **Any money remaining in your account after the final processing period will be forfeited.** However, if you enroll during Open Enrollment for the subsequent plan year and continue your contributions, you can carry over to the new plan year any balance remaining after December 31. You must still adhere to the 180-day or end of plan year deadline as noted above for submitting reimbursement requests. **Your final reimbursement request for expenses incurred during the 2017 plan year must be postmarked on or before February 28, 2018.**

Payroll Deduction Account

The Payroll Deduction Account (PDA) allows you to pay for payroll-deducted parking and bus pass expenses (for example, the Metro Pass) with pre-tax dollars. **If you currently have parking or bus pass deductions from your paycheck, you are already enrolled in the PDA** (and unless you have any *additional out-of-pocket transit expenses, you would not enroll in a TEA*). Enrollment in the PDA is “automatic” when you sign up for these expenses through your agency; **you do not enroll in this program during Open Enrollment.**

How do I take advantage of the savings?

Expenses for parking and bus passes that are deducted from your paycheck will be automatically paid on a pre-tax basis thus increasing your take home pay.

What if I don't want my expenses paid on a pre-tax basis?

If you choose not to participate in the PDA, your parking or bus pass expenses cannot be paid through payroll deduction and you will need to arrange to stop the deductions through your agency and to pay these expenses directly. For assistance in making these arrangements, please contact your HR.

Are there any general guidelines as to whether pre-tax transit expense deductions through this Plan are better than tax deductions or tax credits on my tax return?

If you pay your expenses on a pre-tax basis through the plan, you save federal, state (except in New Jersey and Pennsylvania) and Social Security taxes on the premium accounts. Paying on a pre-tax basis through the Plan would always appear to be to your advantage.

Is there a limitation on the amounts of transit expenses that may be deducted on a pre-tax basis?

Yes. For 2016, the limits are **\$255 per month for qualified parking expense** and **\$130 per month for bus pass or vanpool expenses**. The IRS has not announced the 2017 limits yet. You may elect no more than \$255 per month for qualified parking expenses from the PDA and the TEA-Parking *combined* and you may elect no more than \$130 per month for bus pass or vanpool expenses from the PDA and TEA-Bus Pass/Vanpool *combined*. **These combined amounts may not exceed the monthly limits for any given month.** Participants' elections will not be monitored by 121 Benefits; it is your responsibility to ensure that you do not exceed the maximums allowed by law.

How are payments for payroll-deducted transit expenses handled?

Transit expenses for parking and/or bus passes will be withheld from your gross salary before taxes are deducted, resulting in less tax and more income for you; the transit payments are made directly to the vendor by your agency. For example, let's say a single employee, Terry, makes \$28,000 per year. Fees for Terry's expenses for her bus pass of \$25 per month (\$300 per year) are automatically paid through the PDA.

Sample Paycheck Comparison

	<u>Without the PDA</u>	<u>With the PDA</u>
Gross salary	\$28,000	\$28,000
Bus pass expenses paid	<u>0</u>	<u>(300)</u>
Taxable compensation	\$28,000	\$27,700
Estimated income tax (2014 Federal and State)	(3,179)	(3,118)
Social Security (FICA) tax	<u>(2,142)</u>	<u>(2,119)</u>
Compensation after tax	\$22,679	\$22,463
Bus pass expenses paid after tax	<u>(300)</u>	<u>0</u>
Spendable income after taxes and bus pass expenses	<u>\$22,379</u>	<u>\$22,463</u>

Using this account to pay transit expenses on a pre-tax basis increases Terry's take-home pay by \$84 per year.

Can I change my PDA?

Yes, you can cancel or change your participation in the PDA at any time. Any increases or decreases would occur automatically. For instance, if your parking fees increase, the additional amount will be taken out of your check automatically. If you want to stop your PDA, you will need to make arrangements to discontinue the deductions through your agency and to pay these expenses directly. Your HR will be able to assist you with this.

Transit Expense Accounts

There are two Transit Expense Accounts (TEAs): one for parking expenses and one for bus pass, vanpool, and light rail expenses. Remember, these accounts allow you to pay for certain transit expenses **that are not already paid through your PDA**. You participate in the accounts by enrolling during Open Enrollment. For mid-year enrollment or if you choose a **monthly election**, complete a Transit Expense *Enrollment Form* located on 121 Benefits' website (www.121benefits.com). Once you are enrolled and have contributed to the account, you can submit reimbursement requests for eligible expenses. **You must enroll each year during Open Enrollment for each plan year in which you wish to participate.**

When you enroll in these accounts, you can choose an **annual election** or a **monthly election**. The funds you direct to the TEAs will be set aside before taxes, and will be deducted in equal amounts out of the first two paychecks of each month for the period specified by you. **There is a minimum annual enrollment amount of \$50 in the TEA-Parking and a \$50 minimum in the TEA-Bus pass/Vanpool.**

If you have regular out-of-pocket parking expenses in addition to those deducted from your paycheck through the PDA, and if you don't anticipate falling off payroll during the year, choose the **annual** election option and estimate your **yearly expenses**. **The 2017 limit for the TEA-Parking is \$255 per month, (\$3,060 per year) combined with amounts deducted through your PDA-Parking. *The combined amount may not exceed the monthly limit for any given month.**** For example:

Bernard conducts training sessions that require him to pay \$40 per month for public parking. This amount is in addition to \$35 per month that is deducted from his paycheck through the Parking Deduction Account (PDA):

TEA-Parking	\$40 x 12 months = \$480
PDA	\$35 x 12 months = <u>\$420</u>
Combined Yearly Total	\$900
Combined Monthly Total	\$40 + \$35 = \$75*
Annual Election Amount	\$480

If you must **pre-pay** for parking for the **entire year** or if you anticipate dropping off the payroll at any time during the calendar year, you should consider making a **monthly** election. For instance, if you are employed at an educational institution and have summers off, or if you are a seasonal employee, you should consider electing the monthly option. For example:

Judy pays \$150 in October to park on campus the following year from August through May. Judy has no other transit expenses. Judy could decide to have the \$150 deducted all in one month:

TEA-Parking	$\$150 \times 1 \text{ month} = \150
Total Monthly Election Amount	\$150

If you have intermittent transportation expenses, you may want to select the **Monthly Election** option. For the next example using the TEA-Bus Pass/Vanpool, you cannot elect more than **\$130 per month (\$1560 yearly-2017 limit) combined with the PDA-Bus Pass/Vanpool.** *The combined amount cannot exceed the monthly limit for any given month.* **

Gail lives in an area where she cannot purchase a bus pass through her State employer. She can purchase a bus pass on her own so she can ride the bus during October while her vehicle is being repaired. She expects to spend \$50 for 1 month (\$2.50 per day for 20 days). Gail also pays \$40 per month for parking through her PDA. Gail could decide to have \$50 deducted per month for one month:

TEA-Bus Pass/Vanpool	$\$2.50 \times 20 \text{ days} = \50
PDA-Parking	$\$40 \times 12 \text{ months} = \underline{\$480}$
Combined Monthly Total	$\$50 + \$40 = \$90^{**}$
Total Monthly Election Amount	\$50

What expenses qualify for pre-tax reimbursement under the TEAs?

Eligible transportation expenses for the TEA-Parking are defined as expenses incurred to park your car (or bicycle) in a facility near the business premises of the employer or expenses incurred to park your car (or bicycle) at a location from which you commute to work by (a) mass transit including the light rail system, (b) a Commuter Highway Vehicle (vanpool), or (c) carpool.

Eligible transportation expenses for the TEA-Bus Pass/Vanpool are defined as follows:

- **Bus Passes:** Expenses incurred for a pass, token, fare card, voucher, or similar item for transportation on mass transit including the light rail system, whether or not publicly owned.
- **Vanpools:** Expenses incurred for participation in a commuter highway vehicle (vanpool). Under IRS rules, vanpools are defined as any highway vehicle that has seating capacity of at least six adults excluding the driver, and meets the two following requirements for mileage use. At least 80% of the vehicle mileage use must be reasonably expected to be (1) for transporting employees in connection with travel between their residences and their place of employment, and (2) on trips during which the number of employees transported for commuting is, on average, at least one-half of the adult seating capacity, excluding the driver.

The designated employee “prime member” (often the driver or the person assigned the parking space) who travels in a vanpool and uses commercial parking is eligible for the parking benefit (up to \$255 per month). At the same time, the prime member is eligible to

receive the vanpool benefit (up to \$130 per month). All other employees commuting in a vanpool who are not the “prime member” are only eligible for the vanpool benefit and not the parking benefit. Only one person can receive the parking benefit.

Is there a limitation on the amounts I can designate as transit expenses?

Yes. For 2017 the monthly maximum tax-free limit for the PKEA is \$255 per month. You cannot elect more than \$255 per month for qualified parking expenses from the PDA **combined with** the TEA-Parking.

The BVEA federal monthly maximum is \$130. You cannot elect more than \$130 per month for bus pass or vanpool expenses from the PDA **combined with** the TEA-Bus Pass/Vanpool.

These combined amounts may not exceed the monthly limits for any given month.

Participants’ elections will not be monitored by 121 Benefits. It will be the participant’s responsibility to ensure that the maximums allowed by law are not exceeded. Additional information on eligible transit expenses can be obtained from the IRS or your tax advisor.

When is an expense incurred?

You “incur” an expense on the date that the transit service is purchased or incurred.

Expenses must be submitted for reimbursement within 180 days of the date on which the expense was incurred or paid.

When can employees enroll in the TEA?

New hires can enroll in the TEA online during their enrollment period. Newly insurance eligible employees can enroll by submitting a Transit Expense *Enrollment Form* to SEGIP during their enrollment period.

What is my period of coverage?

If you enroll during Open Enrollment, your period of coverage begins on January 1 if you are on payroll and not on an unpaid leave of absence. If you enroll mid-year, your period of coverage begins on the first day of the pay period following SEGIP’s receipt of your signed enrollment form. Please note that reimbursement will not be made until you have contributed to your TEA.

Your period of coverage ends on December 31 if you are an active employee or the date of your termination if you are no longer a State employee.

Can I change the amount I am contributing to the TEA during the year?

The amount you elect for your TEA can be changed on a monthly basis if necessary by completing a *Change in Participation Form* for the Transit Expense Account. Your first paycheck to reflect the change in deductions depends, in part, on when the change form gets to SEGIP. The effective date is the first day of the pay period following SEGIP’s receipt of

your signed *Change in Participation Form*. Because of payroll system limitations, SEGIP must receive election changes by December 1, 2017. Consult with SEGIP when making a change to be sure it works the way you intend.

Can I enroll in the plan mid-year?

Insurance eligible employees can enroll in the TEAs at any time during the year by submitting a Transit Expense *Enrollment Form* to SEGIP. The effective date is the first day of the pay period following SEGIP's receipt of your signed form.

How do I submit requests for reimbursement?

To request reimbursement:

- You can enter your reimbursement request online. Documentation may be uploaded to the 121 Benefits' website or faxed or mailed to 121 Benefits. Acceptable documentation includes a receipt from the parking facility, your vanpool driver, or the facility from which you purchased your bus pass indicating the date of payment, a description of the service, and the charge for the service.
 - Enter your claim information and upload your documentation on the 121 Benefits' website (www.121benefits.com). Be sure to print the confirmation page showing successful submission of your reimbursement. **Expenses must be submitted for reimbursement within 180 days of the date on which the expense was incurred or paid, or through February 28, 2018, (the end of the run-out period) whichever occurs first.** For example, a January expense submitted for reimbursement in December will be denied reimbursement because it is outside of the 180 day window for reimbursement.
 - If you do not upload the documentation to the website, after checking your documents for accuracy and legibility, fax or mail them to 121 Benefits. **Expenses must be submitted for reimbursement within 180 days of the date on which the expense was incurred or paid, or through February 28, 2018, (the end of the run-out period) whichever occurs first.**
- If you prefer, you may receive reimbursement for your eligible Transit expenses by completing a Transit Expense *Reimbursement Request Form*. Be sure to complete the form in its entirety, making sure to sign and date it before submitting the form. Attach a receipt from the parking facility, your vanpool driver, or the facility from which you purchased your bus pass indicating the date of payment, a description of the service, and the charge for the service. The vanpool driver's signature on the form is also acceptable.
 - You can either fax the form to 121 Benefits (612-877-4321) or mail the form to their address listed on the reimbursement form. If you fax the reimbursement form, be sure to keep your fax confirmation page to provide proof of successful submission should a question arise.

All claims must be submitted, and documentation uploaded and/or sent or postmarked to 121 Benefits by the 2017 plan year deadline of February 28, 2018.

Be sure to keep copies of all documents submitted. This will ensure you have adequate records to support your claim in the event of an IRS inquiry, or should your envelope be lost in the mail. Be sure to submit all necessary documentation by February 28, 2018, which is the 2017 plan year reimbursement deadline.

Expenses must be submitted for reimbursement within 180 days of the date on which the expense was incurred or paid or by the 2017 plan filing deadline, whichever is earlier. Expenses are reimbursed weekly. Reimbursement requests received by noon on Friday will be processed by the following Friday.

How are expenses paid through the TEA?

When you incur an eligible transit expense and submit the claim to 121 Benefits, you will be reimbursed from your account. **The plan will pay the lesser of:**

- The amount of the expense paid or incurred that you are submitting, or
- The total amount you have contributed to your TEA to date, reduced by any previous claims paid from the account during the plan year.

What if both spouses are employed by the State and they both incur transit expenses?

Each employee must enroll in his or her own TEA. One employee cannot submit transit expenses for his/her spouse.

Is there a minimum reimbursement request amount?

There is a minimum reimbursement amount of \$50.00. This minimum does not apply to reimbursements on or after December 31st for the plan year just ended. ***There is no need to wait until the end of the year to submit reimbursement requests.*** Expenses must be submitted for reimbursement within 180 days of the date on which the expense was incurred or paid.

Can I get cash out of my account for reasons other than expense reimbursement?

No. Under federal rules, you can only get money out of the account for reimbursement of eligible expenses. Also, amounts deposited in one account cannot be used to reimburse expenses from another account.

If I have money left in my account at the end of the year, can I carry it forward into the next year?

Yes, but ONLY if you enroll during Open Enrollment or prior to the start of the following plan year (by December 31, 2016) for participation in the following plan year with a \$50 minimum election. **However, expenses must be submitted for reimbursement within 180 days of the date on which the expense was incurred or paid.**

What if I cease my contributions?

If you stop your contributions to your TEA, you can **continue to submit expenses for 180 days from the date on which the expense was incurred or paid, or through February 28, 2018, (the end of the run-out period) whichever occurs first. Any money remaining in your account after the final processing period will be forfeited** if you do not reenroll for the new plan year during Open Enrollment or prior to the start of the plan year.

What happens to my TEA if I leave State employment?

If you leave State employment, your TEA cannot be continued. You may **continue to submit expenses incurred while you were employed for 180 days from the date on which the expense was incurred or paid, or through February 28, 2018 (the end of the run-out period) whichever occurs first. Any money remaining in your account after the final processing period will be forfeited.**

What will happen to my TEA when I retire?

When you retire from State employment, participation in your TEA cannot be continued. You may **continue to submit expenses incurred while you were employed for 180 days from the date on which the expense was incurred or paid, or February 28, 2018, the end of the run-out period, whichever occurs first. Any money remaining in your account after the final processing period will be forfeited.**

What happens if I take a leave of absence?

If during the leave of absence you continue to receive regular pay, sick pay or vacation pay from the State of Minnesota, your contributions to and coverage under the TEA will continue unless you complete a Transit Expense *Change in Participation Form* to stop your deductions.

If your contributions to the TEA stopped because your leave was unpaid, complete a Transit Expense Change in Participation form upon returning to work if you want to resume participation in this account.

Expenses incurred during the uncovered period (the period of your leave) will not be eligible for reimbursement. Therefore, you may want to consider changing your election to minimize the effects of your unpaid leave. **Anytime you return from an unpaid leave and want to reinstate your transit accounts, you must complete a Transit Expense *Change in Participation Form*, and submit it to SEGIP.** Please contact SEGIP for more information.

Who is responsible if I get reimbursed by this plan and also get reimbursed from another source and/or claim a reimbursed expense on my tax return?

The responsibility is yours. Duplications of reimbursements, attempts to take tax credits or deductions for reimbursed expenses, and/or filing erroneous claims constitute tax fraud, and you personally will incur any penalties. Your employer does not have the means to monitor

your personal income tax and other financial affairs, and will not attempt to do so. You should maintain adequate records to support your claims in the event of inquiry by the IRS and keep copies of all documentation sent to the plan administration firm.

Administrative Information

The State of Minnesota sponsors the Flexible Benefits (the Medical/Dental Expense Account and the Dependent Care Expense Account) and Transit Expense Plan explained in this Summary. The Health and Dental Premium Account (HDPHA) is administered by Minnesota Management & Budget. The Payroll Deduction Account (PDA) is administered by each agency. Claims processing for the Medical/Dental Expense Account (MDEA), the Dependent Care Expense Account (DCEA) and the Transit Expense Account (TEA) are administered by 121 Benefits.

The timetable below applies to claims and rules for the Medical/Dental Expense Account, Dependent Care Expense Account and the Transit Expense Account:

Notification of whether the claim is accepted or denied	30 days
Extension due to matters beyond the control of the Plan	15 days
Notification of insufficient information on the claim	15 days
Response by participant to insufficient information on the claim	45 days
Review of claim denial	60 days

The administration firm will provide written notification of any claim denial. The denial will state the following:

1. The specific reason or reasons for denial.
2. Reference to the specific Plan provisions on which the denial was based.
3. A description of any additional material or information necessary for the claimant to perfect the claim.
4. A description of the Plan's appeal procedures and the time limits applicable to such procedures. This will include a statement of the right to bring civil action under section 502 of ERISA following an adverse determination of an appeal.
5. A statement that the participant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records and other information relevant to the claim.
6. If the denial was based on an internal rule, guideline, protocol, or other similar criterion, the specific rule, guideline, protocol, or criterion will be provided free of charge. If this is not practical, a statement will be included that such a rule, guideline, protocol, or criterion was relied upon in making the denial and a copy will be provided free of charge to the claimant upon request. When you receive a final denial, you will have 180 days following receipt of the notification in which to appeal the decision. You may submit written comments, documents, records, and other information relating to the claim to Minnesota Management & Budget

Department at the address listed below. If you request, you will be provided, free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claim. A decision on the appealed claim will be made no later than 60 days after an appeal is filed. An appeal is filed in accordance with the procedures of the Plan. This timing is without regard to whether all the necessary information accompanies the filing.

These claims procedures are triggered when a paper claim is submitted that has been denied. Correspondence sent requesting documentation that is needed to adjudicate a debit card transaction is not considered a claim. A written denial letter will be sent should the documentation be insufficient.

A document, record, or other information shall be considered **relevant** to a claim if it:

1. Was relied upon in making the claim determination;
2. Was submitted, considered, or generated in the course of making the claim determination, without regard to whether it was relied upon in making the claim determination;
3. Demonstrated compliance with the administrative processes and safeguards designed to ensure and to verify that claim determinations are made in accordance with Plan documents and Plan provisions have been applied consistently with respect to all claimants; or
4. Constituted a statement of policy or guidance with respect to the Plan concerning the denied claim.

The appeal review will take into account all comments, documents, records, and other information submitted by the participant relating to the claim, without regard to whether such information was submitted or considered in the initial claim determination. The appeal review will not afford deference to the initial denial and will be conducted by Minnesota Management & Budget Department.

The information in this booklet is not intended to cover all provisions, limitations, and exclusions. As a participant in this plan, you are entitled to examine the Flexible Benefits or Transit Expense Plan Document at:

Minnesota Management & Budget
400 Centennial Office Building
658 Cedar Street
St. Paul, Minnesota 55155-1603

You may also obtain a copy of this document and other plan information upon written request. A reasonable amount may be charged for copies.

Except as required by a collective bargaining agreement, the State of Minnesota reserves the right to change, interpret, withdraw, or add benefits to this plan at its sole discretion and without prior notice, consideration, or approval by an employee or employee group.

This document is available in alternative formats to individuals with disabilities by calling the Minnesota Management & Budget Department (651) 355-0100.

For TTY/TDD communication, contact the Minnesota Relay Service at 1-800-627-3529.

Notice Of Privacy Practices For The State Of Minnesota Flexible Benefits Plan

**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.**

THE EFFECTIVE DATE OF THIS NOTICE IS APRIL 14, 2003.

Introduction

Under the federal Medical Data Privacy Regulations, or “Privacy Regulations,” the State of Minnesota Flexible Benefits Plan (the Medical/Dental expense account) is required to give you this NOTICE OF PRIVACY PRACTICES which tells you about how the Plan protects the privacy of your health information and your rights under the new Privacy Regulations. (The Privacy Regulations can be found at 45 *Code of Federal Regulations* Parts 160 and 164.)

The Privacy Regulations govern the use and disclosure of your individually identifiable health information that is transmitted or maintained by the Plan. This is called “Protected Health Information” or “PHI” under the Regulations.

1. When the Plan Uses and Discloses Your PHI

A. Uses and Disclosures Required by the Privacy Regulations

The Plan is required to give you access to certain PHI if you ask so you can inspect and copy it.

The Plan is required to release your PHI to the Secretary of the federal Department of Health and Human Services to review the Plan’s compliance with the Privacy Regulations.

B. Uses and Disclosures to Carry Out Treatment, Payment, and Health Care Operations

The Plan and its “business associates” have the right to and will use PHI without your consent, authorization, or opportunity to agree or object so the Plan can carry out “treatment, payment, and health care operations.” The Plan can also disclose PHI to the Plan Sponsor and to certain agents of the Plan Sponsor (e.g., staff members of the Employee Insurance Division of the Management and Budget Department in the

Enrollment and Billing, Benefits Services, or Purchasing Units). The Plan Document has been amended to protect your PHI as required by federal law.

A health flexible spending account is involved with the reimbursement of plan participants' unreimbursed medical and dental expenses. PHI can be disclosed by the business associate to the Plan Sponsor for such purposes.

C. Uses and Disclosures that Require Your Written Authorization

Your written authorization generally will be obtained before the Plan will use or disclose psychotherapy notes about you from your psychotherapist.

Your authorization will also generally be obtained before the Plan will release your PHI to persons not specifically authorized to receive the information under the Privacy Regulations, such as your spouse. When your authorization is required for a release of your PHI, you will also have the right to revoke the authorization at any time.

D. Uses and Disclosures that Require that You Have an Opportunity to Agree or Disagree before the Information is Used or Released

The Plan can disclose your PHI to family members, other relatives and your close personal friends if the information is directly relevant to the family or friend's involvement with your care or payment for that care; and you have either agreed to the disclosures or have been given an opportunity to object and have not objected.

E. Other Uses and Disclosures for which Consent, Authorization or Opportunity to Object is Not Required

The Plan can use and disclose your PHI without your consent, authorization or request under the following circumstances; however, as a general rule the Plan will release PHI in these situations only when necessary to protect a person's health or safety:

- 1) When required by law, such as releases to the Secretary of Health and Human Services.
- 2) When permitted for purposes of public health activities, including when necessary to report if you have been exposed to a communicable disease or are at risk of spreading a disease or condition.
- 3) To report information about abuse, neglect or domestic violence to public authorities.
- 4) To a public health oversight agency for oversight activities such as civil, administrative or criminal investigations; inspections; licensing or disciplinary actions (for example, to investigate complaints against providers); and other

activities necessary for appropriate oversight of government benefit programs (for example, to investigate Medicare or Medicaid fraud).

- 5) When required for judicial or administrative proceedings. For example, your PHI may be disclosed in response to a subpoena or discovery request.
- 6) When required for law enforcement purposes (for example, to report certain types of wounds).
- 7) For other law enforcement purposes, including identifying or locating a suspect, fugitive, material witness or missing person.
- 8) To a coroner or medical examiner for the purpose of identifying a deceased person, determining a cause of death or other duties as authorized by law. Disclosure is also permitted to funeral directors, as necessary to carry out their duties with respect to the decedent.
- 9) For research, subject to certain conditions.
- 10) To prevent or lessen a serious and imminent threat to the health or safety of a person or the public and the disclosure is to a person reasonably able to prevent or lessen the threat, including the target of the threat.
- 11) When authorized by and to the extent necessary to comply with workers' compensation or other similar programs established by law.

2. Your Rights

A. Right to Request Restrictions on PHI Uses and Disclosures

You may request the Plan to restrict uses and disclosures of your PHI to carry out treatment, payment or health care operations, or to restrict uses and disclosures to family members, relatives, friends or other persons identified by you who are involved in your care or payment for your care. However, the Plan is not required to agree to your request.

The Plan will accommodate reasonable requests to receive communications of PHI by alternative means or at alternative locations.

You or your personal representative will be required to complete a form to request restrictions on uses and disclosures of your PHI.

These requests should be made to the Plan's "Contact Person" listed at the end of this Notice.

B. Right to Inspect and Copy PHI

You have a right to inspect and obtain a copy of your PHI contained in a "designated record set," for as long as the Plan maintains the PHI.

Designated Record Set includes your medical records and billing records maintained by or for a covered health care provider; enrollment, payment, billing, and claims adjudication; or other information used in whole or in part by or for the Plan to make decisions about you. Information used for quality control or peer review analyses and not used to make decisions about individuals is not in the designated record set.

The requested information will be provided within 30 days if the information is maintained on site or within 60 days if the information is maintained offsite. A single 30-day extension is allowed if the Plan is unable to comply with the deadline.

You or your personal representative will be required to complete a form to request access to the PHI in your designated record set. Requests for access to PHI should be made to the Plan's Contact Person.

If the Plan denies you access, you or your personal representative will be provided with a written denial stating the basis for the denial, a description of how you can exercise those review rights and a description of how you can complain to the Secretary of the U.S. Department of Health and Human Services.

C. Right to Amend PHI

You have the right to request the Plan to amend your PHI or a record about you in a designated record set as long as the PHI is maintained in the designated record set. The request must be made in writing and must provide your reasons supporting your request.

The Plan has 60 days after the request is made to act on the request. A single 30-day extension is allowed if the Plan cannot comply with the deadline. If the request is denied in whole or part, the Plan will provide you with a written denial that explains the basis for the denial. You or your personal representative can then submit a written statement disagreeing with the denial and have that statement included with any future disclosures of your PHI.

Requests to amend your PHI in a designated record set should be made to the Plan's Contact Person at the Plan Administrator's office. You or your personal representative will be required to complete a form to request amendment of the PHI in your designated record set.

D. The Right to Receive an Accounting of PHI Disclosures

At your request, the Plan will also give you an accounting of the Plan's disclosures of your PHI during the six years prior to the date of your request. However, the accounting

need not include PHI disclosures made (1) to carry out treatment, payment or health care operations; (2) to individuals about their own PHI; or (3) prior to the compliance date.

If the accounting cannot be provided within 60 days, an additional 30 days is allowed if the Plan gives you a written statement about the reasons for the delay and the date by which accounting will be provided. If you request more than one accounting within a 12-month period, the Plan will charge a reasonable, cost-based fee for each additional accounting.

E. The Right to Receive a Paper Copy of This Notice Upon Request

Please contact the Plan's Contact Person at the Plan Administrator's office to receive a paper copy of this Notice.

F. Personal Representatives

You may exercise your rights through a personal representative. Your personal representative will be required to produce evidence of his or her authority to act on your behalf before that person will be given access to your PHI or allowed to take any action for you. Proof of this authority may take one of the following forms: (1) a power of attorney for health care purposes notarized by a notary public; (2) a court order of appointment of the person as the conservator or guardian of the individual; or (3) an individual who is the parent of a minor child.

The Plan retains discretion to deny access to your PHI to a personal representative to provide protection to those vulnerable people who depend on others to exercise their rights under these rules and who may be subject to abuse or neglect. This also applies to personal representatives of minors.

3. The Plan's Duties

The Plan is required by law to maintain the privacy of PHI and to provide individuals (participants and beneficiaries) with notice of its legal duties and privacy practices.

This notice is effective beginning April 14, 2003, and the Plan is required to comply with the terms of this notice. The Plan, however, reserves the right to change its privacy practices and to apply the changes to any PHI received or maintained by the Plan before that date. If a privacy practice is changed, a revised version of this notice will be provided by mail to all past and present covered persons for whom the Plan still maintains PHI.

Any revised version of this notice will be distributed within 60 days of the effective date of any material change to the uses or disclosures, the individual's rights, the duties of the Plan or other privacy practices stated in this notice.

A. Minimum Necessary Standard

When using or disclosing PHI or when requesting PHI from another covered entity, the Plan will make reasonable efforts not to use, disclose or request more than the minimum amount of PHI necessary to accomplish the intended purpose of the use, disclosure or request.

This minimum necessary standard will not apply in the following situations:

- 1) disclosures to or requests by a health care provider for treatment;
- 2) disclosures made to the Secretary of the U.S. Department of Health and Human Services;
- 3) uses or disclosures that are required by law; and
- 4) uses or disclosures that are required for the Plan's compliance with legal regulations.

This notice does not apply to information that has been de-identified. De-identified information is information that does not identify an individual and with respect to which there is no reasonable basis to believe the information can be used to identify an individual. In other words, if the information is de-identified, it is not individually identifiable health information and, therefore, not PHI.

The Plan can also use or disclose "summary health information" to the Plan Sponsor for modifying, amending or terminating the Plan. Summary health information summarizes the claims history, claims expenses or type of claims experienced by individuals and from which identifying information has been deleted in accordance with the Privacy Regulations.

4. Your Right to File a Complaint with the Plan or the HHS Secretary

If you believe that your privacy rights have been violated, you may complain to the Plan's Contact Person. You may also file a complaint with the Secretary of the U.S. Department of Health and Human Services, Hubert H. Humphrey Building, 200 Independence Avenue S.W., Washington, D.C. 20201. The Plan will not retaliate against you for filing a complaint.

5. Whom to Contact for More Information

If you have any questions, please contact the Plan's Contact Person, Shari Horsman, Minnesota Management & Budget. The address is 400 Centennial Office Building 658 Cedar Street, St. Paul, MN 55155, and the telephone number is 651-355-0100.

Conclusion

PHI uses and disclosures by the Plan are regulated by the federal HIPAA law. This notice attempts to summarize the Privacy Regulations. The Privacy Regulations will supersede any discrepancy between the information in this notice and the regulations.

Minnesota Management & Budget Notice Of Collection Of Private Data

Minnesota Management & Budget administers the State Employee Group Insurance Program (SEGIP). We are requesting data from you through a vendor, 121 Benefits, which has been authorized to administer the State of Minnesota Pre-tax Benefits Plan. This notice explains why we may request information (data) about you, your dependents and beneficiaries, how we will use it, who will see it, and your obligation to provide that information.

What information will we use?

We will use the information you provide us at this time, as well as information you have previously provided us about yourself, your dependent(s), and/or your beneficiary. If you provide any information about yourself or your dependent or beneficiary that is not necessary, we will not use it for any purpose.

SEMA4, the information system used to administer employee benefits, contains required information fields that may not be necessary for us to process your request. We do not need the gender or marital status for your beneficiary designation, so you may enter “unknown” in these fields. We only need your dependent’s date of death to process a death benefit claim or to discontinue the dependent’s coverage due to his or her death. Student status and disability status are needed only to determine eligibility for insurance continuation for your dependent. We only need your dependent’s social security number to offer insurance continuation or process a death benefit.

Why we ask you for this information?

We ask for this information to process your request to add or change coverage for yourself, your dependent or a beneficiary. The requested information helps us to determine eligibility, to identify you and your dependents and beneficiaries, and to contact you or your dependents and beneficiaries. We use the information so that we can successfully administer SEGIP, including analyzing unidentifiable aggregate data to develop new programs and ensure current programs are effectively and efficiently meeting member needs. We may ask for information about you that we have already collected, including all or part of your social security number, in order to ensure we are matching you to the correct change request or other insurance benefit transaction.

Do you have to answer the questions we ask?

You are not legally required to provide any of the information requested.

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

If you do not answer these questions, the insurance benefit transaction you requested for you or your dependent or other insurance benefit transaction may be delayed or denied.

Who else may see this information about you and your dependents and beneficiaries?

We may give information about you and your dependents and beneficiaries to the insurance carrier you have chosen, SEGIP's representatives, vendors, and actuary, the Legislative Auditor, the Department of Health, any law enforcement agency or other agency with the legal authority to the information, and anyone authorized by a court order. In addition, the parents of a minor may see information on the minor unless there is a law, court order, or other legally binding instrument that blocks the parent from that information. We can use or relates this information only as stated in this notice unless you give your written consent to authorize release of the information to another person/entity, or if Congress or the Minnesota Legislature passes a law allowing or requiring us to release the information or to use it for another purpose.