STATE OF MINNESOTA

FLEXIBLE BENEFITS AND TRANSIT EXPENSE PLAN

2021 Plan Year Summary

MINNESOTA MANAGEMENT AND BUDGET
AND 121 BENEFITS

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Acronyms

COBRA	Consolidated Omnibus Budget Reconciliation Act
DCEA	Dependent Care (Daycare) Expense Account
EIC	Earned Income Credit
EIS	Employee Insurance Section
ESR	Employer Shared Responsibility
FMLA	Family Medical Leave Act
HDPA	Health/Dental Premium Account
HIPAA	Health Insurance Portability and Accountability Act
HRA	Health Reimbursement Arrangement
HSA	Health Savings Account
HR	Agency Human Resources Representative
IRS	Internal Revenue Service
MDEA	Medical/Dental Expense Account
MMB	Minnesota Management and Budget
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 Flexible Benefits and Transit Expense Plan offered by the State Employee Group Insurance Program (SEGIP) can provide you with substantial tax savings by paying your SEGIP health and dental plan premiums, eligible dependent daycare, out-of-pocket medical and dental, and work-related transportation expenses with tax-free dollars. Contributions towards these accounts are deducted from your paychecks before taxes are deducted and since you pay less in taxes, your net income may be greater.

Certain rules and guidelines apply to each benefit, so be sure you fully understand the programs before you enroll.

SEGIP offers the following Flexible Benefit and Transit Expense Plan Accounts:

- The Health and Dental Premium Account (HDPA), which covers the employee paid portions of health and dental premiums for the State Employee Group Insurance Program (SEGIP).
- The Health Savings Account (HSA), which covers the employee pre-tax salary contributions made towards the participant's HSA.
- 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 eligible dependent care (daycare) expenses for qualifying dependents.

The Transit Expense Plan is comprised of the following accounts:

- The Payroll Deduction Account (PDA), which covers parking and transit cards obtained through and paid directly to your agency.
- The Transit Expense Account for Parking (TEA-Parking), which covers your out-of-pocket work-related parking costs.
- The Transit Expense Account for Bus Pass/Vanpool (TEA-Bus Pass/Vanpool), which covers your out-of-pocket work-related transit and vanpool expenses.

These accounts are administered on behalf of the State Employee Group Insurance Program, Minnesota Management and Budget by 121 Benefits. This booklet provides a description of the Flexible Benefits Plan and the Transit Expense Plan.

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

Note: Carefully plan your pretax enrollments and elections. The MDEA and DCEA elections cannot be changed during the plan year without a qualified status change. In addition, Federal regulations require that pretax accounts carry a forfeiture risk. 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 filing deadline of the plan year. Read more about the forfeiture risk in this Summary or if you have any questions regarding these benefits, contact the State Employee Group Insurance Program (SEGIP) at (651) 355-0100, 121 Benefits at (612) 877-4321 or (800) 300-1672, or your Human Resource Office.

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 HDPA, 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 and who participate in the Advantage High Deductible Health Plan (HDHP) are eligible to enroll in the HSA.

New employees who are insurance eligible must enroll in the MDEA and DCEA within 35 days of the first day of employment, re-hire, or reinstatement. During the duration of the COVID-19 peacetime emergency, the usual 35-day waiting period for coverage is waived; however, all employees whose employment begins on or after the date the emergency expires will have a 35-day waiting period before their coverage start date. 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 SEGIP receives the enrollment form, whichever is later.

If you do not enroll in the MDEA or DCEA during your enrollment period, federal regulations require that you wait until an Open Enrollment period (usually 2 weeks beginning towards the end of October or within the month of November) for the next opportunity to participate (except for situations where you incur a "status change"). In most situations, you will be able to start using the plan January 1 if you sign up for the plan during Open Enrollment **AND** you are on payroll on January 1. If you are on an unpaid FMLA leave of absence on January 1 and had elected an MDEA during Open Enrollment, you can begin to participate 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).

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 deducted from the remaining paychecks within the same tax year. If a participant does not have enough funds in their paycheck to cover the deductions, the contributions will need to be paid by the participant with a personal check on an after-tax basis.

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 pay attention to how that change will affect your plan participation. 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 these plans automatically continue from year to year?

Your enrollment in the HDPA and PDA continues from year to year. If you wish to stop the HDPA, contact SEGIP; if you wish to stop the PDA, contact your agency. However, for the MDEA, DCEA, and TEA **you must enroll during Open Enrollment for each plan year in which you wish to participate.**

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 filing deadline of the plan year. Because of the tax savings, the federal regulations require a forfeiture risk. See the applicable sections for the MDEA, DCEA, and TEA for more information on the forfeiture risk. Under some circumstances, participants may carry over to the next plan year any unused MDEA balance of $550 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, 2021. 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. The effective date of the accounts is always prospective of your enrollment; retroactive coverage is prohibited.

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, 121 Benefits, 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 ($137,700 in 2020). 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

The Health and Dental Premium Account (HDPA) allows you to pay your share of MN Advantage Health Plan and State Dental Plan premiums for yourself and your qualified dependents with pretax dollars if you are an active employee on payroll. You are automatically enrolled in this program when you sign up for insurance. No forms are necessary unless you choose to waive 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 this option 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 (https://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 HDPA?**).

Are dependents covered under the HDPA?

Your eligibility to pay the premiums for a dependent on a pre-tax basis depends on whether 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 HDPA if they qualify as a dependent under Section 152 of the Internal Revenue Code by meeting *one of* the criteria listed below. In addition, children up through the end of the month in which they turn 26 are 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 their 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 are.

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 their 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 (2020 Federal and State)	(2,280)	(2,123)
Social Security (FICA) tax	(2,142)	(2,073)
Spendable income	23,578	22,904
Health care premiums paid after tax	(900)	-
Spendable income after taxes and health care premiums	22,678	22,904

Using this account to pay health plan premiums on a pre-tax basis increases Terry's spendable income by $226 a year.

Can I change my HDPA election?

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

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

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 leave[1]

[1] In most occurrences, unpaid leaves will be treated as unpaid FMLA leaves for purposes of administration.

    - Family Medical Leave Act (FMLA) leave
    - Termination and rehire within 30 days (prior HDPA elections at termination are reinstated unless another event has occurred that allows a change)
    - Termination and rehire after 30 days (employee can make new HDPA elections)
    - 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 ***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
- Enrollment or dis-enrollment in Medicare, Medicaid or Medical Assistance
- 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 another 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 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.

- Marketplace changes 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 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 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.

Heath 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 High Deductible Health Plan (HDHP), 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 carries 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 $2,750 (of pre-tax dollars. You participate in the program by enrolling during Open Enrollment. New employees must enroll within 35 days of the first day of their employment, re-hire, or reinstatement, or within 35 days of the enrollment packet print date. Employees who become insurance eligible mid-year must enroll within 30 days of becoming eligible or within 30 days of the enrollment packet print date. You must enroll each year during Open Enrollment for each plan in which you wish to participate**. There is a $100 minimum annual enrollment amount for the MDEA.**

When you enroll in the MDEA, you must decide how much of your wages for the year you wish to contribute to this account to pay for allowed 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. **Carefully plan your election, as your election cannot be changed unless you have a qualified life event, as defined by the Internal Revenue Service (IRS).**

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 expenses for yourself, your spouse, and your qualified dependents, you can either use your flexible spending account debit card to pay for eligible expenses or submit a claim for reimbursement by filling out a *Reimbursement Request Form,* completing the form on-line under your online account at www.121benefits.com, or by using 121 Benefits mobile app. 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 under the MDEA for dependents who qualify as a dependent under Section 152 of the Internal Revenue Code by meeting *one of* the criteria listed below. In addition, eligible expenses for dependent children, incurred up through the calendar year in which they turn 26, can 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 their own support.
- The individual is one of the following:
    - your child (biological, stepchild, adopted child, foster 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 are.

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 their support from you,
- The individual does not satisfy the requirements of qualifying child with respect to any individual, and
- 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 that dependent.

Special rule for divorced parents

If both parents together provide more than 50% of their qualifying child's or qualifying relative's 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 eligible 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 eligible MDEA expenses

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

Here are some examples of expenses specifically excluded from reimbursement:

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

Please see the *MDEA Worksheet* and the list of *Over-the-Counter Items or Drugs* at *www.121benefits.com* for the eligibility of additional expenses.

Effective January 1, 2020 over-the-counter medications and supplies, such as cold medications or feminine hygiene products, are now eligible for reimbursement through your MDEA. Over-the-counter (OTC) supplies (e.g., saline solution or bandages) continue to be eligible for reimbursement under the 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.

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 MDEA period of coverage begins on January 1 if on that day 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. Your period of coverage continues through the calendar year if you continue participation in the plan.

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. The IRS prohibits insurance premiums from being reimbursed through an MDEA. Remember that health and dental premiums deducted from your check are already taken pre-tax through the HDPA.

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, as a new hire, or as a newly eligible participant is irrevocable. You must decide at that time how much you wish to contribute to your MDEA for the upcoming year or the balance of the plan year, depending on when the enrollment is made. However, the federal regulations allow some exceptions to this irrevocability rule that allow for an election change or mid-year enrollment.

What status changes allow mid-year election changes?

According to federal rules, an allowed 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 leave[2]
  - 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 nor less than the amount the employee had been reimbursed for eligible expenses, excluding a carryover amount, if applicable.)
- 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
- Enrollment or dis-enrollment in Medicare, Medicaid or 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.

[2] Unpaid leaves will be treated as FMLA leaves for purposes of administration.

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. SEGIP must receive the completed form(s) 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 2, 2021. **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 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 SEGIP receives the enrollment or change form. The effective date is the event date or the first day of the pay period in which SEGIP receives the form, 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,

(3) using the 121 Benefits Mobile app, or

(4) using your flexible spending account debit card (the 121 Benefits debit card) for automatic payment at participating vendors (remember to keep receipts!).

The first option listed above 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 2021 plan year deadline of Monday, February 28, 2022.

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 Monday, February 28, 2022, which is the 2021 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 via either fax or mail.* Attach the documentation to substantiate your reimbursement request (see below for what is acceptable documentation). Reimbursement forms are available on 121 Benefits' website (https://www.121benefits.com/client-landing/state-of-minnesota/).

The third way to access funds is to use the 121 Benefits Mobile App. You can submit a reimbursement along with a receipt using this Mobile App.

If you submit requests for reimbursements either on-line, using the reimbursement form, or through the Mobile App, expenses will be reimbursed to you weekly. Reimbursement requests received by noon on Friday will be processed 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 fourth way to access funds is to use your flexible spending account debit card (121 Benefits debit 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, either by U.S. mail or by email (if an email address is provided and you have opted to receive communications by email), requesting additional information. You may also opt in to receive text alerts. 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.

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 if the provider's name, dollar amount and over-the-counter item description (if applicable) is listed on the receipt.

What if I need replacement debit cards?

Additional debit cards with the employee's name are $10.00 for a set of two cards. This amount is deducted from your MDEA. You can also order cards ($10.00 fee for one card) online in a dependent's name.

Over-the-Counter (OTC) Medicines

Effective January 1, 2020, over-the-counter medications and supplies, such as cold medications or feminine hygiene products, are now eligible for reimbursement through your MDEA. This means that the debit card will now work to purchase eligible over-the-counter drugs and medicines, provided the individual merchant or store has updated their systems to allow for these purchases. There are three types of merchants at which the debit card can be used to purchase OTC items:

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 OTC items; and
3. At vendors having healthcare related merchant codes (other than merchants described in #2).

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 on-line, using the reimbursement form, or using the Mobile App, 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 2021 plan year, whether submitted by mail, fax, online, Mobile App, or in person (during business hours only) is ***Monday, February 28, 2022***. **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, carefully follow the directions to fax, mail, or upload 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 2021 plan year deadline of *Monday, February 28, 2022.***

If you submit a request for reimbursement on or near the 2021 plan year deadline (Monday, February 28, 2022), and your reimbursement request is denied as ineligible, you are not granted additional time to submit additional expenses after the deadline has passed. The deadline for submitting all 2021 plan year expenses is Monday, February 28, 2022.

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 or postmarked after the reimbursement deadline. **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. Otherwise, the easiest and fastest way to file claims and submit documentation is on the mobile app or online in your individual account.**

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 IRS regulations, the MDEA includes a carryover feature. The IRS changed the maximum allowable carryover amount to $550, and the State is adopting this increase for remaining 2020 funds carried into 2021. If you are a participant in the 2021 MDEA plan on December 31, 2021, contributing your full 2021 election amount may allow up to $550 of unreimbursed money to carry over from your 2021 MDEA to be used for 2022 expenses. If your 2021 plan year balance is greater than $550, any funds remaining in the 2021 account over the $550 after the end of the run-out period on Monday, February 28, 2022, will be forfeited. Carryover funds should not be considered a savings account. The Internal Revenue Service and/or the employer can rescind or limit the availability of carryover funds.

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 because you have had tax savings on those dollars. 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 MDEA period of coverage ends on your termination date. Only expenses incurred 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 through COBRA continuation.

Federal regulations (COBRA) allow you to continue MDEA participation 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 or divorce or children who lose their dependent status.

Exception: Continuation is not available to any employee, spouse, or dependent who has "overspent" the MDEA as of the status change date. 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 $550 of the remaining balance to the following plan year. These carried over funds are available for 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.

You have a limited time to decide. The period during which continuation coverage may be elected (1) must be within 60 days of the qualifying event date 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 their 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 status change date 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.

Contact SEGIP for more information concerning all of the preceding conditions. 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 an election change. 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 paid the monthly invoices to continue your MDEA while on unpaid leave, your original election amount will be automatically reinstated, and pre-tax deductions will begin from your paychecks. 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. SEGIP must receive this form 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 for 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 and are re-enrolling upon your return to work, your effective date will be your return to work date or the first day of the pay period in which SEGIP receives the completed form, 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, 2021. 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.

How can MDEA participation be extended after retirement?

You may request reimbursement for eligible expenses incurred while you were an active employee. As long as you have eligible expenses equal to (or greater than) the amount of total contributions made at the time of retirement, you will not lose any funds. 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 second to the last final paycheck, or 2. Provided your account is not overspent (i.e. total reimbursements at the time of your retirement do not exceed total contributions to-date), you can elect and pay **COBRA continuation payments** to continue your period of coverage. In either case, extending your period of coverage will give you more time to incur eligible expenses. 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 $550 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 pre-taxed payroll 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. 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 either 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 $2,750 (the 2021 maximum) 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 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 an IRS inquiry 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 $2.75 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 the 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 on a tax-free basis, 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 tax-free 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: 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 and contributes or receives employer contributions to an HSA and their expenses could potentially be submitted under your or your spouse's non-limited purpose MDEA or HRA through the end of the year they turn 26, your dependent is not eligible to make or receive tax-free 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 when 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 when 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 they and/or their 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 and 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 in the DCEA during Open Enrollment. New employees who are insurance eligible must enroll within 35 days of employment, re-hire or reinstatement or within 35 days of the print date of their enrollment packet. During the duration of the COVID-19 peacetime emergency, the usual 35-day waiting period for coverage is waived; however, all employees whose employment begins on or after the date the emergency expires will have a 35-day waiting period before their coverage start date. 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. Coverage is effective on the eligibility date or the first day of the pay period in which SEGIP receives the enrollment form, whichever is later. You must enroll each year during Open Enrollment for each plan year in which you wish to participate.

The DCEA is a "use or lose" account, meaning unused funds are forfeited or funds are forfeited if complete reimbursement requests are not submitted by the 2021 plan year filing deadline of Monday, February 28, 2022.

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). DCEA funds are for eligible daycare expenses for your qualified children up to age 13 or adult day care for your qualified disabled spouse or other disabled dependent. DCEA funds may only be used for the time period eligible children or eligible disabled dependents are residing in your home.

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.**

To request reimbursement of eligible dependent care (daycare) expenses, you may:

- Submit claims using 121 Benefits Mobile App,

- Enter the information online and either upload the scanned documentation (including the dates of service, child's name, description of services and Tax ID#) or fax or mail it to 121 Benefits, or
- Fill out a *Reimbursement Request Form* (found on 121 Benefits' website, *www.121benefits.com)*, itemize your expenses including the dates of service, child's name, description of services, 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 mail or fax this information 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?)

Funds are available for reimbursement after they are deducted from your paycheck and contributed to your account.

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. They 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 $42,000 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	$ 80,000	$ 80,000
Pre-tax Dependent Care contribution	-	(5,000)
Adjusted gross income	80,000	75,000
Estimated income tax (federal and MN based on 2019 rates)	(8,262)	(7,395)
Social Security (FICA) tax	(6,120)	(5,738)
Spendable income	65,618	61,867
Dependent care expenses paid after tax	(5,000)	-
Spendable income after taxes and dependent care expenses	60,618	61,867

Using the plan to pay dependent care (daycare) expenses on a pre-tax basis increases Pat's spendable pay by $1,249 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 themselves. 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 childcare expenses will be eligible. Be sure to consult with 121 Benefits if you have any questions about this subject. 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 your period of coverage 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 daycare expenses begin.**

Often, parents find that their needs and plans change in unanticipated ways after the birth of a baby or adoption. For example, the parent 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 on that day 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. Any expenses incurred prior to your enrollment date are not eligible for reimbursement. 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 <u>family</u> 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 they are a full-time student, or physically or mentally unable to care for themselves, 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 them 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 leave[3]
  - 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

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

- Event causing employee's dependent to satisfy or cease to satisfy dependent eligibility requirements
  - Attaining a specified age
- 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)

SEGIP will mail you an enrollment form if you have an employment change that affects your SEGIP insurance benefits eligibility. Complete a State of Minnesota Change in Participation form from 121 Benefits (www.121benefits.com) if you have any other kind of status change. SEGIP must receive the completed form(s) within 30 days (the 30 days includes the event date) of the status change date. Because of payroll system limitations, election changes must be received by SEGIP by December 2, 2021. 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 the first day of employment, re-hire, or reinstatement. During the duration of the COVID-19 peacetime emergency, the usual 35-day waiting period for coverage is waived; however, all employees whose employment begins on or after the date the emergency expires will have a 35-day waiting period before their coverage start date.

Employees who become insurance eligible mid-year must enroll within 30 days of becoming eligible. Coverage is effective on the later of the eligibility date or the first day of the pay period in which SEGIP receives the enrollment form.

How do I submit requests for reimbursement?

Eligible DCEA expenses can be reimbursed by (1) using the 121 Benefits' Mobile App, (2) entering a reimbursement request on-line at the 121 Benefits' website, or (3) completing the Reimbursement Request Form located on 121 Benefits' website (www.121benefits.com).

Enter your reimbursement request online and either upload the documentation to 121 Benefits' 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 2021 plan year deadline of Monday, February 28, 2022.

To receive reimbursement for your eligible DCEA expenses by completing a *Reimbursement Request Form, complete the form in its entirety, making sure to sign and date it before submitting.* 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 Monday, February 28, 2022, which is the 2021 plan year deadline.

You cannot be reimbursed for daycare expenses until after services 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 2021 plan year ***must be postmarked or received by fax on or before Monday, February 28, 2022*.** 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. **Otherwise, the easiest and fastest way to file claims and submit documentation is on the mobile app or online in your individual account**

If you submit a request for reimbursement on or near the 2021 plan year deadline (Monday, February 28, 2022), and your reimbursement request is denied as ineligible, you are not granted additional time to submit additional expenses after the deadline has passed. The deadline for submitting 2021 plan year expenses is Monday, February 28, 2022.

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 subsequent deposits you make during the plan year. 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, HRA, if applicable, and transit passes under the BVEA.

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 31 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. In addition, amounts deposited in one pre-tax account cannot be used to reimburse expenses from another pre-tax 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 details 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 incurred in 2021 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 reimbursement deadline 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 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 terminate. 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 $2,100 for one dependent and between $1,200 and $4,200 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.

Here is 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 taxpayers 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 taxpayers. Under current law, three different credit amounts apply, depending on whether the taxpayer has one, two or more, or no qualifying children.

For 2020, 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	$3,584	$25,220	$47,646
2 qualifying children	$5,920	$25,220	$53,330
3 or more qualifying children	$6,660	$25,220	$56,844
No qualifying children	$538	$14,680	$21,710

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 taxes. 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 Account (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 set up and paid directly through your agency's payroll deduction. This account is explained in further detail in the Payroll Deduction Account 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. 121 Benefits processes claims for the TEAs.

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 and this enrollment continues from year to year. The TEA must be re-elected each year. If you want your TEA period of coverage to begin January 1, you must enroll either during each Open Enrollment period 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** for the TEA 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 Monday, February 28, 2022, the 2021 reimbursement deadline, whichever occurs first.**

If you stop your contributions, you can continue to submit reimbursement requests for eligible parking and/or vanpool expenses towards your available balance in your TEA. The expenses must be submitted within 180 days from the date on which the expense was incurred or paid, or by Monday, February 28, 2022, the reimbursement deadline, whichever occurs first.

If you continue participation in the plan through December 31, 2020, you can submit vanpool and/or parking expenses incurred in 2021 for 180 days from the date on which the expense was incurred or paid, or through Monday, February 28, 2022, the 2021 reimbursement deadline, whichever comes first. **Any money remaining in your account after the final processing period will be forfeited.** However, if you enroll during Open Enrollment or prior to January 1 for the subsequent plan year and continue your contributions, you can carry over any balance remaining after December 31 to the new plan year. 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 2021 plan year must be postmarked on or before Monday, February 28, 2022.**

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 and you do not obtain receipts and submit receipts for reimbursement, 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 2021, the limits are **$270 per month for both qualified parking expenses** and **bus pass, light rail, or vanpool expenses**. You may elect no more than $270 per month for qualified parking expenses from the PDA and the TEA-Parking ***combined*** and you may elect no more than $270 per month for bus pass, light rail, 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-deduction account expenses handled?

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 parking or 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

	Without the PDA	With the PDA
Gross salary	$28,000	$28,000
Bus pass expenses paid	0	(300)
Taxable compensation	$28,000	$27,700
Estimated income tax (2019 Federal and State)	(2,280)	(2,228)
Social Security (FICA) tax	(2,142)	(2,119)
Compensation after tax	$23,578	$23,353
Bus pass expenses paid after tax	(300)	0
Spendable income after taxes and bus pass expenses	$23,278	$23,353

Using this account to pay transit expenses on a pre-tax basis increases Terry's take-home pay by $75 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 in cost 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 be reimbursed 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 for both the TEA-Parking and 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 2021 limit for the TEA-Parking is $270 per month, ($3,180 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 = $420
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, you have a monthly contract** 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 x 1 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 **$270 per month ($3,180 yearly-2021 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 using the BVEA debit card 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 x 20 days = $50
PDA-Parking	$40 x 12 months = $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 employer's business premises 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 $270 per month). At the same time, the prime member is eligible to receive the vanpool benefit (up to $270 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 2021 the monthly maximum tax-free limit for the PKEA is $270 per month. You cannot elect more than $270 per month for qualified parking expenses from the PDA **combined with** the TEA-Parking.

For 2021, the BVEA federal monthly maximum is $270. You cannot elect more than $270 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 is 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 provided. Parking and/or vanpool **expenses must be submitted for reimbursement within 180 days of the date on which the expense was provided 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 on that day 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 on 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, the last day to submit TEA election change requests is November 23, 2021. 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 parking or vanpool reimbursement?

To request reimbursement for parking and/or vanpool expenses:

- You can submit reimbursement requests for parking or vanpool expenses using 121 Benefits Mobile App. Documentation can also be submitted through this app. **Reimbursement requests must be submitted within 180 days of the date on which the expense was incurred or paid, or through Monday, February 28, 2022 (the end of the run-out period), whichever occurs first**.
- If you prefer, you may receive reimbursement for your eligible parking or vanpool 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 or your vanpool driver 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 (612-877-4322) 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.

- You can also enter your parking 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 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. **Parking expenses must be submitted for reimbursement within 180 days of the date on which the expense was incurred or paid, *or* through Monday, February 28, 2022 (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, fax or mail it to 121 Benefits. Check your documents for accuracy and legibility. Documentation must be submitted within the 180-day limit or by the 2021 reimbursement deadline, whichever occurs first.

All parking and vanpool expenses must be submitted for reimbursement within 180 days of the date on which the expense was incurred or paid or by the 2021 plan filing deadline of, whichever is earlier. Expenses are reimbursed weekly. Reimbursement requests received by noon on Friday will be processed the following Friday.

If you submit a request for reimbursement on or near the 2021 plan year deadline Monday, February 28, 2022, and your reimbursement request is denied as ineligible, you are not granted additional time to submit additional expenses after the deadline has passed. The deadline for submitting 2021 plan year expenses is Monday, February 28, 2022.

What is acceptable documentation for parking or vanpool reimbursement requests?
Acceptable documentation includes a receipt from the parking facility or your vanpool driver, indicating the date of payment, a description of the service, and the charge for the service.

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 Monday, February 28, 2022, which is the 2021 plan year reimbursement deadline**.

How are expenses paid through the TEA?

When you incur an eligible parking or vanpool 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 parking or vanpool to date, reduced by any previous claims paid from the account during the plan year.

How am I reimbursed for my bus pass or light rail expenses?

- The IRS changed the regulations regarding how mass transit commuter expenses can be reimbursed through the BVEA. The only method of reimbursement is by using the debit card to pay the transit vendor directly. Reimbursement requests by paper, online, or mobile app will not be processed for commuter mass transit expenses.
- The debit card (121 Benefits debit card) is a VISA card that will be loaded with your Bus Pass/Vanpool Expense Account (BVEA) contributions after each paycheck.
- To use the debit card for bus pass or light rail expenses, you present the card as your method of payment at the transit station or transit service center, or use it online at the transit provider's website, or transit provider's mobile app. If asked at the point of the transaction whether to process your transaction as a debit or credit, respond "credit."
- You will not need to provide documentation for bus and light rail purchases following the use of the debit card for these purchases.

Can I still submit bus pass or light rail expenses using a paper reimbursement form or submit online?

Bus Pass or Light Rail expenses must be purchased using the debit card at the transit station or transit service center, or online at the transit provider's website, or transit provider's mobile app. Reimbursement requests by paper, online, or mobile app will not be processed for commuter mass transit expenses.

Can I use the debit card for vanpool expenses?

Your vanpool expenses need to be submitted either online or using a paper reimbursement request form. The debit card cannot be used for vanpool expense reimbursement.

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 their spouse.

Is there a minimum reimbursement request amount?

There is a minimum reimbursement amount of $50.00 for parking or vanpool expenses. 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.*** **Expenses must be submitted for reimbursement within 180 days of the date on which the expense was incurred or paid or by the plan year filing deadline, whichever occurs first.**

There is no minimum when using the debit card for commuter expenses (bus pass or light rail).

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.

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 with a $50 minimum election during Open Enrollment or prior to the start of the following plan year (by December 31, 2021) for participation in the following plan year.

What if I cease my contributions?

If you stop your contributions to your TEA, you can **continue to submit valid 2021 parking or vanpool expenses for 180 days from the date on which the expense was incurred or paid, *or* through Monday, February 28, 2022 (the end of the run-out period), whichever occurs first.** If you have funds in your account for bus pass or light rail expenses, you can continue to use your debit card for those eligible expenses through the end of the current plan year. **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 parking or vanpool expenses incurred while you were employed for 180 days from the date on which the expense was incurred or paid *or* through Monday, February 28, 2022 (the end of the run-out period), whichever occurs first. Any money remaining in your account after the final processing period will be forfeited.** Your debit card for bus pass or light rail expenses will be termed on your last day of employment and any money remaining in your account after your last day of employment 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 parking or vanpool expenses incurred while you were employed for 180 days from the date on which the expense was incurred or paid, *or* Monday, February 28, 2022 (the end of the run-out period), whichever occurs first. Any money remaining in your account after the final processing period will be forfeited.** Your debit card for bus pass or light rail expenses will be termed on your last day of employment and any money remaining in your account after your last day of employment 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?

The responsibility is yours. Duplication 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 (HDPA) is administered by Minnesota Management and 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 by 121 Benefits of whether the claim is accepted or denied	30 days from submission date
Notification extension due to matters beyond the control of the Plan	15 days
Notification by 121 Benefits to participant of insufficient information on the claim	15 days of submission date
Response by participant to 121 Benefits to provide sufficient information on the claim	45 days from date of letter from 121 Benefits
Response by participant to reimbursement denial	180 days from date of letter from 121 Benefits
Response by Plan Administrator (State of MN) to participant	60 days after receipt of information from participant

Initial Claim Determinations

The Claims Administrator will make a claim reimbursement determination within 30 days after receipt of your claim. You will receive written notification of this claim determination. The 30-day period may be extended for an additional 15 days if the claim determination is delayed for reasons beyond the Claims Administrator's control. In that case, the Claims Administrator will notify you prior to the expiration of the initial 30-day period of the circumstances requiring an extension and the date by which the administrator expects to render a decision. If it is necessary to obtain additional information from you to satisfy the reimbursement determination, the initial claim determination notice will describe the specific information needed, and you will have 45 days from the date of the notice to provide the information. Without complete information, your claim will be denied. If your claim is denied, the Claims Administrator will provide you with a notice identifying (A) the reason or reasons for the denial, (B) any material or information needed to grant the claim and, (C) an explanation of the steps that you must take if you wish to appeal the denial.

Appeals

In the event that a claim reimbursement is denied in whole or in part, you have a right to a full and fair review. Your request to review a claim must be in writing and submitted within 180 days from the claim reimbursement denial notice. Note that if you had an MDEA or Minnesota State HRA claim that was previously denied (for a reason other than an ineligible expense) you have additional time to file an appeal. The timeframe is extended to 180 days after the end of the Outbreak Period. The Claims Administrator will make a claim reimbursement determination within 60 days following receipt of your appeal. In unusual cases, the review may take longer than the initial 60-day period. In no event will an extension exceed 60 days from the end of the initial 60-day period.

Your appeal must include your name, your employee identification number, reason for the appeal, and additional documentation to substantiate your appeal. Send your appeal to:

121 Benefits
730 2nd Ave S, Suite 400
730 Building
Minneapolis, MN 55402-2446
Fax: 612.877.4322 or 800.300.1672

You may submit written comments, documents, or other information in support of your appeal. You will also be provided, upon request and free of charge, reasonable access to and copies of all relevant records used in making the decision. The review will take into account all information regarding the denied or reduced claim reimbursement (whether or not presented or available at the initial determination) and the initial determination will not be given any weight.

The review will be conducted by someone different from the original decision-makers and without deference to any prior decision. If after review the claim is still deemed ineligible per the state's plan and/or Internal Revenue Service (IRS) regulations, and we continue to deny the claim, you will be notified in writing.

These claims procedures are triggered when a claim was submitted and 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.

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 and 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 Minnesota Management and Budget (651) 355-0100.
For TTY/TDD communication, contact the Minnesota Relay Service at 1-800-627-3529.

Medical Data Privacy

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

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

A. Introduction

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

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

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

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

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

B. Health Plans covered by this Notice

This Notice describes the privacy practices of the group health plans listed here and together these plans are collectively referred to as the "Plan" for purposes of this Notice. Each of these plans is independent of one another. This Notice will apply to the extent that You participate in each separate plan. Minnesota Management & Budget / SEGIP contracts with internal and external entities to perform the work of each of these plans.

In accordance with HIPAA, they may share PHI for the treatment, payment, and health care operations. Each entity is required to agree to additional terms and conditions to protect Your PHI.

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

C. The Plan's Rights and Obligations

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

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

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

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

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

Plan will provide the revised Notice, or information about the material change and how to obtain the revised Notice, in the next annual mailing to participants.

D. Uses and Disclosures of Your Protected Health Information

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

i. The Plan may disclose Your PHI, if You are in the Armed Forces, for activities deemed necessary by appropriate military command authorities, for determination of benefit eligibility by the Department of Veterans Affairs, or to foreign military authorities if You are a member of that

foreign military service. The Plan may disclose Your PHI to authorized federal officials for conducting national security and intelligence activities (including for the provision of protective services to the President of the United States) or to the Department of State to make medical suitability determinations. If You are an inmate at a correctional institution, then under certain circumstances the Plan may disclose Your PHI to the correctional institution.

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

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

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

E. Your rights regarding Your Protected Health Information

You have the following rights relating to Your PHI:

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

will provide You with an estimate of the cost of copying or mailing the requested information.

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

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

4. **Right to request restrictions**. You have the right to request that the Plan restrict how it uses or discloses Your PHI for treatment, payment, or health care

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

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

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

F. Complaints

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

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

G. Contact Information for questions

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

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

Minnesota Management and Budget

NOTICE OF COLLECTION OF PRIVATE DATA

(September 2, 2017)

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

What data will we use?

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

Why we ask You for this data?

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

Do You have to answer the questions we ask?

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

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

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

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

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

How else may this data be used?

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