ARTICLE 18 - INSURANCE

Section 1. State Employee Group Insurance Program (SEGIP). During the life of this Agreement, the Employer agrees to offer a Group Insurance Program that includes health, dental, life, and disability coverages equivalent to existing coverages, subject to the provisions of this Article.

All insurance eligible employees will be provided with a Summary Plan Description (SPD) called "Your Employee Benefits". Such SPD shall be provided no less than biennially and prior to the beginning of the insurance year. New insurance eligible employees shall receive a SPD within thirty (30) days of their date of eligibility.

Section 2. Eligibility for Group Participation. This section describes eligibility to participate in the Group Insurance Program.

A. **Employees - Basic Eligibility**. Employees may participate in the Group Insurance Program if they are scheduled to work at least 1044 hours in any twelve consecutive months, except for: (1) emergency, or temporary classified, or intermittent employees; (2) student workers; and (3) interns.

B. **Employees - Special Eligibility**. The following employees are also eligible to participate in the Group Insurance Program:

1. **DNR Employees**. An employee of the Department of Natural Resources may meet the basic eligibility requirement for participation in the Group Insurance Program based on a combination of seasonal and temporary project employment. Eligibility commences after completion of three (3) years of continuous service in which the basic eligibility requirements are met; continues until the employee completes a year in which the basic

eligibility requirements are not met; and commences again after the employee meets or is anticipated to meet the basic eligibility requirements in one (1) year.

2. **Employees with a Work-related Injury/Disability**. An employee who was off the State payroll due to a work-related injury or a work-related disability may continue to participate in the Group Insurance Program as long as such an employee receives workers' compensation payments or while the workers' compensation claim is pending.

3. **Totally Disabled Employees**. Consistent with M.S. 62A.148, certain totally disabled employees may continue to participate in the Group Insurance Program.

4. ~~**Retired**~~ **Separated Employees Under M.S. 43A.27**. Pursuant to M.S. 43A.27, Subdivision 3a(1), ~~A~~an employee who ~~retires~~ separates from State service~~,~~ and who, at the time of separation has five (5) or more years of allowable pension service and is entitled to immediately receive an annuity under a State retirement program and, who is not eligible for regular (non-disability) Medicare coverage, ~~has five (5) or more years of allowable pension service, and is entitled at the time of retirement to immediately receive an annuity under a State retirement program,~~ may continue to participate in the health and dental coverages offered through the Group Insurance Program.

   Consistent with M.S. 43A.27, Subdivision 3a(2), ~~a retired employee of the State who receives an annuity under a State retirement program~~ an employee who separates from State service and who, at the time of separation is at least fifty (50) years of age and at least fifteen (15) years of State service may continue to participate in the health and dental coverages offered through the Group Insurance Program. Retiree coverage must be coordinated with Medicare.

C. **Dependents**. Eligible dependents for the purposes of this Article are as follows:

1. **Spouse**. The spouse of an eligible employee (if legally married under Minnesota law). For the purposes of health insurance coverage, if that spouse works full-time for an organization employing more than one hundred (100) people and elects to receive either credits or cash (1) in place of health insurance or health coverage or (2) in addition to a health plan with a seven hundred and fifty dollar ($750) or greater deductible through his/her employing organization, he/she is not eligible to be a covered dependent for the purposes of this Article. If both spouses work for the State or another organization participating in the State's Group Insurance Program, neither spouse may be covered as a dependent by the other, unless one spouse is not eligible for a full Employer Contribution as defined in Section 3A.

   Effective January 1, 2015 if both spouses work for the State or another organization participating in the State's Group Insurance Program, a spouse may be covered as a dependent by the other.

2. **Children**.

   a. **Health and Dental Coverage**: A dependent child is an eligible employee's child to age twenty-six (26).

   b. **Dependent Child**: A "dependent child" includes an employee's (1) biological child, (2) child legally adopted by or placed for adoption with the employee, (3) step-child, and (4) foster child who has been placed with the employee by an authorized placement agency or by a judgment, decree, or other court order. For a step-child to be considered a dependent child, the employee must be legally married to the child's legal parent or legal guardian. An employee (or the employee's spouse or jointly) must have permanent, full and sole legal and physical custody of the foster child.

c. **Coverage Under Only One Plan**: For purposes of (a) and (b) above, if the employee's adult child (age 18 to 26) works for the State or another organization participating in the State's Group Insurance Program, the child may not be covered as a dependent by the employee unless the child is not eligible for a full Employer Contribution as defined in Section 3A.

Effective January 1, 2015 for purposes of (a) and (b) above, if the employee's adult child (age 18 to 26) works for the State or another organization participating in the State's Group Insurance Program, the child may be covered as a dependent by the employee.

3. **Grandchildren**. A dependent grandchild is an eligible employee's unmarried dependent grandchild who:

a. Is financially dependent upon the employee for principal support and maintenance and has resided with the employee continuously from birth, or

b. Resides with the employee and is dependent upon the employee for principal support and maintenance and is the child of the employee's unmarried child (the parent) to age nineteen (19).

If a grandchild is legally adopted or placed in the legal custody of the grandparent, they are covered as a dependent child under Section 2C (2) and (4).

4. **Disabled Child**. A disabled dependent child is an eligible employee's child or grandchild regardless of marital status, who was covered and then disabled prior to the limiting age or any other limiting term required for dependent coverage and who continues to be incapable of self-sustaining employment by reason of developmental disability, mental illness or

disorder, or physical disability, and is chiefly dependent upon the employee for support and maintenance, provided proof of such incapacity and dependency must be furnished to the health carrier by the employee or enrollee within thirty one (31) days of the child's attainment of the limiting age or any other limiting term required for dependent coverage. The disabled dependent is eligible to continue coverage as long as s/he continues to be disabled and dependent, unless coverage terminates under the contract.

5. **Qualified Medical Child Support Order**. A child who would otherwise meet the eligibility requirements and is required to be covered by a Qualified Medical Child Support Order (QMCSO) is considered an eligible dependent.

6. **Child Coverage Limited to Coverage Under One Employee**. If both spouses work for the State or another organization participating in the State's Group Insurance Program, either spouse, but not both, may cover the eligible dependent children or grandchildren. This restriction also applies to two divorced, legally separated, or unmarried employees who share legal responsibility for their eligible dependent children or grandchildren.

D. **Continuation Coverage**. Consistent with state and federal laws, certain employees, former employees, dependents, and former dependents may continue group health, dental, and/or life coverage at their own expense for a fixed length of time. As of the date of this Agreement, state and federal laws allow certain group coverages to be continued if they would otherwise terminate due to:

a. termination of employment (except for gross misconduct);
b. layoff;
c. reduction of hours to an ineligible status;
d. dependent child becoming ineligible due to change in age, student status, marital status, or financial support (in the case of a foster child or stepchild);

e. death of employee;

f. divorce; or

g. a covered employee's entitlement to or enrollment in Medicare.

Section 3. Eligibility for Employer Contribution. This section describes eligibility for an Employer Contribution toward the cost of coverage.

A. **Full Employer Contribution - Basic Eligibility**. ~~The following employees covered by this Agreement receive the full Employer Contribution:~~Employees covered by this Agreement who are scheduled to work at least seventy-five (75) percent of the time are eligible for the full Employer Contribution. This means:

1. Employees who are scheduled to work at least ~~forty (40)~~eighty (80) hours ~~weekly~~ per pay period for a period of nine (9) months or more in any twelve (12) consecutive months.

2. Employees who are scheduled to work at least sixty (60) hours per pay period for twelve (12) consecutive months, but excluding part-time or seasonal employees serving on less than a seventy-five (75) percent basis.

B. **Partial Employer Contribution - Basic Eligibility**. The following employees covered by this Agreement receive the full Employer Contribution for basic life coverage, and at the employee's option, a partial Employer Contribution for health and dental coverages if they are scheduled to work at least fifty (50) percent but less than seventy-five (75) percent of the time. This means:

1. Employees who hold part-time appointments and who are scheduled to work at least forty (40) hours but less than sixty (60) hours per pay period for twelve (12) consecutive months.

2. Employees who hold part-time appointments and who are scheduled to work at least one thousand forty four (1044) hours over a period of any twelve (12) consecutive months.

The partial Employer Contribution for health and dental coverages is seventy-five (75) percent of the full Employer Contribution.

~~1. **Part-time Employees**. Employees who hold part-time, unlimited appointments and who work at least fifty (50) percent of the time but less than seventy-five (75) percent of the time.~~

~~2. **Seasonal Employees**. Seasonal employees who are scheduled to work at least 1044 hours over a period of any twelve (12) consecutive months.~~

C. **Special Eligibility**. The following employees also receive an Employer Contribution:

1. **DNR Employees**. An employee of the Department of Natural Resources may meet the basic requirements for a full or partial Employer Contribution based on a combination of seasonal and temporary project employment, as described in Section 2B1.

2. **Employees on Layoff**. A classified employee who receives an Employer Contribution, who has three (3) or more years of continuous service, and who has been permanently or seasonally laid off, remains eligible for an Employer Contribution and all other benefits provided under this Article for an extended eligibility period of six (6) months from the date of layoff.

Seasonal Layoff. The calculation in determining the six (6) months duration of eligibility for an Employer contribution begins on the date the employee is seasonally laid off.

Permanent Layoff. The calculation in determining the six (6) month duration of eligibility for an employer contribution begins on the date the employee is permanently laid off or accepts an appointment in lieu of layoff without a break in service with a lesser employer-paid insurance contribution than the employee was receiving in the appointment from which the layoff occurred and is no longer actively employed ~~by the Employer~~ in the appointment from which the layoff occurred.

In the event the employee, while on permanent or seasonal layoff, is rehired to any state job classification with a lesser employer-paid insurance contribution than the employee is receiving under the six (6) months of insurance continuation, the employee shall continue to receive the employer contribution toward the ~~six (6) months of~~ employer-paid insurance for the duration of the six (6) months.

However, notwithstanding the paragraph above, in the event the employee successfully claims another state job in any agency and classification which is insurance eligible without a break in service, and is subsequently non-certified or involuntarily separated, the six (6) month duration for the employer contribution toward insurance benefits will begin at the time the employee is non-certified or otherwise involuntarily separated and is no longer actively employed by the Employer.

In no event shall an extended benefit eligibility period be longer than a total of six (6) months. Further, an employee must be receiving an Employer Contribution under Section 3 (A) or (B) at the time of layoff in order to be eligible for the six (6) months continuation of insurance.

3. **Work-related Injury/Disability**. An employee who receives an Employer Contribution and who is off the State payroll due to a work-related injury or a work-related disability remains eligible for an Employer Contribution as long as such an employee receives workers'

compensation payments. If such employee ceases to receive workers' compensation payments for the injury or disability and is granted a medical leave under Article 10, he/she shall be eligible for an Employer contribution during that leave.

D. **Maintaining Eligibility for Employer Contribution**.

1. **General**. An employee who receives a full or partial Employer Contribution maintains that eligibility as long as the employee meets the Employer Contribution eligibility requirements, and appears on a State payroll for at least one (1) full working day during each payroll period. This requirement does not apply to employees who receive an Employer Contribution while on layoff as described in Section 3C2, or while eligible for workers' compensation payments as described in Section 3C3.

2. **Unpaid Leave of Absence**. If an employee is on an unpaid leave of absence, then vacation leave, compensatory time, or sick leave cannot be used for the purpose of maintaining eligibility for an Employer Contribution by keeping the employee on a State payroll for one (1) working day per pay period.

3. **School Year Employment**. If an employee is employed on the basis of a school year and such employment contemplates absences from the State payroll during the summer months or vacation periods scheduled by the Appointing Authority which occur during the regular school year, the employee shall nonetheless remain eligible for an Employer Contribution, provided that the employee appears on the regular payroll for at least one (1) working day in the payroll period immediately preceding such absences.

4. **Special Leaves**. An employee who is on an approved FMLA leave or on a Voluntary Reduction in Hours as provided elsewhere in this Agreement maintains eligibility for an Employer Contribution.

Section 4. Amount of Employer Contribution. For employees eligible for an Employer Contribution as described in Section 3, the amount of the Employer Contribution will be determined as follows beginning on January 1, ~~2012~~2014. The Employer Contribution amounts and rules in effect on June 30, ~~2011~~ 2013 will continue through December 31, ~~2011~~2013.

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

1. **Employee Coverage**. For plan year beginning on January 1, 2014, ~~F~~for employee health coverage, the Employer contributes an amount equal to one hundred (100) percent of the employee-only premium of the Minnesota Advantage Health Plan (Advantage). Beginning on January 1, 2015, for employee health coverage, the Employer contributes an amount equal to ninety-five percent (95%) of the employee-only premium of the Minnesota Advantage Health Plan (Advantage).

2. **Dependent Coverage**. For dependent health coverage for the ~~2012~~ 2014 and ~~2013~~ 2015 plan years, the Employer contributes an amount equal to eighty-five (85) percent of the dependent premium of the Advantage.

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

1. **Employee Coverage**. For employee dental coverage, the Employer contributes an amount equal to the lesser of ninety (90) percent of the employee premium of the State Dental Plan, or the actual employee premium of the dental plan chosen by the employee. However, for calendar years beginning January 1, ~~2012~~2014, and January 1, ~~2013~~2015, the minimum employee contribution shall be five dollars ($5.00) per month.

2. **Dependent Coverage**. For dependent dental coverage, the Employer contributes an amount equal to the lesser of fifty (50) percent of the dependent premium of the State Dental Plan, or the actual dependent premium of the dental plan chosen by the employee.

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

Section 5. Coverage Changes and Effective Dates.

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

1. **Newly Hired Employees**. All employees hired to an insurance eligible position must make their benefit elections by their initial effective date of coverage as defined in this Article, Section 5C. Insurance eligible employees will automatically be enrolled in basic life coverage. If employees eligible for a full Employer Contribution do not choose a health plan administrator and a primary care clinic by their initial effective date, they will be enrolled in a Benefit Level Two clinic (or Level One, if available) that meets established access standards in the health plan with the largest number of Benefit Level One and Two clinics in the county of the employee's residence at the beginning of the insurance year.

2. **Eligibility Changes**. Employees who become eligible for a full employer contribution must make their benefit elections within thirty (30) calendar days of becoming eligible. If employees do not choose a health plan administrator and a primary care clinic within this thirty (30) day timeframe, they will be enrolled in a Benefit Level Two clinic (or Level One, if available) that meets established access standards in the health plan with the largest number of Benefit Level One and Two clinics in the county of the employee's residence at the beginning of the insurance year.

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

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

B. **When Coverage May be Changed or Cancelled.**

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

   The request to change coverage must be consistent with a change in status that qualifies as a life event, and does not include changing health or dental plans, which may only be

done under the terms of Section 5A above. Any election to add coverage must be made within thirty (30) days following the event, and any election to cancel coverage must be made within sixty (60) days following the event. (An employee and a retired employee may add dependent health or dental coverage following the birth of a child or dependent grandchild, or following the adoption of a child, without regard to the thirty (30) day limit.) These life events (for both employees and retirees) are:

a. A change in legal marital status, including marriage, death of a spouse, divorce, legal separation and annulment.

b. A change in number of dependents, including birth, death, adoption, and placement for adoption.

c. A change in employment status of the employee, or the employee's or retiree's spouse or dependent, including termination or commencement of employment, a strike or lockout, a commencement of or return from an unpaid leave of absence, a change in worksite, and a change in working conditions (including changing between part-time and full-time or hourly and salary) of the employee, the employee's or retiree's spouse or dependent which results in a change in the benefits they receive under a cafeteria plan or a health or dental plan.

d. A dependent ceasing to satisfy eligibility requirements for coverage due to attainment of age or otherwise no longer meets the eligibility requirements under Section 2C.

e. A change in the place of residence of the employee, retiree or their spouse, or dependent.

f. Significant cost or coverage changes (including coverage curtailment and the addition of a benefit package).

g. Family Medical Leave Act (FMLA) leave.

h. Judgments, decrees or orders.

i. A change in coverage of a spouse or dependent under another Employer's plan.

j. Open enrollment under the plan of another Employer.

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

l. A COBRA-qualifying event.

m. Loss of coverage under the group health plan of a governmental or educational institution (a State's children's health insurance program, medical care program of an Indian tribal government, State health benefits risk pool, or foreign government group health plan).

n. Entitlement to Medicare or Medicaid.

o. Any other situations in which the group health or dental plan is required by the applicable federal or state law to allow a change in coverage.

2. **Canceling Dependent Coverage During Open Enrollment**. In addition to the above situations, dependent health or dependent dental coverage may also be cancelled for any

reason during the open enrollment period that applies to each type of plan (as long as allowed under the applicable provisions, regulations and rules of the federal and state law in effect at the beginning of the plan year).

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

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

C. **Effective Date of Coverage**.

1. **Initial Effective Date**. The initial effective date of coverage under the Group Insurance Program is the thirty-fifth (35th) day following the employee's first day of employment, re-hire, or reinstatement with the State. The initial effective date of coverage for an employee whose eligibility has changed is the date of the change. An employee must be actively at work on the initial effective date of coverage, except that an employee who is on paid leave on the date State-paid life insurance benefits increase is also entitled to the increased life insurance coverage. In no event shall an employee's dependent's coverage become effective before the employee's coverage.

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

2. **Delay in Coverage Effective Date**.

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

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

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

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

D. **Open Enrollment**.

1. **Frequency and Duration**. There shall be an open enrollment period for health coverage in each year of this Agreement, and for dental coverage in the first year of this Agreement. Each year of the Agreement, all employees shall have the option to complete a Health Assessment. Open enrollment periods shall last a minimum of fourteen (14) calendar days

in each year of the Agreement. Open enrollment changes become effective on January 1 of each year of this Agreement. Subject to a timely contract settlement, the Employer shall make open enrollment materials available to employees at least fourteen (14) days prior to the start of the open enrollment period.

2. **Eligibility to Participate**. An employee eligible to participate in the State Employee Group Insurance Program, as described in Sections 2A and 2B, may participate in open enrollment. In addition, a person in the following categories may, as allowed in section 5D1 above, make certain changes: (1) a former employee or dependent on continuation coverage, as described in Section 2D, may change plans or add coverage for health and/or dental plans on the same basis as active employees; and (2) an early retiree, prior to becoming eligible for Medicare, may change health and/or dental plans as agreed to for active employees, but may not add dependent coverage.

3. **Materials for Employee Choice**. Each year prior to open enrollment, the Appointing Authority will give eligible employees the information necessary to make open enrollment selections. Employees will be provided a statement of their current coverage each year of the contract.

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

Section 6. Basic Coverages.

A. **Employee and Family Health Coverage**.

1. **Minnesota Advantage Health Plan (Advantage)**. The health coverage portion of the State Employee Group Insurance Program is provided through the Minnesota Advantage Health Plan (Advantage), a self-insured health plan offering four (4) Benefit Level options. Provider networks and claim administration are provided by multiple plan administrators. Coverage offered through Advantage is determined by Section 6A2.

2. **Coverage Under the Minnesota Advantage Health Plan**. From July 1, ~~2011~~ 2013 through December 31, ~~2012~~2013, health coverage under the SEGIP will continue at the level in effect on June 30, ~~2011~~2013. Effective January 1, ~~2013~~2014, Advantage will cover eligible services subject to the copayments, deductibles and coinsurance coverage limits stated. Services provided through Advantage are subject to the managed care procedures and principles, including standards of medical necessity and appropriate practice, of the plan administrators. Coverage details are provided in the Advantage Summary of Benefits.

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

      1) **Plan Administrator**. Employees must elect a plan administrator during their initial enrollment in Advantage and may change their plan administrator election only during the annual open enrollment and when permitted under Section 5. Dependents must be enrolled through the same plan administrator as the employee.

      2) **Benefit Level**. The primary care clinics available through each plan administrator are assigned a Benefit Level. The Benefit Levels are outlined in the benefit chart below. Primary care clinics may be in different Benefit Levels for different plan

administrators. Family members may be enrolled in clinics that are in different Benefits Levels. Employees and their dependents may change to clinics in different Benefit Levels during the annual open enrollment. Employees and their dependents may also elect to move to a clinic in a different Benefit Level within the same plan administrator up to two (2) additional times during the plan year. Unless the individual has a referral from his/her primary care clinic, there are no benefits for services received from providers in Benefit Levels that are different from that of the primary care clinic in which the individual has enrolled.

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

4) **Advantage Benefit Chart for Services Incurred During Plan Years ~~2012~~ 2014 and ~~2013~~2015**.

~~2012 Benefit Provision~~	~~Benefit Level 1 The member pays:~~	~~Benefit Level 2 The member pays:~~	~~Benefit Level 3 The member pays:~~	~~Benefit Level 4 The member pays:~~
~~Deductible for all services except drugs and preventive care (S/F)~~	~~$50/$100~~	~~$140/$280~~	~~$350/$700~~	~~$600/$1,200~~
~~Office visit copay/urgent care (copay waived for preventive services) 1) Having taken health assessment and opted in for health coaching 2) Not having taken health assessment~~	~~1) $17 2) $22~~	~~1) $22 2) $27~~	~~1) $27 2) $32~~	~~1) $37 2) $42~~

2012 Benefit Provision	Benefit Level 1 The member pays:	Benefit Level 2 The member pays:	Benefit Level 3 The member pays:	Benefit Level 4 The member pays:
or not having opted-in for health coaching				
Convenience Clinic (deductible waived)	$10	$10	$10	$10
Emergency room copay	$75	$75	$75	N/A – subject to Deductible and 25% Coinsurance to OOP maximum
Facility copays • Per inpatient admission (waived for admission to Center of Excellence) • Per outpatient surgery	$85 $55	$180 $110	$450 $220	N/A – subject to Deductible and 25% Coinsurance to OOP maximum N/A – subject to Deductible and 25% Coinsurance to OOP maximum
Coinsurance for MRI/CT scan services	5%	5%	10%	N/A – subject to Deductible and 25% Coinsurance to OOP maximum
Coinsurance for services NOT subject to copays	5% (95% coverage after payment of deductible)	5% (95% coverage after payment of deductible)	10% (90% coverage after payment of deductible)	25% for all services to OOP maximum after deductible
Coinsurance for durable medical equipment	20% (80% coverage after payment of 20% coinsurance)	20% (80% coverage after payment of 20% coinsurance)	20% (80% coverage after payment of 20% coinsurance)	25% for all services to OOP maximum after deductible
Copay for three-tier prescription drug plan	Tier 1: $10 Tier 2: $16 Tier 3: $36	Tier 1: $10 Tier 2: $16 Tier 3: $36	Tier 1: $10 Tier 2: $16 Tier 3: $36	Tier 1: $10 Tier 2: $16 Tier 3: $36
Maximum drug out-of-pocket limit (S/F)	$800/$1,600	$800/$1,600	$800/$1,600	$800/$1,600
Maximum non-drug out-of-pocket limit	$1,100/$2,200	$1,100/$2,200	$1,100/$2,200	$1,100/$2,200

~~2012 Benefit Provision~~	~~Benefit Level 1 The member pays:~~	~~Benefit Level 2 The member pays:~~	~~Benefit Level 3 The member pays:~~	~~Benefit Level 4 The member pays:~~
~~(S/F)~~				

~~2013~~ 2014-2015 Benefit Provision	Benefit Level 1 The member pays:	Benefit Level 2 The member pays:	Benefit Level 3 The member pays:	Benefit Level 4 The member pays:
Deductible for all services except drugs and preventive care (S/F)	$75/$150	$180/$360	$400/$800	$1,000/$2,000
Office visit copay/urgent care (copay waived for preventive services) 1) Having taken health assessment and opted-in for health coaching 2) Not having taken health assessment or not having opted-in for health coaching	1) $18 2) $23	1) $23 2) $28	1) $36 2) $41	1) $55 2) $60
In-Network Convenience Clinics and Online Care (deductible waived)	$10	$10	$10	$10
Emergency room copay	$100	$100	$100	N/A – subject to Deductible and 25% Coinsurance to OOP maximum
Facility copays • Per inpatient admission (waived for admission to Center of Excellence) • Per outpatient surgery	$100 $60	$200 $120	$500 $250	N/A – subject to Deductible and 25% Coinsurance to OOP maximum N/A – subject to Deductible and 25% Coinsurance to OOP maximum
Coinsurance for	5%	10%	20%	N/A – subject

~~2013~~ 2014-2015 Benefit Provision	Benefit Level 1 The member pays:	Benefit Level 2 The member pays:	Benefit Level 3 The member pays:	Benefit Level 4 The member pays:
MRI/CT scan services				to Deductible and 25% Coinsurance to OOP maximum
Coinsurance for services NOT subject to copays	5% (95% coverage after payment of deductible)	5% (95% coverage after payment of deductible)	20% (80% coverage after payment of deductible)	25% for all services to OOP maximum after deductible
Coinsurance for durable medical equipment	20% (80% coverage after payment of 20% coinsurance)	20% (80% coverage after payment of 20% coinsurance)	20% (80% coverage after payment of 20% coinsurance)	25% for all services to OOP maximum after deductible
Copay for three-tier prescription drug plan	Tier 1: $12 Tier 2: $18 Tier 3: $38	Tier 1: $12 Tier 2: $18 Tier 3: $38	Tier 1: $12 Tier 2: $18 Tier 3: $38	Tier 1: $12 Tier 2: $18 Tier 3: $38
Maximum drug out-of-pocket limit (S/F)	$800/$1,600	$800/$1,600	$800/$1,600	$800/$1,600
Maximum non-drug out-of-pocket limit (S/F)	$1,100/$2,200	$1,100/$2,200	$1,500/$3,000	$2,500/$5,000

b. **Office Visit Copayments**. In each year of the Agreement, the level of the office visit copayment applicable to an employee and dependents is based upon whether the employee has completed the on-line Health Assessment during open enrollment and has agreed to opt-in for health coaching.

c. **Services received from, or authorized by, a primary care physician within the primary care clinic**. Under Advantage, the health care services outlined in the benefits charts above shall be received from, or authorized by a primary care physician within the primary care clinic. Preventive care, as outlined in the Summary of Benefits, is covered at one hundred (100) percent for services received from or authorized by the primary care clinic. The primary care clinic shall be selected from approved clinics in accordance with the Advantage administrative procedures. Unless otherwise specified

in 6A2, services not received from, or authorized by, a primary care physician within the primary care clinic may not be covered. Unless the individual has a referral from his/her primary care clinic, there are no benefits for services received from providers in Benefit Levels that are different from that of the primary care clinic in which the individual has enrolled.

d. **Services not requiring authorization by a primary care physician within the primary care clinic**.

1) **Eye Exams**. Limited to one (1) routine examination per year for which no copay applies.

2) **Outpatient emergency and urgicenter services within the service area**. The emergency room copay applies to all outpatient emergency visits that do not result in hospital admission within twenty-four (24) hours. The urgicenter copay is the same as the primary care clinic office visit copay.

3) **Emergency and urgently needed care outside the service area**. Professional services of a physician, emergency room treatment, and inpatient hospital services are covered at eighty percent (80%) of the first two thousand dollars ($2,000) of the charges incurred per insurance year, and one-hundred percent (100%) thereafter. The maximum eligible out-of-pocket expense per individual per year for this benefit is four hundred dollars ($400). This benefit is not available when the member's condition permits him or her to receive care within the network of the plan in which the individual is enrolled.

4) **Ambulance**. The deductible and coinsurance for services not subject to copays applies.

e. **Prescription drugs**.

1) **Copayments and annual out-of-pocket maximums**.

~~For the first year of the contract:~~

~~Tier 1 copayment: Ten dollar ($10) copayment per prescription or refill for a Tier 1 drug dispensed in a thirty (30) day supply.~~

~~Tier 2 copayment: Sixteen dollar ($16) copayment per prescription or refill for a Tier 2 drug dispensed in a thirty (30) day supply.~~

~~Tier 3 copayment: Thirty-six dollar ($36) copayment per prescription or refill for a Tier 3 drug dispensed in a thirty (30) day supply.~~

~~Out-of-pocket maximum: There is an annual maximum eligible out-of-pocket expense limit for prescription drugs of eight hundred dollars ($800) per person or one thousand six hundred dollars ($1,600) per family.~~

For the first and second year of the contract:

Tier 1 copayment: Twelve dollar ($12) copayment per prescription or refill for a Tier 1 drug dispensed in a thirty (30) day supply.

Tier 2 copayment: Eighteen dollar ($18) copayment per prescription or refill for a Tier 2 drug dispensed in a thirty (30) day supply.

Tier 3 copayment: Thirty-eight dollar ($38) copayment per prescription or refill for a Tier 3 drug dispensed in a thirty (30) day supply.

Out of pocket maximum: There is an annual maximum eligible out-of-pocket expense limit for prescription drugs of eight hundred dollars ($800) per person or one thousand six hundred dollars ($1,600) per family.

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

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

4) **Special Coverage for "Grandfathered Diabetic Group"**. For insulin dependent diabetics who have been continuously enrolled for health coverage insured or administered by Blue Cross Blue Shield through the SEGIP since January 1, 1991 and who were identified as having used these supplies during the period January 1, 1991 through September 30, 1991 (herein the "Grandfathered Diabetic Group"), diabetic supplies are covered as follows:

- Test tapes and syringes are covered at one hundred (100) percent for the greater of a thirty (30) day supply or one hundred (100) units when purchased with insulin.

5) **Special Coverage for Nicotine Replacement Therapies**. There will be no copayment for formulary nicotine replacement therapies for employees and dependents who take the Health Assessment, opt-in for coaching, and are engaged in a plan-sponsored smoking cessation program, or other program as documented by the health coach.

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

1) Mental health services – inpatient or outpatient.

2) Chemical dependency services – inpatient and outpatient.

3) Chiropractic services.

4) Transplant coverage.

5) Cardiac services.

6) Home infusion therapy.

7) Hospice.

g. **Individuals whose permanent residence and principal work location are outside the State of Minnesota and outside of the service areas of the health plans participating in Advantage**. If these individuals use the plan administrator's national preferred provider organization in their area, services will be covered at Benefit Level

Two. If a national preferred provider is not available in their area, services will be covered at Benefit Level Two through any other provider available in their area. If the national preferred provider organization is available but not used, benefits will be paid at the POS level described in paragraph "i" below. All terms and conditions outlined in the Summary of Benefits will apply.

h. **Children living with an ex-spouse outside the service area of the employee's plan administrator**. Covered children living with former spouses outside the service area of the employee's plan administrator, and enrolled under this provision as of December 31, 2003, will be covered at Benefit Level Two benefits. If available, services must be provided by providers in the plan administrator's national preferred provider organization. If the national preferred provider organization is available but not used, benefits will be paid at the POS level described in paragraph "i" below.

i. **Individuals whose permanent residence is outside the State of Minnesota and outside the service areas of the health plans participating in Advantage**. (This category includes employees temporarily residing outside Minnesota on temporary assignment or paid leave (including sabbatical leaves) and all dependent children (including college students) and spouses living out of area.) The point of service (POS) benefit described below is available to these individuals. All terms and conditions outlined in the Summary of Benefits apply. This benefit is not available for services received within the service areas of the health plans participating in Advantage.

1) **Deductible**. There is a three hundred fifty dollar ($350) annual deductible per person, with a maximum deductible per family per year of seven hundred dollars ($700).

2) **Coinsurance**. After the deductible is satisfied, seventy percent (70%) coverage up to the plan out-of-pocket maximum designated below.

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

~~In the first year of the contract, coverage under Advantage is subject to a plan year, non-prescription drug, out-of-pocket maximum of one thousand one hundred dollars ($1,100) per person or two thousand two hundred dollars ($2,200) per family.~~

In the first and second year of the contract, coverage under Advantage is subject to a plan year, non-prescription drug, out-of-pocket maximum of one thousand one hundred dollars ($1,100) per person or two thousand two hundred dollars ($2,200) per family for members whose primary care clinic is in Cost Level 1 or Cost Level 2; one thousand five hundred dollars ($1,500) per person or three thousand dollars ($3,000) per family for members whose primary care clinic is in Cost Level 3; and two thousand five hundred dollars ($2,500) per person or five thousand dollars ($5,000) per family for members whose primary care clinic is in Cost Level 4.

k. **In-Network Convenience Clinics and Online Care**. Services received at in-network convenience clinics and online care are subject to a ten dollar ($10) copayment in each year of the Agreement. First dollar deductibles are waived for convenience clinic and online care visits. (Note that prescriptions received as a result of a visit are subject to the drug copayment and out-of-pocket maximums described above at 6A2(4)e).)

3. **Benefit Level Two Health Care Network Determination**. Issues regarding the health care networks for the 2013 insurance year shall be negotiated in accordance with the following procedures:

a. At least twelve (12) weeks prior to the open enrollment period for the 2013 insurance year the Employer shall meet and confer with the Joint Labor/Management Committee on Health Plans in an attempt to reach agreement on the Benefit Level Two health care networks.

b. If no agreement is reached within five (5) working days, the Employer and the Joint Labor/Management Committee on behalf of all of the exclusive representatives shall submit a list of providers/provider groups in dispute to a mutually agreed upon neutral expert in health care delivery systems for final and binding resolution. The only providers/provider groups that may be submitted for resolution by this process are those for which, since the list for the 2012 insurance year was established, Benefit Level Two access has changed, or those that are intended to address specific problems caused by a reduction in Benefit Level Two access.

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

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

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

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

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

   a. **Develop programs**.

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

      2) **Pilot Programs**. The Employer may develop voluntary pilot programs to test the acceptability of various risk management programs. Incentives for participation in such programs may include limited short-term improvements to the benefits outlined in this Article. Implementation of such pilot programs is subject to the review and approval of the Joint Labor-Management Committee on Health Plans.

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

c. **Employee participation**. The Employer will assist employees' participation in health promotion and health education programs. Health promotion and health education programs that have been endorsed by the Employer (Minnesota Management & Budget) will be considered to be non-assigned job-related training pursuant to Administrative Procedure 21. Approval for this training is at the discretion of the Appointing Authority and is contingent upon meeting staffing needs in the employee's absence and the availability of funds. Employees are eligible for release time, tuition reimbursement, or a pro rata combination of both. Employees may be reimbursed for up to one hundred (100) percent of tuition or registration costs upon successful completion of the program. Employees may be granted release time, including the travel time, in lieu of reimbursement.

d. **Health Promotion Incentives**. The Joint Labor-Management Committee on Health Plans shall develop a program which provides incentives for employees who participate in a health promotion program. The health promotion program shall emphasize the adoption and maintenance of more healthy lifestyle behaviors and shall encourage wiser usage of the health care system.

6. **Post Retirement Health Care Benefit**. Employees who ~~retire~~ separate on or after January 1, 2008, from State service and who, at the time of separation are insurance eligible and entitled to immediately receive an annuity under a State retirement program shall be entitled to a contribution of two hundred fifty dollars ($250) to the Minnesota State Retirement System's (MSRS) Health Care Savings Plan~~, if at the time of retirement the employee is entitled to an annuity under a State retirement program~~. Employees who have

a HCSP waiver on file shall receive a two hundred fifty dollars ($250) cash payment. An employee who becomes totally and permanently disabled on or after January 1, 2008, who receives a State disability benefit, and is eligible for a deferred annuity under a State retirement program is also eligible for the two hundred fifty dollar ($250) contribution to the MSRS Health Care Savings Plan. Employees are eligible for this benefit only once.

B. **Employee Life Coverage**.

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

Employee's Annual Base Salary	**Group Life Insurance Coverage**	**Accidental Death and Dismemberment Principal Sum**
$10,000 - $15,000	$15,000	$15,000
$15,001 - $20,000	$20,000	$20,000
$20,001 - $25,000	$25,000	$25,000
$25,001 - $30,000	$30,000	$30,000
$30,001 - $35,000	$35,000	$35,000

Employee's Annual Base Salary	**Group Life Insurance Coverage**	**Accidental Death and Dismemberment Principal Sum**
$35,001 - $40,000	$40,000	$40,000
$40,001 - $45,000	$45,000	$45,000
$45,001 - $50,000	$50,000	$50,000
$50,001 - $55,000	$55,000	$55,000
$55,001 - $60,000	$60,000	$60,000
$60,001 - $65,000	$65,000	$65,000
$65,001 - $70,000	$70,000	$70,000
$70,001 - $75,000	$75,000	$75,000
$75,001 - $80,000	$80,000	$80,000
$80,001 - $85,000	$85,000	$85,000
$85,001 – $90,000	$90,000	$90,000
Over $90,000	$95,000	$95,000

2. **Extended Benefits**. An employee who becomes totally disabled before age 70 shall be eligible for the extended benefit provisions of the life insurance policy until age 70. Employees who were disabled prior to July 1, 1983 and who have continuously received benefits shall continue to receive such benefits under the terms of the policy in effect prior to July 1, 1983.

Section 7. Optional Coverages.

A. **Employee and Family Dental Coverage**.

1. **Coverage Options**. Eligible employees may select coverage under any one of the dental plans offered by the Employer, including health maintenance organization plans, the State Dental Plan, or other dental plans. Coverage offered through health maintenance organization plans is subject to change during the life of this Agreement upon action of the health maintenance organization and approval of the Employer after consultation with the Joint Labor/Management Committee on Health Plans. However, actuarial reductions in the level of HMO coverages effective during the term of this Agreement, including increases in copayments, require approval of the Joint Labor/Management Committee on Health Plans. Coverage offered through the State Dental Plan is determined by Section 6B2.

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

   a. **Copayments**. Effective January 1, ~~2010~~2014, the State Dental Plan will cover allowable charges for the following services subject to the copayments and coverage limits stated. Higher out-of-pocket costs apply to services obtained from dental care providers not in the State Dental Plan network. Services provided through the State Dental Plan are subject to the State Dental Plan's managed care procedures and principles, including standards of dental necessity and appropriate practice. The plan shall cover general cleaning two (2) times per plan year and special cleanings (root or deep cleaning) as prescribed by the dentist.

Service	In-Network	Out-of-Network
Diagnostic/Preventive	100%	50% after deductible
Fillings	60% after deductible	50% after deductible

Service	**In-Network**	**Out-of-Network**
Endodontics	60% after deductible	50% after deductible
Periodontics	60% after deductible	50% after deductible
Oral Surgery	60% after deductible	50% after deductible
Crowns	60% after deductible	50% after deductible
Prosthetics	50% after deductible	50% after deductible
Prosthetic Repairs	50% after deductible	50% after deductible
Orthodontics*	50% after deductible	50% after deductible

*Please refer to your certificate of coverage for information regarding age limitations for dependent orthodontic care.

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

c. **Annual maximums**. State Dental Plan coverage is subject to a one thousand five hundred dollar ($1,~~000~~500) annual maximum benefit payable (excluding orthodontia) per person. "Annual" means per insurance year.

d. **Orthodontia lifetime maximum**. Orthodontia benefits are available to eligible dependent children ages 8 through 18 subject to a two thousand four hundred dollar ($2,400) lifetime maximum benefit.

B. **Life Coverage**.

1. **Employee**. An employee may purchase up to five hundred thousand dollars ($500,000) additional life insurance, in increments established by the Employer, subject to satisfactory evidence of insurability. A new employee may purchase up to two (2) times annual salary in optional employee life coverage by their initial effective date of coverage as defined in this Article, Section 5C without evidence of insurability. An employee who becomes eligible for insurance may purchase up to two (2) times annual salary in optional employee life coverage without evidence of insurability within thirty (30) days of the initial effective date as defined in this Article.

2. **Spouse**. An employee may purchase up to five hundred thousand dollars ($500,000) life insurance coverage for his/her spouse in increments established by the Employer, subject to satisfactory evidence of insurability. A new employee may purchase either five thousand dollars ($5,000) or ten thousand dollars ($10,000) in optional spouse life coverage by their initial effective date of coverage as defined in this Article, Section 5C without evidence of insurability. An employee who becomes eligible for insurance may purchase either five thousand dollars ($5,000) or ten thousand dollars ($10,000) in optional spouse coverage without evidence of insurability within thirty (30) days of the initial effective date as defined in this Article.

3. **Children/Grandchildren**. An employee may purchase life insurance in the amount of ten thousand dollars ($10,000) as a package for all eligible children/grandchildren (as defined in Section 2A2 and 2A3 of this Article). For a new employee, child/grandchild coverage requires evidence of insurability if application is made after the initial effective date of coverage as defined in this Article, Section 5C. An employee who becomes eligible for insurance may purchase child/grandchild coverage without evidence of insurability if application is made within thirty (30) days of the initial effective date as defined in this Article. Child/grandchild coverage commences fourteen (14) calendar days after birth.

4. **Accelerated Life**. The additional employee, spouse and child life insurance policies will include an accelerated benefits agreement providing for payment of benefits prior to death if the insured has a terminal condition.

5. **Waiver of Premium**. In the event an employee becomes totally disabled before age seventy (70), there shall be a waiver of premium for all life insurance coverage that the employee had at the time of disability.

6. **Paid Up Life Policy**. At age sixty-five (65) or the date of retirement, an employee who has carried optional employee life insurance for the five (5) consecutive years immediately preceding the date of the employee's retirement or age sixty-five (65), whichever is later, shall receive a post-retirement paid-up life insurance policy in an amount equal to fifteen (15) percent of the smallest amount of optional employee life insurance in force during that five (5) year period. The employee's post-retirement death benefit shall be effective as of the date of the employee's retirement or the employee age sixty-five (65), whichever is later. Employees who retire prior to age sixty-five (65) must be immediately eligible to receive a state retirement annuity and must continue their optional employee life insurance

to age sixty-five (65) in order to remain eligible for the employee post-retirement death benefit.

An employee who has carried optional spouse life insurance for the five (5) consecutive years immediately preceding the date of the employee's retirement or spouse age sixty-five (65), whichever is later, shall receive a post-retirement paid-up life insurance policy in an amount equal to fifteen (15) percent of the smallest amount of optional spouse life insurance in force during that five (5) year period. The spouse post-retirement death benefit shall be effective as of the date of the employee's retirement or spouse age sixty-five (65), whichever is later. The employee must continue the full amount of optional spouse life insurance to the date of the employee's retirement or spouse age sixty-five (65), whichever is later, in order to remain eligible for the spouse post-retirement death benefit.

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

C. **Disability Coverage**.

1. **Short-term Disability Coverage**. An employee may purchase short-term disability coverage that provides benefits of from three hundred dollars ($300) to five thousand dollars ($5,000) per month, up to two-thirds (2/3) of an employee's salary, for up to one hundred eighty (180) days during total disability due to a non-occupational accident or a non-occupational sickness. Benefits are paid from the first day of a disabling injury or from the eighth day of a disabling sickness. For a new employee, coverage applied for by the initial effective date of coverage as defined in this Article, Section 5C does not require evidence of insurability. For an employee who becomes eligible for insurance, coverage applied for within thirty (30) days of the initial effective date does not require evidence of insurability.

2. **Long-term Disability Coverage**. New employees may enroll in long-term disability insurance by their initial effective date of coverage. Employees who become eligible for insurance may enroll in long-term disability insurance within thirty (30) days of their initial effective date as defined in this Article, Section 5C. The terms are the same as for employees who wish to add/increase during the annual open enrollment. During open enrollment only, an employee may purchase long-term disability coverage that provides benefits of from three hundred dollars ($300) to seven thousand dollars ($7,000) per month, based on the employee's salary, commencing on the 181st calendar day of total disability, and not subject to evidence of insurability but with a limited term pre-existing condition exclusion. Employees should be aware that other wage replacement benefits, as described in the certificate of coverage (i.e., Social Security Disability, Minnesota State Retirement Disability, etc.), may result in a reduction of the monthly benefit levels purchased. In any event, the minimum is the greater of three hundred dollars ($300) or fifteen (15) percent of the amount purchased. The minimum benefit will not be reduced by any other wage replacement benefit. In the event that the employee becomes totally disabled before age seventy (70), the premiums on this benefit shall be waived.

D. **Accidental Death and Dismemberment Coverage**. An employee may purchase accidental death and dismemberment coverage that provides principal sum benefits in amounts ranging from five thousand dollars ($5,000) to one hundred thousand dollars ($100,000). Payment is made only for accidental bodily injury or death and may vary, depending upon the extent of dismemberment. An employee may also purchase from five thousand dollars ($5,000) to twenty-five thousand dollars ($25,000) in coverage for his/her spouse, but not in excess of the amount carried by the employee.

E. **Continuation of Optional Coverages During Unpaid Leave or Layoff**. An employee who takes an unpaid leave of absence or who is laid off may discontinue premium payments on

optional policies during the period of leave or layoff. If the employee returns within one (1) year, the employee shall be permitted to pick up all optionals held prior to the leave or layoff. For purposes of reinstating such optional coverages, the following limitations shall be applicable.

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

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