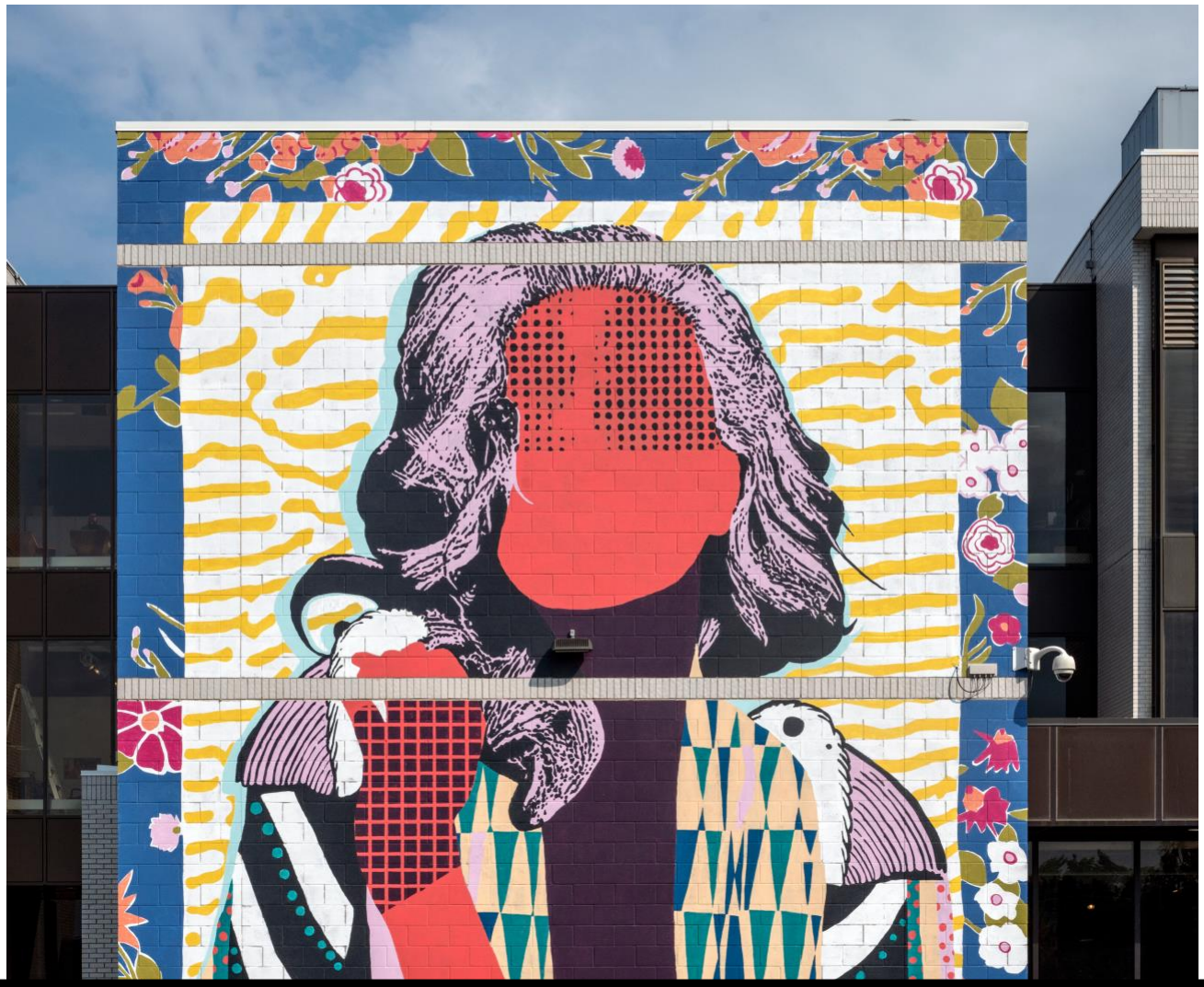
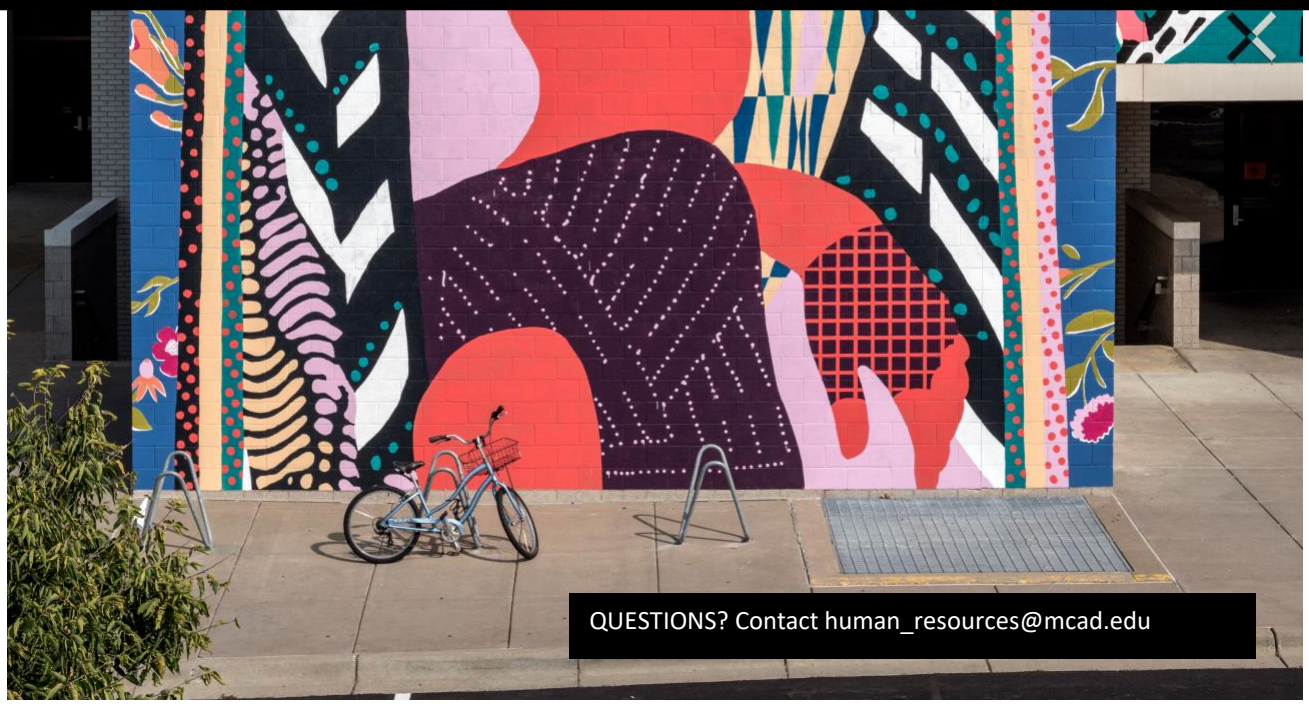


2021 | MCAD EMPLOYEE BENEFITS GUIDE



QUESTIONS? Contact human_resources@mcad.edu

WHAT IS NEW FOR 2021?

WELCOME TO YOUR 2021 MCAD EMPLOYEE BENEFITS GUIDE! The following changes are effective January 1, 2021:

- **NEW ENROLLMENT PLATFORM:** Employees will use the Paylocity Benefits Enhanced platform or the Paylocity Mobile App to enroll in Medical, Dental, Vision, Voluntary Life, FSA and HSA. See page 7 of the Benefits Guide for more information, and keep an eye out for more information from Human Resources.

- **MEDICAL:** The following changes are mandated by HealthPartners for 2021
  - The Frequent Fitness Program is ending on January 1, 2021. The program will be replaced with Wellbeats, a digital fitness solution. Wellbeats offers fitness anytime, anywhere on-demand with hundreds of options to choose from.
  - For plan 1 and pan 2, the Mail Order prescription benefit will have three copays for a three-month supply (previously two copays for a three-month supply).
  - Medications for Pre-Exposure Prophylaxis (PrEP) will be covered at 100% when used for prevention of HIV. Otherwise, coverage follows the outpatient drug benefit.
  - Prostate-Specific Antigen (PSA) Test will no longer be considered a preventive test. It will be covered under the corresponding benefit for non-preventive labs.

- **FLEXIBLE SPENDING ACCOUNTS (FSA) AND HEALTH SAVINGS ACCOUNTS (HSA):**
  - Medical Flexible Spending Account (FSA)
    - The IRS limit is remaining the same for 2021
    - $2,750 for the Medical Flexible Spending Account
  - Health Savings Account (HSA) – 2021 IRS contribution limits
    - Employee Only: $3,600
    - Other Tiers: $7,200

BENEFITS AT A GLANCE

MCAD offers a competitive benefit program that is reviewed annually to ensure it meets the needs of our diverse employee base. See the chart below for a quick look at the information provided in this Benefit Resource Guide. Then, go to each specific section for more detailed information.

Benefit Plan	Options
WHAT'S NEW?	What is new for 2021? Get a general overview.
BENEFITS AT A GLANCE	**YOU ARE HERE**
GENERAL PLAN INFO	Information on eligibility and how to enroll for 2021
2021 MCAD WELL+	MCAD's 2021 WELL+ program kicks off in January. Check in MCAD Intranet to learn more.
MCAD OPEN ENROLLMENT	Information on how to enroll (as well as when/how to make changes throughout the year).
MEDICAL INSURANCE: HEALTH PARTNERS	Choose from three options: • PLAN ONE (CO-PAY PLAN): Open Access $1,000-$40-75% • PLAN TWO (THREE FOR FREE PLAN): Open Access $2,000-75% Three for Free • PLAN THREE (HSA ELIGIBLE PLAN): Open Access $3,000-100% HDHP/HSA Preventive RxPlus Rx Benefits, Network, Premium Costs, Plan Selection Tool, and more!
HEALTH SAVINGS ACCOUNT (HSA)	Pre-tax savings account for high deductible health plan participants
MEDICAL FLEXIBLE SPENDING ACCOUNTS (FSA) & LIMITED FLEXIBLE SPENDING ACCOUNTS	Pre-tax account used to pay for eligible health care expenses Additional Pre-tax account for HSA participants used to pay for eligible Dental and Vision expenses
HSA vs MEDICAL FSA?	Learn about the differences between these two types of accounts.
DEPENDENT CARE FSA	Pre-tax account used to pay for eligible dependent care expenses
DENTAL: HEALTH PARTNERS	Dental plan with in-network and out-of-network coverage for preventive, basic and major services, as well as orthodontia for dependent children
VISION: EYEMED	Vision plan provides coverage for lenses, frames and/or contacts
LIFE AND AD&D (GROUP AND VOLUNTARY)	MCAD provides benefit eligible employees with coverage equal to 1 times your annual salary up to a maximum of $50,000. You may purchase additional coverage for yourself, your spouse, and/or your children
SHORT AND LONG TERM DISABILITY	STD and LTD benefits that continue a portion of your income due to a disability
TRANSIT BENEFITS	Metropass Program and Qualified Bicycle Commuting Reimbursement Program
TUITION BENEFITS	MCAD offers several amazing tuition benefits. Please see the MCAD Staff Handbook and/or the FT Faculty and Adjunct Faculty Administrative Policies Manuals for more information.
RETIREMENT PLANS	403(b) and Supplemental Retirement Account (SRA) plans
PAID TIME OFF BENEFITS	MCAD provides all employees with Earned Sick and Safe Time (ESST). Full Time Faculty enjoy summers off. Staff enjoy several Paid Time Off Benefits. Please see the MCAD Staff Handbook and/or the FT Faculty and Adjunct Faculty Administrative Policies Manuals for more information.
ADDITIONAL PERKS	Wellness Discounts / EAP / Travel Assistance / Identify Theft Protection
BENEFIT GLOSSARY	Definitions of terms you should know in order to best understand and utilize your benefits
IMPORTANT RESOURCES	Listing of the resources available to answer questions or provide information about your benefits
IMPORTANT NOTICES	- Special Enrollment Rights - Newborns' and Mothers' Health Protection Act - Women's Health and Cancer Rights Act of 1998 - Children's Health Insurance Program (CHIP) - Notice of Privacy Practices - MNsure Exchange Notice

GENERAL PLAN INFORMATION

As an MCAD employee, you have a variety of benefit options to choose from. This Benefit Guide provides an overview of the majority of benefits available to you. Please review this Benefit Resource Guide to help you make informed enrollment decisions. You may also share it with your family and keep it for future reference.

ELIGIBILITY

You are eligible to participate in the MCAD health benefit program on the first of the month following your date of hire if you are a full time benefit eligible faculty member, full time benefit eligible staff member (scheduled to work at least 35 hours per week and at least 1,000 or more hours annually), part time benefit eligible staff member (scheduled to work at least 20 hours per week and at least 1,000 or more hours annually). If your position changes and you have averaged 30 hours per week over the previous year, MCAD will notify you of your status change to benefit eligible status. Spouses (opposite- and same-sex) and children (up to age 26) of benefit eligible employees are eligible for most benefits as outlined in the chart below.

Note: Student workers, casual labor staff, temporary employees, or adjunct faculty members are not eligible.

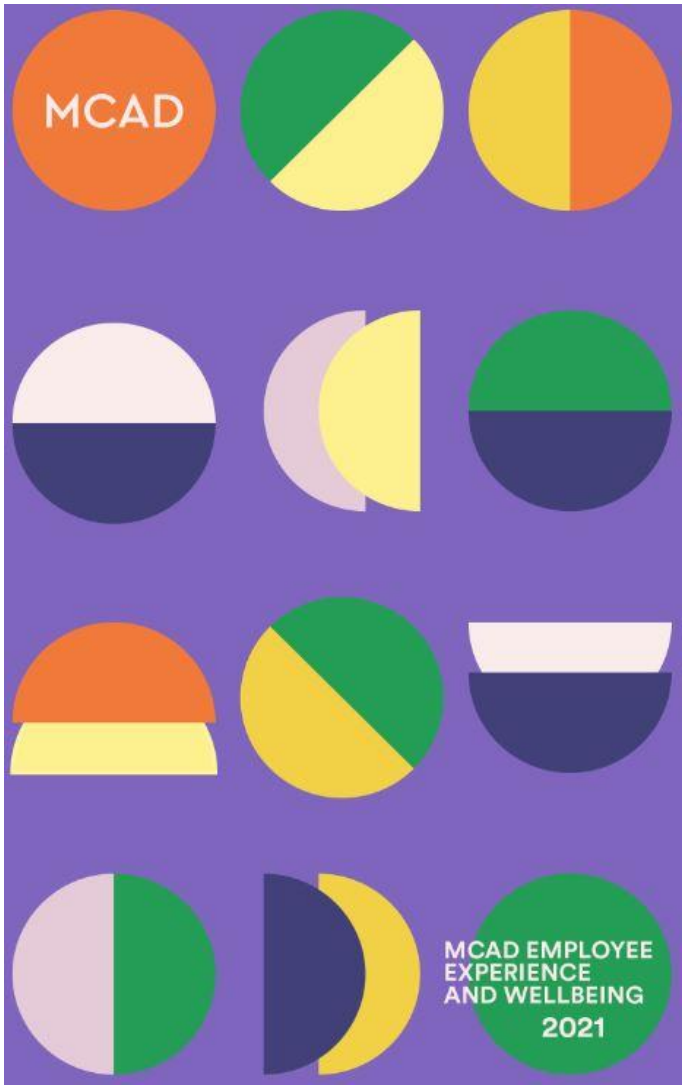
	Benefits eligible MCAD employee	Spouse/Partner	Child
MCAD WELL+ Program	✓		
Medical	✓	✓	✓
Dental	✓	✓	✓
Vision	✓	✓	✓
Health Savings Account	✓	✓	✓ Tax dependent
Medical Flexible Spending Accounts	✓	✓	✓
Dependent Care Flexible Spending Accounts	✓		✓
Tuition Benefits*	✓	✓	✓
Voluntary Life Insurance and AD&D	✓	✓	✓
Basic Life Insurance and AD&D	✓		
Short and Long Term Disability	✓		
Metropass	✓		
Qualified Bicycle Commuting Reimbursement Program*	✓		
Retirement Plan (403b and SRA)*	✓		

*Adjunct Faculty Members are eligible for the Qualified Bicycle Commuting Benefit Reimbursement Program, limited benefits under the Tuition Benefit program, and 403(b) Retirement Plan if they meet two year/750 hour eligibility requirements as described in the 403(b) SPD.

WELL+ MCAD EMPLOYEE EXPERIENCE AND WELLBEING

MCAD WELL+ is a 12 month well-being program which will overlap with the HealthPartners program (which is how you get those great preferred rates on the Medical plans). Each month of the program will focus on an aspect of well-being. There will be activities, self-paced on-demand resources, and more! The objective is to foster a culture of wellness with a focus on overall employee well-being, which in turn hopefully helps support student well-being. It is also an opportunity to highlight existing benefit resources you may not be aware of (or know about, but need a nudge to go use). This maximizes the investment you and MCAD both make in our existing benefits.

- JANUARY : KICKOFF!
- FEBRUARY: MINDFULNESS
- MARCH: NUTRITION
- APRIL: FINANCIAL WELLNESS
- MAY: MOVEMENT
- JUNE: EMOTIONAL & MENTAL WELL-BEING
- JULY: CREATIVITY
- AUGUST: SLEEP HABITS AND SLEEP HYGIENE
- SEPTEMBER: VOLUNTEERISM
- OCTOBER: WRAP UP
- NOV & DEC: EMPLOYEE SURVEY



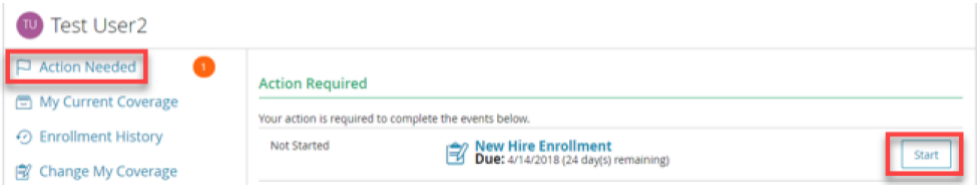
MCAD OPEN ENROLLMENT – ONLINE

Benefits can be elected, changed, and dropped once per year during Open Enrollment. MCAD Open Enrollment occurs each November for benefits effective January 1st of the following year.

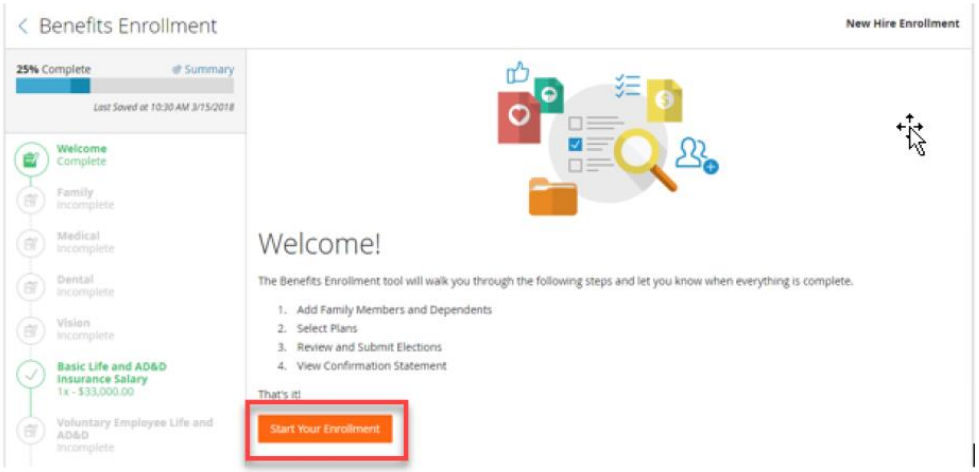
MCAD Open Enrollment will be from November 9th-20th. For 2021, employees will use the **Paylocity Benefits** enrollment platform or the **Paylocity App** to enroll in all benefit plans offered by MCAD. You can also start in one, and complete in the other!

ENROLL VIA PAYLOCITY SELF-SERVICE (WEB)

1. Access **Benefits** from the drop down menu in the upper left hand corner
2. Select **Action Needed** in the sidebar menu
3. Select **Start**



4. Select **Start Your Enrollment**

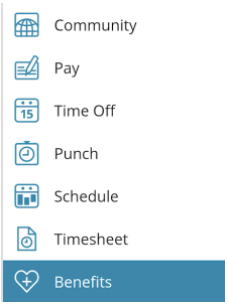


5. Review **Family** information
6. Enter Benefit Elections
    a. Select the dependents to cover. The system will calculate tier and cost based on the dependents selected.
    b. Select the checkmark next to the appropriate **Plan** or **Waive** option
7. Select **Submit** to complete the enrollment

MCAD OPEN ENROLLMENT – PAYLOCITY APP

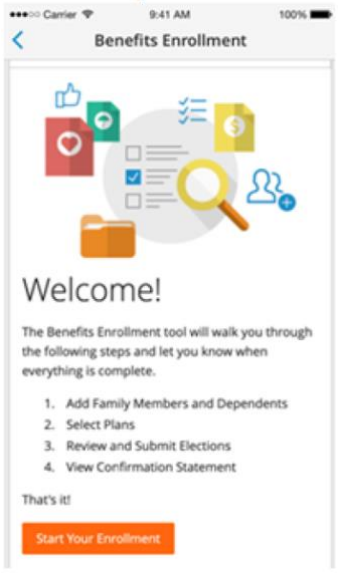
ENROLL VIA PAYLOCITY MOBILE APP

1. Log Into the Paylocity Mobile Application (App)



2. Select **Benefits** in the main menu
3. Select the **Begin** option within the Enrollment Banner

4. Select **Start Your Enrollment**



5. Review **Family** information
6. Enter Benefit Elections
    a. Select the dependents to cover. The system will calculate tier and cost based on the dependents selected.
    b. Select the checkmark next to the appropriate **Plan** or **Waive** option
7. Select **Submit** to complete the enrollment

BENEFIT CHANGES OUTSIDE OF OPEN ENROLLMENT

Open Enrollment is one time per year you are able to make benefit changes. The benefit elections you make during your initial or annual enrollment remain in effect for the entire calendar year due to IRS regulations. You are, however, allowed to modify your elections in certain situations, called "qualifying life events." If you experience a qualifying life event, you may make changes to your benefits within 30 days of the event or 60 days if the event is due to birth or adoption of a child. Qualifying events due to loss of eligibility or loss of coverage, will usually allow entry into the plan on the first of the month following the event. Other events such as marriage or birth of a child, allow entry into the plan on the marriage date or the birth date.

A qualifying life event includes a change in:

- **Legal marital status** – marriage, death of spouse, divorce, legal separation, or annulment
- **Number of dependents** – birth, adoption, placement for adoption, divorce or death of a dependent, or assuming primary support of a child of an unmarried dependent child
- **Employment status** – eligible dependent gains or loses access to employer-sponsored coverage
- **Dependent status** – change due to age or other circumstance which causes your dependent to satisfy or cease to satisfy eligibility requirements under the plan
- **Medicare or Medicaid eligible status** – you or your spouse become Medicare or Medicaid eligible.

Any benefit changes must be consistent with the life event you or your family member experienced. The new election becomes effective as of the date of the change in status or loss of coverage, whichever comes later. If you have any questions about what constitutes a qualifying life event, please contact MCAD's Office of Human Resources human_resources@mcad.edu.

MEDICAL INSURANCE

The cornerstone of MCAD's benefits package is medical coverage. For 2021, MCAD will continue to offer medical coverage through HealthPartners.

Whether you are facing an illness or injury, or simply utilize preventive care, the company offers comprehensive protection against the financial hardship that can accompany a medical need.

During the COVID-19 pandemic, access to health insurance and health care is such an important benefit. To learn more about coverage during COVID-19, please refer to the page on COVID-19 as well as the Human Resources page on the MCAD Intranet.

Please review this section to determine which option best meets the needs of you and your eligible dependents.

MEDICAL PLAN CHOICES

MCAD offers three medical plan options. All options provide high-quality, affordable medical care, including preventive care, doctor's visits, hospitalization, and emergency care. However, each plan has unique characteristics and advantages. The plans are offered through HealthPartners, a non-profit organization providing health coverage to approximately 1.5 million members.

Your choices include:

- PLAN ONE (CO-PAY PLAN): Open Access $1,000-$40-75%
- PLAN TWO (THREE FOR FREE): Open Access $2,000-75% Three for Free
- PLAN THREE (HSA ELIGIBLE): Open Access $3,000-100% HDHP/HSA Preventive RxPlus

PREFERRED VS. REGULAR?

- Preferred plans have lower copays and deductibles.
- Employees must complete the Health Assessment and one well-being activity to earn a Preferred benefit plan in 2021.
- Employees hired on or after July 1, 2020 automatically receive Preferred rates for 2021.
- Regular plans have higher copays ($60) and deductibles ($250-$500 more)
- Please reference the next two pages for more details on the Preferred Vs. Regular Plans.

PLAN ONE (CO-PAY PLAN): OPEN ACCESS $1,000-$40-75%

On this plan, preventive care is covered at 100%. This plan requires that you pay a co-pay for office visits and prescription drugs. All other covered services, including imaging and x-rays associated with an office visit, are subject to the coinsurance and out-of-pocket maximum. Once you've met the annual out-of-pocket maximum, the plan pays 100% of covered services for the rest of the calendar year as long as services are in-network.

Qualified health care expenses can be covered through your contributions to a Medical Flexible Spending Account on a pre-tax basis through payroll deduction. You can use the medical FSA to reimburse expenses for yourself and your dependents up to age 26.

PLAN TWO (THREE FOR FREE PLAN): OPEN ACCESS $2,000-75% THREE FOR FREE

On this plan, preventive care is covered at 100%. This plan requires covered participants to meet an annual deductible before the plan will start to pay for covered services (with the exception of preventive care which is covered at 100%). Once a participant has met the deductible, the plan pays 75% of all covered in-network expenses for the remainder of the calendar year. With this plan, you get your first three doctor visits for free – even if you have haven't reached your deductible yet. You can go to your regular clinic, urgent care or a convenience care clinic. Everyone on your plan gets three free visits.

Qualified health care expenses can be covered through your contributions to a Medical Flexible Spending Account on a pre-tax basis through payroll deduction. You can use the medical FSA to reimburse expenses for yourself and your dependents up to age 26.

PLAN THREE (HSA ELIGIBLE PLAN): OPEN ACCESS $3,000-100% HDHP/HSA PREVENTIVE RXPLUS

On this plan, preventive care is covered at 100%. This plan requires covered participants to meet an annual deductible before the plan will start to pay for covered services – with the exception of preventive care which is covered at 100% and preventive Rx drugs (on IRS list) which are covered subject to a copay. Once a participant has met the deductible, the plan pays 100% of all covered in-network expenses for the remainder of the calendar year.

This plan is paired with a Health Savings Account through Employee Benefits Corporation (EBC). Participants may contribute to a Health Savings Account (HSA) to help cover out-of-pocket costs on a pre-tax basis. Federal rules limit reimbursement to family members who are legal tax dependents or a legal spouse.

REMINDER: For additional information regarding your medical plans, visit www.healthpartners.com. Here you will be able to find a doctor or pharmacy in the Open Access Network, or simply review what each plan offers while exploring some of the value-added benefits that HealthPartners offers.

BENEFIT SUMMARY – PREFERRED PLANS

This is a SUMMARY of your benefits. For a complete listing, visit *www.healthpartners.com* to view your Summary of Benefits and Coverage (SBC) and more. **NOTE:** All medical plans provide **creditable** drug coverage under ACA.



IN-NETWORK	PLAN ONE (CO-PAY PLAN) $1000-$40-75%	PLAN TWO (THREE FOR FREE PLAN) $2,000-75% Three for Free	PLAN THREE (HSA ELIGIBLE PLAN) $3,000-100% HDHP/HSA Prev. RxPlus
Deductible	$1,000 per person $2,000 per family	$2,000 per person $6,000 per family	$3,000 per person $6,000 per family
Out-of-Pocket Maximum	$4,250 per person $8,500 per family	$4,750 per person $9,500 per family	$3,500 per person $7,000 per family
PREVENTIVE CARE – ROUTINE			
Well-child, adult physical and eye exams / immunizations	100% coverage	100% coverage	100% coverage
PHYSICIAN SERVICES			
Physician and specialist visits; urgent care	$40 co-pay	No charge for the first 3 visits; then 75% coverage after deductible.	100% coverage after deductible
Convenience care	$20 co-pay	No charge for the first 3 visits; then 75% coverage after deductible.	100% coverage after deductible
Virtuwell	First 3 visits free; $20 co-pay thereafter	No charge for the first 3 visits; then 75% coverage after deductible. (3 free visits counted separate)	100% coverage after deductible
Imaging	75% coverage	75% coverage after deductible	100% coverage after deductible
HOSPITAL SERVICES			
Inpatient / Outpatient Hospitalization	75% coverage	75% coverage after deductible	100% coverage after deductible
EMERGENCY SERVICES			
Emergency room	$100 co-pay	75% coverage after deductible	100% coverage after deductible
Ambulance	75% coverage	75% coverage after deductible	100% coverage after deductible
MENTAL HEALTH / CHEMICAL DEPENDENCY			
Inpatient	75% coverage	75% coverage after deductible	100% coverage after deductible
Outpatient	$40 co-pay	No charge for the first 3 visits; then 75% coverage after deductible.	100% coverage after deductible
PHARMACY (on HealthPartners formulary)			
Retail – up to 31-day supply	Generic: $12 Brand: $45 Non-formulary: $90	Generic: $12 Brand: $45 Non-formulary: $90	100% coverage after deductible Preventive RxPlus Generic $0 co-pay and Brand $60 copay
Mail Order – up to 93-day supply	Generic: $36 Brand: $135 Non-formulary: $270	Generic: $36 Brand: $135 Non-formulary: $270	100% coverage after deductible Preventive RxPlus Generic $0 co-pay and Brand $180 co-pay
Specialty – up to 31-day supply from designated specialty pharmacy	You pay 20% up to $200 maximum	You pay 20% up to $200 maximum	100% coverage after deductible
OUT-OF-NETWORK	**$1000-$40-75%**	**$2,000-75% Three for Free**	**$3,000-100% HDHP/HSA Prev. RxPlus**
Deductible	$2,000 per person / $4,000 per family	$7,500 per person / $22,500 per family	$13,000 per person / $26,000 per family
Out-of-Pocket Maximum	$8,000 per person / $16,000 per family	$15,000 per person / $30,000 per family	$20,000 per person / $40,000 per family
Coinsurance	50% coverage after deductible	50% coverage after deductible	50% coverage after deductible

BENEFIT SUMMARY – REGULAR PLANS

This is a SUMMARY of your benefits. For a complete listing, visit www.healthpartners.com to view your Summary of Benefits and Coverage (SBC) and more. NOTE: All medical plans provide creditable drug coverage under ACA.



IN-NETWORK	PLAN ONE (CO-PAY PLAN) $1000-$60-75%	PLAN TWO (THREE FOR FREE PLAN) $2,250-75% Three for Free	PLAN THREE (HSA ELIGIBLE PLAN) $3,250-100% HDHP/HSA Prev. RxPlus
Deductible	$1,000 per person $2,000 per family	$2,250 per person $6,500 per family	$3,250 per person $6,500 per family
Out-of-Pocket Maximum	$4,250 per person $8,500 per family	$4,750 per person $9,500 per family	$3,500 per person $7,000 per family
PREVENTIVE CARE – ROUTINE			
Well-child, adult physical and eye exams / immunizations	100% coverage	100% coverage	100% coverage
PHYSICIAN SERVICES			
Physician and specialist visits; urgent care	$60 co-pay	No charge for the first 3 visits; then 75% coverage after deductible.	100% coverage after deductible
Convenience care	$30 co-pay	No charge for the first 3 visits; then 75% coverage after deductible.	100% coverage after deductible
Virtuwell	First 3 visits free; **$30 co-pay thereafter**	No charge for the first 3 visits; then 75% coverage after deductible. (3 free visits counted separate)	100% coverage after deductible
Imaging	75% coverage	75% coverage after deductible	100% coverage after deductible
HOSPITAL SERVICES			
Inpatient / Outpatient Hospitalization	75% coverage	75% coverage after deductible	100% coverage after deductible
EMERGENCY SERVICES			
Emergency room	$100 co-pay	75% coverage after deductible	100% coverage after deductible
Ambulance	75% coverage	75% coverage after deductible	100% coverage after deductible
MENTAL HEALTH / CHEMICAL DEPENDENCY			
Inpatient	75% coverage	75% coverage after deductible	100% coverage after deductible
Outpatient	$60 co-pay	No charge for the first 3 visits; then 75% coverage after deductible.	100% coverage after deductible
PHARMACY (on HealthPartners formulary)			
Retail – up to 31-day supply	Generic: $12 Brand: $45 Non-formulary: $90	Generic: $12 Brand: $45 Non-formulary: $90	100% coverage after deductible Preventive RxPlus Generic $0 co-pay and Brand $60 copay
Mail Order – up to 93-day supply	Generic: $36 Brand: $135 Non-formulary: $270	Generic: $36 Brand: $135 Non-formulary: $270	100% coverage after deductible Preventive RxPlus Generic $0 co-pay and Brand $180 co-pay
Specialty – up to 31-day supply from designated specialty pharmacy	You pay 20% up to $200 maximum	You pay 20% up to $200 maximum	100% coverage after deductible
OUT-OF-NETWORK	**$1000-$60-75%**	**$2,250-75% Three for Free**	**$3,250-100% HDHP/HSA Prev. RxPlus**
Deductible	$2,000 per person / $4,000 per family	$7,500 per person / $22,500 per family	$13,000 per person / $26,000 per family
Out-of-Pocket Maximum	$8,000 per person / $16,000 per family	$15,000 per person / $30,000 per family	$20,000 per person / $40,000 per family
Coinsurance	50% coverage after deductible	50% coverage after deductible	50% coverage after deductible

PRESCRIPTION DRUG COVERAGE

PHARMACY BENEFIT

When you enroll in medical coverage, you automatically have coverage for prescription drugs. All plans provide coverage for drugs on HealthPartners' formulary as well as drugs not on this list. This list is comprised of drugs that meet the participant's medical needs and have proven to be safe and effective – while providing the most value. The list includes brand name and generic drugs that have been approved by the Food and Drug Administration (FDA). A team of physicians and pharmacists meets regularly to review and update the list. All three plans offer coverage for prescription drugs; however, how you pay for your prescriptions will vary by plan and where you fill your prescription.

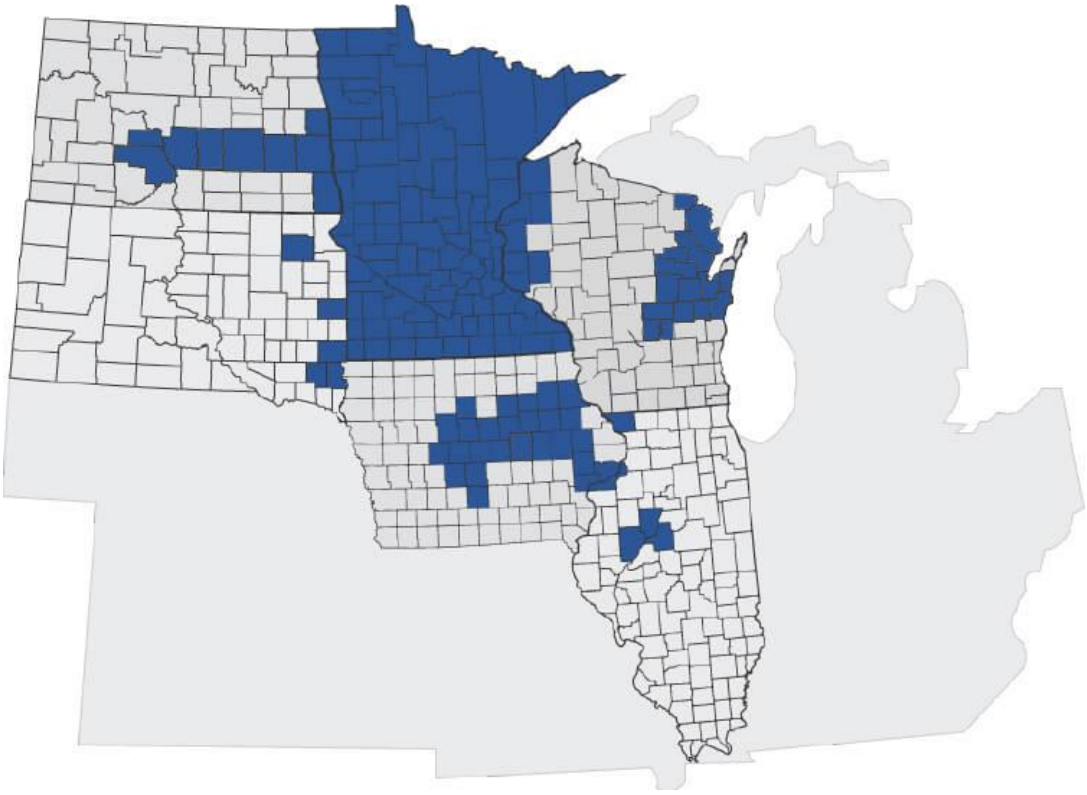
RETAIL PHARMACY: Participants in each of the plans will pay a co-pay based on the tier of the drug purchased. The High Deductible Health plan includes a Preventive RxPlus benefit. This benefit allows participants to pay a co-pay for generic and brand name medications as long as the medications are listed in the RxPlus preventive drug list. For other prescription drugs, participants in the High Deductible Health Plan are responsible for the full cost until the deductible has been met. All plans have an out-of-pocket maximum. Once the out of pocket maximum is met, drugs are then covered at 100% for the remainder of the calendar year.

MAIL ORDER PHARMACY: Participants in each the plans offered can utilize the mail order pharmacy for maintenance medications. Mail order provides the convenience of receiving a 3-month supply mailed directly to your home. Participants in the copay plans will receive a 3-month supply for three co-pays. It is important to note that under the High Deductible Health Plan, only the preventive RxPlus drugs have co-pays. For all other medications, participants in the High Deductible Health Plan are responsible for the full cost until the deductible is met.

GENERIC DRUGS: Generic medications are available once the patent expires on a brand-name drug. Each brand name drug and its generic equivalent share the same chemical ingredients and are often made by the same manufacturer. However, you pay more for the brand-name because their prices include the cost of development and marketing.

Note for Plan Three (HSA Eligible): $3,000-100% HDHP/HSA Preventive RxPlus

The HSA Preventive Maintenance Drug Benefit allows you to receive preventive medications at a copay. Preventive medications are defined as those medications taken by a person who has developed risk factors for a health condition, or to prevent a previous health condition from showing up again. To qualify for the HSA preventive benefit, the maintenance medication MUST be prescribed for the condition (category) in which it is listed on the HealthPartners' Preventive Drug List. The full list is available on the HealthPartners website at www.healthpartners.com.



*FOR ILLSTRATIVE PURPOSES ONLY – FOR FULL HEALTHPARTNERS COVERAGE, VISIT HEALTHPARTNERS.COM

OPEN ACCESS NETWORK

Your medical plan uses the **Open Access Network.** Choose from more than 950,000 doctors and 6,000 hospitals in the United States. Simply go to your network doctor when you need care. No need to select a primary care clinic. And you don't need referrals to see specialists. The network includes the Mayo Health System, Mayo Clinic–Rochester, St. Mary's Hospital and Rochester Methodist Hospital.

It is in your best interest to seek providers who are in-network. If you see a provider that is not in your HealthPartners network, your costs will be significantly higher because you will receive a lower coverage amount under your benefit plan – and your share of the costs will be based on the provider's full charges rather than the discounted rate HealthPartners negotiates with network providers. **In addition, the costs above the usual and customary (U&C) rate are not subject to the out-of-pocket maximum.** This means that once the total of your out-of-network U&C charges reach your out-of-pocket maximum, the plan will pay 100% of the remaining U&C charges, but you will continue to pay the full cost of any charges above U&C.

COST OF MEDICAL COVERAGE

MCAD contributes to your premium. Rates are shown per month and per-pay period and are effective January 1, 2021:

Plan / Tier	OPEN ACCESS NETWORK			
	Total Monthly Premium	**MCAD's Monthly Contribution**	**Employee Cost Per Month**	**Employee Cost Per Pay Period (24)**
PLAN ONE (CO-PAY): $1,000-$40-75%				
1				
Employee	$643.91	$487.82	$156.09	$78.05
Employee + Spouse	$1,770.76	$1,016.42	$754.34	$377.17
Employee + Child(ren)	$1,223.43	$702.25	$521.18	$260.59
Family	$1,963.93	$1,120.43	$843.50	$421.75
PLAN TWO (THREE FOR FREE) $2,000-75% Three for Free				
2				
Employee	$573.13	$483.83	$89.30	$44.65
Employee + Spouse	$1,576.10	$945.69	$630.41	$315.21
Employee + Child(ren)	$1,088.94	$653.36	$435.58	$217.79
Family	$1,748.04	$1,040.96	$707.08	$353.54
PLAN THREE (HSA ELIGIBLE): $3,000-100% HDHP/HSA Preventive RxPlus				
3				
Employee	$577.82	$487.79	$90.03	$45.02
Employee + Spouse	$1,589.01	$953.41	$635.60	$317.80
Employee + Child(ren)	$1,097.86	$658.71	$439.15	$219.58
Family	$1,762.35	$1,049.48	$712.87	$356.44

ONLINE HEALTHCARE – 24/7 VIRTUAL CARE

No crowded waiting rooms.

No Driving.

See a doctor when you need a doctor.

A virtual visit lets you connect with a nurse practitioner or a doctor from your mobile device or computer. When you use one of the provider groups in our virtual visit network, you have benefit coverage for certain non-emergency medical conditions.

Plan 1: No charge for the first three visits; then you pay a **copay**
Plan 2: No charge for the first three visits; then you pay **$59**
Plan 3: You pay **$59**

Virtual Care Options

HealthPartners offers two in-network options
Virtuwell: Nurse practitioner
Doctor on Demand: Chat with a doctor

Virtuwell.com

Save time and money by getting treated right from your smartphone, tablet, or computer.

Easy, fast and guaranteed

- Answer a few questions anytime, anywhere.
- Treatment plan and prescription within 30 minutes.
- You're only charged if virtuwell can treat you, plus unlimited follow-up calls are free.
- A visit is never more than $59. Use your member ID card to check your cost at **virtutell.com/cost/healthpartners**

Examples of Non-Emergency Conditions:

- ✓ Bladder infection
- ✓ Bronchitis
- ✓ Diarrhea
- ✓ Fever
- ✓ Pink eye
- ✓ Rash
- ✓ Seasonal flu
- ✓ Sinus
- ✓ Sore throat
- ✓ Stomach

Doctorondemand.com

The first time you use Virtual Visits, you will need to set up an account at **doctorondemand.com**. You will need to complete the patient registration process to gather medical history, pharmacy preference, primary care physician contact information, and insurance information.

Video chat

- Convenient, quick and affordable.
- Assessment, diagnosis and prescriptions when necessary.
- A visit to treat conditions like colds, the flu and allergies is $59 or less. **Visit doctorondemand.com**
- Access to a team of experienced, licensed **psychiatrists** and **therapists** available 7 days a week, from the privacy of your home. **Note: these visits have a higher cost than the standard $59.**

Virtual Visits doctors use e-prescribing to submit prescriptions to the pharmacy of your choice. Costs for the virtual visit and prescription drugs are based on, and payable under, your medical and pharmacy benefit. They are not covered as part of your Virtual Visits benefit.

**Prescription services may not be available in all states.*

Questions about benefits?

Member Services can answer your benefits and coverage questions. Call HealthPartners at **952-883-5000 or 800-883-2177**

COVID-19 RELATED RESOURCES

CIGNA Life Assistance Program (LAP)

You may have heard a lot about coronavirus disease, also called COVID-19. Anxiety is understandably high as we are learning more about the spread of this disease. Whether your needs are big or small, the Life Assistance Program is here for you. It can help you and your family find solutions and restore your peace of mind.

Personal and confidential video-based counseling sessions

- Convenience
- Choice
- Privacy
- May reduce or eliminate costs for things like child care or travel with face-to-face visits.
- For assistance call the **800-538-3543** to find a network provider who offers virtual care counseling sessions. The provider will give you information on how to setup the video-based session based on the technology they are using.

Dealing with personal problems or substance use issues can be a challenge. But with Cigna, you don't have to go it alone. And you don't have to go far for the care you need.

Virtual sessions with a Cigna Behavioral Health network provider. Get help when, where and how it works best for you. Get quality care with video-based services, in a way that may be more convenient than visiting an office.

Q. What kind of device can I use?

A. Use your smartphone, tablet or computer for online video conferencing.

Q. Will the provider need to see me in person first?

A. You can schedule video-based appointments based on your provider's availability. Depending on your reason for treatment, your provider might require that you be seen face-to-face first.

Q. How much will it cost?

A. There's no cost to you for LAP services.

Life Assistance Program 24/7 Support

Just a phone call away whenever you need us. At no extra cost to you, an advocate can help you assess your needs.
Phone: **800-538-3543**
Website: **www.cignalap.com**

HealthPartners

How much does COVID-19 testing cost?

If you're a HealthPartners member, you have 100% coverage for COVID-19 testing and diagnosis. This includes the cost of the care visit associated with testing.

HealthPartners is also waiving the cost for the treatment of COVID-19 when getting care from an in-network provider, effective March 1 through December 31, 2020. This includes copays, coinsurance and deductibles.

HealthPartners CareLine

If you are a HealthPartners member, nurses are available 24/7 to answer questions about symptoms, help you decide what kind of care you need and offer home treatment suggestions. You can reach us anytime by calling the HealthPartners CareLine℠ at **800-551-0859**.

COVID-19 Employee Assistance Program (EAP) Resources

In the wake of a COVID-19 outbreak, it is important to monitor your own physical and mental health. Know the signs of stress in yourself and your loved ones. Know how to relieve stress, and know when to get help. Below outlines some resources that you and your loved ones can utilize through our Employee Assistance Program (EAP).

In the moment support

- To speak with an EAP counselor 24/7, call **866-326-7194**

iConnectYou App

- Download the **iConnectYou mobile app** to use your Employee Assistance Program (EAP) wherever you are. iConnectYou connects you with professionals who'll give you real-time support for almost anything you can think of.
- **iConnectYou** works with your iPhone, Android or Web Browser. Visit the app store to download it today. Register using your email and a password you create. Use your **passcode 53219** to finish creating your account.

HealthPartners EAP

Check out resources and relevant topics about the impact COVID-19 has on us.
EAP Website: **www.hpeap.com**
Password: **mcad**

HEALTH SAVINGS ACCOUNT (HSA)

If you enroll in PLAN THREE (HSA ELIGIBLE PLAN) $3,000-100% HDHP/HSA Preventive RxPlus Plan, you can contribute to a Health Savings Account (HSA) on a pre-tax basis through payroll deduction. Annual contributions are limited by federal law depending on the level of health coverage you elect. You can start, stop or change your HSA contribution at any time during the year.

Employee Benefits Corporation (EBC) will continue to be the administrator for the Health Savings Accounts.

ELIGIBILITY FOR HEALTH SAVINGS ACCOUNTS (HSA)

Because of the tax-advantaged nature of an HSA, there are specific eligibility requirements that are important to keep in mind, including:

- You can't be covered by another **NON**-HDHP (high deductible health plan). For example, if you are also covered by your spouse or partner on a traditional medical plan, you cannot contribute to an HSA.
- You and your spouse can't enroll in a medical Flexible Spending Account (FSA) that could reimburse your **MEDICAL** expenses. Participation in a limited Flexible Spending Account that covers only dental and vision expenses is allowed.
- You can't be enrolled in a government health plan, such as Medicare A and/or B or Medicaid.
- Children who are not your tax dependents are not eligible for reimbursement from the HSA.
- You may not have an HSA and be claimed as a dependent on someone else's tax return.

If you have questions about any of these eligibility requirements, please contact human_resources@mcad.edu!

HEALTH SAVINGS ACCOUNT CONTRIBUTIONS

Coverage Level	Annual Maximum Contribution	Catch-Up Contribution if Age 55+
Employee	$3,600	$1,000
Family	$7,200	$1,000

NOTE: If you are married and your spouse is also enrolled in a HDHP through his/her employer, your combined HSA contributions cannot exceed the federal maximum shown above.

USING YOUR HSA

Funds in an HSA can be used to pay for:

- Qualified medical expenses
- Qualified dental, vision and hearing expenses
- COBRA continuation coverage if you leave employment
- Qualified long-term care insurance premiums

Funds can also be used to build savings to cover future medical expenses on into retirement, including Medicare premiums and out-of-pocket expenses.

HSA participants receive an HSA debit card, which may be used to pay for qualified health care expenses directly. Or, you may reimburse yourself from your HSA at a later date. You own the amount in your account and may take it with you if you leave MCAD.

NOTE: Changing your contribution amount during the year can be done by contacting human_resources@mcad.edu

MANAGING YOUR HSA

It's easy to manage your HSA using the EBC portal. You can:

- Check your account balance
- File a claim
- View account activity
- Reimburse yourself
- Designate a beneficiary

You do not need to provide proof of your expense to Employee Benefits Corporation (EBC). However, you should keep your receipts in case you are audited and need to provide proof that your withdrawals were for qualified medical expenses.

Tax reporting is required for the HSA. IRS form 8889 **must** be completed with your tax return each year to report total deposits and withdrawals from your account (you do not have to itemize to complete this form).

For additional information, contact EBC's customer service at 800.346.2126 or www.ebcflex.com.

MEDICAL FLEXIBLE SPENDING ACCOUNT (FSA)

The Medical Flexible Spending Account gives participants in the $1,000-$40-75% and $2,000-75% Three for Free plans the opportunity to set aside pre-tax dollars to pay for qualified medical, dental and vision expenses. Examples of eligible expenses include deductibles and co-pays, prescription drug costs, over-the-counter medicines (if prescribed by a doctor), and other non-covered medical, dental, vision and hearing care expenses.

Participants in the $3,000-100% Preventive RxPlus (including Regular Benefit) plan can contribute to a **Limited Purpose Flexible Spending Account** for dental and vision expenses ONLY.

Employee Benefits Corporation (EBC) will continue to be the administrator for the Medical Flexible Spending Accounts.

MEDICAL FSA CONTRIBUTIONS

You may contribute up to $2,750 to your Medical FSA through pre-tax payroll deductions. Estimate expenses carefully, as a federal "use-it-or-lose-it" law applies. This means that if you have not incurred enough expenses to reimburse the funds in your account at the end of the year, your remaining account balance will be forfeited. Only $500 may be carried over to the next plan year. Keep in mind that you cannot change your FSA election mid-year without a corresponding qualifying life event, as described on page 3.

USING YOUR MEDICAL FSA

You can pay for eligible expenses in one of two ways – using the EBC debit card or filing a claim.

- **Debit card**: Use the debit card to pay for eligible health care expenses at the point of service or write your debit card number on your provider's bill – just as you would a credit card. Funds will be taken directly from your EBC medical FSA account.
- **FSA claim form**: Pay the provider directly and then file a claim for reimbursement. You will need to complete an FSA claim form and submit it to EBC along with your receipts.

NOTE: Expenses must be incurred between January 1, 2021 and December 31, 2021. You will have until February 28, 2022 to submit claims.

For More Information

Visit www.ebcflex.com to:

- File a claim
- Check account balance and claim status
- View account history
- Access forms
- Manage your profile

WHAT IS THE DIFFERENCE? COMPARING HSA AND MEDICAL FSA

	HSA	MEDICAL FSA
Who can have this plan?	$3,000-100% HDHP/HSA Preventive RxPlus Plan participants	$1,000-$40-75% and $2,000-75% Three for Free plan participants; $3,000-100% HDHP/HSA Preventive RxPlus plan participants can have a limited purpose flexible spending account
What is the contribution limit?	Employee: $3,600 Family: $7,200	$2,750
Can I make a catch-up contribution?	Yes, up to $1,000 for 2021 if you are age 55+ and not enrolled in Medicare	No
What are the tax advantages?	• Contributions are tax-free • Investment earnings on balance are tax-free • Withdrawals for eligible expenses are never taxed	• Contributions are tax-free • Withdrawals for eligible expenses are never taxed
What expenses are eligible?	Any out-of-pocket expenses for medical, prescription drugs, dental, vision and hearing	
Can I make a contribution change?	Yes, allowed throughout the year at anytime	Maybe, changes are only allowed if you have a Qualifying Life Event (see page 3)
How can I use the funds?	You can spend them now on eligible health care expenses, or save for future health care expenses	You need to spend them on eligible health care expenses incurred in the year designated
Is there a time limit for using fund balance?	No limit	You must file your calendar year claims by February 28th
Can I roll-over my unused funds from year to year?	Yes	Yes - $500 may be carried over. Amounts over $500 will be forfeited (use-it-or-lose-it)
What funds are available to reimburse expenses?	Limited to your current account balance	Entire contribution amount elected for the year
Do I need to provide proof of my expense?	EBC does not require proof; if you are audited, the IRS will require proof.	Yes, proof is required by EBC

DEPENDENT CARE FLEXIBLE SPENDING ACCOUNT

The Dependent Care Flexible Spending Account allows employees to set aside pre-tax dollars to pay for eligible dependent daycare expenses. Contributions are automatically deducted from your paychecks on a pre-tax basis, saving you money by not paying federal, state or Social Security taxes on the portion of your income that you contribute to the plan.

Employee Benefits Corporation (EBC) will continue to be the administrator for the Dependent Care Flexible Spending Accounts.

HOW THE DEPENDENT CARE FSA PLAN WORKS

This account is for eligible work-related daycare expenses. Eligible dependents include children under age 13 and disabled dependents of any age who are incapable of self-care. You can use the funds to pay for daycare, preschool, summer camp, before/after school programs or eligible senior centers while you (and your spouse) are actively working or attending school. The primary purpose should be to provide for the dependent's well-being and protection. Education-focused expenses that can be separated from daycare expenses are not eligible. By law, any unused funds are forfeited after year-end. You may not carry a balance over to the next year. So estimate your eligible expenses carefully and conservatively.

DEPENDENT CARE FSA CONTRIBUTIONS

You may contribute up to $5,000 ($2,500 if married and filing separately) to your Dependent Care FSA through pre-tax payroll deductions. Estimate expenses carefully, as a federal "use-it-or-lose-it" law applies. This means that if you have not incurred enough expenses to reimburse the funds in your account at the end of the year, your remaining account balance will be forfeited. Keep in mind that you cannot change your FSA election mid-year without a corresponding qualifying life event, as described on page 3.

USING YOUR DEPENDENT CARE FSA

When you have incurred dependent care expenses, you must submit a claim for reimbursement – along with proof of the expense. The claim form can serve as a receipt for payment if you have your provider sign the Provider Certification section of the form. Or, you can attach a third-party receipt or billing statement as proof of the expense (canceled checks are not acceptable). The form requires that you provide the federal tax identification number of each provider. Expenses must be incurred between January 1, 2021 and December 31, 2021. You will have until February 28, 2022 to submit claims.

For More Information visit www.ebcflex.com to:

- File a claim
- Check account balance and claim status
- View account history
- Access forms
- Manage your profile

DENTAL INSURANCE

Staying healthy includes good dental care. MCAD's dental plan provides the comprehensive coverage necessary to help you and your family maintain good dental health.

For 2021, MCAD will continue to offer dental coverage through HealthPartners.

HOW THE PLAN WORKS

Plan participants have the flexibility to see any dentist they choose. But greater discounts and benefits are available by seeing an in-network dentist. The provider options include:

- In-Network – contracted providers in HealthPartners Open Access network; better discounts
- Out-of-Network – all other providers; no negotiated discounts

BENEFIT SUMMARY

Dental Service	HealthPartners Open Access Network	Out-of-Network
Diagnostic and Preventive - **Exams & cleanings; x-rays; fluoride treatments; space maintainers; sealants**	Covered at 100%	Covered at 80%
Basic I Services - **Fillings, simple extractions; endodontics; non-surgical periodontics**	Covered at 80%	Covered at 50%
Basic II Services - **Surgical periodontics; other/complex oral surgery**	Covered at 80%	Covered at 50%
Major Restorative - **Crowns, onlays**	Covered at 60%	Covered at 50%
Prosthetics - **Dentures and bridges** - **Dental implants**	Covered at 60%	Covered at 50%
Orthodontics - **For covered dependents under age 19**	Covered at 50% up to $1,500 lifetime maximum	Covered at 50% up to $1,500 lifetime maximum
Annual Deductible	None	$50 / Single $150 / Family
Annual Plan Maximum	$1,500	$1,500 combined
*Your Dental Plan includes the **Little Partners** benefit for children 12 and under. Get dental services covered 100 percent at an in-network dentist.		

COST OF DENTAL COVERAGE

This is an elective employee benefit. Rates are shown per month and per-pay period and are effective January 1,

Plan Tier	Open Access Network	
	Total Monthly Premium	**Employee Cost Per Pay Period (24)**
Employee	$43.74	$21.87
Employee + Spouse	$89.69	$44.85
Employee + Child(ren)	$91.12	$45.56
Family	$149.63	$74.82

FINDING A DENTIST

To check on if your current dentist is in-network and/or to find in-network preferred providers, go to www.healthpartners.com and select the Open Access Dental Network. Enter your zip code and the distance you are willing to travel to find a provider in your area. Or you can also call 952.883.5000.

For more plan information, such as the average cost of dental procedures, claims information, or to print an ID card, go to www.healthpartners.com

VISION INSURANCE

This is a voluntary benefit that features coverage for prescription glasses and contact lenses, as well as other vision-related items.

For 2021, MCAD will continue to offer vision coverage through EyeMed.

HOW THE PLAN WORKS

As with the dental plan, you have the freedom to receive services from any provider. You will, however, receive a greater level of benefit if you use a provider who participates in the EyeMed Insight network. By using a network provider, you may also receive discounts for services not otherwise covered by the vision plan (e.g., sunglasses and laser vision correction).

Please note: This plan provides coverage for eye exams materials and hardware. It is important to note that coverage for routine annual vision exams are **also** provided through your HealthPartners medical plan as a preventive appointment as long as you use an in-network provider.

BENEFIT SUMMARY

	EyeMed Insight Network	Out-of-Network
Exams Services		
Exam	$10 co-pay	Up to $40
Retinal Imaging	Up to $39	Not covered
Eyeglass Lenses*		
Standard Single Vision	$10 co-pay	Reimbursed up to $30
Standard Bifocal	$10 co-pay	Reimbursed up to $50
Standard Trifocal	$10 co-pay	Reimbursed up to $70
Standard Lenticular	$10 co-pay	Reimbursed up to $70
Standard Progressive	$65 co-pay	Reimbursed up to $50
Premium Progressive		
Tier 1	$95 co-pay	Reimbursed up to $50
Tier 2	$105 co-pay	Reimbursed up to $50
Tier 3	$120 co-pay	Reimbursed up to $50
Tier 4	$185 co-pay	Reimbursed up to $50
Frames	$0 co-pay; $130 allowance; 20% off balance over $130 With Freedom Pass, you pay nothing at: LensCrafters, Target Optical or Sears Optical.	Reimbursed up to $91
Contact Lenses		
Conventional	$0 co-pay; $130 allowance; 15% off balance over $130	Reimbursed up to $91
Disposable	$0 co-pay; $130 allowance	Reimbursed up to $91
Medically Necessary	$0 co-pay; Paid-in-full	Reimbursed up to $210
Laser Vision Correction	15% off the retail price or 5% off the promotional price	N/A
Frequency	Exams, Lenses or Contact lenses: Once every 12 months** Frames: Once every 24 months	

*Please refer to the plan document for additional lens options and corresponding copays or % discounts (if applicable). **Contact lenses are in lieu of eyeglass lenses and frames. Members may, however, still be able to receive additional discounts off another complete pair of eyeglasses or conventional contact lenses once the covered benefit has been used.

FREEDOM PASS

As an EyeMed member, you can enjoy a Freedom Pass, a special offer that goes above and beyond your frame allowance. Choose your favorite frame at LensCrafters, Target Optical or Sears Optical and pay nothing.

Here's how it works: Say you love those brand-name frames that cost $180. If you have a frame allowance of $130, Freedom Pass covers the remaining $50. Plus, you can still use your vision benefits to help pay for your lenses and complete your look. Shop these top brands and more:

IN-STORE DISCOUNTS

At participating network providers, members get 40% off an extra pair of eyeglasses or 20% off a partial pair (lenses only or frames only). You also get 20% off non-prescription sunglasses and accessories. Certain in-store promotions can be better than insurance – i.e., buy one pair get one free, select styles $99, etc. You can take advantage of a promotion, and you can still submit an out-of-network claim to get reimbursed for the out-of-network portion of your purchase.

COST OF VISION COVERAGE

This is an elective employee benefit. Rates are shown per month and per-pay period and are effective January 1,

Plan Tier	Open Access Network	
	Total Monthly Premium	**Employee Cost Per Pay Period (24)**
Employee	$7.79	$3.90
Employee + Spouse	$14.80	$7.40
Employee + Child(ren)	$15.58	$7.79
Family	$22.90	$11.45

FOR MORE INFORMATION

To find network providers, view your benefits and claims information or see special offers, go to www.eyemed.com. Access a list of Lasik providers at www.eyemedlasik.com or call 877-5LASER6.

A network provider is a group of professional providers that EyeMed contracts with to provide vision care for members. The network includes opticians, credentialed optometrists, and ophthalmologists who can provide services, eyeglasses and contacts at preferred and discounted rates.

LIFE AND AD&D INSURANCE

You can't always predict – or control – your life. But, you can prepare for it. Protecting the financial interests of your loved ones in the event of your death or serious injury can be invaluable.

For 2021, MCAD will continue to offer life and AD&D (accidental death and dismemberment) benefits through Cigna.

WHAT THE PLAN PROVIDES

Basic Term Life and AD&D – Eligible employees automatically receive the basic portion of the Life and AD&D benefit – there are no choices to be made. Any benefits paid out are tax-free to the recipient.

Voluntary Life and AD&D – You decide if you want to purchase voluntary coverage. You need to choose the level of coverage and who you want to cover – yourself, your spouse and/or your dependent children.

NOTE: You must purchase coverage for yourself in order to elect coverage for your spouse and/or child(ren). Children are eligible to participate to age 26.

VOLUNTARY LIFE: HOW THE PLAN WORKS

New hires may elect up to the guarantee issue amounts without having to submit evidence of insurability. Existing employees making an increase or enrolling for the first time will be subject to evidence of insurability.

Life benefits are payable to your designated beneficiary in the event of your death. An additional AD&D benefit is payable to you in the event of a covered dismemberment or to your beneficiary if your death is the result of an accident.

VOLUNTARY LIFE: BENEFIT SUMMARY

Feature	Basic Term Life/AD&D	Voluntary Life/AD&D		
		Employee	Spouse	Child(ren)
Benefit Amount	1 x annual salary up to a maximum of $50,000	Up to $300,000; increments of $10,000	$150,000, may not exceed 50% of the employee amount in increments of $5,000	$20,000
Guarantee Issue*	Up to $50,000	$100,000	$50,000	$20,000
Employee Age Reduction	- At age 65, benefits will reduce to 65% - At age 70, benefits will reduce to 40% - At age 75, benefits will reduce to 15%	- At age 70, benefits will reduce to 50%		

*Guarantee Issue (GI) refers to the amount of coverage you can purchase without providing evidence of good health.

COST OF VOLUNTARY LIFE AND AD&D COVERAGE

You pay the full cost for additional life and AD&D coverage on an after-tax basis. Cost for life coverage for employee and spouse is based on each person's age. Cost for AD&D is included in the life rate as shown below:

Employee and Spouse Voluntary Life/AD&D Per Month – Per $1,000 of Coverage											
Age	<29	30-34	35-39	40-44	45-49	50-54	55-59	60-64	65-69	70-74	75-79
Employee & Spouse Life	$0.115	$0.122	$0.130	$0.190	$0.290	$0.480	$0.760	$1.130	$1.730	$1.990	$3.750
Dependent Child(ren)	$0.18 per $1,000 for Life										

SHORT AND LONG TERM DISABILITY

Short Term Disability (STD) and Long Term Disability (LTD) insurance is available to all benefit eligible employees. Disability benefits are programs that continue a portion of your salary in case of lost time due to medical disability.

Employees must submit a Physician's Statement of Disability and a Claim Statement as soon as possible stating the nature and dates of disability with return to work date and any restrictions that may apply.

For 2021, MCAD will continue to offer Short and Long Term Disability coverage through Cigna.

SHORT TERM DISABILITY BENEFIT SUMMARY

Feature	
Weekly Benefit Amount	60% of your weekly covered earnings
Maximum Weekly Benefit	$2,000
Benefit Waiting Period	- 30 days for accident - 30 days for injury
Maximum Benefit Period	26 weeks (includes waiting period)

Short Term Disability is a fully employer paid benefit! STD premiums **are taxed** as a default option. This is the approved IRS method to avoid paying taxes on the benefit amount if you go out on disability.

LONG TERM DISABILITY BENEFIT SUMMARY

Feature	
Weekly Benefit Amount	60% of your monthly covered earnings
Maximum Weekly Benefit	$10,000
Benefit Waiting Period	180 days
Maximum Benefit Period	To Social Security Normal Retirement Age (SSNRA)

Long Term Disability continues to be a fully employer paid benefit. LTD premiums **are not taxed** as a default option. You will pay taxes on the benefit amount if you go out on disability.

TRANSPORTATION BENEFITS

There are a variety of options for students, visitors and employees to reduce their carbon footprint when traveling to and from campus. MCAD offers convenient access to the student GO TO bus pass, discounted Metrotransit passes for employees, NICE RIDE bike availability on campus, shuttle services, free carpool and vanpool parking, and the sponsored installation of the HOURCAR for students. All these measures effectively contribute to a major shift in fossil fuel usage, and in just five years MCAD's Single Occupancy Vehicle rate for all students, faculty and staff dropped from 82% to 59%.

METROPASS PROGRAM

WHAT THE PLAN PROVIDES

With Metropass, you gain access to deeply discounted, unlimited-ride transit passes for bus, train, and commuter rail! This flexible program allows you to pay for only those passes that are in use on a monthly basis. Benefit eligible employees can participate in the Metropass program on the first of the month following your date of hire. You can enroll in the Metropass program at any time. If enrollment is received by the 15th of the month, your Metropass will be effective the 1st of the following month.

METROPASS PLAN RATES

Metropass is currently $83 per month. Rates may change. MCAD will subsidize $35 a month of this cost; the cost to the employee is $48 per month. This cost will be deducted on a pre-tax basis from the first and second payroll check of each month, saving you approximately 30% by avoiding state, federal and social security tax on this benefit.

LOST OR STOLEN CARDS, AND CANCELLING ENROLLMENT

If your card is lost or stolen, please contact human_resources@mcad.edu as soon as possible. Please note that should you need a replacement card more than once, there is a $5.00 fee to replace the card fee for each new card. Your enrollment can also be cancelled upon request. Just email human_resources@mcad.edu for more information. MCAD and/or Metro Transit reserve the right to revoke or deactivate your card if you do not comply with the program guidelines.

GUARANTEED RIDE HOME PROGRAM

Metropass participants are eligible for the Guaranteed Ride Home Program, offered through Metro Transit. Enrollment can be done at https://www.metrotransit.org/guaranteed-ride-home.

QUALIFIED BICYCLE COMMUTING REIMBURSEMENT PROGRAM

WHAT THE PLAN PROVIDES

MCAD will reimburse you for reasonable expenses incurred to purchase a bicycle and for bicycle improvements, bicycle repair, and bicycle storage – up to $20 per month. This reimbursement is taxable.

EMPLOYEE ELIGIBILITY

You are eligible to participate in the Qualified Bicycle Commuting Reimbursement Program on the first of the month following your date of hire if you are benefit eligible.

*Adjunct Faculty are also eligible for this benefit!

HOW THE PLAN WORKS

Contact HR to enroll. Ride your bike to work. Track your rides. Record any bicycle related purchases. Submit requests for reimbursement.

THE FINE PRINT

The maximum reimbursement for a calendar year is the lesser of: Your total bicycle expense for the calendar year, or $20 multiplied by the number of bicycle community months in the calendar year. Requests for reimbursement must be received no later than March 15 of the year following the calendar year in which you incur the expenses. Your reimbursement amount will be based on the number of bicycle commuting months you had in the year you made the purchase. You request is complete only if you include the claim form with your signature, receipts of your eligible expenses, and bicycle commuting log (calendar with bicycle commuting days circled). Expenses can occur at any time during the year. You don't have to submit reimbursement forms on a monthly basis – you may turn in a single reimbursement request after the end of the year. Each calendar year is looked at separately for purposes of the reimbursement. Expenses must be incurred in the same year that you earn the reimbursement

Only the month of your active employment can be bicycle commuting months. Any month during which you are not required to come to MCAD's campus is not a bicycle commuting month. A bicycle community month is a month that you regularly used your bicycle for a substantial portion of the travel between your residence and MCAD. A substantial portion of the travel means no less than 50% of your monthly commute. Any month that you receive reimbursement for parking expenses under the Pre-Tax Parking Account, use a Metropass, or pay for a reserved parking space, cannot be counted as a bicycle month.

You will receive reimbursement by check. Please allow two weeks for processing.

OTHER TRANSPORTATION/PARKING RESOURCES

MCAD offers additional transportation and parking resources. Please review the intranet transportation website: Faculty and Staff Transportation Information for more information about:

- Van/Carpool
- Low Emitting Vehicle
- Electric Vehicle Parking

Check out https://intranet.mcad.edu/resources/transportation for more information!

TUITION BENEFITS

Benefits eligible MCAD employees enjoy many tuition benefits. For more information on the specifics of these benefits, please refer to the Staff Handbook, Full Time Faculty Administrative Policies Handbook, and Adjunct Faculty Administrative Policies Handbooks.

RETIREMENT PLAN BENEFITS

MCAD offers both a 403(b) retirement savings plan, and a Supplemental Retirement Account (SRA) retirement savings plan. Both plans are managed through TIAA. TIAA allows you to choose among multiple investment options. Periodically, there may be additions and/or deletions to these investment options. For more information on his benefit and eligibility this benefit, contact human_resources@mcad.edu. For current fund choices and information, go to www.tiaa.com.

PAID TIME OFF BENEFITS

Benefits eligible MCAD employees enjoy many paid time off benefits. These include:

- Earned Sick and Safe Time (ESST) (All employees)
- Paid Holidays and Winter Break (Faculty and Staff)
- Summers off (Faculty) and Summer Days (Staff)
- Generous Vacation time, Volunteer Time Off, and Personal Holidays (Staff)

For more information on the specifics of these benefits, please refer to the Staff Handbook, Full Time Faculty Administrative Policies Handbook, and Adjunct Faculty Administrative Policies Handbooks.

ADDITIONAL PERKS: HEALTHPARTNERS

WELLNESS DISCOUNTS AND RESOURCES

We have a wealth of discounts and resources available for our employees:

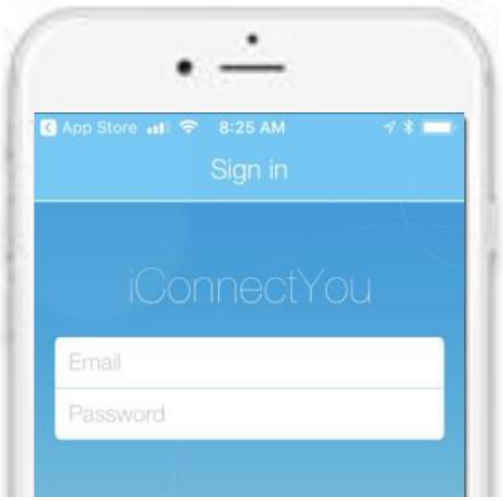
- Fitness Programs & Discounts
- Weight & Nutrition Discounts
- Tobacco Cessation
- Bereavement Assistance
- Financial Planning Assistance
- Travel Assistance
- Vision Discounts
- Hearing Discounts
- Alternative Medicine Services
- Virtuwell & Doctor on Demand
- Prescription Support
- Care Line Service
- BabyLine Service
- Behavioral Health Personalized Assistance Line

EMPLOYEE ASSISTANCE PROGRAM

Life doesn't always go as planned. No matter what your situation is, HealthPartners Employee Assistance Program (EAP) can help. Your EAP is available anytime for you and anyone in your household. Get help with almost anything you can think of, all at no extra cost.

24/7 help with:

- Making a budget
- Finding child care
- Managing stress on the job
- Parenting tips and resources
- Grieving
- Adopting a new baby
- Knowing what your legal options are
- And more!



Connect how it's best for you:

- Call 866-326-7194
- Log on to hpeap.com using the password: mcad
- Download the iConnectYou mobile app and use passcode 53219

ADDITIONAL PERKS: CIGNA

CIGNA provides the following enhancements to our benefit programs at no additional cost to you or your family members.

HEALTH ADVOCATE

Provided to you, your family, your parents and parents-in-law. The personal health advocate will:

- Find a Doctor, hospital, second opinion or diagnostic service
- Resolve health coverage issues, medical claims, denials and appeals
- Estimate procedure costs and negotiate fees
- Locate home care, special services, senior care or hospice
- Identify wellness services and alternative medicine
- Medical Bill Saver- reduce out of pocket costs for employees.

HEALTHY REWARDS DISCOUNT PROGRAM

You and your family can take advantage of discounts (up to 60%) on a range of health and wellness-related services and products to take better care of yourselves so that you live longer, healthier lives. Discounts include:

- Vision and hearing care
- Weight Management
- Fitness Club memberships – Curves, Gold's Gym, and more
- Smoking cessation – Tobacco Solutions, Quitnet
- Chiropractic care
- Massage therapy
- Acupuncture
- Pharmacy and vitamins
- Yoga Journal subscriptions, DVDs
- Mayo Clinic Books

WILL PREPARATION

CIGNA's online Will Center allows you to easily complete essential life and health legal documents at no cost to you. These include:

- Funeral Planning Services
- Last Will & Testament
- Living Will
- Healthcare Power of Attorney
- Financial Power of Attorney

IDENTITY THEFT PROTECTION

CIGNA's personal case managers can assist you with credit card fraud, financial or medical identity theft. You have access to one-on-one assistance 24/7, 365 days a year in every country in the world.

CIGNA SECURE TRAVEL

This program provides emergency medical, financial, legal, and communication assistance to covered individuals traveling domestically and internationally. Services include:

- Medical evacuation services
- 24 hour multi-lingual assistance
- Pre-departure services
- Assistance with lost or stolen items
- Travel arrangements for companion or dependent child
- Prescription refill services

CIGNASSURANCE

This is a package of financial, bereavement, and legal services to help your Life / Accident beneficiaries. Your loved ones will have access to:

- Bereavement Counseling with Professional Behavioral Health Experts
- Legal Assistance from Licensed, Practicing Attorneys
- Expert Financial Guidance – no products are sold

WORK WELLNESS WEBSITE

www.cigna.com/workwellness

- Valuable information for Disability Customers, all in one place
- Comprehensive information on filing a claim and what to expect
- Helpful information and support for most common disability conditions
- Tips for preventing a condition from becoming a disability
- Preparing to return to work
- All value added benefits in one location

CIGNA EMPLOYEE ASSISTANCE PLAN

Reducing absence, increasing employee productivity and overall wellness. CIGNA's PHD and Master's level staff will provide you and your family with extra support to help you with a variety of issues 24/7, 365 days per year.

- Stress reduction
- Prenatal care
- Parenting
- Education
- Child care
- Adoption
- Special needs
- Senior care
- Pet care
- Budgeting / Debt Management
- Face to face counseling for behavioral issues

BENEFIT GLOSSARY

Coinsurance: Coinsurance is the rate at which you and the plan share expenses. For example, 75% coverage indicates 75% of the cost is paid by the plan and it is your responsibility as a participant to pay the remaining 25% of the cost of service. The coinsurance rates vary depending on the medical plan and whether the services are incurred in-network or out-of-network. (Note: coinsurance shown in other documents may indicate the participant's coinsurance percentage rather than the plan's percentage.)

Copay: The fixed-dollar amount you pay for specific services. After you pay this amount, the plan pays the rest of the cost of your service or prescription.

Deductible: The annual amount you must pay for non-preventive services before the plan starts to pay benefits.

Embedded Deductible: The IRS regulates the minimum deductible level at which a high deductible health plan may have an embedded deductible. Plans with an embedded deductible have a single deductible "embedded" within the family deductible to help limit an individual's expenses. This means that if one person in a family meets the single deductible, the plan coinsurance would start. Without an embedded deductible, one person in a family would need to meet the entire family deductible before the plan coinsurance would go into effect.

Flexible Spending Account (FSA): An account that an employee may contribute to in order to pay for certain expenses on a pre-tax basis. An employee can have a medical flexible spending account to pay for medical, dental, vision and hearing expenses (limited to dental, vision and hearing if you also have an HSA) and/or a dependent care flexible spending account to pay for dependent care expenses. Use-it or lose-it rules apply.

Health Savings Account (HSA): A savings account used in conjunction with a high deductible health insurance policy that allows users to save money tax-free against medical expenses. Funds roll over from year to year.

Out-of-Pocket Maximum: For your protection, both plans have annual out-of-pocket maximums that "cap" the amount you must pay toward covered expenses. Once you meet your out-of-pocket maximum, the plan pays 100% of your covered expenses for the rest of the calendar year. Deductibles, co-pays and coinsurance count toward your out-of-pocket maximum. Out-of-pocket maximums differ for in-network and out-of-network services.

Pharmacy Formulary: A list of prescription drugs used by practitioners to identify drugs that offer the greatest overall value. A team of physicians and pharmacists regularly reviews new and existing drugs to be sure the Preferred Drug List continues to meet the needs of members and providers. Drugs may be added to the list at any time during the year; however, HealthPartners strives to limit removing drugs to no more than twice a year. If a change to the list affects a drug you are taking, HealthPartners will send you a letter telling you about the change.

Premium: The amount you pay out of your paycheck toward the cost of coverage.

Preventive Care: Routine preventive care is critical to maintaining your health and uncovering problems early. All MCAD's medical plans cover certain preventive services at 100% (no deductible or co-pay) from in-network providers. Services include annual wellness exams and certain screenings based on age for you and your covered dependents.

Prior Authorization: Prior Authorization approval is needed by HealthPartners for coverage of a certain medications, services or supplies. Medications that require Prior Authorization are noted on the Preferred Drug List with a "PA" next to the drug name. Examples of services or supplies that require Prior Authorization are listed in your Certificate of Coverage. To verify whether a specific service or supply requires prior authorization, call Customer Service. As a provider in the HealthPartners network, your doctor will know how to request Prior Authorization.

Step Therapy: Step Therapy is a program focused on using cost-effective prescription drugs as first-line treatment when appropriate. The program is used for certain conditions where there are many treatment options available. Drugs that require Step Therapy are noted on the Preferred Drug List. In Step Therapy, you try the preferred (Step 1) drug or drugs first. Step 1 drugs are cost efficient and effective options. If the Step 1 drug isn't effective, you can then try the Step 2 drug. In some cases, you may need to try more than one Step 1 drug before trying a Step 2 drug. If you don't try the Step 1 drug or drugs first, then a Step 2 drug won't be covered. Your doctor can request an exception to this process.

Usual and Customary (U&C): Payment for health care services received out-of-network is based on the U&C rates. The rate will be used to determine how much will be paid for a specific service. When out-of-network, you are responsible for the difference between what your provider charges and what the plan considers U&C, plus any co-insurance. The amount above and beyond the U&C rate is your responsibility and does not count towards the plan deductible or the out-of-pocket maximums.

IMPORTANT RESOURCES

MCAD OFFICE OF HUMAN RESOURCES	
human_resources@mcad.edu	
Autumn Amadou-Blegen, AVP of Human Resources aamadoublegen@mcad.edu, 651.874.3798**,** Room M18	**Itohan Ogagarue**, Senior Human Resources Generalist iogagarue@mcad.edu, 612.874.3504, Room M16
Matt Everhart, Senior Human Resources Analyst meverhart@mcad.edu, 612.874.3769, Room M16	**Jess Neau**, HR/Payroll Coordinator payroll@mcad.edu, 612.874.3710, Room M21

INSURANCE AND BENEFIT INFORMATION	
Medical Insurance - **HealthPartners** - Group #706 Networks: Open Access Member Services: 952.883.5000	www.healthpartners.com - Access benefit and claim information - Order replacement or temporary cards - Estimate health care and pharmacy costs
Dental Insurance - HealthPartners - Group #706 Networks: Open Access Member Services: 952.883.5000	www.healthpartners.com - Access benefit and claim information - Order replacement or temporary cards
Vision Insurance- **EyeMed** – Group # 1025243 Member Services: 866.804.0982	www.eyemed.com - Locate participating provider - Print benefit cards
Life & Disability Insurance - **CIGNA** Group/Voluntary Life and AD&D #610561; 610562 Short/Long Term Disability #611103; 611104 Member Services: 800.362.4462	www.cigna.com - Request information on how to file claims - Customer service
Health Savings Account (HSA) - EBC 800.831.4790	www.ebcflex.com - Request replacement debit cards - Check account balances - Update Beneficiary Information
Flexible Spending Accounts (FSA) - EBC Member Services: 800.831.4790	www.ebcflex.com - Request replacement debit cards - Check account balances - Submit claims for reimbursement - Submit documentation for debit card transactions
Employee Assistance Program (EAP) **HealthPartners** 866.326.7194	www.hpeap.com - Password: **mcad** - iConnectYou app passcode: **53219** - 100% Confidential - Available 24/7
Life Assistance Program **CIGNA** 800.538.3543	www.cignalap.com - Webinars - Legal consultation and referrals - Financial consultations

IMPORTANT NOTICES

According to federal and state legal directives, we are required to provide the following information.

SPECIAL ENROLLMENT RIGHTS

You may be eligible to enroll yourself and your dependents in a medical plan without waiting for an open enrollment period if:

- You or your eligible dependents declines the Medical Plan because you have other group medical coverage, then you lose the other coverage because you are no longer eligible, or because the employer failed to pay the required premium. In such cases, you must enroll in the Medical Plan within 30 days after losing the other coverage. You will have to provide proof that you had other coverage.
- You or your eligible dependents declines the Medical Plan because you have COBRA coverage under another group medical plan, then you exhaust your COBRA coverage. In such cases, you must complete your entire COBRA coverage period, and you must enroll in the Medical Plan within 30 days after completing your COBRA coverage period. You will have to provide proof that you completed your COBRA coverage period.
- You decline the Medical Plan and then a new dependent is added to your family due to marriage, birth, adoption, or placement for adoption. In such cases, you must enroll in the Medical Plan within 30 days after the marriage, birth, adoption or placement for adoption. You will have to provide proof of the event.
- You and your eligible dependents become eligible for premium assistance through a state Medicaid or Children's Health Insurance program (CHIP) and when you lose coverage under one of these programs. In such a case, you must request enrollment not later than 60 days after the loss of Medicaid or CHIP coverage or not later than 60 days of the determination of eligibility for Medicaid or CHIP premium assistance.

NEWBORNS' AND MOTHERS' HEALTH PROTECTION ACT

Under federal law, health care plans may not restrict any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a normal delivery, or less than 96 hours following a Cesarean section. However, federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother and with the mother's consent, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable).

WOMEN'S HEALTH AND CANCER RIGHTS ACT OF 1998

Under the Women's Health and Cancer Rights Act, group health plans must make certain benefits available to participants of health plans who have undergone a mastectomy. In particular, plans that provide medical and surgical benefits for a mastectomy must also provide coverage for:

- Reconstruction of the breast on which the mastectomy has been performed
- Surgery and reconstruction of the other breast to produce a symmetrical appearance;
- External breast prostheses (breast forms that fit into a bra) that are needed before or during the reconstruction; and
- Treatment of physical complications in all stages of mastectomy, including lymphedemas.

Coverage is determined by the health plan, in coordination with the physician and patient.

PREMIUM ASSISTANCE UNDER MEDICAID AND THE CHILDREN'S HEALTH INSURANCE PROGRAM (CHIP)

If you or your children are eligible for Medicaid or CHIP and you're eligible for health coverage from your employer, your state may have a premium assistance program that can help pay for coverage, using funds from their Medicaid or CHIP programs. If you or your children aren't eligible for Medicaid or CHIP, you won't be eligible for these premium assistance programs but you may be able to buy individual insurance coverage through the Health Insurance Marketplace. For more information, visit www.healthcare.gov.

If you or your dependents are already enrolled in Medicaid or CHIP and you live in a State listed below, contact your State Medicaid or CHIP office to find out if premium assistance is available.

If you or your dependents are NOT currently enrolled in Medicaid or CHIP, and you think you or any of your dependents might be eligible for either of these programs, contact your State Medicaid or CHIP office or dial **1-877-KIDS NOW** or **www.insurekidsnow.gov** to find out how to apply. If you qualify, ask your state if it has a program that might help you pay the premiums for an employer-sponsored plan.

If you or your dependents are eligible for premium assistance under Medicaid or CHIP, as well as eligible under your employer plan, your employer must allow you to enroll in your employer plan if you aren't already enrolled. This is called a "special enrollment" opportunity, and **you must request coverage within 60 days of being determined eligible for premium assistance**. If you have questions about enrolling in your employer plan, contact the Department of Labor at www.askebsa.dol.gov or call 1-866-444-EBSA (3272).

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of July 31, 2020. Contact your State for more information on eligibility –

ALABAMA – Medicaid	**CALIFORNIA – Medicaid**
Website: http://myalhipp.com/ Phone: 1-855-692-5447	Website: https://www.dhcs.ca.gov/services/Pages/TPLRD_CAU_cont.aspx Phone: 916-440-5676
ALASKA – Medicaid	**COLORADO – Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)**
The AK Health Insurance Premium Payment Program Website: http://myakhipp.com/ Phone: 1-866-251-4861 Email: CustomerService@MyAKHIPP.com Medicaid Eligibility: http://dhss.alaska.gov/dpa/Pages/medicaid/default.aspx	Health First Colorado Website: https://www.healthfirstcolorado.com/ Health First Colorado Member Contact Center: 1-800-221-3943/ State Relay 711 CHP+: https://www.colorado.gov/pacific/hcpf/child-health-plan-plus CHP+ Customer Service: 1-800-359-1991/ State Relay 711 Health Insurance Buy-In Program (HIBI): https://www.colorado.gov/pacific/hcpf/health-insurance-buy-program HIBI Customer Service: 1-855-692-6442
ARKANSAS – Medicaid	**FLORIDA – Medicaid**
Website: http://myarhipp.com/ Phone: 1-855-MyARHIPP (855-692-7447)	Website: https://www.flmedicaidtplrecovery.com/flmedicaidtplrecovery.com/hipp/index.html Phone: 1-877-357-3268
GEORGIA – Medicaid	**MASSACHUSETTS – Medicaid and CHIP**
Website: https://medicaid.georgia.gov/health-insurance- premium-payment-program-hipp Phone: 678-564-1162 ext 2131	Website: http://www.mass.gov/eohhs/gov/departments/masshealth/ Phone: 1-800-862-4840
INDIANA – Medicaid	**MINNESOTA – Medicaid**
Healthy Indiana Plan for low-income adults 19-64 Website: http://www.in.gov/fssa/hip/ Phone: 1-877-438-4479 All other Medicaid Website: https://www.in.gov/medicaid/ Phone 1-800-457-4584	Website: https://mn.gov/dhs/people-we-serve/children-and- families/health-care/health-care-programs/programs- and-services/other-insurance.jsp Phone: 1-800-657-3739
IOWA – Medicaid and CHIP (Hawki)	**MISSOURI – Medicaid**
Medicaid Website: https://dhs.iowa.gov/ime/members Medicaid Phone: 1-800-338-8366 Hawki Website: http://dhs.iowa.gov/Hawki Hawki Phone: 1-800-257-8563	Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005

KANSAS – Medicaid	MONTANA – Medicaid
Website: http://www.kdheks.gov/hcf/default.htm Phone: 1-800-792-4884	Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084
KENTUCKY – Medicaid	**NEBRASKA – Medicaid**
Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP) Website: https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx Phone: 1-855-459-6328 Email: KIHIPP.PROGRAM@ky.gov KCHIP Website: https://kidshealth.ky.gov/Pages/index.aspx Phone: 1-877-524-4718 Kentucky Medicaid Website: https://chfs.ky.gov	Website: http://www.ACCESSNebraska.ne.gov Phone: 1-855-632-7633 Lincoln: 402-473-7000 Omaha: 402-595-1178
LOUISIANA – Medicaid	**NEVADA – Medicaid**
Website: www.medicaid.la.gov or www.ldh.la.gov/lahipp Phone: 1-888-342-6207 (Medicaid hotline) or 1-855-618-5488 (LaHIPP)	Medicaid Website: http://dhcfp.nv.gov Medicaid Phone: 1-800-992-0900
MAINE – Medicaid	**NEW HAMPSHIRE – Medicaid**
Enrollment Website: https://www.maine.gov/dhhs/ofi/applications-forms Phone: 1-800-442-6003 TTY: Maine relay 711 Private Health Insurance Premium Webpage: https://www.maine.gov/dhhs/ofi/applications-forms Phone: 1-800-977-6740. TTY: Maine relay 711	Website: https://www.dhhs.nh.gov/oii/hipp.htm Phone: 603-271-5218 Toll free number for the HIPP program: 1-800-852- 3345, ext 5218

NEW JERSEY – Medicaid and CHIP	SOUTH DAKOTA - Medicaid
Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/ Medicaid Phone: 609-631-2392 CHIP Website: http://www.njfamilycare.org/index.html CHIP Phone: 1-800-701-0710	Website: http://dss.sd.gov Phone: 1-888-828-0059
NEW YORK – Medicaid	**TEXAS – Medicaid**
Website: https://www.health.ny.gov/health_care/medicaid/ Phone: 1-800-541-2831	Website: http://gethipptexas.com/ Phone: 1-800-440-0493
NORTH CAROLINA – Medicaid	**UTAH – Medicaid and CHIP**
Website: https://medicaid.ncdhhs.gov/ Phone: 919-855-4100	Medicaid Website: https://medicaid.utah.gov/ CHIP Website: http://health.utah.gov/chip Phone: 1-877-543-7669

NORTH DAKOTA – Medicaid	VERMONT– Medicaid
Website: http://www.nd.gov/dhs/services/medicalserv/medicaid/ Phone: 1-844-854-4825	Website: http://www.greenmountaincare.org/ Phone: 1-800-250-8427
OKLAHOMA – Medicaid and CHIP	**VIRGINIA – Medicaid and CHIP**
Website: http://www.insureoklahoma.org Phone: 1-888-365-3742	Website: https://www.coverva.org/hipp/ Medicaid Phone: 1-800-432-5924 CHIP Phone: 1-855-242-8282
OREGON – Medicaid	**WASHINGTON – Medicaid**
Website: http://healthcare.oregon.gov/Pages/index.aspx http://www.oregonhealthcare.gov/index-es.html Phone: 1-800-699-9075	Website: https://www.hca.wa.gov/ Phone: 1-800-562-3022
PENNSYLVANIA – Medicaid	**WEST VIRGINIA – Medicaid**
Website: https://www.dhs.pa.gov/providers/Providers/Pages/Medical/HIPP-Program.aspx Phone: 1-800-692-7462	Website: http://mywvhipp.com/ Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)
RHODE ISLAND – Medicaid and CHIP	**WISCONSIN–Medicaid and CHIP**
Website: http://www.eohhs.ri.gov/ Phone: 1-855-697-4347, or 401-462-0311 (Direct RIte Share Line)	Website: https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm Phone: 1-800-362-3002
SOUTH CAROLINA – Medicaid	**WYOMING – Medicaid**
Website: https://www.scdhhs.gov Phone: 1-888-549-0820	Website: https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/ Phone: 1-800-251-1269

To see if any other states have added a premium assistance program since July 31, 2020, or for more information on special enrollment rights, contact either:

U.S. Department of Labor
Benefits Security Administration
www.dol.gov/agencies/ebsa

1-866-444-EBSA (3272)

U.S. Department of Health and Human Services Employee
Centers for Medicare & Medicaid Services
www.cms.hhs.gov

1-877-267-2323, Menu Option 4, Ext. 61565

PAPERWORK REDUCTION ACT STATEMENT

According to the Paperwork Reduction Act of 1995 (Pub. L. 104-13) (PRA), no persons are required to respond to a collection of information unless such collection displays a valid Office of Management and Budget (OMB) control number. The Department notes that a Federal agency cannot conduct or sponsor a collection of information unless it is approved by OMB under the PRA, and displays a currently valid OMB control number, and the public is not required to respond to a collection of information unless it displays a currently valid OMB control number. See 44 U.S.C. 3507. Also, notwithstanding any other provisions of law, no person shall be subject to penalty for failing to comply with a collection of information if the collection of information does not display a currently valid OMB control number. See 44 U.S.C. 3512.

The public reporting burden for this collection of information is estimated to average approximately seven minutes per respondent. Interested parties are encouraged to send comments regarding the burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to the U.S. Department of Labor, Employee Benefits Security Administration, Office of Policy and Research, Attention: PRA Clearance Officer, 200 Constitution Avenue, N.W., Room N-5718, Washington, DC 20210 or email ebsa.opr@dol.gov and reference the OMB Control Number 1210-0137.

OMB Control Number 1210-0137 (expires 1/31/2023)

MCAD'S HEALTH PLANS NOTICE OF PRIVACY PRACTICES

Effective January 01, 2021

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. If you have any questions about this notice, please contact the Privacy Officer:

Assistant Vice President, Human Resources
Autumn Amadou-Blegen
2501 Stevens Avenue
Minneapolis, MN 55404
Phone: (612) 874-3798

WHO WILL FOLLOW THIS NOTICE

This notice describes the medical information practices of the MCAD's Cafeteria Plan, the MCAD Medical Plan and the MCAD Dental Plan ("Health Plan") and that of any third party that assists in the administration of Health Plan claims.

For purposes of HIPAA and this notice, the Health Plan includes the following: Cafeteria Plan

OUR PLEDGE REGARDING MEDICAL INFORMATION

We understand that medical information about you and your health is personal. We are committed to protecting medical information about you. This notice applies to all of the medical records maintained by the Health Plan. 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.

This notice tells you about the ways in which we may use and disclose medical information about you. It also describes our obligations and your rights regarding the use and disclosure of medical information.

We are required by law to:

- make sure that medical information that identifies you is kept private;
- give you this notice of our legal duties and privacy practices with respect to medical information about you; and
- follow the terms of the notice that are currently in effect.

HOW WE MAY USE AND DISCLOSE MEDICAL INFORMATION ABOUT YOU

The following categories describe different ways that we use and disclose medical information. For each category of uses or disclosures, we will explain what we mean and present some examples. These examples are not exhaustive. Not every use or disclosure in a category will be listed. However, all of the ways we are permitted to use and disclose information will fall within one of the categories.

Please note: In most instances, how information is used and disclosed has not changed. The descriptions reflect how the Health Plan has traditionally operated.

For Treatment (as described in applicable regulations). We may use or disclose medical information about you to facilitate medical treatment or services by providers. We may disclose medical information about you to providers, including doctors, nurses, technicians, medical students, or other hospital personnel who are involved in taking care of you.

For Payment (as described in applicable regulations). We may use and disclose medical information about you to determine eligibility for benefits, to facilitate payment for the treatment and services you receive from health care providers, to determine benefit responsibility under the Health Plan, or to coordinate Health Plan coverage. For example, we may tell your health care provider about your medical history to determine whether a particular treatment is experimental, investigational, or medically necessary or to determine whether the Health Plan covers the treatment. We may also share medical information with a utilization review or pre-certification service provider. Likewise, we may share medical information with another entity to assist with the adjudication (legal actions) or subrogation (third party reimbursements) of health claims or to another health plan to coordinate benefit payments.

For Health Care Operations (as described in applicable regulations). We may use and disclose medical information about you for other Health Plan operations. These uses and disclosures are necessary to run the Health Plan. For example, we may use medical information in connection with: conducting quality assessment and improvement activities; underwriting, premium rating, and other activities relating to Health Plan coverage; submitting claims for stop-loss (or excess loss) coverage; conducting or arranging for medical review, legal services, audit services, and fraud and abuse detection programs; business planning and development such as cost management; and business management and general Health Plan administrative activities.

As Required By Law. We will disclose medical information about you when required to do so by federal, state or local law. For example, we may disclose medical information when required by a court order or subpoena.

To Avert a Serious Threat to Health or Safety. The Health Plan may use and disclose medical information about you when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person. However disclosure would be limited to someone able to help prevent the threat.

SPECIAL SITUATIONS

Disclosure to Health Plan Sponsor. Information may be disclosed to another health plan for purposes of facilitating claims payments under that plan. In addition, medical information may be disclosed to MCAD's personnel solely for administering benefits under the Health Plan.

Organ and Tissue Donation. If you are an organ donor, we may release medical information to organizations that handle organ procurement or organ, eye or tissue transplantation or to an organ donation bank, as necessary to facilitate organ or tissue donation and transplantation.

Military and Veterans. If you are a member of the armed forces, we may release medical information about you as required by military command authorities. We may also release medical information about foreign military personnel to the appropriate foreign military authority.

Workers' Compensation. We may release medical information about you for workers' compensation or similar programs. These programs provide benefits for work-related injuries or illness.

Public Health Risks. We may disclose medical information about you for public health activities. These activities generally include the following:

- to prevent or control disease, injury or disability;
- to report births and deaths;
- to report reactions to medications or problems with products;
- to notify people of recalls of products they may be using;
- to notify a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition;
- to notify the appropriate government authority if we believe an individual has been the victim of abuse, neglect or domestic violence. We will only make this disclosure if you agree or when required or authorized by law.

Health Oversight Activities. We may disclose medical information to a health oversight agency for activities authorized by law. These oversight activities include, for example, audits, investigations, inspections, and licensure. These activities are necessary for the government to monitor the health care system, government programs, and compliance with civil rights laws.

Lawsuits and Disputes. If you are involved in a lawsuit or a dispute, we may disclose medical information about you in response to a court or administrative order. We may also disclose medical information about you in response to a subpoena, discovery request, or other lawful process by someone else involved in the dispute, but only if efforts have been made to tell you about the request or to obtain an order protecting the information requested.

Law Enforcement. We may release medical information if asked to do so by a law enforcement official:

- in response to a court order, subpoena, warrant, summons or similar process;
- to identify or locate a suspect, fugitive, material witness, or missing person;
- about the victim of a crime if, under certain limited circumstances, we are unable to obtain the person's agreement;
- about a death we believe may be the result of criminal conduct; and
- in emergency circumstances to report a crime; the location of the crime or victims; or the identity, description or location of the person who committed the crime.

Coroners, Medical Examiners and Funeral Directors. We may release medical information to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death. We may also release medical information about patients of the hospital to funeral directors as necessary to carry out their duties.

National Security and Intelligence Activities. We may release medical information about you to authorized federal officials for intelligence, counterintelligence, and other national security activities authorized by law.

Inmates. If you are an inmate of a correctional institution or under the custody of a law enforcement official, we may release medical information about you to the correctional institution or law enforcement official. This release would be necessary (1) for the institution to provide you with health care; (2) to protect your health and safety or the health and safety of others; or (3) for the safety and security of the correctional institution.

YOUR RIGHTS REGARDING MEDICAL INFORMATION ABOUT YOU

You have the following rights regarding medical information we maintain about you:

Right to Inspect and Copy. You have the right to inspect and copy medical information that may be used to make decisions about your Health Plan benefits. To inspect and copy the medical information that may be used to make decisions about you, you must submit your request in writing to the Privacy Officer. If you request a copy of the information, we may charge a fee for the costs of copying, mailing or other supplies associated with your request.

We may deny your request to inspect and copy in certain very limited circumstances. If you are denied access to medical information, you may request that the denial be reviewed.

Right to Amend. If you feel that medical information we have about you is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept by or for the Health Plan.

To request an amendment, your request must be made in writing and submitted to the Privacy Officer. In addition, you must provide a reason that supports your request.

We may deny your request for an amendment if it is not in writing or does not include a reason to support the request. In addition, we may deny your request if you ask us to amend information that:

- is not part of the medical information kept by or for the Health Plan;
- was not created by us, unless the person or entity that created the information is no longer available to make the amendment;
- is not part of the information which you would be permitted to inspect and copy; or is accurate and complete.

Right to an Accounting of Disclosures. You have the right to request an "accounting of disclosures" where such disclosure was made for any purpose other than treatment, payment, or health care operations.

To request this list of accounting of disclosures, you must submit your request in writing to Privacy Officer. Your request must state a time period which may not be longer than six years and may not include dates before April 14, 2004. Your request should indicate in what form you want the list (for example, paper or electronic). The first list you request within a 12 month period will be free. For additional lists, we may charge you for the costs of providing the list. We 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.

Right to Request Restrictions. You have the right to request a restriction or limitation on the medical information we use or disclose about you for treatment, payment or health care operations. You also have the right to request a limit on the medical information we disclose about you to someone who is involved in your care or the payment for your care, like a family member or friend. For example, you could ask that we not use or disclose information about a surgery. We are not required to agree to your request.

To request restrictions, you must make your request in writing to the Privacy Officer. In your request, you must tell us (1) what information you want to limit; (2) whether you want to limit our use, disclosure or both; and (3) to whom you want the limits to apply, for example, disclosures to your spouse.

Right to Request Confidential Communications. You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. For example, you can ask that we only contact you at work or by mail. To request confidential communications, you must make your request in writing to the Privacy Officer. We will not ask you the reason for your request. We will accommodate all reasonable requests. Your request must specify how or where you wish to be contacted.

Right to a Paper Copy of This Notice. You have the right to a paper copy of this notice. You may ask us to give you a 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. To obtain a paper copy of this notice, contact the Privacy Officer.

CHANGES TO THIS NOTICE

We reserve the right to change this notice. We reserve the right to make the revised or changed notice effective for medical information we already have about you as well as any information we receive in the future. We will post a copy of the current notice on the Health Plan website. The notice will contain on the first page, in the top right hand corner, the effective date.

COMPLAINTS

If you believe your privacy rights have been violated, you may file a complaint with the Health Plan or with the Secretary of the Department of Health and Human Services. To file a complaint with the Health Plan, contact the Privacy Officer. All complaints must be submitted in writing.

To file a complaint with the Department of Health and Human Services, contact:

Office for Civil Rights
U.S. Department of Health & Human Services

233 N. Michigan Ave. - Suite 240
Chicago, IL 60601
(312) 886-2359; (312) 353-5693 (TDD)
(312) 886-1807 FAX

You will not be penalized for filing a complaint.

OTHER USES OF MEDICAL INFORMATION

Other uses and disclosures of medical information not covered by this notice or the other applicable laws will be made only with your written permission. If you provide us permission to use or disclose medical information about you, you may revoke that permission, in writing, at any time. If you revoke your permission, we will no longer use or disclose medical information about you for the reasons covered by your written authorization. You understand that we are unable to take back any disclosures we have already made with your permission, and that we are required to retain our records of the care that we provided to you.

MNSURE COVERAGE OPTIONS AND YOUR HEALTH COVERAGE: FOR EMPLOYEES WHOSE EMPLOYERS OFFER HEALTH COVERAGE (MINNESOTA EMPLOYEES)

GENERAL INFORMATION

When key parts of the health care law known as the Affordable Care Act take effect, there will be a new place to buy health insurance in Minnesota; MNsure. To assist you as you evaluate options for you and your family, this notice provides some basic information about MNsure and employment-based health coverage offered by your employer.

WHAT IS MNSURE?

MNsure is designed to help you find health insurance that meets your needs and fits your budget. MNsure offers "onestop shopping" to find and compare private health insurance options. You may also be eligible for a new kind of tax credit that lowers your monthly premium for health insurance plans sold through MNsure or free or low-cost insurance from Medical Assistance or MinnesotaCare. Open enrollment for health insurance coverage through MNsure begins November 1, 2020 for coverage starting as early as January 1, 2021.

CAN I SAVE MONEY ON MY HEALTH INSURANCE PREMIUMS THROUGH MNSURE?

Yes. You may qualify to save money and lower or eliminate your monthly premium. You may qualify for a tax credit or MinnesotaCare only if your employer does not offer coverage, or offers coverage that doesn't meet certain standards. The savings on your premium that you're eligible for depends on your household income.

DOES EMPLOYER HEALTH COVERAGE AFFECT ELIGIBILITY FOR PREMIUM SAVINGS THROUGH MNSURE?

Yes. If you have an offer of health coverage from your employer that meets certain standards, you will not be eligible for a tax credit or MinnesotaCare through MNsure and may wish to enroll in your employer's health plan. However, you may be eligible for a tax credit that lowers your monthly premium, a reduction in

certain cost- sharing, or MinnesotaCare if your employer does not offer coverage that meets certain standards. If the cost of a plan from your employer for you, the employee only, is more than 9.83% of your household income for the year, or if the coverage does not meet the "minimum value" standard set by the Affordable Care Act, you may be eligible for a tax credit.[1]

If you are seeking help paying costs for health coverage through MNsure, you will need information about the cost and value of your employer coverage to complete an online or paper application. If your employer offers health coverage to you, ask your employer to complete and give you the Health Coverage from Jobs (Appendix A) form. If your employer does not offer coverage to you, you do not need your employer to complete the Health Coverage from Jobs (Appendix A) form.

Note: If you purchase a health plan through MNsure instead of accepting health coverage offered by your employer, then you may lose the employer contribution (if any) to the employer-offered coverage. Also, this employer in contribution, as well as your employee contribution to employer-offered coverage, is often excluded from income for Federal and State income tax purposes. Your payments for coverage through MNsure are made on an after –tax basis.

HOW CAN I GET MORE INFORMATION?

There is help available to you to evaluate your coverage options through MNsure, including your eligibility for coverage through MNsure and its cost. Please visit **www.mnsure.org** for more information, including an online application for health insurance coverage, or call 1-855-3MNsure (1-855-366-7873).

[1] An employer-sponsored health plan meets the "minimum value standard" if the plan's share of the total allowed benefit costs covered by the plan is no less than 60 percent of such costs.

FEDERAL COVERAGE OPTIONS AND YOUR HEALTH COVERAGE: FOR EMPLOYEES WHOSE EMPLOYERS OFFER HEALTH COVERAGE (FEDERAL NOTICE – STATES OUTSIDE OF MINNESOTA)

GENERAL INFORMATION

When key parts of the health care law known as the Affordable Care Act take effect, there will be a new place to buy health insurance; the Marketplace. To assist you as you evaluate options for you and your family, this notice provides some basic information about the Marketplace and employment-based health coverage offered by your employer.

WHAT IS THE HEALTH INSURANCE MARKET PLACE?

The Marketplace is designed to help you find health insurance that meets your needs and fits your budget. The Marketplace offers "one-stop shopping" to find and compare private health insurance options. You may also be eligible for a new kind of tax credit that lowers your monthly premium for health insurance plans sold through the Marketplace. Open enrollment for health insurance coverage through the Marketplace begins November 1, 2020 for coverage starting as early as January 1, 2021.

CAN I SAVE MONEY ON MY HEALTH INSURANCE PREMIUMS IN THE MARKETPLACE?

Yes. You may qualify to save money and lower or eliminate your monthly premium, but only if your employer does not offer coverage, or offers coverage that doesn't meet certain standards. The savings on your premium that you're eligible for depends on your household income.

DOES EMPLOYER HEALTH COVERAGE AFFECT ELIGIBILITY FOR PREMIUM SAVINGS THROUGH THE MARKETPLACE?

Yes. If you have an offer of health coverage from your employer that meets certain standards, you will not be eligible for a tax credit through the Marketplace and may wish to enroll in your employer's health plan. However, you may be eligible for a tax credit that lowers your monthly premium, a reduction in certain cost-sharing if your employer does not offer coverage that meets certain standards. If the cost of a plan from your employer for you, the employee only, is more than 9.83% of your household income for the year, or if the coverage does not meet the "minimum value" standard set by the Affordable Care Act, you may be eligible for a tax credit.[1]

If you are seeking help paying costs for health coverage through the Marketplace, you will need information about the cost and value of your employer coverage to complete an online or paper application. If your employer offers health coverage to you, ask your employer to complete and give you the Health Coverage from Jobs (Appendix A) form. If your employer does not offer coverage to you, you do not need your employer to complete the Health Coverage from Jobs (Appendix A) form.

Note: If you purchase a health plan through the Marketplace instead of accepting health coverage offered by your employer, then you may lose the employer contribution (if any) to the employer-offered coverage. Also, this employer in contribution, as well as your employee contribution to employer-offered coverage, is often excluded from income for Federal and State income tax purposes. Your payments for coverage through the Marketplace are made on an after –tax basis.

HOW CAN I GET MORE INFORMATION?

There is help available to you to evaluate your coverage options through the Marketplace, including your eligibility for coverage and cost. Please visit **www.HealthCare.gov** for more information, including an online application for health insurance coverage and contact information for a Health Insurance Marketplace in your area.

[1] An employer-sponsored health plan meets the "minimum value standard" if the plan's share of the total allowed benefit costs covered by the plan is no less than 60 percent of such costs.