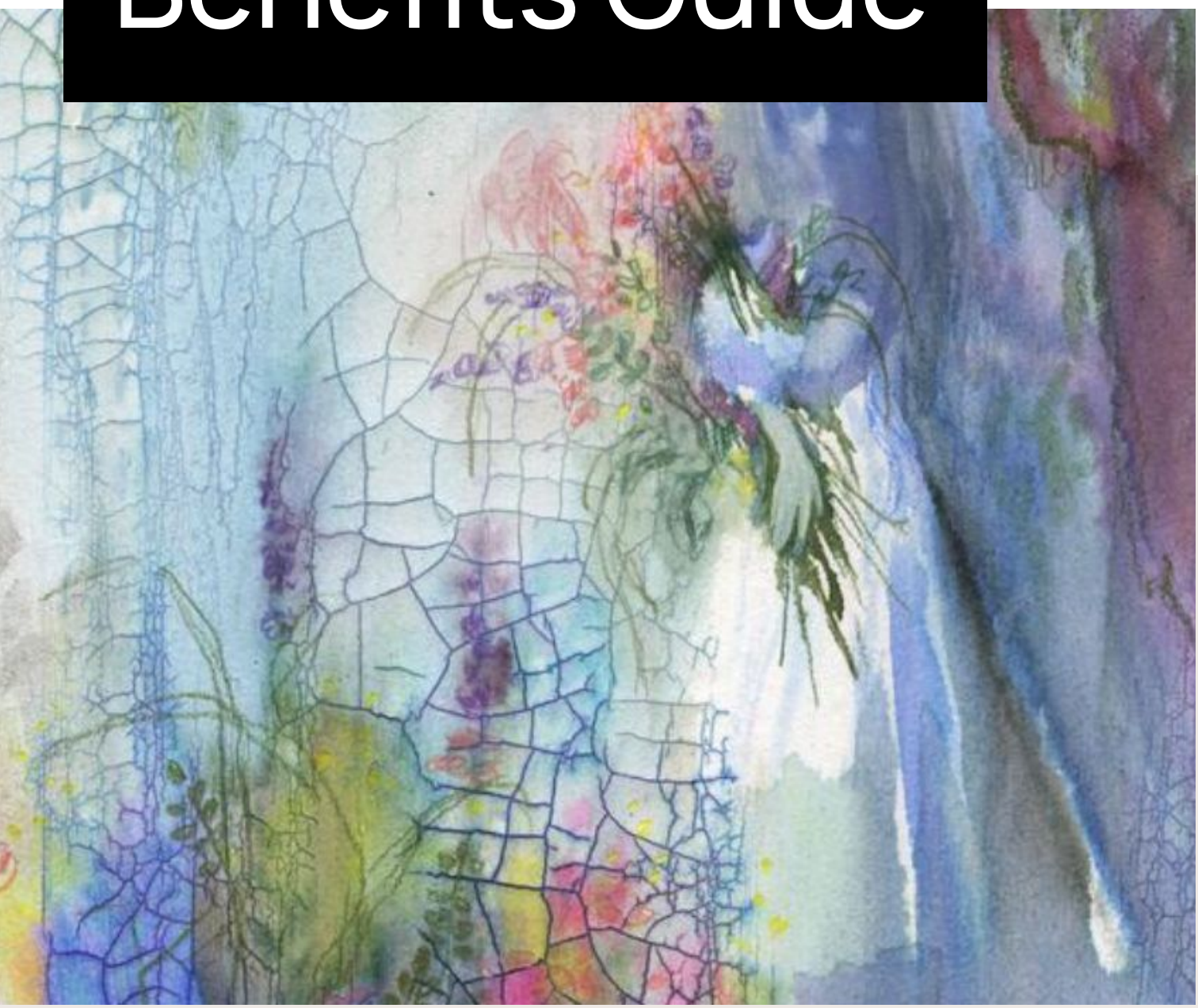
MCAD

2026 Benefits Guide



Welcome to your benefits

Select the category title for quick navigation

What's inside?

This guide is dedicated to helping you understand your benefit options, serving as a go-to reference for high-level plan details and resources throughout the year. Please note, while this guide offers general plan information. The most comprehensive overviews can be obtained from carrier plan documents.

Want to access additional tips and tools?

Click here or scan the QR code to access a 'Benefits Tips & Tools' guide, packed with helpful information on using and maximizing your benefits.

Eligibility & Enrollment

Who is eligible to enroll?

You can enroll in the benefits program below if you are a regular full-time employee scheduled a minimum of 35 hours per week or a part-time staff member scheduled 20+ hours per week and at least 1,000 or more hours annually. Eligible employees may also choose to enroll the following eligible dependents:

Your lawful spouse

Your state registered or unregistered domestic partner

Your children up to age 26, including natural, stepchildren, or legally adopted children, foster children who have been placed with you, and any other children you support for whom you are the legal guardian or for whom you are required to provide coverage as the result of a qualified medical child support order

Your unmarried child(ren) of any age who are principally supported by you and incapable of self-support due to a physical or mental disability

To learn more, click here.

How do I enroll?

- To enroll, simply follow these steps:
- Go to access.paylocity.com or download the mobile app
- On the homepage, click “Start your enrollment”
- You will be guided to enter your personal information, family information, benefit plan selections, and to click ‘Confirm’.
- Scan the QR code to download the mobile app!

paylocity
Forward Together.

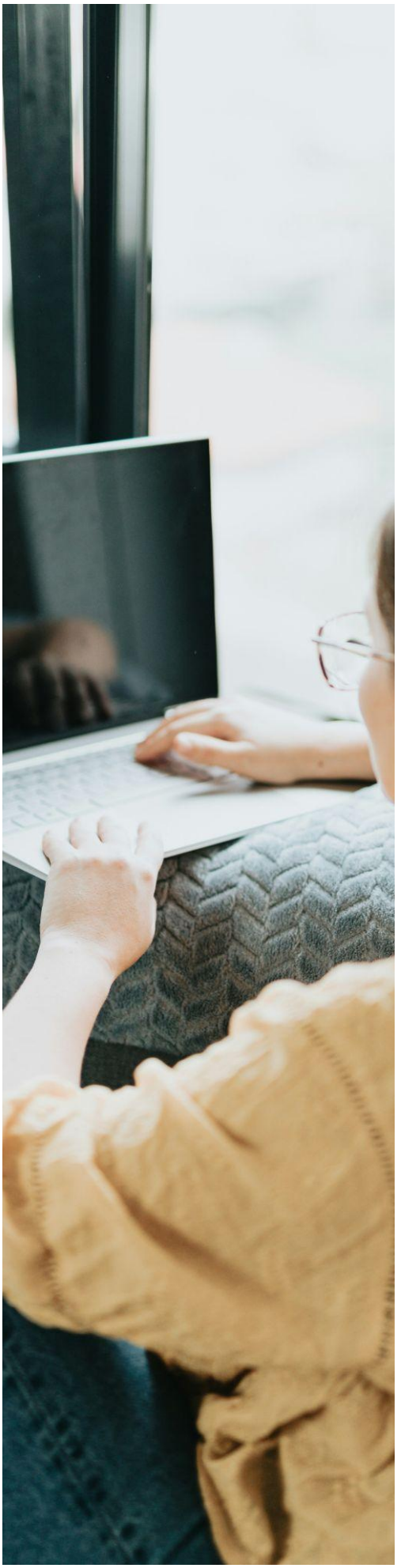
When do I enroll?

Open Enrollment (OE) is your annual opportunity to enroll in or change benefits. Outside of OE, you can make changes if you're a new hire or experience a qualifying life event (QLE). For a QLE benefits change, you must notify HR within 30 days of the event and provide proof, if required. The following are examples of QLEs, but you can click here for a comprehensive list, as defined by the IRS.

Marriage	Death of a spouse or dependent
Divorce	Loss of coverage
Legal separation	Change in residence
Birth or adoption of a child	Changes in employment status
Change in a child’s dependent status	Gain or loss of Medicare or Medicaid eligibility

When does my coverage start?

The plan year begins 1/1/2026. As a new hire, coverage is effective first of the month following your date of hire.



What's new this plan year?

Waiver Reimbursement

- Employees who waive medical coverage will be credited $100 per month by MCAD.

New York Life Benefits: Moving to Unum

- All currently offered ancillary benefits through NY Life will now be administered through Unum.

Specific Lines Transitioning to Unum

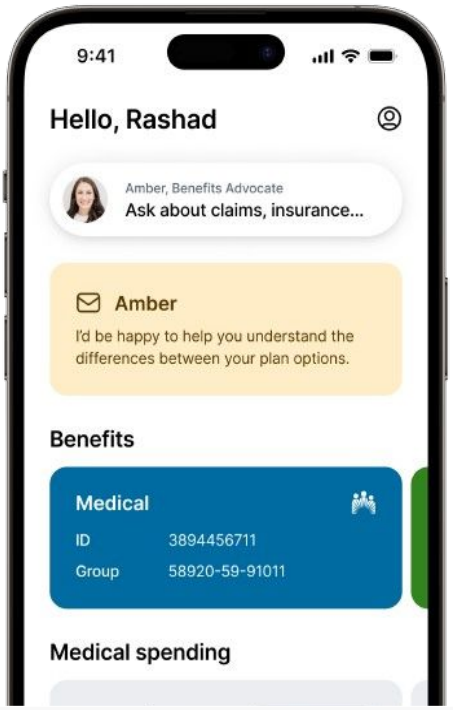
- Basic Life & AD&D
- Voluntary Life & AD&D
- Short-Term Disability (STD) - STD waiting period has moved from 2 weeks to 30 days
- Long-Term Disability (LTD)
- Hospital Indemnity *new*
- Accident *new*
- Critical Illness *new*

Pet Insurance

- We are now offering Pet Insurance through MetLife.
- You will need to enroll directly with MetLife for Pet Insurance. Rates are determined individually based on your pet's information

Download the Nava Benefits App

Year-round benefits support in your back pocket



Your benefits one-stop shop

- View all your benefits in one page
- Find in-network providers
- Track your deductible spend
- Access your ID cards

Benefit Advocates guidance

- Explore plan options
- Answer questions about your elections
- Resolve enrollment issues or claims

Support without the wait

- Receive instant, personalized answers to questions about your benefits

Invite your family members to have app access

- Sign into the app, select the top right profile icon, then click Family Access
- They'll receive an automated email and text

DOWNLOAD THE APP TODAY

Use your phone number or email address to log in

Scan to download

Scan to watch a brief video

Core Benefits

Benefits Terminology

Navigating the world of benefits can be challenging, especially with all the jargon involved. To make it easier, the following list reflects some common terms you should know.

Prefer learning through videos? Simply scan this QR code to explore a comprehensive library of short, engaging videos covering a wide range of benefits topics.

Balance Bill

When a healthcare provider bills a patient for the difference between what the patient's health insurance reimburses and what the provider chooses to charge.

Copay

Flat dollar amount that an individual is required to pay for a covered healthcare service or prescription.

Coinsurance

The percentage of cost-sharing between the insured member and the insurance carrier.

Deductible

The amount that you have to pay before cost-sharing begins with the insurance carrier.

Formulary

A tiered list of covered prescription drugs, with higher subsidies for low-cost generics compared to pricier brand-name or specialty drugs.

In-Network

Healthcare providers, such as doctors and hospitals, have agreements with the health plan, offering better cost coverage for members than out-of-network providers.

Out-of-Network

Healthcare providers without agreements with the plan, resulting in higher out-of-pocket costs for the insured member.

Out-of-Pocket Limit

The most you will have to pay for covered healthcare services in a plan year.

Premium

The amount of money an individual pays to an insurance company for coverage.

Primary Care Physician (PCP)

Provider who is the main point of contact for patients, offering general medical care, preventive services, and coordinating referrals.

Preventive Care

Routine healthcare, including screenings, checkups and patient counseling to prevent or discover health problems.

Specialist

A healthcare professional with advanced expertise in a specific field of medicine or healthcare.

Medical Plan Options

Find your ideal match

Choosing the optimal plan for you and your family can feel like you're solving a puzzle. Here, we unravel some key differences to guide you through your decision-making journey. Please note, this chart is used for general purposes. Review your medical plan summaries for further details.

	PPO	HDHP
Primary Care Physician (PCP) Election	Not required	Not required
Specialist Referral	Not required	Not required
Compatible with an HSA	No	Yes
FSA Pairing	Healthcare FSA Dependent Care FSA	Dependent Care FSA Limited Purpose FSA
Additional Details	You can receive both in or out-of-network care but will have lower out-of-pocket costs if you stay in-network. Emergencies covered worldwide.	HDHPs have lower payroll deductions but higher deductibles than most plans. Pairs with a Health Savings Account (HSA) allowing you to contribute pre-tax dollars to cover qualified medical expenses. Emergencies covered worldwide.

Preferred Provider Organization (PPO)

In-Network or Out-of-Network

Primary Physician

or

Specialist (no referral needed)

High Deductible Health Plan (HDHP)

In-Network or Out-of-Network

Health Savings Account (HSA) Funds

Primary Care Physician

or

Specialist

Medical Plan Options

			Plan 01 (Co-pay Plan)	Plan 02 (Three for Free Plan)
			HealthPartners	HealthPartners
In-Network	Annual Deductible	Individual	$1,500	$2,500
		Family	$4,500	$7,500
	Out-of-Pocket Maximum	Individual	$5,000	$5,000
		Family	$10,000	$10,000
	Doctor Visit	Primary Care	$45	No charge for first 3 visits; then 25%*
		Specialist	$45	No charge for first 3 visits; then 25%*
	Preventive Care		100% covered	100% covered
	Emergency Care		25%*	25%*
	Urgent Care		$45	No charge for first 3 visits; then 25%*
	Hospitalization	Inpatient	25%*	25%*
		Outpatient	25%*	25%*
	Prescription Drugs (Retail)	Rx Deductible	N/A	N/A
		Generic	$25	$25
		Preferred	$60	$60
		Non-Preferred	$150	$150
		Speciality Level	20-30%*	20-30%*
Out-of-Network	Annual Deductible	Individual	$7,500	$7,500
		Family	$22,500	$22,500
	Out-of-Pocket Maximum	Individual	$15,000	$15,000
		Family	$30,000	$30,000
	Emergency Care		25%*	25%*

*Cost share after the deductible is met. The deductible and annual maximum resets each calendar year on January 1st.

The chart above is a summary only. Please refer to your Evidence of Coverage for complete details of plan benefits, limitations, and exclusions.

Preventive treatments and services are only 100% covered if they are included in the ACA's preventive health services coverage mandate.

Medical Plan Options

			Plan 03 (HDHP $4,000)	Plan 04 (HDHP $7,000)
			HealthPartners	HealthPartners
In-Network	Annual Deductible	Individual	$4,000	$7,000
		Family	$8,000	$14,000
	Out-of-Pocket Maximum	Individual	$4,000	$7,000
		Family	$8,000	$14,000
	Doctor Visit	Primary Care	0%*	0%*
		Specialist	0%*	0%*
	Preventive Care		100% covered	100% covered
	Emergency Care		0%*	0%*
	Urgent Care		0%*	0%*
	Hospitalization	Inpatient	0%*	0%*
		Outpatient	0%*	0%*
	Prescription Drugs (Retail)	Rx Deductible	Combined with medical	Combined with medical
		Generic	0%*	0%*
		Preferred	0%*	0%*
		Non-Preferred	0%*	0%*
		Speciality	0%*	0%*
Out-of-Network	Annual Deductible	Individual	$13,000	$13,000
		Family	$26,000	$26,000
	Out-of-Pocket Maximum	Individual	$20,000	$20,000
		Family	$40,000	$40,000
	Emergency Care		0%*	0%*

*Cost share after the deductible is met. The deductible and annual maximum resets each calendar year on January 1st.

The chart above is a summary only. Please refer to your Evidence of Coverage for complete details of plan benefits, limitations, and exclusions.

Preventive treatments and services are only 100% covered if they are included in the ACA's preventive health services coverage mandate.

Access to Care

Tailored care, timely choices

Healthcare services accommodate a variety of needs, providing different access points depending on the severity and urgency of the situation. Explore the available options and examples of care to familiarize yourself with when to use them.

TELEHEALTH
Non-urgent needs

- Common cold and flu
- Minor respiratory infections
- Allergies
- Skin conditions
- Eye infections or irritations
- Mental health concerns

PRIMARY CARE PHYSICIAN (PCP)
Common conditions & preventive care

- Regular check-ups & screenings
- Vaccinations
- Common illnesses & infections
- Chronic condition management
- Required referrals
- Medication management

URGENT CARE (UC)
Common conditions & symptoms

- Bronchitis
- Colds, flu, fever
- Sore throat
- Dehydration
- Urinary tract infection
- Simple fractures

EMERGENCY ROOM (ER)
Life-threatening injuries or illnesses

- Chest pain or discomfort
- Shortness of breath
- Palpitations
- Loss of consciousness
- Confusion
- Seizures

Dental Benefits

Unleash your superpower smile

You and your eligible dependents have the opportunity to enroll in HealthPartners' Dental Preferred Provider Organization (PPO) plan. The Dental PPO plan is structured to provide you the flexibility to receive dental care from any licensed dentist you choose. It's important to note you'll maximize your plan benefits by selecting an in-network PPO dentist rather than using an out-of-network dentist who has not agreed to provide services at the negotiated rate. Additionally, when you choose in-network PPO dentists, there is no need to fill out claim forms.

	HealthPartners Dental Plan	
	In-Network	**Out-of-Network**
Annual Deductible	$0 Individual / $0 Family	$50 Individual / $150 Family
Annual Maximum	$1,500	$1,500
Preventative Services	100% covered	80%
Basic Services	80%	50%
Major Services	60%	50%
Orthodontia (through age 18)	50%	50%
Ortho Lifetime Maximum	$1,500	$1,500

∗Cost share after the deductible is met. The deductible and annual maximum resets each calendar year on January 1st.

The chart above is a summary only. Please refer to your Evidence of Coverage for complete details of plan benefits, limitations, and exclusions. Preventive treatments and services are only 100% covered if they are included in the ACA's preventive health services coverage mandate.

Find a Dental Provider

To check 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 Network.

Enter your zip code and the distance you are willing to travel or you can also call 952.883.5000.

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

Vision Benefits

Clear vision for a brighter tomorrow

Similar to a traditional PPO, the EyeMed Vision PPO plan allows you to an maximize your benefits by choosing in-network providers and doctors. If you opt for an out-of-network doctor, you'll cover all expenses upfront and submit a claim for reimbursement up to the allowed amount.

	EyeMed Vision Plan	
	In-Network	**Out-of-Network**
Frequency Exam Lenses Frames	 12 Months 12 Months 24 Months	
Examination	$10 Copay	Reimbursement Up to $40
Lenses Single Bifocal Trifocal	 $10 Copay $10 Copay $10 Copay	Reimbursement Up to $30 Up to $50 Up to $70
Frames	$130 allowance	Reimbursement Up to $91
Contact Lenses (in lieu of frames)	$130 allowance	Reimbursement Up to $91

The charts above are summary only. Please refer to your Evidence of Coverage for complete details of plan benefits, limitations, and exclusions. Preventive treatments and services are only 100% covered if they are included in the ACA's preventive health services coverage mandate.

Find a Vision Provider

To find network providers, view your benefits and claims information, or see special offers, visit your custom Virtual Benefit Fair and enter the password "RR873PBB".

Tax-Advantaged Accounts

Health Savings Account (HSA)

A Health Savings Account is a tax-advantaged financial tool designed to help you save and invest money specifically for qualified medical expenses. Since it's your account, you get to keep whatever you don't use, and it rolls over year after year. **Best part, if you enroll in Plan 04 (HDHP $7,000), MCAD will contribute $100 to your HSA at the start of the plan year!** It's a great way to take charge of your healthcare costs and stash away some funds for the future.

Components of an HSA

You own the HSA

It pairs with a high-deductible health (HDHP) plan

You select how much to contribute

You receive tax advantages

Unused funds roll over annually

Eligibility

- Enrolled in Plan 03 (HDHP $4,000) or Plan 04 (HDHP $7,000)
- Not covered by another non-HSA health plan
- Not enrolled in a Healthcare FSA
- Not receiving Medicare/Tricare benefits
- You can't be claimed as a dependent on someone else's tax return

Annual Contribution Limits

- Employee Only: $4,400
- Employee + Dependent: $8,750
- Age 55+ Catch Up: $1,000

Qualified Expenses

- Medical, dental and vision deductibles
- Prescription medication
- Acupuncture and chiropractic care
- Labs and x-rays
- And more!
- To view a full list, click here!

Additional Information

- Contact Employee Benefits Corporation's customer service at 800-346-2126 or www.ebcflex.com

Employee Benefits Corporation

The HSA Advantage

Check out this example of an HSA in action!

This table compares two financial scenarios: with and without a Health Savings Account (HSA).

- **Without HSA:** A $60,000 income is fully taxable, resulting in $12,000 in taxes (20% rate). After taxes, net pay is $48,000. Paying $1,300 in healthcare expenses out-of-pocket leaves $46,700 in disposable income.
- **With HSA:** Contributing $1,300 to an HSA lowers taxable income to $58,700, reducing taxes to $11,740—a $260 tax savings. Net pay is $48,260, and since healthcare expenses are covered pre-tax, disposable income remains $48,260.

The result? An extra $1,560 in annual spending power by reducing taxable income and using pre-tax dollars for healthcare.

Potential HSA Savings	Without HSA	With HSA
Annual Income	$60,000.00	$60,000.00
Weekly Pre-tax HSA Election	$0.00	-$25.00
Annual Pre-tax HSA Election	$0.00	-$1,300.00
Taxable Income	$60,000.00	$58,700.00
Annual Taxes Withheld (20%)	-$12,000.00	-$11,740.00
Net Pay	$48,000.00	$48,260.00
Annual Expenses (After Tax)	-$1,300.00	$0.00
Net Spending Income	$46,700.00	$48,260.00
Increase in Annual Spending Income	N/A	**$1,560.00**

Flexible Spending Account (FSA)

A Flexible Spending Account (FSA) is a tax-advantaged account that allows you to set aside pre-tax dollars for eligible healthcare or dependent care expenses. By using an FSA, you can lower your taxable income and save money on out-of-pocket costs. Please note, you must enroll in the FSA within 30 days of your hire date or during annual open enrollment. Your elections are binding for the plan year and cannot be adjusted unless you experience a Qualifying Life Event.

Healthcare FSA

A Healthcare FSA pays for qualified healthcare expenses with pre-tax dollars.

Eligibility: You can't enroll in a Healthcare FSA if you are contributing to a HSA.

2026 Max Annual Contribution Limit $3,400

Click here to learn what qualifies as eligible expenses.

Limited Purpose FSA

Unlike the Healthcare FSA, the limited purpose FSA is HSA-compatible. These FSA funds can be used for covering expenses related to dental and vision services.

2026 Max Annual Contribution Limit $3,400

Qualified Expenses:

- Dental surgery
- Orthodontia
- Eye exams
- Corrective/laser eye surgery
- Prescription glasses
- Contact Lenses

Dependent Care FSA

This benefit allows you to set aside money on a pre-tax basis for qualified Dependent Care expenses for children under age 13 and adult IRS dependents incapable of self-care.

2026 Max Annual Contribution Limit: $7,500 for individuals or married couples filing jointly and $3,750 for married individuals filing separately

Click here to learn what qualifies as eligible expenses.

FSA Plan Rules

Healthcare FSA & Limited Purpose:

- **Carryover:** This plan allows you to carry over up to $680 of unused Healthcare FSA funds at the end of the plan year as long as you re-enroll.

All Plans:

- **Run-out Period:** The plan allows for an annual run-out period through February 28, 2027, which allows you to seek reimbursements for expenses incurred during the plan year.

HSA vs. FSA: Key Differences

HSAs and FSAs both help you save on healthcare costs with pre-tax dollars, but they have some key differences. Understanding these differences can help you make the ultimate choice for your healthcare savings strategy.

	HSA	FSA
Eligibility & Ownership	• Available with Plan 03 (HDHP $4,000) or Plan 04 (HDHP $7,000) enrollment. • If you have existing funds in a Healthcare FSA, you can't enroll in a HSA. • Owned by the employee	• Eligible with MCAD's healthcare plans. • You can't enroll in a Healthcare FSA if you are contributing to a HSA. • Owned by the employer.
Contributions & Taxes	• Pre-tax contributions can be elected year-round. • MCAD contributes $100 with Plan 04 (HDHP $7,000) enrollment. • Withdrawals tax-free. • Subject to maximum annual contributions.	• Pre-tax contributions elected at beginning of year. • Withdrawals tax-free. • Subject to maximum annual contributions.
Eligible Expenses	• For qualified medical expenses, including long-term care and certain non-medical expenses post-65. • Click here for a full list	• Healthcare FSA: For eligible healthcare expenses (medical, dental, and vision). • Limited FSA: For eligible dental and vision expenses. • Dependent Care FSA: For dependent care expenses. • Click here for a full list
Rollover of Funds	• Funds roll over yearly and remain with you regardless of employment changes.	• Healthcare & Limited Purpose FSA: $680 rollover. Funds do not follow an employee, unless they have COBRA • Dependent Care FSA: Funds do not rollover.

Life & Disability

Basic Life and AD&D

Embrace the journey, safeguard the adventure

As part of our commitment to your wellbeing, you are eligible for Basic Life and AD&D Insurance, which provides financial protection to you and your loved ones in the unfortunate event of your passing or accidental injury.

Life Insurance

This coverage ensures that in the event of your passing, a lump-sum payment will be provided to your designated beneficiary. This benefit extends to all causes of death, including natural causes, illnesses and accidents.

Accidental Death and Dismemberment (AD&D) Insurance

AD&D insurance offers additional protection specifically for accidents. In the case of accidental death or certain injuries, this coverage provides a benefit to you or your beneficiaries.

Basic Life and AD&D Coverage

The benefits specified below are covered entirely by MCAD and are facilitated through New York Life.

- Basic Life Insurance of 1x annual earnings up to $50,000
- AD&D 1x your annual earnings up to $50,000

Please note, benefits reduce once you reach age 65, 70, and 75.

Remember to keep your beneficiaries current. Designate one or multiple beneficiaries to receive payments based on the percentages you allocate.

Disability Insurance

Protect your tomorrow, today

SHORT-TERM DISABILITY

Unum's Short-Term Disability (STD) coverage offers benefits after you've been absent from work 30 consecutive days and provides 60% of your weekly income, up to $2,000 per week for up to 22 weeks.

LONG-TERM DISABILITY

In the event your disability surpasses 180 days, Unum's Long-Term Disability (LTD) coverage steps in, replacing 60% of your monthly income, with a maximum benefit of $10,000 per month.

STATE DISABILITY

State disability programs provide financial support to individuals facing temporary or permanent disabilities. Consult the regulations of the state you currently reside in for specific information regarding their partial wage-replacement disability insurance plan.

Voluntary Coverage

100% employee-paid benefits

Voluntary Life and AD&D

If you wish to enhance your employer-paid insurance, you have the option to acquire additional Life and AD&D coverage for yourself and/or your dependents through Unum. Here are the details:

Employee Increments	$10,000
Employee Maximum	$300,000
Employee Guarantee Issue	$100,000 (applies to new hires and those who are eligible for benefits by MCAD for the first time)
Spouse Increments	$5,000 (employee must be enrolled in Voluntary Employee Life)
Spouse Maximum	$150,000, may not exceed 50% of the employee amount
Spouse Guarantee Issue	$30,000 (applies to initial offer of coverage only)
Benefit Reduction	50% at age 70
Child Benefits	$1,000 increments up to $20,000 (employee must be enrolled in Voluntary Employee Life)
AD&D	Coverage matches voluntary life amounts

Any insurance amounts beyond the guarantee issue amounts listed above will require Evidence of Insurability (EOI) to be completed. Approval from the insurance company is required for the coverage to become effective.

If you do not enroll in the plan during the initial enrollment period, supplemental life insurance will necessitate proof of good health, subject to approval by the insurance company before it becomes effective. For more details about this plan, please review the plan summary.

Refer to your Summary Plan Description for exclusions and additional details. Note that benefits coverage may decrease after reaching age 65, and certain restrictions may apply if you or your dependents are hospitalized or terminally ill.

Voluntary Benefits

Unum Critical Illness Insurance Benefits

Coverage Basics

- Provides a lump-sum payment to the insured in the event of a specified critical illness diagnosis.
- Pays you cash benefits directly (unless assigned).
- You have the flexibility to use the funds as you see fit!

Employee	$10,000, $20,000 or $30,000
Spouse	50% of employee benefit
Dependent Child	50% of employee benefit (automatically covered)

Unum Accident Insurance Benefits

Coverage Basics

- When an accident occurs, this coverage helps pay expenses that major medical insurance may not fully cover.
- Pays you cash benefits directly (unless assigned), which can be used for a variety of services.
- Benefits can be applied to ambulance rates, diagnostics, intensive care, therapy, rehabilitation costs, and much more.

Emergency Room Treatment	$100
Ambulance	Air: $1,000 Ground: $300
At-Home Care	$100
Follow-up Doctor Visit	$75 up to 2 visits
Hospital Admission	$1,000
Hospital Daily Stay	$300
Wellness Stipend (annual)	$50

For a full schedule of benefits as well as associated costs, please refer to your Unum benefit summary.

Voluntary Benefits

Unum Hospital Insurance Benefits

Coverage Basics

- Provides financial benefits for covered hospital stays when you're sick, injured, or on maternity leave.
- Offers additional support for the out-of-pocket costs associated with hospitalization.
- You receive cash benefits directly, unless assigned otherwise.

For a full schedule of benefits as well as associated costs, please refer to the carrier's benefit summary.

Hospital Admission	$1,500 per admission (max 1 admission per year)
Hospital Confinement	$100 per day (to a max of 365 days)
Intensive Care Unit Admission	$1,500 per admission (max 1 admission per year)
Intensive Care Unit Confinement	$100 per day (to a max of 30 days)

Pet Insurance

Our pets mean more to us than ever—they're family. Protecting their health is just as important as protecting our own. MetLife Pet Insurance helps safeguard your furry companions from the unexpected by reimbursing you for covered veterinary expenses due to accidents or illnesses. Give yourself peace of mind knowing your pet—and your budget—are protected.

Why is Pet Insurance important?

- A small monthly payment can help you prepare for unexpected vet expenses down the road.
- More than 6 in 10 pet owners said their pet has had an emergency medical expense.
- 24% of pet parents have credit card or personal loan debt to cover pet health and vet costs.
- Average annual cost for a routine vet visit is $212 for a dog and $160 for a cat; and average annual cost for a surgical vet visit is $426 for a dog and $214 for a cat.
- Pet insurance may not cover pre-existing conditions.

How does MetLife Pet Insurance work?

1. Select & enroll in the coverage best for you and your pet.
2. Download the MetLife mobile app.
3. Take your pet to the vet.
   Pay the bill and send it with your claim to MetLife (app, online portal, email, fax, or postal service).
4. Receive reimbursement by check or direct deposit if the claim expense is covered under the policy.

What's covered?

- Accidental injuries
- Illnesses
- Exam fees
- Surgeries
- Medications
- Ultrasounds
- Hospital stays
- X-rays and diagnostic tests
- Hip dysplasia
- Hereditary, congenital, and chronic conditions
- Alternative therapies and more!

Call to get a quote or enroll today

- Call 1 (800) 438-6388
- Or click here to obtain a quote!

For a full schedule of benefits and exclusions, please refer to the MetLife benefit summary.

Additional Offerings

Planning for Retirement

Building a foundation for your retirement dreams

Facilitated by TIAA, the 403(b) Defined Contribution Account, Supplemental Retirement Account (SRA), and Roth IRA post-tax plans empower you to proactively prepare for your future. Once eligible, you have the option to designate a percentage of your salary to be withheld and invested in your retirement account, in accordance with federal regulations and guidelines. For confirmation of eligibility and enrollment dates, please consult Human Resources.

To be eligible for the 403(b) plan, an employee must work the required number of qualifying hours with MCAD for two consecutive years or sign a service waiver.

The SRA allows eligible employees to contribute to their retirement plan. Any employee who is not a student worker can contribute to their retirement goals through the SRA. This plan gives employees the option to begin contributing to retirement prior to meeting 403(b) match eligibility or it can be used as a supplement to the 403(b) plan.

The Roth IRA allows employees to contribute post-tax earnings (as opposed to a traditional IRA where you put in pre-tax money), so your contributions and earnings in a Roth IRA grow tax-free.

For current fund choices and investment options, go to www.tiaa.org or call 800.842.2755.

Please note, Nava Benefits does not serve as an advisor, broker-dealer, or registered investment advisor for this plan. All terms and conditions are subject to applicable laws, regulations, and policies. In case of any conflict between your plan document and this information, the plan documents will always take precedence.

Employee Assistance Program (EAP)

Confidential assistance for life's challenges

Life can be challenging, and we all face moments when things feel overwhelming—whether due to personal struggles, work pressures, or just the day-to-day stresses. During these tough times, it's important to remember that you're not alone – the EAP is here for you.

What's offered

You and your dependents are provided confidential, short-term counseling and support services, providing a helping hand when you're facing personal or work-related challenges.

Topics for support

- Mental health
- Work-life balance
- Relationship issues
- Grief and loss
- Substance abuse
- Trauma counseling
- Conflict resolution
- Burnout
- Career development
- Harassment
- Parenting support
- Elder care
- Financial stress
- Major life changes
- And more

Access the EAP

- www.hpeap.com (password: hpeap)
- 866.326.7194

HealthPartners

Transportation through Metropass

Administered by MCAD

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 discounted Metrotransit passes for employees, NICE RIDE bike availability near campus, free carpool and vanpool parking, and the sponsored installation of the HOURCAR.

Metro Pass 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, or $24 per pay period. 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 benefits@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.

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.

Transportation through Metropass

Administered by MCAD

Where to Park On Campus (Campus and Parking Map)

There are unrestricted parking spots on the streets surrounding the campus. The MCAD parking lot (Lot C) is located at 2572 2nd Ave S, the intersection of 26th Street East and Second Avenue South. Month-to-month parking contracts are available to any staff at the Minneapolis Institute of Art (Mia) ramp at 2400 3rd Ave S. For rates and information, check out the Mia parking site.

- Lot A- Main-entrance Parking
- Lot B - Restricted/Assigned Parking
- Lot C - Hourly Parking
- Lots D and E – Restricted/Assigned Parking.
- The Hive Indoor and Surface – Restricted/Assigned Parking Parking

Rates for Lot C:

- $0.25 per hour for MCAD Commuters with ID (when signed up for the subscription)
- $6 flat rate for Guest and General Public.

Please Note: *MCAD is required by the City of Minneapolis to charge for parking. The College reserves the right to alter the parking rates at any time and without notice.

Parking Resources

- Pay for parking
- Parking Policies and Procedures

Personal Safety Tips

- Lock all vehicle doors and close all windows tightly.
- Do not leave valuable items in the vehicle, especially in plain sight.
- Park in a well-traveled, well-lit area.
- Do not leave your vehicle on city streets in one spot for several days without checking on it.
- Report crimes or suspicious individuals to Campus Safety.
- Report ice or maintenance problems to the Facilities Office or Campus Safety.
- Notify Campus Safety when your vehicle becomes disabled and it will need to stay in any MCAD parking area overnight.
- Drive slowly through the parking lot and side streets, and watch for children!
- Look under, around and in the backseat of your vehicle as you approach it.
- Don’t walk alone at night. Call or text Campus Safety 612- 874- 3801 for an escort.
- Don’t walk with headphones covering your ears! You can’t hear individuals approaching you.
- Always lock your bike. Any lock is better than nothing, but a U-Lock is the recommended type to use.
- Bring an inexpensive bike to campus.
- If you have quick-release hubs, don't forget to lock your wheels and seatpost.
- Write down your bike's serial number for matching in case of theft.
- Alert the Campus Safety of suspicious activity

Bicycle Commuting Reimbursement Program

Administered by MCAD

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 qualifying 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.

Details

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. Your request is complete only if you include the claim form with your signature and receipts of your eligible expenses.

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 bicycling 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 Resources

- **Bike and Scooter Share:** Through the equitable distribution of shared electric bicycles and scooters, Lime aims to reduce dependence on automobiles for short distance transportation, leaving a cleaner, healthier planet.
- **Car Share:** MCAD is a hub for HOURCAR, a non-profit car company for hourly rentals. Available cars can be found on the alley side of the 2537 Apartment Building and checked out by members on a scheduled basis.

Tuition Reimbursement

Administered by MCAD

Full-time employees employed for at least six months and part-time employees employed for at least one year are eligible for tuition benefits. Employees and their dependents may be eligible for one or more of the following:

MCAD Tuition Waiver Program

This program allows employees or their dependents to take courses at MCAD. Employees are eligible to waive tuition for one three-credit course per semester. Dependents are allowed to waive tuition up to a full course load each semester.

Requests for tuition waivers and tuition reimbursement forms should be directed to the Office of Human Resources. Tuition waiver requests must be completed each semester, or you will be charged for the class. The form below is to be used by MCAD employees in requesting a tuition waiver for themselves to take one class per semester, as well as for employee or their dependents to attend the MCAD Graduate or Undergraduate Program, if admitted to those programs.

Online Tuition Waiver Form

Tuition Reimbursement Program

Once they have met the eligibility requirements, employees are eligible to participate in the Tuition Reimbursement Program. Courses directly relevant to an employee's current position, taken at an accredited, non-MCAD institution will be reimbursed up to $5,250 per fiscal year. This is for tuition only; fees, materials, books, etc. are not eligible.

There may be situations where the number of eligible applicants exceeds the College's budgeted amount for tuition reimbursement. In this case, the reimbursement may be given on a pro rata basis.

Tuition Reimbursement Form

Tuition Exchange Scholarship Program

Tuition Exchange is a reciprocal educational scholarship program. Over 600 schools, including MCAD, participate in the Tuition Exchange Scholarship Program. This program is for dependents and is managed by Tuition Exchange. The student must apply and be accepted into the school separately from the Tuition Exchange Scholarship Program. For more details, Tuition Exchange put together a 15 minute video giving an overview of the program.

Public Service Loan Forgiveness (PSLF)

As a not-for-profit organization, MCAD employees may be able to receive loan forgiveness under the Public Service Loan Forgiveness (PSLF) Program. PSLF forgives the remaining balance on your Direct Loans after you have made 120 qualifying monthly payments under a qualifying repayment plan while working full-time for a qualifying employer.

Paid Time Off

Pause, play & prosper

Holidays

All regular full-time and part-time benefits eligible staff are currently eligible for fourteen (14) paid holidays and up to two (2) personal holidays.

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

Paid Time Off (PTO)

Benefit-eligible employees may enjoy many paid time off benefits. More details can be found in the Employee Handbook. These benefits 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, Volunteer Time Off, and Personal Holidays (Staff)
- Paid Family Medical and Extended Illness Leave

Costs, Directory & Notices

Cost Breakdown

Open Access + Mayo Clinic Network

Coverage	Total Monthly Cost	Employer Monthly Contribution	Employee Monthly Contribution	Employee Payroll Deduction (24)
Plan 01 (co-pay)				
Employee Only	$1,075.15	$835.37	$239.88	$119.94
Employee + Spouse	$2,956.98	$1,169.21	$1,787.77	$893.89
Employee + Child(ren)	$2,042.98	$1,336.90	$706.08	$353.04
Employee + Family	$3,279.54	$1,671.05	$1,608.49	$804.25
Plan 02 (Three for Free)				
Employee Only	$1,009.93	$884.74	$125.19	$62.59
Employee + Spouse	$2,777.34	$1,242.97	$1,534.37	$767.18
Employee + Child(ren)	$1,918.87	$1,416.54	$502,33	$251.17
Employee + Family	$3,080.31	$1,772.87	$1,307.44	$653.72
Plan 03 (HDHP $4,000)				
Employee Only	$1,014.88	$872.84	$142.04	$71.02
Employee + Spouse	$2,790.96	$1,232.04	$1,558.92	$779.46
Employee + Child(ren)	$1,928.28	$1,398.78	$529.50	$264.75
Employee + Family	$3,095.41	$1,753.51	$1,341.90	$670.95
Plan 04 (HDHP $7,000)				
Employee Only	$891.20	$793.92	$97.28	$48.64
Employee + Spouse	$2,450.83	$1,160.47	$1,290.36	$645.18
Employee + Child(ren)	$1,693.29	$1,279.53	$413.76	$206.88
Employee + Family	$2,718.18	$1,613.53	$1,104.65	$552.32

Cost Breakdown

Perform Network W/O Mayo

Coverage	Total Monthly Cost	Employer Monthly Contribution	Employee Monthly Contribution	Employee Payroll Deduction (24)
Plan 01 (co-pay)				
Employee Only	$1,053.75	$835.37	$218.38	$109.19
Employee + Spouse	$2,897.84	$1,169.21	$1,728.63	$864.32
Employee + Child(ren)	$2,002.12	$1,336.91	$665.21	$332.60
Employee + Family	$3,213.95	$1,670.76	$1,543.19	$771.59
Plan 02 (Three for Free)				
Employee Only	$989.73	$884.68	$105.05	$52.53
Employee + Spouse	$2,721.80	$1,242.79	$1,479.01	$739.50
Employee + Child(ren)	$1,880.50	$1,416.42	$464.08	$232.04
Employee + Family	$3,018.70	$1,772.67	$1,246.03	$623.01
Plan 03 (HDHP $4,000)				
Employee Only	$994.59	$872.71	$121.88	$60.94
Employee + Spouse	$2,735.14	$1,231.64	$1,503.50	$751.75
Employee + Child(ren)	$1,889.72	$1,398.50	$491.22	$245.61
Employee + Family	$3,033.51	$1,753.06	$1,280.45	$640.23
Plan 04 (HDHP $7,000)				
Employee Only	$873.38	$791.94	$81.44	$40.72
Employee + Spouse	$2,401.82	$1,159.19	$1,242.63	$621.32
Employee + Child(ren)	$1,659.42	$1,277.71	$381.71	$190.85
Employee + Family	$2,663.82	$1,611.97	$1,051.85	$525.93

Cost Breakdown

Achieve Network | HealthPartners & Park Nicollet

Coverage	Total Monthly Cost	Employer Monthly Contribution	Employee Monthly Contribution	Employee Payroll Deduction (24)
Plan 01 (co-pay)				
Employee Only	$1,010.74	$835.37	$175.37	$87.69
Employee + Spouse	$2,779.56	$1,169.22	$1,610.34	$805.17
Employee + Child(ren)	$1,920.40	$1,336.92	$583.48	$291.74
Employee + Family	$3,082.77	$1,670.77	$1,412.00	$706.00
Plan 02 (Three for Free)				
Employee Only	$949.34	$884.55	$64.79	$32.39
Employee + Spouse	$2,610.70	$1,242.46	$1,368.24	$684.12
Employee + Child(ren)	$1,803.74	$1,416.17	$387.57	$193.79
Employee + Family	$2,895.49	$1,772.28	$1,123.21	$561.61
Plan 03 (HDHP $4,000)				
Employee Only	$953.99	$872.38	$81.61	$40.80
Employee + Spouse	$2,623.50	$1,230.82	$1,392.68	$696.34
Employee + Child(ren)	$1,812.59	$1,397.93	$414.66	$207.33
Employee + Family	$2,909.69	$1,752.15	$1,157.54	$578.77
Plan 04 (HDHP $7,000)				
Employee Only	$837.73	$787.75	$49.98	$24.99
Employee + Spouse	$2,303.78	$1,156.53	$1,147.25	$573.62
Employee + Child(ren)	$1,591.69	$1,273.82	$317.87	$158.93
Employee + Family	$2,555.09	$1,608.67	$946.42	$473.21

Cost Breakdown

Coverage	Total Monthly Cost	Employee Payroll Deduction (24)
Dental Plan		
Employee Only	$43.80	$21.90
Employee + Spouse	$87.69	$43.85
Employee + Child(ren)	$89.05	$44.53
Employee + Family	$144.97	$72.49
Vision Plan		
Employee Only	$7.79	$3.90
Employee + Spouse	$14.80	$7.40
Employee + Child(ren)	$15.58	$7.79
Employee + Family	$22.90	$11.45

Directory

	Group / Policy #	Contact Information
ENROLLMENT & ELIGIBILITY		
Human Resources Hope Denardo, Sr. Director of HR		612.874.3798 benefits@mcad.edu
Online Benefits Enrollment Vendor Paylocity		benefits.paylocity.com
MEDICAL COVERAGE		
HealthPartners	0706	952.883.5000 www.healthpartners.com
DENTAL COVERAGE		
HealthPartners	0706	952.883.5000 www.healthpartners.com
VISION COVERAGE		
EyeMed	MCAD-1025243	844.873.7853 www.eyemed.com
LIFE, AD&D AND DISABILITY		
Unum		866.679.3054 www.unum.com
FLEXIBLE SPENDING ACCOUNT (FSA)		
Employee Benefits Corporation	M94548	800.346.2126 www.ebcflex.com
HEALTH SAVINGS ACCOUNT (HSA)		
Employee Benefits Corporation	M94548	800.346.2126 www.ebcflex.com
EMPLOYEE ASSISTANCE PROGRAM (EAP)		
HealthPartners		866.326.7194 hpeap.com
BENEFITS BROKER		
Nava Benefits		membersupport@navabenefits.com

MCAD Required Notices for Health Plan Administration

This document contains the enrollment notices that are required to be provided by your employer.
For questions pertaining to any of the information below, Please contact your HR team.

General Notice of COBRA Rights
Continuation Coverage Rights Under COBRA

Introduction

You're getting this notice because you recently gained coverage under a group health plan (the Plan). This notice has important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan. This notice explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect your right to get it. When you become eligible for COBRA, you may also become eligible for other coverage options that may cost less than COBRA continuation coverage.

The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage can become available to you and other members of your family when group health coverage would otherwise end. For more information about your rights and obligations under the Plan and under federal law, you should review the Plan's Summary Plan Description or contact the Plan Administrator.

You may have other options available to you when you lose group health coverage. For example, you may be eligible to buy an individual plan through the Health Insurance Marketplace. By enrolling in coverage through the Marketplace, you may qualify for lower costs on your monthly premiums and lower out-of-pocket costs. Additionally, you may qualify for a 30-day special enrollment period for another group health plan for which you are eligible (such as a spouse's plan), even if that plan generally doesn't accept late enrollees.

What is COBRA continuation coverage?

COBRA continuation coverage is a continuation of Plan coverage when it would otherwise end because of a life event. This is also called a "qualifying event." Specific qualifying events are listed later in this notice. After a qualifying event, COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." You, your spouse, and your dependent children could become qualified beneficiaries if coverage under the Plan is lost because of the qualifying event. Under the Plan, qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage.

If you're an employee, you'll become a qualified beneficiary if you lose your coverage under the Plan because of the following qualifying events:

- Your hours of employment are reduced, or
- Your employment ends for any reason other than your gross misconduct.

If you're the spouse of an employee, you'll become a qualified beneficiary if you lose your coverage under the Plan because of the following qualifying events:

- Your spouse dies;
- Your spouse's hours of employment are reduced;
- Your spouse's employment ends for any reason other than his or her gross misconduct;
- Your spouse becomes entitled to Medicare benefits (under Part A, Part B, or both); or
- You become divorced or legally separated from your spouse.

Your dependent children will become qualified beneficiaries if they lose coverage under the Plan because of the following qualifying events:

- The parent-employee dies;
- The parent-employee's hours of employment are reduced;
- The parent-employee's employment ends for any reason other than his or her gross misconduct;
- The parent-employee becomes entitled to Medicare benefits (Part A, Part B, or both);
- The parents become divorced or legally separated; or
- The child stops being eligible for coverage under the Plan as a "dependent child."

When is COBRA continuation coverage available?

The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Plan Administrator has been notified that a qualifying event has occurred. The employer must notify the Plan Administrator of the following qualifying events:

- The end of employment or reduction of hours of employment;
- Death of the employee; or
- The employee's becoming entitled to Medicare benefits (under Part A, Part B, or both).

For all other qualifying events (divorce or legal separation of the employee and spouse or a dependent child's losing eligibility for coverage as a dependent child), you must notify the Plan Administrator within 60 days after the qualifying event occurs. You must provide this notice to: Human Resources.

How is COBRA continuation coverage provided?

Once the Plan Administrator receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. Covered employees may elect COBRA continuation coverage on behalf of their spouses, and parents may elect COBRA continuation coverage on behalf of their children.

COBRA continuation coverage is a temporary continuation of coverage that generally lasts for 18 months due to employment termination or reduction of hours of work. Certain qualifying events, or a second qualifying event during the initial period of coverage, may permit a beneficiary to receive a maximum of 36 months of coverage.

There are also ways in which this 18-month period of COBRA continuation coverage can be extended:

Disability extension of 18-month period of COBRA continuation coverage

If you or anyone in your family covered under the Plan is determined by Social Security to be disabled and you notify the Plan Administrator in a timely fashion, you and your entire family may be entitled to get up to an additional 11 months of COBRA continuation coverage, for a maximum of 29 months. The disability would have to have started at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period of COBRA continuation coverage.

Second qualifying event extension of 18-month period of continuation coverage

If your family experiences another qualifying event during the 18 months of COBRA continuation coverage, the spouse and dependent children in your family can get up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months, if the Plan is properly notified about the second qualifying event. This extension may be available to the spouse and any dependent children getting COBRA continuation coverage if the employee or former employee dies; becomes entitled to Medicare benefits (under Part A, Part B, or both); gets divorced or legally separated; or if the dependent child stops being eligible under the Plan as a dependent child. This extension is only available if the second qualifying event would have caused the spouse or dependent child to lose coverage under the Plan had the first qualifying event not occurred.

General Notice Of COBRA Rights (Continued)

Are there other coverage options besides COBRA Continuation Coverage?

Yes. Instead of enrolling in COBRA continuation coverage, there may be other coverage options for you and your family through the Health Insurance Marketplace, Medicaid, Children's Health Insurance Program (CHIP), or other group health plan coverage options (such as a spouse's plan) through what is called a "special enrollment period." Some of these options may cost less than COBRA continuation coverage. You can learn more about many of these options at www.HealthCare.gov.

Can I enroll in Medicare instead of COBRA continuation coverage after my group health plan coverage ends?

In general, if you don't enroll in Medicare Part A or B when you are first eligible because you are still employed, after the Medicare initial enrollment period, you have an 8-month special enrollment period[1] to sign up for Medicare Part A or B, beginning on the earlier of:

- The month after your employment ends; or
- The month after group health plan coverage based on current employment ends.

If you don't enroll in Medicare and elect COBRA continuation coverage instead, you may have to pay a Part B late enrollment penalty and you may have a gap in coverage if you decide you want Part B later. If you elect COBRA continuation coverage and later enroll in Medicare Part A or B before the COBRA continuation coverage ends, the Plan may terminate your continuation coverage. However, if Medicare Part A or B is effective on or before the date of the COBRA election, COBRA coverage may not be discontinued on account of Medicare entitlement, even if you enroll in the other part of Medicare after the date of the election of COBRA coverage.

If you are enrolled in both COBRA continuation coverage and Medicare, Medicare will generally pay first (primary payer) and COBRA continuation coverage will pay second. Certain plans may pay as if secondary to Medicare, even if you are not enrolled in Medicare.

For more information visit https://www.medicare.gov/medicare-and-you.

If you have questions

Questions concerning your Plan or your COBRA continuation coverage rights should be addressed to the contact or contacts identified below. For more information about your rights under the Employee Retirement Income Security Act (ERISA), including COBRA, the Patient Protection and Affordable Care Act, and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit www.dol.gov/ebsa. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.) For more information about the Marketplace, visit www.HealthCare.gov.

Keep your Plan informed of address changes

To protect your family's rights, let the Plan Administrator know about any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the Plan Administrator.

Plan contact information

Human Resources
Hope Denardo, Senior Director of Human Resources
Email: benefits@mcad.edu
Phone: 612.874.3798

[1] https://www.medicare.gov/sign-up-change-plans

General Notice of Userra Rights
Your Rights Under USERRA

A. The Uniformed Services Employment and Reemployment Rights Act

USERRA protects the job rights of individuals who voluntarily or involuntarily leave employment positions to undertake military service or certain types of service in the National Disaster Medical System. USERRA also prohibits employers from discriminating against past and present members of the uniformed services, and applicants to the uniformed services.

B. Reemployment Rights

You have the right to be reemployed in your civilian job if you leave that job to perform service in the uniformed service and:

- You ensure that your employer receives advance written or verbal notice of your service;
- You have five years or less of cumulative service in the uniformed services while with that particular employer;
- You return to work or apply for reemployment in a timely manner after conclusion of service; and
- You have not been separated from service with a disqualifying discharge or under other than honorable conditions.

If you are eligible to be reemployed, you must be restored to the job and benefits you would have attained if you had not been absent due to military service or, in some cases, a comparable job.

C. Right To Be Free From Discrimination and Retaliation

If you:

- Are a past or present member of the uniformed service;
- Have applied for membership in the uniformed service; or
- Are obligated to serve in the uniformed service; then an employer may not deny you
    - Initial employment;
    - Reemployment;
    - Retention in employment;
    - Promotion; or
    - Any benefit of employment because of this status.

In addition, an employer may not retaliate against anyone assisting in the enforcement of USERRA rights, including testifying or making a statement in connection with a proceeding under USERRA, even if that person has no service connection.

D. Health Insurance Protection

- If you leave your job to perform military service, you have the right to elect to continue your existing employer based health plan coverage for you and your dependents for up to 24 months while in the military.
- Even if you do not elect to continue coverage during your military service, you have the right to be reinstated in your employer's health plan when you are reemployed, generally without any waiting periods or exclusions (e.g., pre-existing condition exclusions) except for service-connected illnesses or injuries.

E. Enforcement

- The U.S. Department of Labor, Veterans' Employment and Training Service (VETS) is authorized to investigate and resolve complaints of USERRA violations.

For assistance in filing a complaint, or for any other information on USERRA, contact VETS at 1-866-4-USA-DOL or visit its Web site at http://www.dol.gov/agencies/vets/. An interactive online USERRA Advisor can be viewed at https://webapps.dol.gov/elaws/vets/userra/

- If you file a complaint with VETS and VETS is unable to resolve it, you may request that your case be referred to the Department of Justice or the Office of Special Counsel, as applicable, for representation.

Your Rights Under USERRA (Continued)

- You may also bypass the VETS process and bring a civil action against an employer for violations of USERRA.

The rights listed here may vary depending on the circumstances. The text of this notice was prepared by VETS, and may be viewed on the Internet at this address: *http://www.dol.gov/vets/programs/userra/poster.htm*. Federal law requires employers to notify employees of their rights under USERRA, and employers may meet this requirement by displaying the text of this notice where they customarily place notices for employees. U.S. Department of Labor, Veterans' Employment and Training Service, 1-866-487-2365.

Important Notice from MCAD About Your Prescription Drug Coverage and Medicare

This Notice Applies to You (or Dependent) ONLY if such person is (1) enrolled in a group medical plan offered by MCAD AND (2) eligible for Medicare.

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with MCAD and about your options under Medicare's prescription drug coverage. This information can help you decide whether or not you want to join a Medicare drug plan. If you are considering joining, you should compare your current coverage, including which drugs are covered at what cost, with the coverage and costs of the plans offering Medicare prescription drug coverage in your area. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice.

There are two important things you need to know about your current coverage and Medicare's prescription drug coverage:

1. Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.
2. MCAD has determined that the prescription drug coverage offered by the HealthPartners plans is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

When Can You Join A Medicare Drug Plan?

You can join a Medicare drug plan when you first become eligible for Medicare and each year from October 15th to December 7th.

However, if you lose your current creditable prescription drug coverage, through no fault of your own, you will also be eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare drug plan.

What Happens To Your Current Coverage If You Decide to Join A Medicare Drug Plan?

If you decide to join a Medicare drug plan, your current MCAD coverage will be affected.

If you do decide to join a Medicare drug plan and drop your current coverage, be aware that you and your dependents may not be able to get this coverage back.

When Will You Pay A Higher Premium (Penalty) To Join A Medicare Drug Plan?

You should also know that if you drop or lose your current coverage with MCAD and don't join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later.

If you go 63 continuous days or longer without creditable prescription drug coverage, your monthly premium may go up by at least 1% of the Medicare base beneficiary premium per month for every month that you did not have that coverage. For example, if you go nineteen months without creditable coverage, your premium may consistently be at least 19% higher than the Medicare base beneficiary premium. You may have to pay this higher premium (a penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following October to join.

For More Information About This Notice or Your Current Prescription Drug Coverage:

Contact the person listed below for further information. Note: You'll get this notice each year. You will also get it before the next period you can join a Medicare drug plan, and if this coverage through MCAD changes. You also may request a copy of this notice at any time.

For More Information About Your Options Under Medicare Prescription Drug Coverage:

More detailed information about Medicare plans that offer prescription drug coverage is in the "Medicare & You" handbook. You'll get a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare drug plans.

For more information about Medicare prescription drug coverage:

- Visit www.medicare.gov
- Call your State Health Insurance Assistance Program (see the inside back cover of your copy of the "Medicare & You" handbook for their telephone number) for personalized help
- Call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

If you have limited income and resources, extra help paying for Medicare prescription drug coverage is available. For information about this extra help, visit Social Security on the web at www.socialsecurity.gov, or call them at 1-800-772-1213 (TTY 1-800-325-0778).

Remember: Keep this Creditable Coverage notice. If you decide to join one of the Medicare drug plans, you may be required to provide a copy of this notice when you join to show whether or not you have maintained creditable coverage and, therefore, whether or not you are required to pay a higher premium (a penalty).

11/6/2025
Human Resources
Hope Denardo, Senior Director of Human Resources
Email: benefits@mcad.edu
Phone: 612.874.3798

Michelle’s Law Notice

Michelle’s Law is a federal law passed in 2008 that extends coverage for a dependent child over the age of 26 when enrolled as a full-time student in post-secondary education prior to a medically necessary leave of absence suffered by the child, which causes the loss of full-time student status.

Group health plan of MCAD includes eligibility of coverage for an employee’s dependent child, defined as an employee's eligible dependent child under Code § 152(f)(1), who is over the age of 26, pursuant to a state-mandated benefit requires full-time student status, who is receiving health coverage as a full-time student in a post-secondary educational institution and who would otherwise lose health coverage because they take a medically necessary leave of absence that would cause the loss of full-time student status, may be entitled to up to one year of continued coverage due to the medically necessary leave.

To be eligible for this extension, the dependent child's treating physician must provide a written certification to the plan administrator that the child is suffering from a serious illness or injury and the leave of absence from the post-secondary institution is medically necessary.

A child on a medically necessary leave of absence is entitled to receive the same plan benefits as other dependent children covered under the plan. Any change to plan coverage that occurs during the Michelle’s Law extension of eligibility will apply to the dependent child to the same extent as it applies to other children covered under the plan.

Newborns’ And Mothers’ Health Protection Act Notice

Group health plans and health insurance issuers generally may not, under federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal 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, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under federal law, require that a provider obtain authorization from the plan or the insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

Notice of Special Enrollment Rights

If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance or group health plan coverage, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing toward your or your dependents' other coverage). However, you must request enrollment within 30 days after your or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage).

In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents. However, you must request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption.

If you are declining enrollment for yourself or your dependents (including your spouse) while coverage under Medicaid or a state Children's Health Insurance Program (CHIP) is in effect, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage. However, you must request enrollment within 60 days after your or your dependents' Medicaid or CHIP coverage ends. If you or your dependents (including your spouse) become eligible for a state premium assistance subsidy from Medicaid or a CHIP program with respect to coverage under this plan, you may be able to enroll yourself and your dependents (including your spouse) in this plan. However, you must request enrollment within 60 days after you or your dependents become eligible for the premium assistance.

To request special enrollment or obtain more information, contact:

Human Resources
Hope Denardo, Senior Director of Human Resources
Email: benefits@mcad.edu
Phone: 612.874.3798

Coverage for Clinical Trial Participants

Effective for plan years beginning on or after Jan. 1, 2014, non-grandfathered health plans cannot terminate coverage because an individual chooses to participate in a clinical trial for cancer or other life-threatening diseases or deny coverage for routine care that would otherwise be provided just because an individual is enrolled in a clinical trial.

Notice of Lifetime Limits

The lifetime limit on the dollar value of benefits does not apply to the MCAD Health Plans as the plan does not have any lifetime maximums. Individuals whose coverage ended by reason of reaching a lifetime limit under another plan are eligible to enroll in the plan. Individuals have 30 days from the date of this notice to request enrollment. For more information contact MCAD Human Resources.

Annual Limits on Essential Health Benefits

Effective for plan years beginning on or after Jan. 1, 2014, health plans are prohibited from placing annual limits on essential health benefits. The ACA's prohibition on annual limits was phased in over a three-year period; restricted annual limits were permitted for plan years beginning before Jan. 1, 2014. Some plans received annual limit waivers from HHS during the phase-in period. These waivers all expire effective for the 2014 plan year.

Excessive Waiting Period

Effective for plan years beginning on or after Jan. 1, 2014, a health plan may not impose a waiting period that exceeds 90 days. A waiting period is the period of time that must pass before coverage for an employee or dependent who is otherwise eligible to enroll in the plan becomes effective. Other conditions for eligibility are permissible, as long as they are not designed to avoid compliance with the ACA's 90-day waiting period limit. MCAD does not impose a waiting period that exceeds this limit.

Notice of HIPAA Pre-existing Condition Exclusions

Under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), a "preexisting condition" is a condition for which medical advice; diagnosis, care, or treatment was recommended and received within the six-month period ending on the enrollment date in a health plan (the look-back period). Taking prescription medications during the look-back period constitutes receiving treatment. This plan does not impose preexisting condition exclusion. All questions about the preexisting condition exclusion and creditable coverage, for more information contact MCAD Human Resources.

Protections from Disclosure of Medical Information

We are required by law to maintain the privacy and security of your personally identifiable health information. Although the wellness program and MCAD may use aggregate information it collects to design a program based on identified health risks in the workplace, MCAD will never disclose any of your personal information either publicly or to the employer, except as necessary to respond to a request from you for a reasonable accommodation needed to participate in the wellness program, or as expressly permitted by law. Medical information that personally identifies you in connection with the wellness program will not be provided to your supervisors or managers and may never be used to make decisions regarding your employment.

Your health information will not be sold, exchanged, transferred, or otherwise disclosed except to the extent permitted by law to carry out specific activities related to the wellness program, and you will not be asked or required to waive the confidentiality of your health information as a condition of participating in the wellness program or receiving an incentive. Anyone who receives your information to provide you services as part of the wellness program will abide by the same confidentiality requirements. The only individual(s) who will receive your personally identifiable health information are doctors or registered nurses to provide you with services under the wellness program.

In addition, all medical information obtained through the wellness program will be maintained separate from your personnel records, information stored electronically will be encrypted, and no information you provide as part of the wellness program will be used in making any employment decision. Appropriate precautions will be taken to avoid any data breach. We will notify you immediately if a data breach occurs involving information you provide in connection with the wellness program.

You may not be discriminated against in employment because of the medical information you provide as part of participating in the wellness program. You will not be subjected to retaliation if you choose not to participate.
If you have questions or concerns regarding this notice or protections against discrimination and retaliation, please contact:
Human Resources
Hope Denardo, Senior Director of Human Resources
Email: benefits@mcad.edu
Phone: 612.874.3798

Notice of HIPAA Privacy Practice

Our MCAD Pledge to You: This notice is intended to inform you of the privacy practices followed by the MCAD Group Medical Plan (the Plan) and the Plan's legal obligations regarding your protected health information under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). The notice also explains the privacy rights you and your family members have as participants of the Plan. It is effective on 11/1/2021. The Plan often needs access to your protected health information in order to provide payment for health services and perform plan administrative functions. We want to assure the plan participants covered under the Plan that we comply with federal privacy laws and respect your right to privacy. The MCAD Group Medical Plan requires all members of our workforce and third parties that are provided access to protected health information to comply with the privacy practices outlined below.
Protected Health Information: Your protected health information is protected by the HIPAA Privacy Rule. Generally, protected health information is information that identifies an individual created or received by a healthcare provider, health plan or an employer on behalf of a group health plan that relates to physical or mental health conditions, provision of health care, or payment for health care, whether past, present or future.

Notice of HIPAA Privacy Practices

Your Information. Your Rights. Our Responsibilities.

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.

Our Uses and Disclosures

We may use and share your information as we:

- Help manage the health care treatment you receive
- Run our organization
- Pay for your health services
- Administer your health plan
- Help with public health and safety issues
- Do research
- Comply with the law
- Respond to organ and tissue donation requests and work with a medical examiner or funeral director
- Address workers' compensation, law enforcement, and other government requests
- Respond to lawsuits and legal actions

Your Rights

When it comes to your health information, you have certain rights. This section explains your rights and some of our responsibilities to help you.

Get a copy of health and claims records

- You can ask to see or get a copy of your health and claims records and other health information we have about you. Ask us how to do this.
- We will provide a copy or a summary of your health and claims records, usually within 30 days of your request. We may charge a reasonable, cost-based fee.

Ask us to correct health and claims records

- You can ask us to correct your health and claims records if you think they are incorrect or incomplete. Ask us how to do this.
- We may say "no" to your request, but we'll tell you why in writing within 60 days.

Request confidential communications

- You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address.
- We will consider all reasonable requests, and must say "yes" if you tell us you would be in danger if we do not.

Ask us to limit what we use or share

- You can ask us not to use or share certain health information for treatment, payment, or our operations.
- We are not required to agree to your request, and we may say "no" if it would affect your care.

Get a list of those with whom we've shared information

- You can ask for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, who we shared it with, and why.
- We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

Get a copy of this privacy notice

- You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.

Choose someone to act for you

- If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.
- We will make sure the person has this authority and can act for you before we take any action.

File a complaint if you feel your rights are violated

- You can complain if you feel we have violated your rights by contacting us using the information on page 1.
- You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting www.hhs.gov/ocr/privacy/hipaa/complaints/.
- We will not retaliate against you for filing a complaint.

Your Information. Your Rights. Our Responsibilities.

Your Choices

For certain health information, you can tell us your choices about what we share.

If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

In these cases, you have both the right and choice to tell us to:

- Share information with your family, close friends, or others involved in payment for your care
- hare information in a disaster relief situation

If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.

In these cases we *never* share your information unless you give us written permission:

- Marketing purposes
- Sale of your information

Our Uses and Disclosures

Help manage the health care treatment you receive

We can use your health information and share it with professionals who are treating you.

Example: A doctor sends us information about your diagnosis and treatment plan so we can arrange additional services.

Run our organization

We can use and disclose your information to run our organization and contact you when necessary. We are not allowed to use genetic information to decide whether we will give you coverage and the price of that coverage. This does not apply to long term care plans.

Example: We use health information about you to develop better services for you.

Pay for your health services

We can use and disclose your health information as we pay for your health services.

Example: We share information about you with your dental plan to coordinate payment for your dental work.

Administer your plan

We may disclose your health information to your health plan sponsor for plan administration.

Example: Your company contracts with us to provide a health plan, and we provide your company with certain statistics to explain the premiums we charge.

How else can we use or share your health information?

We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html.

Help with public health and safety issues

We can share health information about you for certain situations such as:
- Preventing disease
- Helping with product recalls
- Reporting adverse reactions to medications
- Reporting suspected abuse, neglect, or domestic violence
- Preventing or reducing a serious threat to anyone's health or safety

Do research
- We can use or share your information for health research.

Comply with the law
- We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.

Respond to organ and tissue donation requests and work with a medical examiner or funeral director
- We can share health information about you with organ procurement organizations.
- We can share health information with a coroner, medical examiner, or funeral director when an individual dies.

Address workers' compensation, law enforcement, and other government requests

We can use or share health information about you:
- For workers' compensation claims
- For law enforcement purposes or with a law enforcement official
- With health oversight agencies for activities authorized by law
- For special government functions such as military, national security, and presidential protective services

Respond to lawsuits and legal actions
- We can share health information about you in response to a court or administrative order, or in response to a subpoena.

Our Responsibilities

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html.

Changes to the Terms of this Notice

We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, on our website, and we will mail a copy to you.

Important Notes About this Notice

Human Resources
Hope Denardo, Senior Director of Human Resources
Email: benefits@mcad.edu
Phone: 612.874.3798

Your Rights and Protections Against Surprise Medical Bills

When you get emergency care or are treated by an out-of-network provider at an in-network hospital or ambulatory surgical center, you are protected from balance billing. In these cases, you shouldn't be charged more than your plan's copayments, coinsurance and/or deductible.

What is "balance billing" (sometimes referred to as "surprise billing")

When you see a doctor or other health care provider, you may owe certain out-of-pocket cost, like a copayment, coinsurance, or deductible. You may have additional costs or have to pay the entire bill if you see a provider or visit a healthcare facility that isn't in your health plan's network.

"Out-of-network" means providers and facilities that haven't signed a contract with your health plan to provide services. Out-of-network providers may be allowed to bill you for the difference between what your plan pays and the full amount charged for a service. This is called "balance billing". This amount is likely more than in-network costs for the same service and might not count toward your plan's deductible or annual out-of-pocket limit.

"Surprise billing" is an unexpected balance bill. This can happen when you can't control who is involved in your care, like when you have an emergency or when you schedule a visit at an in-network facility but are unexpectedly treated by an out-of-network provider. Surprise medical bills could cost thousands of dollars depending on the procedure or service.

You're protected from balance billing for:

Emergency Services

If you have an emergency medical condition and get emergency services from an out-of-network provider or facility, the most they can bill you is your plan's in-network cost-sharing amount (such as copayments, coinsurance, and deductibles). You can't be balance billed for these emergency services. This includes services you may get after you're in stable condition, unless you give written consent and give up your protections not to be balanced billed for these post-stabilization services.

[*Insert plain language summary of any applicable state balance billing laws or requirements OR state-developed language as appropriate*]

Certain services at an in-network hospital or ambulatory surgical center

When you get services from an in-network hospital or ambulatory surgical center, certain providers there may be out-of-network. In these cases, the most those providers can bill you is your plan's in-network cost-sharing amount. This applies to emergency medicine, anesthesia, pathology, radiology, laboratory, neonatology, assistant surgeon, hospitalist, or intensivist services. These providers can't balance bill you and may not ask you to give up your protections not to be balance billed.

If you get other types of services at these in-network facilities, out-of-network providers can't balance bill you, unless you give written consent and give up your protections.

You're never required to give up your protections from balance billing. You also aren't required to get out-of-network care. You can choose a provider or facility in your plan's network.

When balance billing isn't allowed, you also have these protections:

- You're only responsible for paying your share of the cost (like the copayments, coinsurance and deductible that you would pay if the provider or facility was in-network). Your health plan will pay any additional costs to out-of-network providers and facilities directly.

- Generally, your health plan must:
    - Cover emergency services without requiring you to get approval for services in advance (also known as "prior authorization").
    - Cover emergency services by out-of-network providers.
    - Base what you owe the provider or facility (cost-sharing) on what it would pay an in-network provider or facility and show that amount in your explanation of benefits.
    - Count any amount you pay for emergency services or out-of-network services toward your in-network deductible and out-of-pocket limit.

If you think you've been wrongly billed, contact the CMS. The federal phone number for information and complaints is: 1-800-895-3059.

Visit https://www.cms.gov/files/document/nsa-state-laws.pdf for more information about your rights under federal law.

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 March 17, 2025. Contact your State for more information on eligibility –

ALABAMA – Medicaid	ALASKA – Medicaid
Website: http://myalhipp.com/ Phone: 1-855-692-5447	The AK Health Insurance Premium Payment Program Website: http://myakhipp.com/ Phone: 1-866-251-4861 Email: CustomerService@MyAKHIPP.com Medicaid Eligibility: https://health.alaska.gov/dpa/Pages/default.aspx
ARKANSAS – Medicaid	**CALIFORNIA – Medicaid**
Website: http://myarhipp.com/ Phone: 1-855-MyARHIPP (855-692-7447)	Health Insurance Premium Payment (HIPP) Program Website: http://dhcs.ca.gov/hipp Phone: 916-445-8322 Fax: 916-440-5676 Email: hipp@dhcs.ca.gov
COLORADO – Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)	**FLORIDA – Medicaid**
Health First Colorado Website: https://www.healthfirstcolorado.com/ Health First Colorado Member Contact Center: 1-800-221-3943/State Relay 711 CHP+: https://hcpf.colorado.gov/child-health-plan-plus CHP+ Customer Service: 1-800-359-1991/State Relay 711 Health Insurance Buy-In Program (HIBI): https://www.mycohibi.com/ HIBI Customer Service: 1-855-692-6442	Website:https://www.flmedicaidtplrecovery.com/flmedicaidtplrecovery.com/hipp/index.html Phone: 1-877-357-3268

GEORGIA – Medicaid	INDIANA – Medicaid
GA HIPP Website: https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp Phone: 678-564-1162, Press 1 GA CHIPRA Website: https://medicaid.georgia.gov/programs/third-party-liability/childrens-health-insurance-program-reauthorization-act-2009-chipra Phone: 678-564-1162, Press 2	Health Insurance Premium Payment Program All other Medicaid Website: https://www.in.gov/medicaid/ http://www.in.gov/fssa/dfr/ Family and Social Services Administration Phone: 1-800-403-0864 Member Services Phone: 1-800-457-4584
IOWA – Medicaid and CHIP (Hawki)	**KANSAS – Medicaid**
Medicaid Website: Iowa Medicaid | Health & Human Services Medicaid Phone: 1-800-338-8366 Hawki Website: Hawki - Healthy and Well Kids in Iowa | Health & Human Services Hawki Phone: 1-800-257-8563 HIPP Website: Health Insurance Premium Payment (HIPP) | Health & Human Services (iowa.gov) HIPP Phone: 1-888-346-9562	Website: https://www.kancare.ks.gov/ Phone: 1-800-792-4884 HIPP Phone: 1-800-967-4660
KENTUCKY – Medicaid	**LOUISIANA – 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://kynect.ky.gov Phone: 1-877-524-4718 Kentucky Medicaid Website: https://chfs.ky.gov/agencies/dms	Website: www.medicaid.la.gov or www.ldh.la.gov/lahipp Phone: 1-888-342-6207 (Medicaid hotline) or 1-855-618-5488 (LaHIPP)
MAINE – Medicaid	**MASSACHUSETTS – Medicaid and CHIP**
Enrollment Website: https://www.mymaineconnection.gov/benefits/s/?language=en_US 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.mass.gov/masshealth/pa Phone: 1-800-862-4840 TTY: 711 Email: masspremassistance@accenture.com
MINNESOTA – Medicaid	**MISSOURI – Medicaid**
Website: https://mn.gov/dhs/health-care-coverage/ Phone: 1-800-657-3672	Website: :http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005

MONTANA – Medicaid	NEBRASKA – Medicaid
Website:http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084 Email: HHSHIPPProgram@mt.gov	Website: http://www.ACCESSNebraska.ne.gov Phone: 1-855-632-7633 Lincoln: 402-473-7000 Omaha: 402-595-1178
NEVADA – Medicaid	**NEW HAMPSHIRE – Medicaid**
Medicaid Website: http://dhcfp.nv.gov Medicaid Phone: 1-800-992-0900	Website: https://www.dhhs.nh.gov/programs-services/medicaid/health-insurance-premium-program Phone: 603-271-5218 Toll free number for the HIPP program: 1-800-852-3345, ext. 15218 Email: DHHS.ThirdPartyLiabi@dhhs.nh.gov
NEW JERSEY – Medicaid and CHIP	**NEW YORK – Medicaid**
Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/ Phone: 1-800-356-1561 CHIP Premium Assistance Phone: 609-631-2392 CHIP Website: http://www.njfamilycare.org/index.html CHIP Phone: 1-800-701-0710 (TTY: 711)	Website: https://www.health.ny.gov/health_care/medicaid/ Phone: 1-800-541-2831
NORTH CAROLINA – Medicaid	**NORTH DAKOTA – Medicaid**
Website: https://medicaid.ncdhhs.gov/ Phone: 919-855-4100	Website: https://www.hhs.nd.gov/healthcare Phone: 1-844-854-4825
OKLAHOMA – Medicaid and CHIP	**OREGON – Medicaid and CHIP**
Website: http://www.insureoklahoma.org Phone: 1-888-365-3742	Website: http://healthcare.oregon.gov/Pages/index.aspx Phone: 1-800-699-9075
PENNSYLVANIA – Medicaid and CHIP	**RHODE ISLAND – Medicaid and CHIP**
Website: https://www.pa.gov/en/services/dhs/apply-for-medicaid-health-insurance-premium-payment-program-hipp.html Phone: 1-800-692-7462 CHIP Website: Children's Health Insurance Program (CHIP) (pa.gov) CHIP Phone: 1-800-986-KIDS (5437)	Website: http://www.eohhs.ri.gov/ Phone: 1-855-697-4347, or 401-462-0311 (Direct RIte Share Line)
SOUTH CAROLINA – Medicaid	**SOUTH DAKOTA - Medicaid**
Website: https://www.scdhhs.gov Phone: 1-888-549-0820	Website: http://dss.sd.gov Phone: 1-888-828-0059

TEXAS – Medicaid	UTAH – Medicaid and CHIP
Website: Health Insurance Premium Payment (HIPP) Program | Texas Health and Human Services Phone: 1-800-440-0493	Utah's Premium Partnership for Health Insurance (UPP) Website: https://medicaid.utah.gov/upp/ Email: upp@utah.gov Phone: 1-888-222-2542 Adult Expansion Website: https://medicaid.utah.gov/expansion/ Utah Medicaid Buyout Program Website: https://medicaid.utah.gov/buyout-program/ CHIP Website: https://chip.utah.gov/
VERMONT– Medicaid	**VIRGINIA – Medicaid and CHIP**
Website: Health Insurance Premium Payment (HIPP) Program | Department of Vermont Health Access Phone: 1-800-250-8427	Website: https://coverva.dmas.virginia.gov/learn/premium-assistance/famis-select https://coverva.dmas.virginia.gov/learn/premium-assistance/health-insurance-premium-payment-hipp-programs Medicaid/CHIP Phone: 1-800-432-5924
WASHINGTON – Medicaid	**WEST VIRGINIA – Medicaid and CHIP**
Website: https://www.hca.wa.gov/ Phone: 1-800-562-3022	Website: https://dhhr.wv.gov/bms/ http://mywvhipp.com/ Medicaid Phone: 304-558-1700 CHIP Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)
WISCONSIN – Medicaid and CHIP	**WYOMING – Medicaid**
Website: https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm Phone: 1-800-362-3002	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 March 17, 2025, or for more information on special enrollment rights, contact either:

U.S. Department of Labor
Employee Benefits Security Administration
www.dol.gov/agencies/ebsa
1-866-444-EBSA (3272)

U.S. Department of Health and Human Services
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 1/31/2026)

Health Insurance Marketplace Coverage Options and Your Health Coverage

Form Approved
OMB No. 1210-0149
(expires 12-31-2026)

PART A: General Information

Even if you are offered health coverage through your employment, you may have other coverage options through the Health Insurance Marketplace ("Marketplace"). To assist you as you evaluate options for you and your family, this notice provides some basic information about the Health Insurance Marketplace and health coverage offered through your employment.

What is the Health Insurance Marketplace?

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 in your geographic area.

Can I Save Money on my Health Insurance Premiums in the Marketplace?

You may qualify to save money and lower your monthly premium and other out-of-pocket costs, but only if your employer does not offer coverage, or offers coverage that is not considered affordable for you and doesn't meet certain minimum value standards (discussed below). The savings that you're eligible for depends on your household income. You may also be eligible for a tax credit that lowers your costs.

Does Employment-Based Health Coverage Affect Eligibility for Premium Savings through the Marketplace?

Yes. If you have an offer of health coverage from your employer that is considered affordable for you and meets certain minimum value standards, you will not be eligible for a tax credit, or advance payment of the tax credit, for your Marketplace coverage and may wish to enroll in your employment-based health plan. However, you may be eligible for a tax credit, and advance payments of the credit that lowers your monthly premium, or a reduction in certain cost-sharing, if your employer does not offer coverage to you at all or does not offer coverage that is considered affordable for you or meet minimum value standards. If your share of the premium cost of all plans offered to you through your employment is more than 9.12%[1] of your annual household income, or if the coverage through your employment does not meet the "minimum value" standard set by the Affordable Care Act, you may be eligible for a tax credit, and advance payment of the credit, if you do not enroll in the employment-based health coverage. For family members of the employee, coverage is considered affordable if the employee's cost of premiums for the lowest-cost plan that would cover all family members does not exceed 9.12% of the employee's household income.[1][2]

Note: If you purchase a health plan through the Marketplace instead of accepting health coverage offered through your employment, then you may lose access to whatever the employer contributes to the employment-based coverage. Also, this employer contribution -as well as your employee contribution to employment-based coverage- is generally excluded from income for federal and state income tax purposes. Your payments for coverage through the Marketplace are made on an after-tax basis. In addition, note that if the health coverage offered through your employment does not meet the affordability or minimum value standards, but you accept that coverage anyway, you will not be eligible for a tax credit. You should consider all of these factors in determining whether to purchase a health plan through the Marketplace.

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[1] Indexed annually; see https://www.irs.gov/pub/irs-drop/rp-22-34.pdf for 2023.

[2] An employer-sponsored or other employment-based 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. For purposes of eligibility for the premium tax credit, to meet the "minimum value standard," the health plan must also provide substantial coverage of both inpatient hospital services and physician services.

When Can I Enroll in Health Insurance Coverage through the Marketplace?

You can enroll in a Marketplace health insurance plan during the annual Marketplace Open Enrollment Period. Open Enrollment varies by state but generally starts November 1 and continues through at least December 15.

Outside the annual Open Enrollment Period, you can sign up for health insurance if you qualify for a Special Enrollment Period. In general, you qualify for a Special Enrollment Period if you've had certain qualifying life events, such as getting married, having a baby, adopting a child, or losing eligibility for other health coverage. Depending on your Special Enrollment Period type, you may have 60 days before or 60 days following the qualifying life event to enroll in a Marketplace plan.

There is also a Marketplace Special Enrollment Period for individuals and their families who lose eligibility for Medicaid or Children's Health Insurance Program (CHIP) coverage on or after March 31, 2023, through July 31, 2024. Since the onset of the nationwide COVID-19 public health emergency, state Medicaid and CHIP agencies generally have not terminated the enrollment of any Medicaid or CHIP beneficiary who was enrolled on or after March 18, 2020, through March 31, 2023. As state Medicaid and CHIP agencies resume regular eligibility and enrollment practices, many individuals may no longer be eligible for Medicaid or CHIP coverage starting as early as March 31, 2023. The U.S. Department of Health and Human Services **is offering a temporary Marketplace Special Enrollment period to allow these individuals to enroll in Marketplace coverage.**

Marketplace-eligible individuals who live in states served by HealthCare.gov and either- submit a new application or update an existing application on HealthCare.gov between March 31, 2023 and July 31, 2024, and attest to a termination date of Medicaid or CHIP coverage within the same time period, are eligible for a 60-day Special Enrollment Period. **That means that if you lose Medicaid or CHIP coverage between March 31, 2023, and July 31, 2024, you may be able to enroll in Marketplace coverage within 60 days of when you lost Medicaid or CHIP coverage.** In addition, if you or your family members are enrolled in Medicaid or CHIP coverage, it is important to make sure that your contact information is up to date to make sure you get any information about changes to your eligibility. To learn more, visit HealthCare.gov or call the Marketplace Call Center at 1-800-318-2596. TTY users can call 1-855-889-4325.

What about Alternatives to Marketplace Health Insurance Coverage?

If you or your family are eligible for coverage in an employment-based health plan (such as an employer-sponsored health plan), you or your family may also be eligible for a Special Enrollment Period to enroll in that health plan in certain circumstances, including if you or your dependents were enrolled in Medicaid or CHIP coverage and lost that coverage. Generally, you have 60 days after the loss of Medicaid or CHIP coverage to enroll in an employment-based health plan, but if you and your family lost eligibility for Medicaid or CHIP coverage between March 31, 2023 and July 10, 2023, you can request this special enrollment in the employment-based health plan through September 8, 2023. Confirm the deadline with your employer or your employment-based health plan.

Alternatively, you can enroll in Medicaid or CHIP coverage at any time by filling out an application through the Marketplace or applying directly through your state Medicaid agency. Visit https://www.healthcare.gov/medicaid-chip/getting-medicaid-chip/ for more details.

How Can I Get More Information?

For more information about your coverage offered through your employment, please check your health plan's summary plan description or contact

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

PART B: Information About Health Coverage Offered by Your Employer

This section contains information about any health coverage offered by your employer. If you decide to complete an application for coverage in the Marketplace, you will be asked to provide this information. This information is numbered to correspond to the Marketplace application.

3. Employer name	4. Employer Identification Number (EIN)
MCAD	04-1160745
5. Employer address	**6. Employer phone number**
2501 Stevens Avenue	612-874-3798

7. City	8. State	9. ZIP code
Minneapolis	MN	55404

10. Who can we contact about employee health coverage at this job?	
Human Resources	
11. Phone number (if different from above)	**12. Email address**
	benefits@mcad.edu

Here is some basic information about health coverage offered by this employer:

- As your employer, we offer a health plan to:
  - ☐ All employees. Eligible employees are:
  - ☒ Some employees. Eligible employees are:

    Full-time benefit eligible and part-time benefit eligible
- With respect to dependents:
  - ☒ We do offer coverage. Eligible dependents are:

    Spouses, domestic partners, and dependent children
  - ☐ We do not offer coverage.

☒ If checked, this coverage meets the minimum value standard, and the cost of this coverage to you is intended to be affordable, based on employee wages.

** Even if your employer intends your coverage to be affordable, you may still be eligible for a premium discount through the Marketplace. The Marketplace will use your household income, along with other factors, to determine whether you may be eligible for a premium discount. If, for example, your wages vary from week to week (perhaps you are an hourly employee or you work on a commission basis), if you are newly employed mid-year, or if you have other income losses, you may still qualify for a premium discount.

If you decide to shop for coverage in the Marketplace, **HealthCare.gov** will guide you through the process. Here's the employer information you'll enter when you visit **HealthCare.gov** to find out if you can get a tax credit to lower your monthly premiums.

The information below corresponds to the Marketplace Employer Coverage Tool. Completing this section is optional for employers, but will help ensure employees understand their coverage choices.

13. **Is the employee currently eligible for coverage offered by this employer, or will the employee be eligible in the next 3 months?**

☒ **Yes** (Continue)
13a. If the employee is not eligible today, including as a result of a waiting or probationary period, when is the employee eligible for coverage? First of the month following date of hire (mm/dd/yyyy) (Continue)
☐ **No** (STOP and return this form to employee)

14. Does the employer offer a health plan that meets the minimum value standard*?
☐ Yes (Go to question 15) ☐ No (STOP and return form to employee)

15. For the lowest-cost plan that meets the minimum value standard* **offered only to the employee** (don't include family plans): If the employer has wellness programs, provide the premium that the employee would pay if he/ she received the maximum discount for any tobacco cessation programs, and didn't receive any other discounts based on wellness programs.
a. How much would the employee have to pay in premiums for this plan? $_____
b. How often? ☐ Weekly ☐ Every 2 weeks ☐ Twice a month ☐ Monthly ☐ Quarterly ☐ Yearly

If the plan year will end soon and you know that the health plans offered will change, go to question 16. If you don't know, STOP and return form to employee.

16. What change will the employer make for the new plan year?_____
☐ Employer won't offer health coverage
☐ Employer will start offering health coverage to employees or change the premium for the lowest-cost plan available only to the employee that meets the minimum value standard.* (Premium should reflect the discount for wellness programs. See question 15.)
a. How much would the employee have to pay in premiums for this plan? $_____
b. How often? ☐ Weekly ☐ Every 2 weeks ☐ Twice a month ☐ Monthly ☐ Quarterly ☐ Yearly

• 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 (Section 36B(c)(2)(C)(ii) of the Internal Revenue Code of 1986)

The brief benefit summaries presented in this guide provide only concise overviews and do not comprehensively detail the coverage offered by your health and welfare plans. For a more thorough understanding of the benefits coverage, we recommend consulting the plan's Evidence of Coverage or Summary Plan Description, as it serves as the binding document between the member and the chosen health plan. For specific details regarding benefit and claims review procedures for each plan, please refer to the Evidence of Coverage.

These Open Enrollment Materials ("Materials") also serve as a Summary of Material Modifications ("SMM") and describe updates that affect your employer's Benefit Plan (the "Plan's") summary plan descriptions. Please read these Materials carefully and keep them with your summary plan descriptions for future reference. If there is any discrepancy between these Materials, the summary plan descriptions and the Plan document, the Plan document will control. Your employer reserves the right to end, suspend, or amend the Plan or the benefits provided thereunder, at any time, for any reason, in whole or in part.

The rates quoted for these benefits are subject to change based on final enrollment and/or underwriting requirements. This information is provided solely for informational purposes and does not constitute an offer of coverage or medical advice. It offers a partial, general description of plan or program benefits and does not establish a contractual agreement. To ascertain the governing contract provisions, encompassing procedures, exclusions, and limitations related to your plan, please refer to your plan documents.

All terms and conditions of your plan or program are subject to applicable laws, regulations, and policies. In the event of any inconsistencies between this information and your plan documents, the information in the plan documents will always take precedence.

NAVA

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