2025 Employee Benefits

MUNICIPAL BUILDING COMMISSION

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If you (and/or your dependents) have Medicare or will become eligible for Medicare in the next 12 months, a Federal law gives you more choices about your prescription drug coverage.
Please see page 18 for more details.

MBC is committed to your total health.

The employees and families of MBC are the most valued assets of the organization. MBC provides coverages, tools, and programs to get healthy, stay healthy and obtain the best care possible when you need it. Some tools are for employees and families on the medical plan, and other offerings are for everyone. Throughout the year, you will have a variety of opportunities to learn about available resources, check your health, and participate in activities to get and stay healthy.

Benefit Items

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Eligibility

Employees are eligible for MBC sponsored benefits on the first day of the month following the first 30 days of employment. All elections are in effect for the entire plan year and can only be changed during Open Enrollment unless you experience a qualified life event.

Eligible Dependents

Your eligible dependents may participate in the medical and dental plans. Eligible dependents include:

- Your spouse – the person to whom you are legally married
- Your children under age 26
- Your disabled children of any age

The term "children" includes:

- Natural children, stepchildren, adopted children and legal wards

Qualifying Life Events

A qualifying event (such as gain or loss of other group coverage, marriage, divorce, birth, adoption, death, etc.) may allow you to change your plan elections mid-year. Depending on the nature of the change, you may be able to:

- Enroll for coverage
- Waive coverage
- Switch from single to family coverage or from family to single coverage

The requested change must be consistent with your change in status, and you must submit your change to the human resource department within 31 days after the change.

Benefit Resource Center

In our partnership with our broker (USI), we are excited to offer our employees access to the USI Benefit Resource Center (BRC). The BRC has trained individuals who are available to help you choose the right plan for you and your family, answer questions about your benefit coverage, help research and solve elevated claims and any other benefit related items you may need assistance with.

Phone: 855-874-0742

Email: BRCMT@usi.com

Hours: Monday – Friday 10:00am to 7:00pm Central

If you need assistance outside of regular business hours, please leave a message and a USI Benefit Specialist will promptly return your call or email by end of the following business day.

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We Speak Insurance. Our Benefit Specialist can help you with:

- Deciding which plan is the best for you
- Benefit plan & policy questions
- Eligibility & claim problems with carriers
- Information about claim appeals & process
- Allowable family status election changes
- Transition of care when changing carriers
- Claim escalation, appeal & resolution
- Medicare basics with your employer plan
- Coordination of benefits
- Finding in-network providers
- Access to care issues
- Obtaining case management services
- Group disability claims
- Filing claims for out-of-network services

Contact Information

Benefit Plans	Carrier	Phone Number	Website
Medical	Medica	866-810-5238	https://www.medica.com/
Dental	Delta Dental of Minnesota	800-448-3815	https://www.deltadentalmn.org/
Health Reimbursement Arrangement	Benefit Resource, Inc (TPA)	800-473-9595	https://www.benefitresource.com/
Life and AD&D	Standard Insurance Company	888-937-4783	https://www.standard.com/
FSA Plan	Benefit Resource, Inc (TPA)	800-473-9595	https://www.benefitresource.com/

Medical Benefits

Everyone has different medical benefit needs. Municipal Building Commission offers medical benefits through **Medica.** You are eligible for this benefit of consecutive full-time employment.

Health Plan Benefits	$2,000 - $20% Plan	
	In-Network	**Out-of-Network**
Deductible *per calendar year*	$2,000 /single $4,000/family	$3,000 /single $6,000/family
Out of Pocket Max *per calendar year*	$3,000 /single $6,000/family	$6,000 /single $12,000/family
Preventive Services ***well childcare, Immunizations, prenatal care, mammograms, colonoscopies, annual preventive visits, routine vision & hearing exams***	You pay $0	You pay 40% after deductible
Physician Services ***office visits, urgent care, retail health clinics, chiropractic manipulation, specialist visit, mental health, and substance abuse***	You pay 20% after deductible	You pay 40% after deductible
Imaging ***CT/PET scans, MRI***	You pay 20% after deductible	You pay 40% after deductible
Ambulance, Emergency Room, Durable Medical Equipment	You pay 20% after deductible	You pay 40% after deductible
Hospital, Outpatient, or Inpatient	You pay 20% after deductible	You pay 40% after deductible
Retail Prescription Drugs, 31 days		
Generic	You pay $10	You pay 40% after deductible
Preferred Brand	You pay $25	You pay 40% after deductible
Non-Preferred Brand	You pay $50	You pay 40% after deductible
Preferred Specialty Brand	You pay $25	Not covered
Non-Preferred Specialty Brand	You pay $50	Not covered
Mail Order Prescription Drugs, 93 days		
Generic	You pay $20	You pay 40% after deductible
Preferred Brand	You pay $50	You pay 40% after deductible
Non-Preferred Brand	You pay $100	You pay 40% after deductible
Preferred Specialty Brand	Not covered	Not covered
Non-Preferred Specialty Brand	Not covered	Not covered

Always use a provider within your chosen network for the highest level of benefits. Out-of-network coverage is included. If you see an out-of-network provider your out-of-pocket costs will be higher.
Refer to the plan specific Summary of Benefits & Coverage (SBC) or certificate of coverage for a more detailed explanation of your health plan benefits.

Questions? Call customer service at (800) 952-3455 or visit **medica.com**.

Health Plan Networks

Our health plans offer four choices in provider networks. You will need to select one of the networks described below, Medica Choice Passport, Medica Elect or one of the ACO's. Your covered spouse and dependent children must elect the same network as you.

Medica Choice® Passport: This network is one of the largest with nationwide in-network coverage. There are no referrals needed when you see in-network providers.

Medica Elect®: This network is a medium-sized regional network. You must enroll in a Primary Care Clinic. Your Primary Care Clinic is associated with a care system. Each family member can choose a different Primary Care Clinic. The following care systems are some examples of those included in the Medica Elect Network; Allina, Children's, Hennepin Healthcare, Park Nicollet, Integrity, Lakeview, Minnesota Healthcare, Riverway/North Suburban and St. Luke's. If you need to see a specialist or go to the hospital, make sure they are in your care system.

Accountable Care Organizations (ACOs): ACOs are networks or teams of health care providers that collaborate with Medica to make health care more efficient and improve the member experience. ACOs deliver improvements in costs, member engagement and care coordination.

Network		
Park Nicollet	Western and South MN metro 20 primary care clinics and 4 hospitals/medical centers including • TRIA Orthopedic • Same day primary care appointments • 24/7 nurse and advisor line	**Plan Features** • Same day primary care appointments • 24/7 nurse and advisor line
VantagePlus	MN metro 655 clinics and 12 hospitals including Health Fairview, and North Memorial	**Plan Features** • Same day primary care appointments • Personalized on-boarding • Dedicated help from a specialized pharmacist

Health Plan Premiums

MBC pays 90% of medical insurance premiums for employee and family members under the age of 26.
The MBC offers four (4) Medica benefit plans to employees with two (2) coverage options:

- Single for employee only coverage
- Family for employee + dependent(s) coverage.

	Bi-Monthly		Monthly	
	Single	Family	Single	Family
Medica Choice Passport	$55.25	$154.46	$110.50	$308.91
Medica Elect	$48.35	$135.15	$96.69	$270.29
VantagePlus	$46.97	$131.29	$93.93	$262.57
Park Nicollet First	$46.97	$131.29	$93.93	$262.57

Dental Benefits

The MBC pays 100% of dental insurance premiums regardless of the plan option. The MBC offers two (2) Delta benefit plans to employees with four (4) coverage options:

- Single
- Employee + Spouse
- Employee + Child(ren)
- Family

We offer the Delta Dental Millennium Choice Enhanced dental plan.
There are two dental options: Plan Option I and Plan Option II.
The major difference between the plan options is the level of coverage and the network size of available providers.

- **Plan Option I** requires use of a Delta Dental PPO or Delta Premier network provider to obtain the highest level of benefit coverage.
- **Plan Option II** requires use of a Delta Premier network provider to obtain the highest level of benefit coverage.

Features	Plan Option I		Plan Option II
	Delta PPO	Delta Premier	Delta Premier /Out of Network
Annual Maximum	$2,000	$2,000	$1,000
Annual Deductible ***Does not apply to diagnostic & preventive***	None	$25/person; $75/family	$25/person; $75/family
Diagnostic & Preventive ***Cleanings, x-rays, fluoride***	You pay $0	You pay 20%	You pay $0
Basic Restorative Care ***Amalgam (silver) fillings, sealants***	You pay 10%	You pay 50%	You pay 20%
Oral Surgery ***Simple extractions***	You pay $0	You pay 50%	You pay 20%
Complex Oral Surgery ***Surgical***	You pay 20%	You pay 20%	You pay 20%
Other Complex Oral Surgery ***Tooth reimplantation***	You pay 20%	You pay 20%	You pay 20%
Endodontic Therapy ***Root canal treatment***	You pay 20%	You pay 50%	You pay 50%
Periodontics ***Gum disease treatment***	You pay 20%	You pay 50%	You pay 50%
Major Restoratives ***Posterior composite resins, crowns***	You pay 50%	You pay 50%	You pay 50%
Prosthetics and Implants	You pay 50%	You pay 50%	You pay 50%
Orthodontics ***Only available for ages 8-18***	You pay 50% *$1,000 lifetime max*		

Questions? Call customer service at (800) 448-3815 or card or visit **deltadentalmn.org**.

Voluntary Employee Beneficiary Association (VEBA)

- To be eligible to receive VEBA contributions, you must be an active employee and covered under one of MBC's medical health plan.
- VEBA contributions are deposited on the 1st & 2nd paycheck of the month (24 paychecks).
- Administered by BRi.

Coverage Level	Monthly VEBA Contribution
Single	$100.00
Family	$200.00

Flexible Spending Accounts

We offer Flexible Spending Accounts (FSAs) administered by BRi. FSAs allow you to set aside money to pay certain out-of-pocket expenses pre-tax. You make contributions to your FSAs from your paycheck with pre-tax dollars, which reduces your taxable income.

Medical FSA

You can use the Medical FSA to pay for medical, dental, and vision expenses not paid by your health plan, such as deductibles, coinsurance, and copayments. The maximum amount you can contribute to this account in 2025 is $3,300.

Note that at the end of the plan year, up to $610 may be rolled over into the next plan year. Any amount over $640 will be forfeited.

Dependent Care FSA

You can use this account to pay for work-related daycare expenses that are necessary to allow you and your spouse to work or attend school. Expenses can include daycare, preschool, summer day camp, before or after school programs or eligible senior centers. Eligible dependents include children under age 13 and disabled dependents of any age who are incapable of self-care.

The maximum amount you can contribute to this account in 2025 is $5,000 for individuals or married couples filing jointly, or $2,500 for a married person filing separately.

Transportation Reimbursement Account

Set aside pre-tax contributions for transit passes, commuter highway vehicles and qualified parking benefits up to $325/month. You can rollover your contribution from month to month and funds carry over from year to year.

Filing a Claim

Download BRI's mobile app. You can also go online to **benefitresource.com**. To fully utilize your Medical FSA, check out the list of eligible health care expenses on the IRS website at **irs.gov**.

Questions? Call customer service at (800) 473-9595, email **participantservices@benefitresource.com** or visit **benefitresource.com**.

Basic Life and AD&D

The MBC provides Basic Life and Accidental Death and Dismemberment (AD&D) insurance through The Standard to all benefit-eligible employees. **This coverage is paid in full by MBC.**

Employees are covered by a term life insurance and AD&D benefit of 1x your base annual salary up to a maximum of $50,000. Benefit reductions apply as you age.

Voluntary Life Insurance and AD&D

Employee Benefit	**Available election** • Up to 5 x annual salary to a maximum of $500,000 • Can purchase in $10,000 units • $50,000 guaranteed for new employees; any amount over $50,000 requires health history questions • Life can be elected stand alone or include AD&D; Life and AD&D amounts must match
Spouse Benefit	**Available election** • Up to $150,000 • Can purchase in $5,000 units • $10,000 guaranteed for new employees; any amount over $10,000 requires health history questions • Life can be elected stand alone or include AD&D; Life and AD&D amounts must match
Child(ren) Benefit (through age 25)	**Available election** • $5,000 • Amount is guaranteed • Life can be elected stand alone or include AD&D; Life and AD&D amounts must match

Benefit-eligible employees may elect voluntary life and accidental death and dismemberment (AD&D) insurance through The Standard. These plans are paid 100% by you and are intended to supplement the Basic Life and AD&D. You may also purchase coverage for your spouse and child(ren). You must elect coverage for yourself to elect coverage for spouse and child(ren). If you do not elect coverage when you are first eligible, any future amounts will require health history questions. You will not pay premium nor have coverage until your evidence of insurability form is approved by The Standard. Benefit reductions apply as you age.

VOLUNTARY LIFE/AD&D INSURANCE RATES

The premiums are shown per $1,000 increments **Child(ren),** regardless of # of children:

- **Life:** $.20 per $1,000
- **AD&D:** $.045 per $1,000

Employee's Age	Life
Less than 30	$.06
30-34	$.08
35-39	$.09
40-44	$.108
45-49	$.18
50-54	$.33
55-59	$.43
60-64	$.695
65-69	$1.27
70-74	$2.06
75+	$2.06
AD&D	$.06

Spouse's Age	Life
Less than 30	$.073
30-34	$.0.74
35-39	$.082
40-44	$.126
45-49	$.179
50-54	$.312
55-59	$.529
60-64	$.823
65-69	$1.464
70-74	$3.194
75+	$12.109
AD&D	$.06

Life and AD&D

Long-Term Disability

The MBC provides long term disability insurance through The Standard to all benefit-eligible employees. **It is paid in full by MBC.** This coverage is designed to replace a portion of your income when you're disabled for an extended period due to an illness or injury.

Benefits begin after 90 days for a qualifying disability. The benefit amount is 60% of monthly earnings to $6,000 maximum per month. The benefit duration is to your social security normal retirement age (SSNRA) when a qualifying disability occurs before age 60. There are some benefit limitations based on illness, mental health, and substance abuse. Please refer to the contract concerning plan limitations and exclusions.

Metropass

The MBC offers a discount on a metropass for all MBC employees. A metropass provides unlimited access to buses and trains in the metro area.

- The cost of a metropass is $83/month and is deducted from the 2nd paycheck of each month.
- The cost of the metropass is deducted on a pre-tax basis.

Questions? Get route and schedule information by calling (612) 373-3333 or visit **metrotransit.org**.

Retirement

PERA - MBC employees earn a pension.

The MBC participates in the Public Employees Retirement Association (PERA). You and the MBC both contribute a percentage of your pay to fund future benefits.
In 2023, the employee contribution is 6.5% of gross salary, and the employer contribution is 7.5% of that same salary.

Questions? Call (651) 296-7460 or visit **mnpera.org**.

Minnesota Deferred Compensation Plan

The Minnesota Deferred Compensation Plan (MNDCP) is a voluntary savings plan intended for long-term investing for retirement. The MNDCP is available to all MBC employees. The MNDCP allows you to build retirement savings through automatic payroll deductions - you control how your money is invested.
You are eligible to withdraw savings from your MNDCP account at any age upon retirement, termination of employment, or disability. If you are still employed, you are eligible to withdraw your MNDCP savings any time after age 59½. Upon your death your designated beneficiary(ies) can withdraw funds.

Questions? Call (651) 296-2761 or visit **msrs.state.mn.us**.

Employee Assistance Program

Master's level staff will provide you and your family with extra support to help you with a variety of issues 24/7, 365 days per year, including:

- Stress reduction
- Childcare, divorce, parenting, adoption
- Senior care
- Pet care
- Budgeting/Debt Management
- Substance abuse
- Free face to face counseling sessions; 3 visits per person, per issue

Questions? Call (888) 293-6948 or visit **workhealthlife.com/Standard3**.

Paid Time Off

Sick Leave: Earn 3.70 hours of sick leave per 2 week pay period. 12 days a year.

Vacation Leave: Earn 3.70 hours of vacation leave per 2 week pay period. Accrued hours increase per years of service. Accrual starts at 12 days a year.

Years of Service	Day Accrued Per Year
1 - 4	12 Days
5 - 7	15 Days
8 - 9	16 Days
10 - 15	18 Days
16 - 17	21 Days
18 - 20	22 Days
21+	26 Days

Holidays

Eleven (11) paid holidays per year.

Holiday	Observed
New Year's Day	January 1
Martine Luther King Day	Third Monday in January
President's Day	Third Monday in February
Memorial Day	Last Monday in May
Juneteenth	June 19
Independence Day	July 4
Labor Day	First Monday in September
Veterans Day	November 11
Thanksgiving Day	Fourth Thursday in November
Thanksgiving Friday	Day after Thanksgiving
Christmas Day	December 25

Personal Business Day: One (1) personal business day per year.

Parental Leave: 120 hours (3 weeks) of paid parental leave within 12 weeks following the birth or adoption of a child.

Worker's Compensation

MBC employees have protection under the Minnesota Worker's Compensation laws. Workers Compensation Insurance provides compensation to employees who have a work-related injury or disease. The goals of the workers compensation system are to 1) help the employee return to work as soon as possible, and 2) to restore the employee as much as possible to their economic status before the work-related injury.

To ensure coverage, the employee must report any injury/disease to their supervisor immediately. An employee's failure to promptly report the work-related injury or disease might result in the delay of benefits or in some cases, in the denial of benefits to the employee. Employees who are injured on the job and seek medical attention are required to provide medical verification that they are clear to return to work. Hennepin County administers the MBC's worker's compensation claims. Questions can be directed to Hennepin County Claims Adjuster Deb Norsten at (612) 348-3163 or **Deb.norsten@hennepin.us.**

Employee Training and Development

The MBC believes a work environment that promotes continuous learning and development benefits both the employee and the organization. The MBC encourages employees to seek opportunities that will enhance their effectiveness in their position and allow them to contribute with enhanced expertise, skills, and abilities. The following is a summary of training and development opportunities and services that the MBC provides subject to budgetary guidelines:

- Tuition reimbursement for approved technical school, college, and graduate classes.
- Seminars and workshops offered through Hennepin County or City of Minneapolis or outside organizations.
- Professional and trade society Memberships.
- Subscriptions and reference materials.

Public Service Loan Forgiveness (PSLF)

As an employee of the MBC, you 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.

Questions? Call (855) 265-4038 or visit studentaid.gov.

These documents are available upon request through the Human Resources Department. Information provided in this brochure is not a guarantee of benefits.

Legal Notices

Important Legal Notices Affecting Your Health Plan Coverage

THE WOMEN'S HEALTH CANCER RIGHTS ACT OF 1998 (WHCRA)

If you have had or are going to have a mastectomy, you may be entitled to certain benefits under the Women's Health and Cancer Rights Act of 1998 (WHCRA). For individuals receiving mastectomy-related benefits, coverage will be provided in a manner determined in consultation with the attending physician and the patient, for:

- All stages of reconstruction of the breast on which the mastectomy was performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance;
- Prostheses; and
- Treatment of physical complications of the mastectomy, including lymphedema.

These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under this plan.

NEWBORNS ACT DISCLOSURE − FEDERAL

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.

Further, if you decline enrollment for yourself or eligible dependents (including your spouse) while Medicaid coverage or coverage under a State CHIP program is in effect, you may be able to enroll yourself and your dependents in this plan if:

- coverage is lost under Medicaid or a State CHIP program; or
- you or your dependents become eligible for a premium assistance subsidy from the State.

In either case, you must request enrollment within 60 days from the loss of coverage or the date you become eligible for premium assistance.

To request special enrollment or obtain more information, contact the person listed at the end of this summary.

STATEMENT OF ERISA RIGHTS

As a participant in the Plan you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 ("ERISA"). ERISA provides that all participants shall be entitled to:

Receive Information about Your Plan and Benefits

- Examine, without charge, at the Plan Administrator's office and at other specified locations, the Plan and Plan documents, including the insurance contract and copies of all documents filed by the Plan with the U.S. Department of Labor, if any, such as annual reports and Plan descriptions.
- Obtain copies of the Plan documents and other Plan information upon written request to the Plan Administrator. The Plan Administrator may make a reasonable charge for the copies.
- Receive a summary of the Plan's annual financial report, if required to be furnished under ERISA. The Plan Administrator is required by law to furnish each participant with a copy of this summary annual report, if any.

Continue Group Health Plan Coverage

If applicable, you may continue health care coverage for yourself, spouse, or dependents if there is a loss of coverage under the plan as a result of a qualifying event. You and your dependents may have to pay for such coverage. Review the summary plan description and the documents governing the Plan for the rules on COBRA continuation of coverage rights.

Prudent Actions by Plan Fiduciaries

In addition to creating rights for participants, ERISA imposes duties upon the people who are responsible for the operation of the Plan. These people, called "fiduciaries" of the Plan, have a duty to operate the Plan prudently and in the interest of you and other Plan participants.
No one, including the Company or any other person, may fire you or discriminate against you in any way to prevent you from obtaining welfare benefits or exercising your rights under ERISA.

Enforce your Rights

If your claim for a welfare benefit is denied in whole or in part, you must receive a written explanation of the reason for the denial. You have a right to have the Plan reviewed and reconsider your claim.

Under ERISA, there are steps you can take to enforce these rights. For instance, if you request materials from the Plan Administrator and do not receive them within 30 days, you may file suit in federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to $110 per day, until you receive the materials, unless the materials were not sent due to reasons beyond the control of the Plan Administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, and you have exhausted the available claims procedures under the Plan, you may file suit in a state or federal court. If it should happen that Plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose (for example, if the court finds your claim is frivolous) the court may order you to pay these costs and fees.

Assistance with your Questions

If you have any questions about your Plan, this statement, or your rights under ERISA, you should contact the nearest office of the Employee Benefits and Security Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits and Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210.

CONTACT INFORMATION

Questions regarding any of this information can be directed to:
Human Rsources

350 South 5th St, Room 105

Minneapolis, Minnesota United States 55415

612-695-6117

MODEL INDIVIDUAL CREDITABLE COVERAGE DISCLOSURE NOTICE LANGUAGE FOR USE ON OR AFTER APRIL 1, 2011

Important Notice from Medica About Your Prescription Drug Coverage and 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 Medica 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. Medica has determined that the prescription drug coverage offered by Medica for the plan year 2025 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, the following options may apply:

- You may stay in the Medica Plan and not enroll in the Medicare prescription drug coverage at this time. You may be able to enroll in the Medicare prescription drug program at a later date without penalty either:
    - During the Medicare prescription drug annual enrollment period, or
    - If you lose Medica's creditable coverage.
- You may stay in the Medica Plan's and also enroll in a Medicare prescription drug plan. The Medica Plan's will be the primary payer for prescription drugs and Medicare Part D will become the secondary payer.
- You may decline coverage in the Medica Plan's and enroll in Medicare as your only payer for all medical and prescription drug expenses. If you do not enroll in the Medica Plan's, you are not able to receive coverage through the plan unless and until you are eligible to reenroll in the plan at the next open enrollment period or due to a status change under the cafeteria plan or special enrollment event.

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 Medica 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 below.

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 Medica 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).

Date:	11/1/2024
Name/Entity of Sender:	Municipal Building Commissions
Contact Position/Office:	Human Resources
Address:	350 South 5th St, Room 105, Minneapolis, MN 55415
Phone Number:	612-695-6117

Premium Assistance Under Medicaid and the Children's Health Insurance Program (CHIP)

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

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

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

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

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of July 31, 2024. Contact your State for more information on eligibility –

ALABAMA – Medicaid
Website: http://myalhipp.com/ Phone: 1-855-692-5447
ALASKA – Medicaid
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
Website: http://myarhipp.com/ Phone: 1-855-MyARHIPP (855-692-7447)
CALIFORNIA – Medicaid
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+)

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

FLORIDA – Medicaid

Website: https://www.flmedicaidtplrecovery.com/flmedicaidtplrecovery.com/hipp/index.html
Phone: 1-877-357-3268

GEORGIA – 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

INDIANA – Medicaid

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)

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

KANSAS – Medicaid

Website: https://www.kancare.ks.gov/
Phone: 1-800-792-4884
HIPP Phone: 1-800-967-4660

KENTUCKY – 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

LOUISIANA – Medicaid

Website: www.medicaid.la.gov or www.ldh.la.gov/lahipp
Phone: 1-888-342-6207 (Medicaid hotline) or
1-855-618-5488 (LaHIPP)

MAINE – Medicaid

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

MASSACHUSETTS – Medicaid and CHIP

Website: https://www.mass.gov/masshealth/pa
Phone: 1-800-862-4840
TTY: 711
Email: masspremassistance@accenture.com

MINNESOTA – Medicaid

Website: http://mn.gov/dhs/people-we-serve/seniors/health-care/health-care-programs/programs-and-services/medical-assistance.jsphttps://mn.gov/dhs/health-care-coverage/
Phone: 1-800-657-3739

MISSOURI – Medicaid

Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm
Phone: 573-751-2005

MONTANA – Medicaid

Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP
Phone: 1-800-694-3084
Email: HHSHIPPProgram@mt.gov

NEBRASKA – Medicaid

Website: http://www.ACCESSNebraska.ne.gov
Phone: 1-855-632-7633
Lincoln: 402-473-7000
Omaha: 402-595-1178

NEVADA – Medicaid

Medicaid Website: http://dhcfp.nv.gov
Medicaid Phone: 1-800-992-0900

NEW HAMPSHIRE – Medicaid

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

Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/
Phone: 1-800-356-1561
Medicaid Phone: 609-631-2392
CHIP Website: http://www.njfamilycare.org/index.html
CHIP Phone: 1-800-701-0710 (TTY: 711)

NEW YORK – Medicaid

Website: https://www.health.ny.gov/health_care/medicaid/
Phone: 1-800-541-2831

NORTH CAROLINA – Medicaid

Website: https://medicaid.ncdhhs.gov/
Phone: 919-855-4100

NORTH DAKOTA – Medicaid

Website: https://www.hhs.nd.gov/healthcare
Phone: 1-844-854-4825

OKLAHOMA – Medicaid and CHIP

Website: http://www.insureoklahoma.org
Phone: 1-888-365-3742

OREGON – Medicaid and CHIP

Website: http://healthcare.oregon.gov/Pages/index.aspx
Phone: 1-800-699-9075

PENNSYLVANIA – 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)

RHODE ISLAND – Medicaid and CHIP

Website: http://www.eohhs.ri.gov/
Phone: 1-855-697-4347, or
401-462-0311 (Direct RIte Share Line)

SOUTH CAROLINA – Medicaid

Website: https://www.scdhhs.gov
Phone: 1-888-549-0820

SOUTH DAKOTA – Medicaid

Website: http://dss.sd.gov
Phone: 1-888-828-0059

TEXAS – Medicaid

Website: Health Insurance Premium Payment (HIPP) Program | Texas Health and Human Services
Phone: 1-800-440-0493

UTAH – Medicaid and CHIP

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

Website: Health Insurance Premium Payment (HIPP) Program | Department of Vermont Health Access
Phone: 1-800-250-8427

VIRGINIA – Medicaid and CHIP

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

Website: https://www.hca.wa.gov/
Phone: 1-800-562-3022

WEST VIRGINIA – Medicaid and CHIP

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
Website: https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm Phone: 1-800-362-3002
WYOMING – Medicaid
Website: https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/ Phone: 1-800-251-1269

To see if any other states have added a premium assistance program since July 31, 2024, 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.[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 these factors in determining whether to purchase a health plan through the Marketplace.

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

[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.

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:

Name of Entity/Sender:	Municipal Building Commission
Contact--Position/Office:	Human Resources
Address:	350 South 5th Street, Room 105, Minneapolis, MN 55415
Phone Number:	612-695-6117

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) 30-0960525
5. Employer address 350 South 5th street, room 105		6. Employer phone number 612-695-6117
7. City Minneapolis	8. State MN	9. ZIP code 55415
10. Who can we contact about employee health coverage at this job?		
11. Phone number (if different from above)	12. Email address	

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:
- With respect to dependents:
  - ☒ We do offer coverage. Eligible dependents are:

    Married Spouse, Children under 26, and disabled children of all ages
  - ☐ 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? _____ (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