

RS Eden

2025

Employee Benefit Guide



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If you 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 20-21 for more details.

This document is an outline of the coverage provided under your employer's benefit plans based on information provided by your company. It does not include all the terms, coverage, exclusions, limitations, and conditions contained in the official Plan Document, applicable insurance policies and contracts (collectively, the "plan documents"). The plan documents themselves must be read for those details. The intent of this document is to provide you with general information about your employer's benefit plans. It does not necessarily address all the specific issues which may be applicable to you. It should not be construed as, nor is it intended to provide, legal advice. To the extent that any of the information contained in this document is inconsistent with the plan documents, the provisions set forth in the plan documents will govern in

Benefits Overview

RS EDEN is proud to offer a comprehensive benefits package to eligible, full-time employees who work 30 hours or more hours per week. The complete benefits package is briefly summarized in this booklet. You will receive plan booklets, which give you more detailed information about each of these programs.

You share the costs of some benefits (medical, dental and vision), and RS EDEN provides other benefits at no cost to you (life, accidental death & dismemberment). In addition, there are voluntary benefits with reasonable group rates that you can purchase through payroll deductions.

Benefits Offered

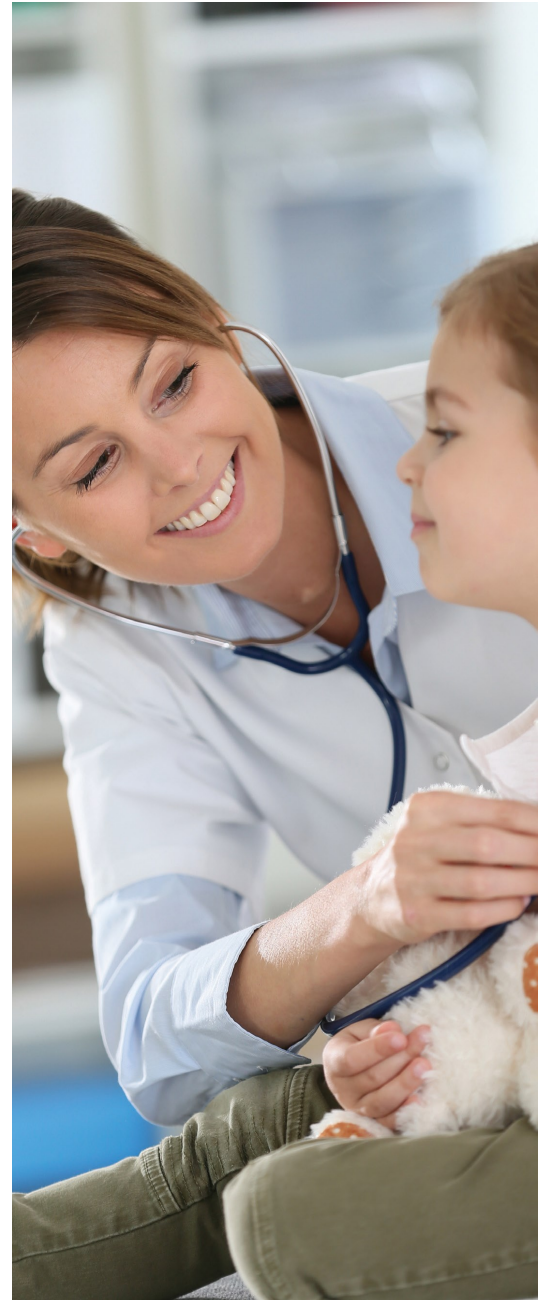
- Medical
- Health Savings Account (HSA)
- Dental
- Vision
- Base Life and AD&D Insurance
- Voluntary Life and AD&D Insurance
- Dependent Care Flexible Spending Account (DCAP/FSA)
- Voluntary Short-Term Disability
- Voluntary Long-Term Disability
- Accident, Critical Illness and Hospital Indemnity
- Retirement Plan
- Paid Vacation
- Designated Holidays

Eligibility and Enrollment

You and your dependents are eligible for RS EDEN benefits on the first of the month following 30 days.

Eligible dependents are your spouse, children under age 26, disabled dependents of any age, or RS EDEN eligible dependents.

Elections made now will remain until the next open enrollment unless you or your family members experience a qualifying event. If you experience a qualifying event, you must contact HR within 30 days.



Contact Information

Benefit	Vendor	Phone	Website or Email
Medical	ICHRA /MEDSURETY	952.303.5700	www.medsurety.com
Voluntary Dental	The Standard	888.937.4783	www.standard.com
Voluntary Vision	EyeMed Vision Care	866.939.3633	www.eyemedvisioncare.com
Health Savings Account	MEDSURETY	952.303.5700	www.medsurety.com
Dependent Care FSA	MEDSURETY	952.303.5700	www.medsurety.com
Life and AD&D	The Standard	888.937.4783	www.standard.com
Voluntary Life and AD&D	The Standard	888.937.4783	www.standard.com
Voluntary Short Term Disability	The Standard	888.937.4783	www.standard.com
Voluntary Long Term Disability	The Standard	888.937.4783	www.standard.com
Accident	The Standard	888.937.4783	www.standard.com
Critical Illness	The Standard	888.937.4783	www.standard.com
Hospital Indemnity	The Standard	888.937.4783	www.standard.com
Human Resources	Jasmine Yang	612.382.6096	jyang@rseden.org



Coverage Costs

Below is an overview of your benefit coverage costs.

Per-paycheck (26) Cost for the ICHRA Medical Plan

The RS Eden Contribution is based on the age of the employee, spouse and child(ren)

Example: if the Employee is 40, the spouse is 42, and the child is 10 the contribution amount is =
 $\$243.16 + \$257.90 + \$140 = \640.06

Age	Contribution
0	\$140.00
1	\$140.00
2	\$140.00
3	\$140.00
4	\$140.00
5	\$140.00
6	\$140.00
7	\$140.00
8	\$140.00
9	\$140.00
10	\$140.00
11	\$140.00
12	\$140.00
13	\$140.00
14	\$140.00
15	\$140.00
16	\$140.00
17	\$140.00
18	\$140.00
19	\$140.00
20	\$140.00
21	\$140.00
22	\$140.00
23	\$140.00
24	\$140.00
25	\$140.00

Age	Contribution
26	\$140.00
27	\$147.37
28	\$157.74
29	\$162.11
30	\$169.47
31	\$176.84
32	\$184.21
33	\$191.58
34	\$198.95
35	\$206.32
36	\$213.68
37	\$221.05
38	\$228.42
39	\$235.79
40	\$243.16
41	\$250.53
42	\$257.90
43	\$265.26
44	\$272.63
45	\$280.00
46	\$287.37
47	\$294.74
48	\$302.11
49	\$309.48
50	\$316.48
51	\$324.21

Age	Contribution
52	\$331.58
53	\$338.95
54	\$346.32
55	\$353.69
56	\$361.05
57	\$368.42
58	\$375.79
59	\$383.16
60	\$390.53
61	\$397.90
62	\$405.27
63	\$412.63
64	\$420.00
65+	\$411.00

Coverage Costs

Below is an overview of your benefit coverage costs.

Per-paycheck (26) Cost for Dental and Vision Coverage

Dental Rates	Pay Period (26)
Coverage Tier	
Employee Only	\$13.30
Employee + Spouse	\$26.15
Employee + Child(ren)	\$35.22
Employee + Family	\$48.46

Vision Rates	Pay Period (26)
Coverage Tier	
Employee Only	\$3.29
Employee + Spouse	\$6.25
Employee + Child(ren)	\$6.25
Employee + Family	\$9.18

Per-paycheck (26) Cost for Voluntary Life and AD&D Insurance (per \$1,000 of coverage)

Employee Age	< 25	25-29	30-34	35-39	40-44	45-49	50-54	55-59	60-64	65-70	70+
Employee	\$0.03	\$0.03	\$0.04	\$0.04	\$0.06	\$0.09	\$0.13	\$0.22	\$0.32	\$0.59	\$1.02
Spouse	\$0.03	\$0.03	\$0.04	\$0.04	\$0.06	\$0.09	\$0.13	\$0.22	\$0.32	\$0.59	\$1.02
Child(ren)	\$0.09										

Note: Your life and AD&D benefits will reduce by 33% at age 65; 55% at age 70.

RS EDEN Holidays & Vacation

Designated Holidays

1. New Year's Day
2. Martin Luther King Day
3. President's Day
4. Memorial Day
5. Juneteenth
6. Independence Day
7. Labor Day
8. Thanksgiving Day
9. Friday after Thanksgiving
10. Christmas Day
11. Floating Holiday (Personal Day)
12. Employee's Birthday



Vacation - Accrual

- a. First through second year—Two weeks (80 hours) per year (3.07 hours/pay period)
- b. Third through fifth years—Three weeks (120 hours) per year (4.61 hours/pay period)
- c. Sixth through ninth years—Four weeks (160 hours) per year (6.15 hours/pay period)
- d. Ten or more years—Five weeks (200 hours) per year (7.69 hours/pay period)

Sick Pay- Accrual

3.69 hours/pay period

Medical Coverage (ICHRA)

Individual Coverage Health Reimbursement Account (ICHRA)

RS Eden offers employees with the option to purchase medical insurance through an Individual Coverage Health Reimbursement Arrangement (ICHRA). Employees are able to select and purchase their medical insurance from either the health insurance marketplace*, off-exchange health insurance plan, or a Medicare supplement plan. RS Eden will pay a flat amount based on your age and the ages of those you enroll in the plan. Use the following steps to help you decide which plan to enroll in:

1. Determine what's available where you live

Where you reside will determine which plans are available to you. You must live within your selected network's service area to enroll and remain on the plan. If you are age 65 or older and eligible for Medicare, contact Human Resources to learn more about your options.

2. Choose your network

This is who and where your care comes from (ex: doctors/clinics). You have the option to choose a plan network that best meets your needs. Unless it's an emergency, there is no coverage if you visit a provider that is not in your network. This means you'll be responsible for the full cost of care. Refer to the following page for network options.

3. Choose your plan

The carriers use three metal levels (Bronze, Silver and Gold) to describe the features of each plan. When choosing a plan, ask yourself the following questions:

- Which doctors, clinics and/or hospitals are important to keep in-network?
- Will my prescriptions be covered?
- Do I want an HSA plan or not?

4. Elect individual or family coverage

Plans are available for individuals to age 65, and dependents are eligible to age 26. If you wish to cover dependents, each member of your family will have the option to select a different plan. However, if you select different plans, you will be subject to separate deductibles.

5. Calculate your monthly premium

The amount that RS Eden will contribute will depend on your age and the ages of those you enroll on the plan. Refer to the charts on the following pages to calculate your monthly premium.

Terms to Know

- **Copay** - A set dollar amount you pay for a covered health care service, usually when you receive the service.
- **Deductible** - What you pay out of pocket for health care services before the plan begins to pay a portion.
- **Coinsurance** - Your share of the costs of covered health care services after you reach the deductible. You pay the percentage noted in the table above, and the medical plan pays the rest.
- **Out-of-pocket Maximum** - What you have to pay before the plan pays 100% of your covered costs.
- **Network** - The facilities and providers the medical plan has contracted with to provide health care services. In-network providers typically provide services at a lower negotiated rate.

Medical Coverage

RS Eden’s medical coverage allows employees to select the health plan that best meets their needs. Options include HealthPartners, BlueCross and BlueShield of MN, Medica, and UCare. All of the plans are portable — if you choose to leave RS Eden, you can take your plan with you. Coverage is guarantee issue for employees who enroll during the open enrollment period or when they have a qualifying event. There are no pre-existing condition exclusions.

Network Options

- 1. BlueCross and BlueShield of Minnesota:** Blue Plus Metro (Allina) and Blue Plus Minnesota Value (Allina, Fairview, U of MN, North Memorial)
- 2. HealthPartners:** Peak and Select (Park Nicollet) and Apex (Park Nicollet, Allina, Fairview U of MN)
- 3. Medica:** Applause (Allina, North Memorial) and provider-specific plans like: North Memorial Acclaim, Ridgeview and Bold M Health Fairview
- 4. UCare:** This option is available to employees, but your portion of the premium will be paid post-tax. (Fairview, Allina and Park Nicollet)

Plan Options

- 1. BlueCross and BlueShield of Minnesota**
 - Metro MN 3 plans: 1 lower deductible plan / 2 HDHP HSA plans
 - Minnesota Value: 8 plans / 3 HDHP HSA plans
- 2. HealthPartners**
 - Nine plans per product: 2 HDHP HSA plans
- 3. Medica**
 - Ten plans per product: 8 non-HSA plans, 2 HDHP HSA plans
- 4. UCare**
 - Twelve plans: 8 non-HSA, 4 HDHP HSA plans

Eye exams for adults are **not** covered on marketplace plans. RS EDEN’s vision plan through EyeMed covers an annual eye exam.

Metal Levels

Bronze	Silver	Gold
⇒ Lower monthly premium	⇒ Balance between monthly premium and deductible, HSA compatible	⇒ Higher monthly premium
⇒ Higher deductible, HSA compatible		⇒ Lower deductible
Good option if you don’t go to the doctor or pharmacy very often	Good option if you aren’t sure how often you’ll go to the doctor or pharmacy	Good option if you go to the doctor or pharmacy frequently



ICHRA

Individual Coverage Health Reimbursement Arrangement

What is an Individual Coverage Health Reimbursement Arrangement (ICHRA)?

A benefit provided by your employer that sets money aside for you to spend on individual or individual family medical insurance premiums.

Can I enroll?

To be eligible for an ICHRA, you must be enrolled in individual health insurance coverage or Medicare Parts A and B, or Part C. You may not be enrolled in your spouse's group health insurance plan and enrolled in an ICHRA.

HOW DO I GET THE MOST FROM MY ICHRA?

Online account access

You can log in to your online account and review your ICHRA balance, premium payment status

Text alerts

Sign up for text alerts in your online account and stay on top of your ICHRA balance and premium payments.

Purchase a policy that fits your needs!

MEDSURETY can help:

Complete the medical quote request form [Click Here](#)
Schedule a call with our medical policy advisor [Schedule](#)

We look forward to helping you find a policy that meets your healthcare needs."



What does it cover?

- Individual health insurance premiums
- Medicare premiums Part A, B, C and D
- Medicare Supplement premiums
- 213D eligible expenses

Eligible expenses are subject to employer design.





Frequently Asked Questions about your ICHRA

- 1. What is an Individual Coverage Health Reimbursement Account (ICHRA)?**
The ICHRA is an employer-sponsored plan that can be used to reimburse you for your eligible insurance premiums. It is not an insurance program, but a financial reimbursement plan funded entirely by your employer. Your employer has designated a specific dollar amount to credit to the account (either monthly or annual contributions). You choose if you wish to also contribute pre-tax to the account. Unused account balances will be forfeited at the end of the run-out period.
- 2. Do I have to have health insurance to have an individual coverage health reimbursement arrangement (ICHRA)?**
Yes, ICHRA's reimburse you for the cost of health coverage, therefore you need to have active coverage.
- 3. Who can put money in my ICHRA?**
ICHRA's can be funded by the employer and/or an employee.
- 4. How do I know how much is contributed to my HRA each plan year?**
At the beginning of each plan year, your employer will notify you of the amount they will contribute to your HRA for that plan year.
- 5. Do I need to enroll each plan period?**
Yes. All eligible employees must enroll each year during the open enrollment period. Your employer will instruct you on how to complete enrollment.
- 6. What is an eligible expense?**
Eligible expenses under the ICHRA plan are determined by your employer. Generally, the following expenses are eligible under an ICHRA plan:

 - Health insurance premiums
 - Dental insurance premiums
 - Vision insurance premiums
- 7. What's the maximum reimbursement amount from my HRA?**
ICHRA's are normally funded on a monthly or payroll basis. You will only be reimbursed the amount that you've earned in the plan. Contact your benefits department for specific information about your plan design.

8. Do funds carry over at the end of the plan period?
No, funds are not carried over at the end of the plan period. Any unused funds left at the end of the run out period will be forfeited

CONTACT US:

Local: 952-303-5700

Toll Free: 888-816-4234

Fax: 952-856-2656

Email: customerservice@medsurety.com

www.medsurety.com



Individual Medical Policy Placement

In addition to being a TPA, MEDSURETY is a licensed agent that will help you find an individual or family medical plan that qualifies for your employer's ICHRA contribution.

EXPLORE→REVIEW→CHOOSE→ENROLL

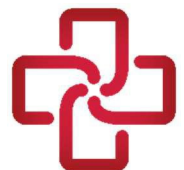
LET'S GET STARTED

Complete the medical quote request form
[Click Here.](#)

Schedule a call with our medical policy advisor
[Schedule.](#)



We **work** with all the major insurance **carriers** and their individual **plans** to offer variety and a **personalized** selection delivering the **best** fit for you and your family.



Voluntary Dental Coverage

RS Eden offers a dental plan through The Standard. Review the chart below for the amount The Standard will pay for the dental service listed.

	Voluntary Dental Plan	
	In Network	Out of Network
Calendar Year Deductible (Individual/Family)	\$50/\$150	\$50/\$150
Calendar Year Maximum (Per Person)	\$1,000	\$1,000
Preventive Care (Routine Exam, Bitewing X-rays, Full Mouth/ Panoramic X-rays, Periapical X-rays, Cleaning, Fluoride for Children 18 and under, Space Maintainers, Pre-Diagnostic Test)	100%	80%
Basic Services (Sealants, Fillings for Cavities, Restorative Composites)	80% after deductible	50% after deductible
Major Services (Onlays, Crowns, Crown Repair, Endodontics (surgical & nonsurgical), Periodontics (surgical & nonsurgical), Denture Repair, Implants, Prosthodontics, Simple Extractions, Complex Extractions, Anesthesia, TMD (surgical & nonsurgical))	50% after deductible	50% after deductible
Orthodontia (Children up to age 19)	50%	50%
Orthodontia Lifetime Maximum (Per Person)	\$1,000	\$1,000



Finding In-network Dentists

You pay less for services when you use a dentist in The Standard network. You can find an in-network dentist by visiting www.standard.com or calling 888.937.4783.

Voluntary Vision Coverage

RS Eden’s vision plan through EyeMed Vision Care covers routine eye exams and helps you pay for glasses or contact lenses. Review the chart below for the amount you will pay for the vision service listed.

	Voluntary Vision Plan	
	In Network	Out of Network
Eye Exam (Once every 12 months)	\$10 copay	Reimburse up to \$40
Lenses (Once every 12 months)		
Single Vision	\$10 copay	Reimburse up to \$30
Bifocal	\$10 copay	Reimburse up to \$50
Trifocal	\$10 copay	Reimburse up to \$70
Frames (Once every 12 months)	\$130 allowance plus 20% off	Reimburse up to \$91
Contact Lenses (Once every 12 months)		
Fitting	Standard: \$40 allowance and two follow-up visits; Premium: 10% off retail price	N/A
Elective	Conventional: \$130 allowance plus 15% off; Disposable: \$130 allowance	Reimburse up to \$130
Medically Necessary	Covered in full	Reimburse up to \$210

Finding In-network Eye Doctors

You can find an in-network eye doctor in the EyeMed Vision Care network by visiting www.eyemedvisioncare.com or calling 866.939.3633.



Spending Accounts

Paying for Health Care

RS Eden offers several ways to set aside pre-tax dollars to pay for medical, prescription drug, dental and vision care expenses. The health care accounts available to you depend on the medical plan you choose.

	Health Savings Account (HSA)
What medical plan can I choose?	HDHP
What expenses are eligible?	Medical, prescription drug, dental and vision care (See IRS Publication 502 for the types of expenses that may be eligible)
When can I use the funds?	Funds are available as you contribute to the account
Can I roll over funds each year?	Yes, funds roll over from year to year and are yours to keep (even if you leave the company or retire)
How do I pay for eligible expenses?	With your MEDSURETY debit card (you can also submit claims for reimbursement online at www.medsurety.com)
How much can I contribute each year?	\$4,300 for individual coverage or \$8,550 for family coverage (this total includes company funding) and additional \$1,000 for catch up contributions in 2025
Can I change my contributions throughout the year?	Yes, you can log on to www.medsurety.com to change your per-paycheck contributions at any time

Note: By law, you are not allowed to contribute to an HSA if you have disqualifying coverage, such as Medicare or a general purpose health FSA.

What Are the Tax Implications of an HSA?

Contributions to your HSA reduce your taxable income, and qualified medical expenses are never taxed. All money set aside in an HSA grows tax-deferred until age 65, when funds can be withdrawn for any non-medical purpose at ordinary tax rates, or tax-free when used for medical expenses. You may contribute additional funds to your HSA (\$1,000 per tax year) if you will be 55 years or older by December 31. Learn more at www.medsurety.com.



Spending Accounts

Paying for Dependent Care

You can contribute pre-tax dollars into a dependent care FSA to pay for eligible child or elderly care expenses.

	Dependent Care FSA
What is it?	An account that allows you to set aside pre-tax dollars from each paycheck to pay for eligible child or elderly care expenses while you and your spouse work full time
Why should I consider it?	You can lower your taxable income to save some money while you take care of your daycare expenses
What expenses are eligible?	Daycare expenses for your children under age 13 or dependents who are mentally or physically incapable of caring for themselves (including elderly dependents)
When can I use the funds?	Funds are available as you contribute to the account with each paycheck
Can I roll over funds each year?	No, you will lose any funds remaining in your account at the end of the year
How do I pay for eligible expenses?	With your MEDSURETY debit card (you can also submit claims for reimbursement online at www.medsurety.com)
How much can I contribute each year?	You can contribute \$5,000 to your dependent health care FSA in 2025



Important Note

Both the health care and dependent care FSAs have a use-it-or-lose-it rule. You will lose any unused funds at the end of the year.

Life, AD&D and Disability Insurance

Life and AD&D Insurance

RS Eden provides basic life and accidental death and dismemberment (AD&D) insurance through The Standard at no cost to eligible employees. If you want additional coverage for yourself, your spouse, or your children, you can purchase voluntary coverage at our group rates.

	How it Works	Basic Life and AD&D (Company-paid benefit)	Voluntary Life and AD&D (Employee-paid benefit)
Life	Your beneficiaries receive this benefit if you pass away	\$50,000	You: Increments of \$10,000 up to 8x annual earnings to max \$500,000 Your spouse: Increments of \$5,000 up to \$250,000 not to exceed 100% of EE's amount Your child(ren): Live Birth to Age 25: \$2,000 to max \$10,000 not to exceed 100% of EE's amount
AD&D	You (or your beneficiaries) receive this benefit if you pass away or are seriously injured in an accident	\$50,000	You: Increments of \$10,000 up to 8x annual earnings to max \$500,000 Your spouse: Increments of \$5,000 up to \$250,000 not to exceed 100% of EE's amount Your child(ren): Live Birth to Age 25: \$2,000 to max \$10,000 not to exceed 100% of EE's amount



Keep Your Beneficiaries Up to Date

You must log on to www.standard.com to designate a beneficiary (the person who will receive the benefit) for your life and AD&D insurance. Make sure to keep this person's information updated so your benefit is paid according to your wishes.

Disability Insurance

RS Eden also provides disability insurance through The Standard. This benefit replaces a portion of your income if you become disabled and are unable to work.

	How it Works	Who Pays for the Benefit
Short-term Disability	You receive 60% of your income up to \$1,000 per week. Benefits begin after 7 calendar days of absence from work and continue for up to 90 days.	Employee
Long-term Disability	You receive 60% of your income up to \$5,000 per month. Benefits begin when short-term disability benefits end and continue until you reach to age 65, or to SSNRA, or 3 years 6 months, whichever is longest.	Employee

Voluntary Benefits

While you can't predict life's unexpected events, you can plan for them by choosing benefits that help protect what's important to you.

Accident

Administered by The Standard

The Accident plan provides cash payments directly to you to help cover out-of-pocket costs, such as deductibles or coinsurance. The full schedule of benefits payable for accidental injuries include initial/follow-up treatment, ambulance trips, medical imaging, surgeries, concussion, dislocations and fractures, hospital stays, AD&D, and health screening benefits. It is important to note this benefit is for off the job accidents only. Some benefits are payable once per covered accident, while others are once per plan year. See Benefit Summary for detailed information and schedule of benefits and exclusions.

Critical Illness

Administered by The Standard

Critical illness insurance provides a lump-sum payment for an insured person diagnosed with any of the following critical illnesses while insurance is in effect for the insured person, after any applicable waiting period and subject to any pre-existing condition limitation: Cancer, Heart Attack, Stroke, Organ Transplant, Kidney Failure, and more. See Benefit Summary for detailed information and schedule of benefits and exclusions. The Critical Illness has a guarantee issue of \$20,000 for employee, and \$10,000 for the spouse. If you exceed these amounts, Standard will require EOI for amounts above this.

Hospital Indemnity

Administered by The Standard

Hospital indemnity coverage eases the financial impact of an employee's hospitalization by providing a lump sum payment to help cover the costs associated with a hospital stay. Hospital indemnity coverage can be used to supplement medical insurance to help handle additional out-of-pocket costs that add up after a hospital stay. This can include copayments, coinsurance, deductibles, and incidental hospital expenses or other expenses such as transportation and lodging needs. See Benefit Summary for detailed information and schedule of benefits and exclusions.



Standard Value Adds

Services to Help You Now

Visit the Life Services Toolkit website at standard.com/mytoolkit and enter user name "assurance" for information and tools to help you make important life decisions.

- **Estate Planning Assistance:** Online tools walk you through the steps to prepare a will and create other documents, such as living wills, powers of attorney and advance directives.
- **Financial Planning:** Consult online services to help you manage debt, calculate mortgage and loan payments, and take care of other financial matters with confidence.
- **Health and Wellness:** Timely articles about nutrition, stress management and wellness help employees and their families lead healthy lives.
- **Identity Theft Prevention:** Check the website for ways to thwart identity thieves and resolve issues if identity theft occurs.
- **Funeral Arrangements:** Use the website for guidance on how to begin, to educate yourself on funeral costs, find funeral-related services and make decisions about funeral arrangements in advance.

Services for Your Beneficiary

- **Grief Support:** Care Managers with advanced training are on call to provide confidential grief sessions by phone or in person. Your beneficiaries are eligible for up to six face-to-face sessions.

Our Care Managers may offer your beneficiaries additional grief support through support kits sent to their home, based on each individual's needs. As part of this program, age-appropriate books can be sent for children and teens.

- **Legal Services:** In addition to online estate planning tools, your beneficiaries can obtain legal assistance from experienced attorneys. They can schedule an initial office visit or a telephone consultation for up to 30 minutes with a network attorney. Beneficiaries who wish to retain a participating attorney after the initial consultation receive a 25% rate reduction from the attorney's normal hourly or fixed-fee rates.
- **Financial Assistance:** Your beneficiaries can schedule up to 30-minute telephone sessions with financial counselors who can help with issues such as budgeting strategies, and credit and debt management.
- **Support Services:** During an emotional time, your beneficiaries can receive help planning a funeral or memorial service. WorkLife advisors can guide them to resources to help manage household repairs and chores, find child care and elder care providers or organize a move or relocation.
- **Online Resources:** Your beneficiaries can easily access additional services and features on the Life Services Toolkit website for beneficiaries, including online resources about funeral costs, find funeral-related services and make decisions about funeral arrangements.



Beneficiaries can participate in phone consultations or in-person meetings with trained grief counselors.

For beneficiary services, visit standard.com/mytoolkit (user name: support) or call the assistance line at 800.378.5742

Standard Value Adds

Security That Travels with You

Travel Assistance is available when you travel more than 100 miles from home or internationally for up to 180 days for business or pleasure. It offers aid before and during your trip, including:

- Visa, weather, and currency exchange information
- Credit Card and passport replacement
- Replace prescription medication or lost corrective lenses
- Emergency assistance

Contact Travel Assistance

800.872.1414

United States, Canada, Puerto Rico,
U.S. Virgin Islands and Bermuda

Everywhere else
+1.609.986.1234

Text:
+1.609.334.0807

Email:
medservices@assistamerica.com

An Expert by Your Side

At no additional cost, you can contact Health Advocate^{SM1} and be assigned a Personal Health Advocate, typically a registered nurse, who will remain on your case until it's fully resolved. From start to finish, you'll work with one person sparing you the headache of explaining your concerns to someone who might be unfamiliar with your situation.

Fortunately, you don't have to take on the healthcare system by yourself. While you're out on a short term disability claim, you can connect with a Personal Health Advocate who'll help you navigate the complexities of the healthcare system. Simply take advantage of Health Advocacy Select, a service that's included with your group Short Term Disability insurance coverage through Standard Insurance Company (The Standard).

Personal Health
Advocates available
Monday – Friday,
8 a.m. – 10 p.m.,
Eastern at:

844.450.5543

Employee Assistance Program



Depression, grief, loss and
emotional well-being



Family, marital and other
relationship issues



Life improvement and
goal-setting



Addictions such as alcohol
and drug abuse



Stress or anxiety with work
or family



Financial and legal concerns



Identity theft and fraud
resolution



Online will preparation and
other legal documents

Contact **EAP**

888.293.6948

(TTY Services: 711)

24 hours a day,
seven days a week

healthadvocate.com/standard3

NOTE: It's a violation of your
company's contract to share this
information with individuals who
are not eligible for this service.

Legal Notices

Women’s Health & Cancer Rights Act

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 the plan. Therefore, the following deductibles and coinsurance apply:

If you would like more information on WHCRA benefits, please call your Plan Administrator at 612.383.6096 or jyang@rseden.org.

Newborns’ and Mothers’ Health Protection Act

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 insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

Legal Notices

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	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.flmedicaidtprecovery.com/flmedicaidtprecovery.com/hipp/index.html Phone: 1-877-357-3268

Legal Notices

GEORGIA – Medicaid	INDIANA – Medicaid
<p>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</p>	<p>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</p>
IOWA – Medicaid and CHIP (Hawki)	KANSAS – Medicaid
<p>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</p>	<p>Website: https://www.kancare.ks.gov/ Phone: 1-800-792-4884 HIPP Phone: 1-800-967-4660</p>
KENTUCKY – Medicaid	LOUISIANA – Medicaid
<p>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: KIHIPPPROGRAM@ky.gov KCHIP Website: https://kynect.ky.gov Phone: 1-877-524-4718 Kentucky Medicaid Website: https://chfs.ky.gov/agencies/dms</p>	<p>Website: www.medicicaid.la.gov or www.ldh.la.gov/lahipp Phone: 1-888-342-6207 (Medicaid hotline) or 1-855-618-5488 (LaHIPP)</p>
MAINE – Medicaid	MASSACHUSETTS – Medicaid and CHIP
<p>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</p>	<p>Website: https://www.mass.gov/masshealth/pa Phone: 1-800-862-4840 TTY: 711 Email: masspremassistance@accenture.com</p>
MINNESOTA – Medicaid	MISSOURI – Medicaid
<p>Website: https://mn.gov/dhs/health-care-coverage/ Phone: 1-800-657-3672</p>	<p>Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005</p>
MONTANA – Medicaid	NEBRASKA – Medicaid
<p>Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084 Email: HSHIPPProgram@mt.gov</p>	<p>Website: http://www.ACCESSNebraska.ne.gov Phone: 1-855-632-7633 Lincoln: 402-473-7000 Omaha: 402-595-1178</p>
NEVADA – Medicaid	NEW HAMPSHIRE – Medicaid
<p>Medicaid Website: http://dhcnp.nv.gov Medicaid Phone: 1-800-992-0900</p>	<p>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</p>

Legal Notices

<p align="center">NEW JERSEY – Medicaid and CHIP</p> <p>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)</p>	<p align="center">NEW YORK – Medicaid</p> <p>Website: https://www.health.ny.gov/health_care/medicaid/ Phone: 1-800-541-2831</p>
<p align="center">NORTH CAROLINA – Medicaid</p> <p>Website: https://medicaid.ncdhhs.gov/ Phone: 919-855-4100</p>	<p align="center">NORTH DAKOTA – Medicaid</p> <p>Website: https://www.hhs.nd.gov/healthcare Phone: 1-844-854-4825</p>
<p align="center">OKLAHOMA – Medicaid and CHIP</p> <p>Website: http://www.insureoklahoma.org Phone: 1-888-365-3742</p>	<p align="center">OREGON – Medicaid and CHIP</p> <p>Website: http://healthcare.oregon.gov/Pages/index.aspx Phone: 1-800-699-9075</p>
<p align="center">PENNSYLVANIA – Medicaid and CHIP</p> <p>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)</p>	<p align="center">RHODE ISLAND – Medicaid and CHIP</p> <p>Website: http://www.eohhs.ri.gov/ Phone: 1-855-697-4347, or 401-462-0311 (Direct Rlte Share Line)</p>
<p align="center">SOUTH CAROLINA – Medicaid</p> <p>Website: https://www.scdhhs.gov Phone: 1-888-549-0820</p>	<p align="center">SOUTH DAKOTA - Medicaid</p> <p>Website: http://dss.sd.gov Phone: 1-888-828-0059</p>
<p align="center">TEXAS – Medicaid</p> <p>Website: Health Insurance Premium Payment (HIPP) Program Texas Health and Human Services Phone: 1-800-440-0493</p>	<p align="center">UTAH – Medicaid and CHIP</p> <p>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/</p>
<p align="center">VERMONT– Medicaid</p> <p>Website: Health Insurance Premium Payment (HIPP) Program Department of Vermont Health Access Phone: 1-800-250-8427</p>	<p align="center">VIRGINIA – Medicaid and CHIP</p> <p>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</p>
<p align="center">WASHINGTON – Medicaid</p> <p>Website: https://www.hca.wa.gov/ Phone: 1-800-562-3022</p>	<p align="center">WEST VIRGINIA – Medicaid and CHIP</p> <p>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)</p>
<p align="center">WISCONSIN – Medicaid and CHIP</p> <p>Website: https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm Phone: 1-800-362-3002</p>	<p align="center">WYOMING – Medicaid</p> <p>Website: https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/ Phone: 1-800-251-1269</p>

Legal Notices

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)

Legal Notices

HIPAA Notice of Privacy Practices Reminder

Protecting Your Health Information Privacy Rights

RS Eden is committed to the privacy of your health information. The administrators of the RS Eden Health Plan (the “Plan”) use strict privacy standards to protect your health information from unauthorized use or disclosure.

The Plan’s policies protecting your privacy rights and your rights under the law are described in the Plan’s Notice of Privacy Practices. You may receive a copy of the Notice of Privacy Practices by contacting Jasmine Yang - HR Assistant at 612.383.6096 or jyang@rseden.org.

HIPAA Special Enrollment Rights

RS Eden Health Plan Notice of Your HIPAA Special Enrollment Rights

Our records show that you are eligible to participate in the RS Eden Health Plan (to actually participate, you must complete an enrollment form and pay part of the premium through payroll deduction).

A federal law called HIPAA requires that we notify you about an important provision in the plan - your right to enroll in the plan under its “special enrollment provision” if you acquire a new dependent, or if you decline coverage under this plan for yourself or an eligible dependent while other coverage is in effect and later lose that other coverage for certain qualifying reasons.

Loss of Other Coverage (Excluding Medicaid or a State Children’s Health Insurance Program). If you decline enrollment for yourself or for an eligible dependent (including your spouse) while other health insurance or group health plan coverage 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 (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).

Loss of Coverage for Medicaid or a State Children’s Health Insurance Program. If you decline enrollment for yourself or for an eligible dependent (including your spouse) while Medicaid coverage or coverage under a state children’s health insurance program 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’ coverage ends under Medicaid or a state children’s health insurance program.

New Dependent by Marriage, Birth, Adoption, or Placement for Adoption. 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 new dependents. However, you must request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption.

Eligibility for Premium Assistance Under Medicaid or a State Children’s Health Insurance Program – If you or your dependents (including your spouse) become eligible for a state premium assistance subsidy from Medicaid or through a state children’s health insurance program with respect to coverage under this plan, you may be able to enroll yourself and your dependents in this plan. However, you must request enrollment within 60 days after your or your dependents’ determination of eligibility for such assistance.

To request special enrollment or to obtain more information about the plan’s special enrollment provisions, contact Jasmine Yang - HR Assistant at 612.383.6096 or jyang@rseden.org.

Legal Notices

Important Warning

If you decline enrollment for yourself or for an eligible dependent, you must complete our form to decline coverage. On the form, you are required to state that coverage under another group health plan or other health insurance coverage (including Medicaid or a state children's health insurance program) is the reason for declining enrollment, and you are asked to identify that coverage. If you do not complete the form, you and your dependents will not be entitled to special enrollment rights upon a loss of other coverage as described above, but you will still have special enrollment rights when you have a new dependent by marriage, birth, adoption, or placement for adoption, or by virtue of gaining eligibility for a state premium assistance subsidy from Medicaid or through a state children's health insurance program with respect to coverage under this plan, as described above. If you do not gain special enrollment rights upon a loss of other coverage, you cannot enroll yourself or your dependents in the plan at any time other than the plan's annual open enrollment period, unless special enrollment rights apply because of a new dependent by marriage, birth, adoption, or placement for adoption, or by virtue of gaining eligibility for a state premium assistance subsidy from Medicaid or through a state children's health insurance program with respect to coverage under this plan.

Legal Notices

Notice of Creditable Coverage

Important Notice from RS Eden 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 RS Eden 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. RS Eden has determined that the prescription drug coverage offered by the medical plan 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 RS Eden coverage may be affected.

If you do decide to join a Medicare drug plan and drop your current RS Eden coverage, be aware that you and your dependents may or 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 RS Eden 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 RS Eden changes. You also may request a copy of this notice at any time.

Legal Notices

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:	January 01, 2025
Name of Entity/Sender:	RS Eden
Contact—Position/Office:	Jasmine Yang - HR Assistant
Office Address:	1931 W Broadway Ave Minneapolis, Minnesota 55411-2400 United States
Phone Number:	612.383.6096

Legal Notices

COBRA General Notice

Model General Notice of COBRA Continuation Coverage Rights (For use by single-employer group health plans)

** 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."

Legal Notices

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;
- 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: Jasmine Yang.

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.

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, Medicare, 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/.

Legal Notices

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 period¹ 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

**RS Eden
Jasmine Yang - HR Assistant
1931 W Broadway Ave
Minneapolis, Minnesota 55411-2400
United States
612.383.6096**

¹ <https://www.medicare.gov/basics/get-started-with-medicare/sign-up/when-does-medicare-coverage-start>

Legal Notices

Marketplace Notice

Health Insurance Marketplace Coverage Options and Your Health Coverage

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.¹²

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.

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

²An 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.

Legal Notices

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](https://www.healthcare.gov) and either- submit a new application or update an existing application on [HealthCare.gov](https://www.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](https://www.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 Jasmine Yang.

The Marketplace can help you evaluate your coverage options, including your eligibility for coverage through the Marketplace and its cost. Please visit [HealthCare.gov](https://www.healthcare.gov) for more information, including an online application for health insurance coverage and contact information for a Health Insurance Marketplace in your area.



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