RASMUSSEN
GROUP

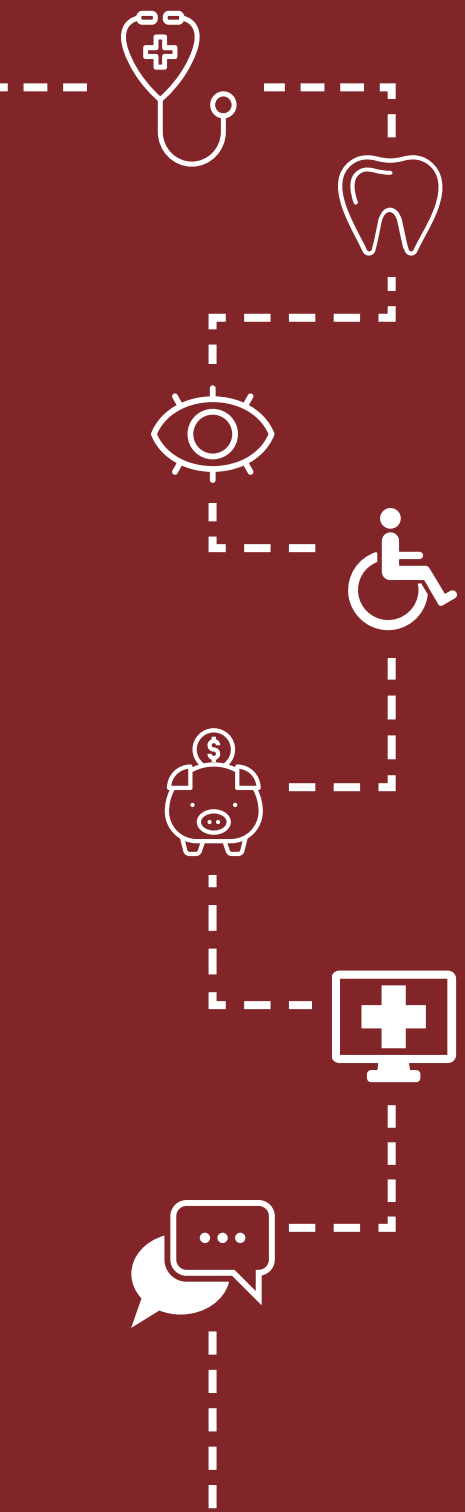
The Rasmussen Group, Inc

Benefits Guide

2026

Enrolling in Your Benefits

You will enroll in your 2026 benefits through Paylocity: https://access.paylocity.com



Your Rasmussen Group Benefits

At The Rasmussen Group, Inc. (the Company), we understand the important role that benefits play in the lives of you and your family. Every year, we strive to offer benefit plans that not only reward you for your hard work but offer you and your family comprehensive and affordable health and wellness protection.

This benefits guide can help familiarize you with benefits available to you as a valued Rasmussen Group employee. This guide also provides useful tips, tools, and resources to help you think through your options and make well-informed decisions regarding your benefits. As a new hire and then annually during open enrollment, you have an opportunity to make changes to your benefits elections.

As you prepare to enroll, ask yourself:

- What benefit coverage do I, or my family, need for the upcoming year? For example, are you in the right plan? Is your family financially protected if you can't work due to an unexpected illness or accident?
- Should I be funding a Health Savings Account?
- Am I taking advantage of the Company's 401k match?
- Have I looked into both the Traditional pre-tax and Roth post-tax 401k options?
- Am I participating in other Company optional benefits (like wellness, voluntary life insurance coverage, short-term disability, etc.)?

Getting the most value from your benefits depends on how well you understand our plans and how you choose to use them. We encourage you to take the time to educate yourself about your options and choose the best coverage for you and your family.

As always, thank you for all you do for the success of our Company.

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Eligibility

Full-time employees who work 30 or more hours per week consistently are eligible for benefits outlined in this guide. Employees are eligible for benefits on the first of the month following 30 days after their full-time date of hire.

Dependents

You may elect to enroll your dependents in the medical, dental, vision, accident or voluntary life plans. Eligibility varies by coverage so you will want to review the provisions in the respective section of this guide. For medical, dental, and vision coverage, eligible dependents are listed below:

- Your legal spouse
- Your children, regardless of marital status, student status, dependency and residency, to the end of the month in which they turn age 26
- Your unmarried child who is a full time student and is covered by the plan before age 26
- Your unmarried children of any age who are mentally or physically disabled and totally dependent on you for support, and who were continuously enrolled in the current medical plan before the age of 26
- Your children who are covered by a Qualified Medical Child Support Order

The Company reserves the right to audit dependents to ensure compliance with the definition of dependent(s).

Changes to your Benefits

Generally, you may only make or change your existing benefit elections as a new hire or during the annual open enrollment period. However, you may change your benefit elections during the year if you experience an event such as:

- Marriage, divorce or legal separation
- Birth or adoption of a child
- Loss or gain of other coverage by the employee or dependent
- Eligibility for Medicare or Medicaid

For any qualifying life event, you must inform the Company's Human Resources Department within 30 calendar days of its occurrence. The coverage change will be effective the first of the month following the qualifying event date.

If you do not experience a qualified event, you will have to wait until the next open enrollment period to make changes.

Medical and Pharmacy Plan Overview

Currently we offer three PPO (Preferred Provider Organization) Plans; a Copay plan and two High Deductible Health Plans. We also offer an HMO (Health Maintenance Organization) High Deductible Health Plan, which mirrors our most popular PPO high deductible health plan (HDHP1). All four plans are through Wellmark Blue Cross Blue Shield.

To select the plan that best suits your family, you should consider the key differences between the plans, the cost of coverage (including payroll deductions) and how the plan covers services throughout the year.

A brief overview of the differences between the Copay and High Deductible Health Plans is shown on the next few pages to assist you in choosing the right plan. For more detailed information on what is or is not covered by each plan, you may download the Summary of Benefits & Coverage through Paylocity.

How the COPAY PLAN works:

In-Network

1. Copays

You pay a set amount for certain covered services performed at a doctor's office or for covered prescriptions filled at a pharmacy.

2. Your Deductible

When facing certain covered expenses, usually in a hospital or outpatient surgery center setting, you pay for those services until you meet your deductible. There may be some services at your doctor's office that also apply to the deductible

3. Your Coverage and Coinsurance

Once you meet your deductible, you and the plan share the cost of covered medical expenses. This is called "Coinsurance". The plan will pay 80% of each eligible expense, and you will pay the rest until you reach your Out-of-Pocket-Maximum. Again, this usually applies in a hospital or outpatient setting, but it can happen at a doctor's office.

4. Your Out-of-Pocket Maximum

Any amounts you pay as Copays, Deductible or Coinsurance apply to your annual Out-of-Pocket-Maximum. Once you reach this maximum, the plan pays 100% of covered In-Network medical and pharmacy expenses for the rest of the calendar year.

Out-of-Network

Utilizing Out-of-Network medical services can cost you significantly more than In-Network medical services. With Out-of-Network expenses there are no copays, all claims go to an Out-of-Network deductible, and your coinsurance cost is higher until you hit your Out-of-Network Out-of-Pocket-Maximum.

The Out-of-Network Out-of-Pocket-Maximum is also separate and distinct from the In-Network Out-of-Pocket-Maximum. An Out-of-Network provider can bill you outside the insurance for any amounts over and above the maximum allowed charge for the services they rendered. Out-of-Network medical services classified as medical emergencies by Wellmark are treated as In-Network medical services.

Medical and Pharmacy Plan Overview

How the PPO HIGH DEDUCTIBLE HEALTH PLANS and HMO HIGH DEDUCTIBLE HEALTH PLAN In-Network medical services work:

1. Your Deductible

You pay for most medical expenses until you have met the deductible. If you elect to open and maintain a Health Savings Account (HSA), you can use that account to pay for these expenses.

2. Your Coverage and Your Out-of-Pocket Maximum

Once you reach your annual deductible, you have met your Out-of-Pocket-Maximum. The plan pays 100% of covered medical and pharmacy expenses for the rest of the calendar year.

Both the PPO and HMO networks utilize the same, nationwide pharmacy network.

While the PPO is a nationwide network, the HMO is Wellmark of Iowa's statewide network. The HMO network includes 100% of Iowa hospitals, 96% of Iowa doctors, and select hospitals and doctors in counties adjacent to Iowa. The counties outside of Iowa best served by Wellmark's HMO network include Douglas and Sarpy in Nebraska, as well as Putnam, Schuyler, Scotland and Clark in Missouri. There are no referrals needed for any In-Network medical service providers.

You must stay within the HMO network for claims to be covered.

How the HMO HIGH DEDUCTIBLE HEALTH PLAN Out-of-Network medical services work:

There is **NO** Out-of-Network coverage, except for emergency medical services classified as medical emergencies by Wellmark which are treated as In-Network medical services. If you feel that you face a medical emergency, go to the Emergency Room.

Even if you are referred to an out-of-network medical service provider, there is no coverage.

If you elect to go out of network, you will pay 100% of the medical services cost and there is no deductible or Out-of-Pocket-Maximum. If you are outside the In-Network footprint you can utilize Doctor On Demand to seek care for minor illnesses. *See pages 10 and 11 for more information regarding Doctor On Demand.*

To ensure your medical services provider is in the HMO network visit www.wellmark.com and follow the below steps:

- Click Member Resources on the home page.
- Click Find a Provider.
- On the next screen, click Search Now.
- Click Choose a Plan.
- Click Browse a List of Plans located in the middle of the page.
- Select "Wellmark Blue HMO".
- Click Confirm Selection.
- Search for your provider.

If unable to locate your provider, contact Wellmark at 1-800-524-9242 to confirm In-Network or out of network coverage.

Medical and Pharmacy Coverage Summary

Medical Benefits	Copay Plan (COPAY)		High Deductible Health Plan 1 (HDHP1)	
Weekly Deductions	52 Weeks	30 Weeks	52 Weeks	30 Weeks
Employee Only	$78.68	$136.38	$52.80	$91.52
Employee + Spouse	$176.58	$306.07	$113.45	$196.65
Employee + Child(ren)	$156.41	$271.11	$101.30	$175.59
Family	$199.79	$346.30	$121.56	$210.70
In-Network Benefit Levels				
Annual Deductible	$2,000 per person, not to exceed $4,000 if you cover Dependents		$3,000 for employee only OR $6,000	
Annual Out of Pocket Maximum (OPM)	$4,500 per person, not to exceed $9,000 if you cover Dependents			
Preventive Care	100% Covered		100% Covered	
Doctor on Demand (Virtual Visit)	$35 Copay		$0 for Primary Visits *See page 10*	
Offiice Visit Urgent Care Outpatient Mental Health/ Substance Abuse Office Visit	$35 Copay		All claims applied to deductible. There are no copays. Once you have met your deductible, the Plan pays 100%	
Inpatient/Outpatient Surgery Emergency Room Labs and X-Rays Inpatient/Outpatient Mental Health/ Substance Abuse (Facility Charges)	20% After Deductible			
Pharmacy Prescriptions[1]				
Retail Prescription Tiers	$10 / $50 / $80		No Copay - Discounted Cost Amount Applied to Deductible	
Mail In Prescription	90 day supply for 2 copays			
Specialty Prescription Tiers	$100 / $150 / $300			
Company HSA Contributions[2]				
Employee Only	-		-	
Employee + Spouse	-		-	
Employee + Child(ren)	-		-	
Family	-		-	

[1]Refer to page 8 for more information on prescription drug tiers. Speciality prescriptions must be filled through CVS Speciality Rx.
[2]If an employee is eligible to open an HSA account with Fidelity, the Company will contribute this amount for each weekly health insurance premium withheld. See page 12 for Important Information About the HSA.

High Deductible Health Plan HMO (HDHPHMO)		High Deductible Health Plan 2 (HDHP2)	
52 Weeks	30 Weeks	52 Weeks	30 Weeks
$48.11	$83.39	$39.87	$69.11
$103.37	$179.17	$103.57	$179.52
$92.30	$159.99	$93.97	$162.88
$110.76	$191.98	$107.11	$185.66
In-Network Benefit Levels			
$3,000 for employee only OR $6,000		$6,000 per covered person not to exceed $12,000	
100% Covered		100% Covered	
$0 for Primary Visits *See page 10*		$0 for Primary Visits *See page 10*	
All claims applied to deductible. There are no copays. Once you have met your deductible, the Plan pays 100%		All claims applied to deductible. There are no copays. Once you have met your deductible, the Plan pays 100%	
Pharmacy Prescriptions[1]			
No Copay - Discounted Cost Amount Applied to Deductible		No Copay - Discounted Cost Amount Applied to Deductible	
Company HSA Contributions[2]			
-		$10.50	$18.20
-		$20.50	$35.53
-		$18.50	$32.07
-		$26.00	$45.07

Notes

Making the Most of Your Plan

Getting the most out of your plan also depends on how well you understand it. Keep these important tips in mind when you use your plan.

- **In-Network providers and pharmacies:** You will generally pay less if you see a provider within the medical and pharmacy network.
- **Preventive care:** In-Network preventive care is covered at 100% (no cost to you). Preventive care is often received during an annual physical exam and includes certain immunizations, lab tests, screenings and other services intended to prevent illness or detect problems before you notice any symptoms. Wellmark follows federal standards and guidelines to determine what services fall under this category. Be sure to ask your doctor's office at the time of service if they will file the claim as a Preventive Service.
- **Pharmacy coverage:** Medications are placed in categories, called tiers, based on drug cost, safety, and effectiveness.

These tiers also affect your coverage and cost:

- **Tier 1:** Typically includes generic drugs that offer equivalent uses, doses, strength, quality and performance as a brand-name drug, but is not trademarked.
- **Tier 2:** Typically drug brands with a patent and trademark name that is considered "preferred" because it is appropriate to use for medical purposes and is usually less expensive than other brand-name options.
- **Tier 3:** Typically a brand name drug with a patent and trademark name, but some higher priced generics that are unique in dosage or have much lower priced alternatives may also be in this tier.
- **Specialty:** A drug that requires special handling, administration, or monitoring, and must be filled through CVS Specialty Pharmacy only.
- **Mail order pharmacy:** If you take a maintenance medication on an ongoing basis for a condition like high cholesterol or high blood pressure, you can use the mail order pharmacy to receive a 90-day supply of your medication.

Medical Plan Resources

Wellmark (Medical)

Make the most of your coverage by registering at www.wellmark.com. Here you can better understand your health benefits, find a trusted healthcare provider, see accurate costs of medical procedures, track and organize your family's medical claims and expenses, sign up to receive your health statements online, and order your ID cards.

Wellmark: 1-800-524-9242

CVS/Caremark (Rx)

If you are regularly prescribed a prescription, you can receive up to a 90-day supply through the mail service pharmacy with a reduced copayment. The cost of mail order prescriptions is one copay for a 30-day supply and two copays for a 90-day supply. Visit www.caremark.com to find a pharmacy near you.

CVS Caremark Mail Service Pharmacy: 1-866-611-5961
CVS Specialty Pharmacy: 1-800-237-2767

Doctor on Demand

See a doctor in minutes! Visit a doctor on your smartphone, tablet, or computer virtually anywhere, any time. Getting sick is bad enough without having to get out of bed to see a doctor. With Doctor on Demand, you and your covered family members can connect face-to-face with a board-certified doctor **24 hours a day, 7 days a week, 365 days a year.** Download the Doctor on Demand app or visit www.doctorondemand.com. *See page 10 and 11 for more information.*

Doctor on Demand: 1-800-997-6196

Livongo

Making it easy, and affordable, for you to maintain your health is a top priority for us. That's why we offer two programs for free through your Wellmark Blue Cross Blue Shield health benefits. The Livongo diabetes prevention and diabetes management programs make living healthy and managing weight easier with smart technology, guidance on healthy habits, and personalized health coaching.
See if you qualify by visiting www.teladochealth.com/livongo.

Livongo: 1-800-945-4355 Registration Code: RASGROUP

Doctor on Demand

When covered by one of the Company's health plans, you have access to Doctor on Demand. Doctor on Demand is a virtual health care service that provides on-demand access or same-day appointments with board certified physicians or next-day appointments with psychologists and psychiatrists from any device with a front-facing camera such as a smartphone, tablet, or computer. This provides for convenient access to health care without needing to leave your home or if you are traveling outside the In-Network service area.

How Does It Work?

- Download the Doctor on Demand app or visit www.doctorondemand.com
- Create an account. Use your health insurance information card to register.
- Book a visit! Select to see the next available provider or schedule your appointment at your convenience.
- Start your live virtual visit during your scheduled appointment time!

Virtual consultations take place through video, where the healthcare provider can diagnose and treat a variety of conditions. Prescriptions can be sent directly to your pharmacy if necessary.

What does Doctor on Demand treat?

Doctor on Demand physicians are able to treat urgent and everyday care (non-emergency) conditions such as upper respiratory infections (cold, flu, covid, sinus, etc.), allergies, yeast infections, UTI's, rashes, sports injuries, nausea, diarrhea, heartburn, back pain and much more.

Psychologists and psychiatrists can treat stress, anxiety, relationship issues, depression, changes in mood, alcohol and tobacco addictions, and eating disorders. Psychiatrists can also manage prescription refills, a psychiatric evaluation, or even an initial diagnosis.

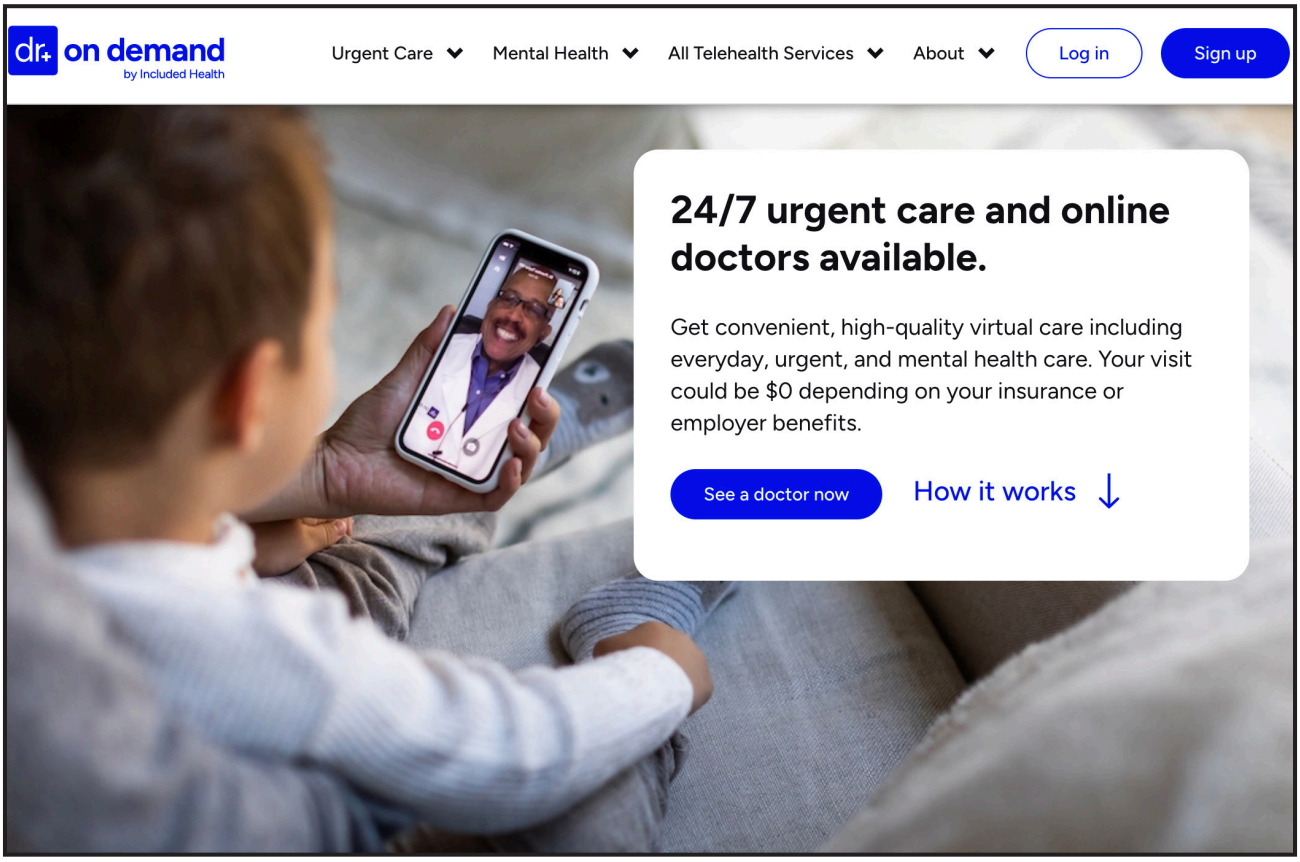
Costs and Coverage

Virtual doctor visits through Doctor On Demand are typically covered by your health plan and offer a convenient, lower-cost alternative to in-person care. If you're enrolled in a High Deductible Health Plan (HDHP), primary care visits are $0.00! Other virtual visit types, such as mental health, still apply toward your deductible using discounted fees negotiated by Wellmark. These discounted fees typically range from $85–$300, depending on the service provided. If you're enrolled in the Copay plan, virtual visits follow the standard copay structure, most commonly a $35 copay per visit.

Using Doctor on Demand with the HMO High Deductible Health Plan

The HMO High Deductible Health Plan only covers care provided by in-network doctors or hospitals, except in emergencies, within the Wellmark's HMO network. With all our Plans, including the HMO plan, **Doctor On Demand is considered an in-network provider**, which means you can use the service without needing to physically visit a doctor.

With the HMO plan, it's important that you choose a provider who is considered In-Network under the plan as the HMO plan does not cover out-of-network providers. By using Doctor On Demand, you have access to a wide range of services that are considered to be In-Network. It's important that you enter your HMO plan details when registering with any health or pharmacy provider to ensure that your visits are covered. If a prescription is issued during your virtual visit, be sure to have them send the prescription to a pharmacy that participates in Wellmark's nationwide pharmacy network. For questions about using Doctor on Demand with the HMO plan, visit www.wellmark.com or call 1-800-524-9242 to confirm coverage.



Convenient Telehealth Appointments for Urgent Care and Mental Health Support

Health Savings Account

A Health Savings Account (HSA) is an option available to employees enrolled in one of the High Deductible Medical Plans. This is a savings account owned by the employee and funded through pre-tax payroll deductions. This account earns tax free interest, and unused funds roll over and accumulate year after year.

Funds can be withdrawn to pay deductibles, co-pays, health expenses, COBRA premiums, long-term care insurance premiums, or other eligible expenses. *The list of eligible expenses is defined by the IRS Publication 969 IRS.gov/Pub969.*

2026 Annual HSA Maximum Contribution Limits

Self Only:
$4,400

Family:
$8,750

Participating employees age 55 or older are allowed a catch-up contribution of $1,000 annually.
Maximum limits are set and regulated by the IRS.

If you enroll in the HDHP2 plan, the Company will contribute a weekly amount into your HSA on your behalf *(see Coverage Summary on page 6 and 7).* You can also contribute your own money tax-free totaling up to the annual HSA maximum contribution limits.

Important Information About the HSA

HSAs opened through our Company will be offered through Fidelity; however, an HSA may be opened at any financial institution that offers this type of savings account. In order to fund an HSA through pre-tax payroll deductions, employees will need to open an account through our Company, administered by Fidelity. The Company utilizes Fidelity as accounts have no fees to employees, no minimum balance requirements, cash deposits earn interest through a Fidelity money market fund, and there's the ability to invest your funds with $0 commissions for U.S. stock and EFT trades.

Prior to opening an account, it is your responsibility to determine if you are eligible by meeting the below requirements:

- You must be enrolled in an HSA-eligible health plan.
- You cannot be covered by any other health plan that is not an HSA-eligible health plan.
- You cannot currently be enrolled in Medicare.
- You cannot be claimed as a dependent on another person's tax return.

Opening and managing your HSA with Fidelity is fast and easy. For convenience, you can open a Fidelity HSA online. You may also transfer money from your current HSA to Fidelity. To begin, simply log into Fidelity NetBenefits at www.netbenefits.com and select Open next to Health Savings Account. You will also maintain your account through Fidelity NetBenefits using your username and password established when you opened your account.

Your Fidelity HSA also allows you to invest a portion of your HSA contributions. You can start investing at any time and there's no required minimum to begin investing.

Those age 65 or older are advised to consult with a tax advisor prior to opening an account or making a contribution.

Fidelity: www.netbenefits.com 1-800-544-3716

Flexible Spending Accounts

A Flexible Spending Account (FSA) helps you pay for health care or dependent care using tax-free dollars.

Your contribution is deducted from your paycheck on a pre-tax basis and put into the FSA. When you incur expenses, you can access the funds in your account to pay for eligible expenses. *To review eligible expenses, go to myameriflex.crunch.help/participants/eligible-expenses.*

Enrollment into the FSA is once a year, only during open enrollment for an effective date of January 1. FSA elections are effective from January 1 through December 31 and are administered by Ameriflex.

Account Type	Eligible Expenses	Annual Contribution Limits
Health Care FSA	Most medical, dental and vision expenses that are not covered by your health plan (such as over-the-counter medication, copayments, coinsurance, deductibles, eyeglasses and contact lenses)	Maximum contribution for 2026 is $3,400 You cannot enroll if you are enrolled in and contribute to a Health Savings Account (HSA)
Dependent Care FSA	Dependent care expenses (such as day care, extended care, after school care, or assistance for elderly dependent or incapacitated dependent)	Maximum contribution for 2026 is $7,500

Important Information About the FSA

FSA participants can receive immediate reimbursement for qualified expense by using their FSA debit card. A debit card will be issued after enrollment into the plan. When not utilizing the debit card, a paper claim may be submitted to Ameriflex. Claims for reimbursement must be submitted by March 31 of the following year.

Prior to enrolling in the FSA plan it is important that you estimate how much money you expect to spend for out-of-pocket health care and/or dependent care. Any unused money remaining in your account(s) will be forfeited. This is known as the "use it or lose it" rule and it is governed by IRS regulations. FSAs do not automatically continue from year to year; you must actively enroll each year.

For more information regarding your FSA, please contact Ameriflex at 1-888-868 FLEX (3539). All participants must register at www.myameriflex.com to track claims, submit claims, and access personal information.

Dental Plan

Regular dental exams and cleanings are important in order to detect problems before they become more serious – and expensive. Annual dental exams can also be the first insight to some medical concerns such as diabetes, heart disease, oral cancer and osteoporosis. This is also an important part of your overall health and wellbeing.

We offer an Employee Only Preventive Plan at no cost to you which includes up to $500 of preventive services annually. We also offer an option to cover any eligible dependents or to broaden your coverage. Both plans are through Delta Dental.

Dental Plan	Deducted Over 52 Weeks	Deducted Over 30 Weeks
Employee Only	$2.94	$5.09
Employee + Spouse	$6.90	$11.96
Employee + Child(ren)	$8.67	$15.02
Family	$13.84	$23.99

If you choose to cover eligible dependents or broaden your coverage, the following benefits are subject to the annual deductibles of $25 (single) or $75 (family) and maximum calendar year benefit of $1,500:

Dental Benefit Category	Coinsurance
Preventive Diagnostic (Cleanings & Exams & X-rays)	Deductible waived - 0%
Routine and Restorative Services Cavity Repair and Tooth Extractions - Emergency Treatment - General Anesthesia - Restoration of Decayed or Fractured Teeth - Routine Oral Surgery	20%
Root Canals Endodontic Services - Root Canals	20%
Gum and Bone Diseases Periodontal Services Conservative Procedures (Non-Surgical)	20%
High Cost Restoration Cast Restoration - Crowns - Inlays	50%
Prosthetics Bridges - Dentures - Implants	50%
Orthodontics Orthodontics are a covered benefit for children up to 19 years of age with a lifetime maximum benefit of $2,000	50%

Delta Dental Customer Service: www.deltadentalia.com 1-800-544-0718

Vision Plan

The vision plan provides coverage for routine eye exams and pays for all, or a portion of, the cost of glasses or contact lenses. We offer a vision plan through Vision Service Plan (VSP).

Vision Service Plan	Deducted Over 52 Weeks	Deducted Over 30 Weeks
Employee Only	$3.81	$6.60
Employee + 1	$6.10	$10.57
Employee + Children	$6.22	$10.79
Family	$10.04	$17.40

Visions Benefits	In-Network	Non-Network
Benefit Frequency		
Vision Examination	Every 12 Months	
Frames	Every 24 Months	
Lenses	Every 12 Months	
Benefit Copay		
Examination	$10 Copay	Plan pays up to $50
Materials	$25 Copay	See below
Lenses & Frames		
Frames	$200 allowance for a wide selection of frames $220 allowance for featured frame brands 20% savings on the amount over your allowance	Plan pays up to $70
Lenses	Materials Copay - single vision, lined bifocal, lined trifocal, lenticular & standard progressive lenses	Plan pays up to $50 for single vision, $75 for lined bifocal or progressive, $100 for lined trifocal, $125 for lenticular lenses
Lens Enhancements	Progressive lenses, scratch-resistant coating, anti-reflective coating, average savings of 35-40% on other lens enhancements	N/A
Contacts (instead of Glasses)	Up to $200 allowance	Up to $105 allowance

Using Your VSP Vision Benefits

When you received care from a VSP participating provider, you can maximize your benefits and receive discounts.

1. Find a VSP doctor by calling Customer Service at 1-800-877-7195 or by going online to www.vsp.com.
2. Make an appointment with the doctor of your choice and identify yourself as a VSP member.
3. Your doctor and VSP will handle the rest.

Take advantage of Exclusive Member Extras, like an extra $20 on featured frame brands or save even more on your eye wear. Visit a Premier Doctor for additional offers.

VSP members can also receive discounts on hearing aids through TruHearing. Visit www.vsp.hearing.com for details.

Group Life Insurance

Life insurance is an important part of your financial well-being. We provide all benefits eligible full-time employees with Group Life and Accidental Death and Dismemberment (AD&D) insurance. This benefit is paid **100%** by the Company. In addition, there is a group life insurance benefit for spouses and dependent children at no cost to you. Group Life benefits are provided through Lincoln Financial Group.

Life Benefit	Employee	Spouse & Dependent
Group Life and Accidental Death and Dismemberment (AD&D)	100% of Basic Annual Earnings (Approx. regular hourly wage x 2,080)	Does not include AD&D $10,000 Spouse $1,000 Child: 1 day up to 6 months $5,000 Child: 6 months up to 19 years and unmarried. If dependent is a full-time student, coverage ends at 23 years.
Maximum Amount	$100,000	

Benefit Reduction	Employee	Spouse
Benefits will reduce:	35% at age 65 An additional 15% at Age 70 Benefits will terminate upon retirement	No reduction of benefits at age 65 Benefits terminate at age 70

Beneficiary Designations

It is important to ensure your beneficiary designations remain up-to-date. You can review and change your designations at anytime through the Paylocity website http://access.paylocity.com or by contacting the Human Resources Department.

Lincoln Financial Group 1-800-423-2765 www.lincolnfinancial.com

Voluntary Life Insurance

You may choose to purchase additional life coverage for yourself and your dependents at affordable rates. Rates are based on age and the coverage level chosen. You must be enrolled in Voluntary Employee Life Insurance in order to purchase coverage for your eligible dependents. If you elect this coverage, you will be responsible for paying 100% of the benefit cost.

When you are initially eligible, you may elect coverage amounts up to the Guarantee Issue amount without Evidence of Insurability (EOI), and with EOI for amounts over the Guarantee Issue limit.

During the annual open enrollment period, you have an option to increase your Voluntary Life Insurance by $20,000, and spouse's Voluntary Life by $10,000 with **no underwriting required!** This is subject to the maximum limits.

Life Benefit	Employee	Spouse	Dependent
Amount	Choice of $10,000 increments	Choice of $5,000 increments	$1,000 - 1 day up to 6 months $10,000 - 6 Months to 19 years and unmarried. If dependent is a full-time student, coverage ends at 25 years. Newborns are not eligible
	Not to exceed 10 times your salary	Not to exceed 50% of employee elected amount	
	Employees Age 70 and older, maximum benefit is $50,000	-	
	-	Employee must elect coverage for dependents to be eligible	
Minimum Amount	$10,000	$5,000	N/A
Maximum Amount	$500,000	$250,000	
Guarantee Issue - New Hire Applicants Only	$200,000 under Age 70	$30,000	$10,000
	$20,000 Age 70-74	-	
	No Guarantee Issue Age 75 and older	No Guarantee Issue Spouse Age 60 and older	
Benefit Reduction	**Employee**	**Spouse**	**Dependent**
Benefits will reduce:	35% at Age 65	35% at spouse Age 65	N/A
	An additional 15% of the original amount at Age 70	An additional 15% of the original amount at spouse Age 70	N/A
	Benefits will terminate upon retirement	Benefits will terminate upon employee's retirement	N/A

Evidence of Insurability

Evidence of Insurability (EOI) is satisfied by completing an online questionnaire at Lincoln Financial Group's online portal www.mylincolnportal.com. First time users, register with Company code RASGRP.

In some cases, you may be auto approved for coverage. If not, Lincoln will review your application and contact you if more information is needed. Failure to complete the EOI process or declination based on the EOI, will result in you needing to be approved for all future increases. In all cases, you will be notified of the application outcome.

Voluntary Life Insurance amounts that require EOI do not become effective (and therefore not deducted from your pay) until approval is obtained from Lincoln Financial Group. For coverage amounts up to the guaranteed issues, payroll deductions will being on your eligibility effective date.

Employee and spouse voluntary life costs are based on your age or on your spouse's age. If you have moved into an age bracket with a higher monthly rate, you and/or your spouse may experience an increase in your voluntary life insurance costs.

Lincoln Financial Group 1-800-423-2765 www.lincolnfinancial.com

Accident and Short-Term Disability

We offer additional voluntary benefits through Lincoln Financial Group, including Accident Insurance and Short-Term Disability Insurance.

Voluntary Accident Insurance

Accident Insurance pays you cash should you, or a covered family member, suffer an accidental injury. Eligible family members include legal spouse and unmarried dependent child(ren) less than 25 years of age, unless child(ren) is a full-time student or has a qualifying disability. If you elect this coverage, you are responsible for 100% of the benefit cost. There are over 40 accidents and/or services covered (such as emergency room visits, ambulance transportation, hospital admission and confinement, surgeries, concussions, and more). This coverage is guaranteed issue with no medical exams or questionnaires.

Coverage Type	Deducted Over 52 Weeks	Deducted Over 30 Weeks
Employee Only	$3.27	$5.67
Employee + Spouse	$5.26	$9.11
Employee + Child(ren)	$5.64	$9.78
Family	$7.62	$13.20

Short-Term Disability Insurance (STD)

STD is designed to provide income replacement if you become sick or disabled and are unable to work. This coverage replaces 60% of your pre-disability weekly earnings for up to 26 weeks, with a maximum weekly benefit of $700.00. You must be actively at work for the policy to become effective, and there must be a loss of income to qualify for benefits. Typically, benefits are payable as of the first day if you are disabled due to a non-work-related injury, and payable after one week due to illness.

If a claim is made within the first six months of active coverage, Lincoln Financial may review the claim to determine if a pre-existing condition exists prior to the claim being covered. If the condition existed within three months prior to your policy going into effect, the claim may not be covered.

Rates are based on actual W2 earnings. For new employees, and those electing coverage who have not yet received a W2 from the Company, you may refer to the Lincoln Life Short Term Disability Rates or ask Rasmussen HR.

If you have been covered under the policy for a minimum of 12 months and terminate due to reasons other than disability, retirement, or leave of absence, you may be able to port your coverage.

Actively at Work Provision

New enrollments in Voluntary Life (including annual increases), Short Term Disability and Accident insurance require you to be Actively at Work for the coverage to be effective. If you are on seasonal layoff, your new coverage or increase in coverage will begin the first day you return to work.

Additional Benefits

Employee Assistance Program

Because personal issues can affect every aspect of your life, we automatically provide you and your family with an Employee Assistance Program (EAP) through Employee and Family Resources (EFR) at **no cost to you**. You can call the EAP 24/7 for confidential assistance with nearly any personal matter you may be experiencing. The EAP provides you and your family with six counseling sessions or unlimited telephone consultation sessions per problem occurrence, per year, at no cost to you. EAP can help you with:

- Mental Wellbeing
- Relationship Problems
- Work-Related Issues
- Depression & Anxiety
- Family Conflict
- Legal Issues
- Retirement Planning
- Financial Planning
- Stress
- Eldercare
- Alcohol/Drug Problems
- Identity Theft

Confidential assistance is available at any time by calling 1-800-327-4692 or logging on to www.efr.org.

Employee Wellness Program

The Company strongly believes in helping employees be well at work, at home, and into retirement.

We offer an employee wellness program called *Work Well* that is available to all full-time employees and their spouse at no cost to you. It is designed to encourage employees and their families to engage in wellness activities and make healthy lifestyle changes. Although participation is not required, eligibility begins immediately upon date of hire. The 2026 *Work Well* plan year will run October 1, 2025 through December 31, 2026.

Employees and their spouse can earn up to 40,000 points ($400) by participating in a variety of wellness activities such as annual physical exam, eye exams, dental visits, participating in the wellbeing survey, and much more!

Follow these steps to join:

1. Visit www.rasmussenworkwell.com
2. Select JOIN NOW
3. Enter your first name, last name and social security number
4. Confirm your information
5. Create a username and password, then create your profile
6. Download the Navigate Wellbeing app for more convenient access to activities and rewards

401(k) Retirement Plan

The Company offers a 401(k) Retirement Savings Plan through Principal Financial Group. To be eligible, you must be at least 18 years of age and complete one full month of service with the Company.

Upon meeting these requirements, you will be automatically enrolled into the Company's Traditional 401(k) Plan on the 1st day of the following month at a 6% contribution rate. Meaning 6% of your eligible compensation will be deducted from your paycheck and contributed to the plan on a weekly basis.

For every dollar you contribute to the retirement plan, the Company will **match 50%** up to **6% of your annual contributions**. To receive the maximum company match, you must contribute at least 6% of your compensation. All company match contributions are traditional contributions, not Roth.

You will need to set up your online account and multi-factor authentication by visiting www.principal.com/welcome or call 1-800-547-7754.

The IRS maximum annual contribution limit for 2026 is $24,500. For those age 50 or older, the annual catch-up contribution limit is $8,000 for a total annual contribution limit of $32,500. Eligible participants aged 60-63 can contribute an additional catch-up contribution up to $11,250, for a maximum contribution of $35,750.

There are two options for contributions, both of which are deducted through payroll.

401(k) Type	Deduction Type	Benefit
Traditional 401(k)	Pre-tax deduction	Lowers your taxable income, taxable distributions at retirement
Roth 401(k)	Post-tax deduction	Taken after-tax, tax-free distributions at retirement

Vesting

Vesting refers to your "ownership" of the Company match in your retirement account. You are always vested 100% in the funds you contribute to the plan.

Years of Service	< 2 years	2	3	4	5	6
Vested %	0%	20%	40%	60%	80%	100%

Investments

Both your contributions and company match contributions are automatically enrolled in the Vanguard Target Retirement Fund that aligns with the year closest to your 65th birthday, unless you elect a different investment option through your online account. This investment is designed to adjust automatically over time, becoming more conservative in investment risk level as retirement approaches.

Withdrawals and Rollovers

Withdrawals before age 59 and ½ will be subject to a 10% penalty, plus taxes at your current income tax bracket on traditional contributions, unless you meet the qualifications for certain circumstances detailed by the IRS rules for 401(k) s such as a first-time homeowner down payment or certain hardships. **The plan does not allow for loans**.

When you leave the Company or retire, you may choose to roll over your 401(k) balance into another retirement account.

For information on withdrawals, rollovers, or investment options you can visit www.principal.com or contact Principal's Engagement Center at 1-800-547-7754.

Additional Information

Employee Advocacy

Fulcrum Benefits is our valued consultant and partner for our health and welfare benefits plans. As our consultant, Fulcrum Benefits can help you navigate the tools and resources that are provided by the companies who serve our employees and provide you any additional assistance you may need in understanding your benefits or working through life/STD insurance claim issues.

Fulcrum Benefits: 515-278-1800
Jeff Augustine: jeff@fulcrumbenefits.com
Shaun Bennett: shaun@fulcrumbenefits.com

Family Medical Leave Act (FMLA)

If you have been employed with the Company for 12 months and have worked a minimum of 1,250 hours in the prior 12 months, you may be eligible for up to 12 weeks of unpaid leave per year under the Family Medical Leave Act. FMLA can be used for an illness of your own, care needed for a family member, care for a newborn and certain other medical needs.

COBRA

The Consolidated Omnibus Budget Reconciliation Act (COBRA) gives workers and their families who lose their health benefits the right to choose to continue group health benefits provided by their group health plan for limited periods of time under certain circumstances such as voluntary or involuntary job loss, reduction in the hours worked, transition between jobs, death, divorce, and other life events. If a covered event should occur, you or your eligible dependents may be eligible for COBRA coverage.

Summary of Benefits and Coverage (SBC)

SBCs are available free of charge by contacting the Human Resources Department. This includes hard paper copies. For electronic copies, visit the Company's website www.rasmussengroup.com and navigate to Employee Resources. The Company website also contains information regarding additional notices from carriers.

2026 Employee Contributions

Wellmark Health Rates

Medical	Cost per month	Deducted Over 52 Weeks	Deducted Over 30 Weeks
Copay			
Employee	$340.95	$78.68	$136.38
Employee + Spouse	$765.18	$176.58	$306.07
Employee + Child(ren)	$677.78	$156.41	$271.11
Family	$865.76	$199.79	$346.30
HDHP 1			
Employee	$228.80	$52.80	$91.52
Employee + Spouse	$491.62	$113.45	$196.65
Employee + Child(ren)	$438.97	$101.30	$175.59
Family	$526.76	$121.56	$210.70
HDHP HMO			
Employee	$208.48	$48.11	$83.39
Employee + Spouse	$447.94	$103.37	$179.17
Employee + Child(ren)	$399.97	$92.30	$159.99
Family	$479.96	$110.76	$191.98
HDHP 2			
Employee	$172.77	$39.87	$69.11
Employee + Spouse	$448.80	$103.57	$179.52
Employee + Child(ren)	$407.20	$93.97	$162.88
Family	$464.14	$107.11	$185.66

Delta Dental Rates

Dental	Cost per month	Deducted Over 52 Weeks	Deducted Over 30 Weeks
Employee	$12.72	$2.94	$5.09
Employee + Spouse	$29.89	$6.90	$11.96
Employee + Child(ren)	$37.56	$8.67	$15.02
Family	$59.97	$13.84	$23.99

Vision Service Plan (VSP) Rates

Vision	Cost per month	Deducted Over 52 Weeks	Deducted Over 30 Weeks
Employee	$16.51	$3.81	$6.60
Employee + 1	$26.42	$6.10	$10.57
Employee + Children	$26.97	$6.22	$10.79
Family	$43.49	$10.04	$17.40

Lincoln Accident Rates

Accident	Cost per month	Deducted Over 52 Weeks	Deducted Over 30 Weeks
Employee	$14.18	$3.27	$5.67
Employee + Spouse	$22.78	$5.26	$9.11
Employee + Child(ren)	$24.45	$5.64	$9.78
Family	$33.00	$7.62	$13.20

Weekly Deduction Estimator

Benefits	Weekly Cost
Medical	
HSA/FSA	
Dental	
Vision	
Voluntary Life	
Accident	
Short Term Disability	
TOTAL	

Privacy Practice Notice

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED, AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY. THE PRIVACY OF YOUR MEDICAL INFORMATION IS IMPORTANT TO US.

Our Legal Duty

We are required by applicable federal and state law to maintain the privacy of your medical information. We are also required to give you this notice about our privacy practices, our legal duties, and your rights concerning your medical information. We must follow the privacy practices that are described in this notice while it is in effect. This notice has been updated with an effective date of 10/1/2022, and will remain in effect until we replace it.

We reserve the right to change our privacy practices and the terms of this notice at any time, provided such changes are permitted by applicable law. We reserve the right to make the changes in our privacy practices and the new terms of our notice effective for all medical information that we maintain, including medical information we created or received before we made the changes.

Before we make a significant change in our privacy practices, we will change this notice and send the new notice available to our health plan subscribers at the time of the change.

You may request a copy of our notice at any time. For more information about our privacy practices, or for additional copies of this notice, please contact us using the information listed at the end of this notice.

Uses and Disclosures or Medical Information

We use and disclose medical information about you for treatment, payment, and health care operations. For example:

Treatment: We may use or disclose your medical information to a physician or other health care provider in order to provide treatment to you.

Payment: We may use and disclose your medical information to pay claims from physicians, hospitals and other providers for services delivered to you that are covered by your health plan, to determine your eligibility for benefits, to coordinate benefits, to examine medical necessity, to obtain premiums, to issue explanations of benefits to the person who subscribes to the health plan in which you participate, and the like. We may disclose your medical information to a health care provider or entity subject to the federal Privacy Rules so they can obtain payment or engage in these payment activities.

Health Care Operations: We may use and disclose your medical information in connection with our health care operations. Health care operations may include:

- rating our risk and determining our premiums for your health plan;
- quality assessment and improvement activities;
- reviewing the competence or qualifications of health care professionals, evaluating practitioners and providers performance: conducting training programs, accreditation, certification, licensing or credentialing activities;
- medical review, legal services, and auditing, including fraud and abuse detection and compliance;
- business planning and development; and
- business management and general administrative activities, including management activities relating to privacy, customer service, resolution of internal grievances, and creating de-identified medical information or a limited data set.

We may disclose your medical information to another entity which has a relationship with you and is subject to the federal Privacy Rules, for their health care operations relating to quality assessment and improvement activities, reviewing the competence or qualifications of health care professionals, or detecting or preventing health care fraud and abuse.

On Your Authorization: You may give us written authorization to use your medical information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. To the extent that we maintain or receive psychotherapy notes about you, most disclosures of these notes require your authorization. In addition, most uses and disclosures of medical information for marketing purposes, and disclosures that constitute a sale of protected health information, require your authorization. Unless you give us a written authorization, we will not use or disclose your medical information for any reason except those described in this notice.

To Your Family and Friends: We may disclose your medical information to a family member, friend or other person to the extent necessary to help with your health care or with payment for your health care. We may use or disclose your name, location, and general condition or death to notify, or assist in the notification of (including identifying or locating), a person involved in your care.

Before we disclose your medical information to a person involved in your health care or payment for your health care, we will provide you with an opportunity to object to such uses or disclosures. If you are not present, or in the event of your incapacity or an emergency, we will disclose your medical information based on our professional judgment of whether the disclosure would be in your best interest.

Your Employer or Organization Sponsoring Your Group Health Plan: We may disclose your medical information and the medical information of others enrolled in your group health plan to the employer or other organization that sponsors your group health plan to permit the plan sponsor to perform plan administration functions. Please see your group health plan document for a full explanation of the limited uses and disclosures that the plan sponsor may make of your medical information in providing plan administration.

We may also disclose summary information about the enrollees in your group health plan to the plan sponsor to use to obtain premium bids for the health insurance coverage offered through your group health plan or to decide whether to modify, amend or terminate your group health plan. The summary information we may disclose summarizes claims history, claims expenses, or types of claims experienced by the enrollees in your group health plan. The summary information will be stripped of demographic information about the enrollees in the group health plan, but the plan sponsor may still be able to identify you or other members in your group health plan from the summary information.

Disaster Relief: We may use or disclose your medical information to a public or private entity authorized by law or by its charter to assist in disaster relief efforts.

Public Benefit: We may use or disclose your medical information as authorized by law for the following purposes deemed to be in the public interest or benefit:

- as required by law;

- for public health activities, including disease and vital statistic reporting, child abuse reporting, FDA oversight,
- to report adult abuse, neglect, or domestic violence;
- to health oversight agencies;
- in response to court and administrative orders and other lawful processes;
- to law enforcement officials pursuant to subpoenas and other lawful processes, concerning crime victims,
- to coroners, medical examiners, and funeral directors;
- to organ procurement organizations;
- to avert a serious threat to health or safety;
- in connection with certain research activities;
- to the military and to federal officials for lawful intelligence, counterintelligence, and national security activities;
- to correctional institutions regarding inmates; and
- as authorized by state worker's compensation laws.

Health Related Products and Services: We may use your medical information to contact you with information about health- related benefits and services or about treatment alternatives that may be of interest to you. We may disclose your medical information to a business associate to assist us in these activities.

We may use or disclose your medical information to encourage you to purchase or use a product or service by face-to-face communication or to provide you with promotional gifts.

Individual Rights

Access: You have the right to look at or get copies of your medical information, with limited exceptions. You may request that we provide copies in a format other than photocopies. This may include an electronic copy in certain circumstances. We will use the format you request unless we cannot practicably do so.

Disclosure Accounting: You have the right to receive a list of instances in which we or our business associates disclosed your medical information for purposes other than treatment, payment, health care operations, as authorized by you, and for certain other activities, since April 14, 2003. We will provide you with the date on which we made the disclosure, the name of the person or entity to whom we disclosed your medical information, a description of the medical information we disclosed, the reason for the disclosure, and certain other information. If you request this accounting more than once in a 12-month period, we may charge you a reasonable, cost-based fee for responding to these additional requests. Contact us using the information listed at the end of this notice for a full explanation of our fee structure.

Restriction: You have the right to request that we place additional restrictions on our use or disclosure of your medical information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in an emergency). Any agreement to additional restrictions must be in writing and signed by a person authorized to make such an agreement on our behalf. We will not be bound unless our agreement is so memorialized in writing.

Confidential Communication: You have the right to request that we communicate with you about your medical information by alternative means or to alternative locations. You must make your request in writing, and you must state that the information could endanger you if it is not communicated in confidence as you request. We must accommodate your request if it is reasonable, specifies the alternative means or location, and continues to permit us to collect premiums and pay claims under your health plan, including issuance of explanations of benefits to the subscriber of the health plan in which you participate. An explanation of benefits issued to the subscriber for health care that you received for which you did not request confidential communications or about the subscriber or others covered by the health plan in which you participate, may contain sufficient information to reveal that you obtained healthcare for which we paid, even though you requested that we communicate with you about that health care in confidence.

Amendment: You have the right to request that we amend your medical information. Your request must be in writing, and it must explain why the information should be amended. We may deny your request if we did not create the information you want amended and the originator remains available or for certain other reasons. If we deny your request, we will provide you a written explanation. You may respond with a statement of disagreement to be appended to the information you wanted amended. If we accept your request to amend the information, we will make reasonable efforts to inform others, including people you name, of the amendment and to include the changes in any future disclosures of that information.

Electronic Notice: If you receive this notice on our web site or by electronic mail (e-mail), you are entitled to receive this notice in written form. Please contact us using the information listed at the end of this notice to obtain this notice in written form.

Breach Notification: In the event of a breach of your unsecured health information, we will provide you notification of such a breach, as required by law.

Questions & Complaints

If you want more information about our privacy practices, or have questions or concerns, please contact us using the information listed at the end of this notice.

If you are concerned that we may have violated your privacy rights, or you disagree with a decision we made about access to your medical information or in response to a request you made to amend or restrict the use or disclosure of your medical information or to have us communicate with you by alternative means or at alternative locations, you may complain to us using the contact information listed at the end of this notice. You also may submit a written complaint to the U.S. Department of Health and Human Services. We will provide you with the address to file your complaint with the U.S. Department of Health and Human Services upon request.

We support your right to the privacy of your medical information. We will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

Contact Office: Human Resources Department

Telephone: 515-266-5173

Fax: 515-506-1727

E-mail: HR@rasmussengroup.com

Address: P.O. Box 3333, Des Moines, IA 50316

Continuation Coverage Rights Under COBRA

You're getting this notice because you recently gained coverage under The Rasmussen Group, Inc.'s, 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 generally 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 your Summary Plan Description or contact the Human Resources Department.

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.

You will become a qualified beneficiary if you lose your coverage under the Plan because either one of the following qualifying events happen:

- Your hours of employment are reduced, or
- Your employment ends for any reason other than your gross misconduct.
- Your spouse will become a qualified beneficiary if he or she loses coverage under the Plan because of any of the qualifying events below:
- Your hours of employment are reduced;
- Your employment ends, for any reason other than your gross misconduct;
- You die;
- You become entitled to Medicare benefits (under Part A, Part B, or both); or
- You become divorced or legally separated
- Your dependent children will become qualified beneficiaries if they lose coverage under the Plan because of the following qualifying events:
- Your hours of employment are reduced;
- Your employment ends, for any reason other than your gross misconduct;
- You die;
- You become entitled to Medicare benefits (under Part A, Part B, or both); or
- You become divorced or legally separated;
- The dependent stops being eligible for coverage under the Plan as a "dependent child"

When is COBRA continuation coverage available?

The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Human Resources Department has been notified that a qualifying event has occurred. The employer must notify the Human Resources Department 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 Human Resources Department within 60 days after the qualifying event occurs. You must provide this notice to the Human Resources Department. The 60-day notice requirement starts in the latest of these dates: (a) Social Security disability determination (b) date of the termination/reduction of hours (c) the date of loss of coverage due to the qualifying event.

How is COBRA continuation coverage provided?

Once the Human Resources Department 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 Human Resources Department 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.

The qualified beneficiary must provide the Benefits Plan Administrator the Social Security determination of disability within 60 days and prior to the exhaustion of the original 18-month period. They must also notify the Human Resources Department within 30 days if Social Security makes a final determination that the person no longer is disabled.

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 Human Resources Department 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.

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

In general, if you don't enroll in Medicare Part A or B when you are first eligible because you are still employed, after the Medicare initial enrollment period, you have an 8-month special enrollment period 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 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 Human Resources Department 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 Human Resources Department.

Plan contact information

For more information, you may contact the Human Resources Department at 515-266-5173.

Medicare Part D Creditable and Non-Creditable Coverage

If you or your dependent is eligible for, but elects to defer, the Medicare Part D pharmacy program, you or your eligible family member need to make sure to elect a medical plan with "creditable coverage." A prescription drug coverage is considered creditable if it is at least as generous as Medicare Part D prescription drug coverage. The Copay Plan and HDHP1 meet the criteria of creditable coverage and can be selected with no penalty to the Medicare Part D pharmacy program. If you or an eligible family member will soon be eligible for the Medicare Part D pharmacy program, the Copay Plan or HDHP1 may be selected with no potential future penalty to your Medicare pharmacy plan once elected. The HDHP2 plan is deemed non-creditable. A prescription drug coverage plan is considered non-creditable when the amount the plan expects to pay for prescription drugs for individuals is less than that which Medicare prescription drug coverage would be expected to pay. This is important because, most likely, you will get more held with your drug costs if you join a Medicare drug plan. While you can still choose this plan, you or your eligible family member may face the Medicare Part D penalty for delaying entry into the program without creditable coverage in place. You may refer to the Company's website to review Medicare Part D Creditable Coverage and Medicare Part D Non-Creditable Coverage notices.

Health Insurance Marketplace Coverage Options and Your Health Coverage

Part A: General Information

When key parts of the health care law took effect in 2014, there was a new way to buy health insurance: the Health Insurance Marketplace. To assist you as you evaluate options for you and your family, this notice provides some basic information about the new Marketplace and employment-based health coverage offered by your employer.

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. You may also be eligible for a new kind of tax credit that lowers your monthly premium right away. Open enrollment for health insurance coverage through the marketplace began in October 2013.

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

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

Does Employer Health Coverage Affect Eligibility for Premium Savings through the Marketplace?

Yes. If you have an offer of health coverage from your employer that meets certain standards, you will not be eligible for a tax credit through the marketplace and may wish to enroll in your employer's health plan. However, you may be eligible for a tax credit that lowers your monthly premium, or a reduction in certain cost-sharing if your employer does not offer coverage to you at all or does not offer coverage that meets certain standards. If the cost of a plan from your employer that would cover you (and not any other members of your family) is more than 9.5% of your household income for the year, or if the coverage your employer provides does not meet the "minimum value" standard set by the Affordable Care Act, you may be eligible for a tax credit. An employer-sponsored health plan meets the "minimum value standard" if the plan's share of the total allowed benefit costs covered by the plan is no less than 60 percent of such costs.

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

How Can I Get More Information?

For more information about your coverage offered by your employer, please check your summary plan description or contact the Human Resources Deparment at 515-266-5173.

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. If you decide to complete an application for coverage in the Marketplace, contact the Human Resources Department for additional plan information that will be needed for your application.

The information below in Part B will be needed to complete an application for coverage in the Marketplace.

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.

- **Employer Name:** The Rasmussen Group, Inc
- **Employer Identification Number (EIN):**
  Available upon request
- **Employer address:**
  PO Box 3333 - 5550 NE 22nd Street
- **Employer phone number:** 515-266-5173
- **City:** Des Moines
- **State:** Iowa
- **ZIP code:** 50316
- **Who can we contact about employee health coverage at this job?**
  Human Resources Department
- **Phone number (if different from above)**
- **Email address:**
  HR@rasmussengroup.com

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

As your employer, we offer a health plan to all Full-Time employees and seasonal employees scheduled to work 30 hours a week after initial waiting period is satisfied.

With respect to dependents we offer a health plan to spouse and children, including step-children, up to age 26 of eligible employees who elect dependent coverage and pay the additional premium.

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 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.

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

2. Does the employer offer a health plan that meets the minimum value standard? Yes

An employer-sponsored health plan meets the "minimum value standard" if the plan's share of the total allowed benefit costs covered by the plan is no less than 60 percent of such costs *(Section 36B(c)(2)(C)(ii) of the Internal Revenue Code of 1986).*

3. 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.

- How much would the employee have to pay in premiums for this plan? $172.77
- How often? Monthly

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

4. 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 above.)

   - How much would the employee have to pay in premiums for this plan? $_____
   - How often? Monthly

Women's Health and 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, copays and coinsurance applicable to other medical and surgical benefits provided under your medical plan. If you would like more information on WHCRA benefits, call your plan administrator 515-266-5173.

Newborns' and Mothers' Health Protection Act (NMHPA)

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).

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, 2022. Contact your State for more information on eligibility.

ALABAMA – Medicaid
HIPP Website: https://dhs.iowa.gov/ime/members/medicaid-a-to-z/hipp
HIPP Phone: 1-888-346-9562

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
Website:
Health Insurance Premium Payment (HIPP) Program
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://www.colorado.gov/pacific/hcpf/child-health-plan-plus
CHP+ Customer Service: 1-800-359-1991/ State Relay 711
Health Insurance Buy-In Program (HIBI): https://www.colorado.gov/pacific/hcpf/health-insurance-buy-program
HIBI Customer Service: 1-855-692-6442

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
Healthy Indiana Plan for low-income adults 19-64
Website: http://www.in.gov/fssa/hip/
Phone: 1-877-438-4479
All other Medicaid
Website: https://www.in.gov/medicaid/
Phone 1-800-457-4584

IOWA – Medicaid and CHIP (Hawki)
Medicaid Website:
https://dhs.iowa.gov/ime/members
Medicaid Phone: 1-800-338-8366
Hawki Website:
http://dhs.iowa.gov/Hawki
Hawki Phone: 1-800-257-8563
HIPP Website: https://dhs.iowa.gov/ime/members/medicaid-a-to-z/hipp
HIPP Phone: 1-888-346-9562

KANSAS – Medicaid
Website: https://www.kancare.ks.gov/
Phone: 1-800-792-4884

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://kidshealth.ky.gov/Pages/index.aspx
Phone: 1-877-524-4718
Kentucky Medicaid Website: https://chfs.ky.gov

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.maine.gov/dhhs/ofi/applications-forms
Phone: 1-800-442-6003
TTY: Maine relay 711
Private Health Insurance Premium Webpage:
https://www.maine.gov/dhhs/ofi/applications-forms
Phone: -800-977-6740.
TTY: Maine relay 711

MASSACHUSETTS – Medicaid and CHIP
Website: https://www.mass.gov/masshealth/pa
Phone: 1-800-862-4840
TTY: (617) 886-8102

MINNESOTA – Medicaid
Website:
https://mn.gov/dhs/people-we-serve/children-and-families/health-care/health-care-programs/programs-and-services/other-insurance.jsp
Phone: 1-800-657-3739

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 5218

NEW JERSEY – Medicaid and CHIP
Medicaid Website:
http://www.state.nj.us/humanservices/dmahs/clients/medicaid/
Medicaid Phone: 609-631-2392
CHIP Website: http://www.njfamilycare.org/index.html
CHIP Phone: 1-800-701-0710

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: http://www.nd.gov/dhs/services/medicalserv/medicaid/
Phone: 1-844-854-4825

OKLAHOMA – Medicaid and CHIP
Website: http://www.insureoklahoma.org
Phone: 1-888-365-3742

OREGON – Medicaid
Website: http://healthcare.oregon.gov/Pages/index.aspx
http://www.oregonhealthcare.gov/index-es.html
Phone: 1-800-699-9075

PENNSYLVANIA – Medicaid
Website: https://www.dhs.pa.gov/Services/Assistance/Pages/HIPP-

Program.aspx
Phone: 1-800-692-7462

RHODE ISLAND – Medicaid and CHIP
Website: http://www.eohhs.ri.gov/
Phone: 1-855-697-4347, or 401-462-0311 (Direct Rlte 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: http://gethipptexas.com/
Phone: 1-800-440-0493

UTAH – Medicaid and CHIP
Medicaid Website: https://medicaid.utah.gov/
CHIP Website: http://health.utah.gov/chip
Phone: 1-877-543-7669

VERMONT– Medicaid
Website: http://www.greenmountaincare.org/
Phone: 1-800-250-8427
VIRGINIA – Medicaid and CHIP
Website: https://www.coverva.org/en/famis-select
https://www.coverva.org/en/hipp
Medicaid Phone: 1-800-432-5924
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, 2022, 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

Contact Us

Rasmussen Group Human Resources
5550 NE 22nd Street | Des Moines, IA 50313
hr@rasmussengroup.com | 515.266.5173
Fulcrum Benefits | 515.278.1800

Medical	Dental	Vision
Wellmark **800.524.9242** **www.wellmark.com**	**Delta Dental of Iowa** **800.544.0718** **www.deltadentalia.com**	**Vision Service Plan (VSP)** **800.877.7195** **www.vsp.com**

401(k) Retirement Plan	Life - Accident - Disability	Employee Assistance Program
Principal Financial Group **800.547.7754** **www.principal.com**	**Lincoln Financial** **800.423.2765** **www.lincolnfinancial.com**	**Employee & Family Resources** **800.327.4692** **www.efr.org**

Health Savings Account	Flexible Spending Account	Rasmussen Work Well Portal
Fidelity **800.544.3716** **www.netbenefits.com**	**Ameriflex** **888.868.3539** **www.myameriflex.com**	**Navigate Wellbeing** **888.282.0822** **www.rasmussenworkwell.com**

THE RASMUSSEN GROUP

HARD WORK'S WORTH IT.

About this Guide

This Benefits Guide contains brief summaries of the plans available to eligible employees. The guide is a source of reference only. It is not a legal document and shall not be construed as a guarantee of benefits nor of continued employment at The Rasmussen Group, Inc. All benefit plans are governed by master policies, contracts and plan documents. Any discrepancies between any information provided through this summary and the actual terms of such policies, contracts and plan documents shall be governed by the terms of such policies, contracts and plan documents. The Rasmussen Group, Inc., reserves the right to amend, suspend, or terminate any benefit plan, in whole or in part, at any time.

You may obtain a Summary of Benefits and Coverage for any benefit plan by contacting the The Rasmussen Group, Inc.'s Human Resources Department at 515-266-5173, or by going to The Rasmussen Group, Inc.'s website at www.rasmussengroup.com under Employee Resources.