2024

New Hire Benefits Guide

Columbia College
established 1851

2024 Benefits Overview

Welcome to your

2024 BENEFITS OVERVIEW

- We are excited to have you join the Columbia College family. We recognize the importance of benefits within the overall compensation package provided to all of our eligible employees. As a full-time employee of Columbia College you are eligible for a comprehensive set of group benefit programs. These programs are designed with multiple options to meet the individual needs of our employees and their dependents.
- Make sure you review this guide and make note of your enrollment deadline so you don't miss out on enrolling in your benefits for 2024!

Prior to your enrollment, you will receive step-by-step enrollment instructions from our HR team.

Consider this booklet your benefits survival guide. Inside, you'll find everything you need to make informed benefits decisions, including in-depth information regarding your plan options, our policies and more.

REMEMBER! Your New Hire enrollment period is the one time of year you can elect the benefits that you would like for and your dependents for 2024 (unless you experience a qualifying event).

2024 NEW HIRE OFFERINGS AT A GLANCE

- 2 Medical Plans
  - HDHP Plan
  - PPO Plan
- Dental Plan
- Vision Plan
- Tax Savings Accounts
  - Health Savings Account
  - Flexible Spending Accounts
- Employer Paid Life and AD&D
- Voluntary Life and AD&D
- Employer Paid Long Term Disability
- Voluntary Short Term Disability
- Voluntary Accident Plan
- Voluntary Critical Illness Plan
- Voluntary Hospital Indemnity Plan
- 403(b) Retirement Plan
- Vacation and Sick Leave
- Employee Education Grant, Graduate Education Grant, Tuition Exchange Programs

Table of Contents

Welcome 2
Contact Information & Table of Contents 3
Understanding Medical Plan Options 4
Your Medical Insurance Plan Options and Costs 5
Care Options and When to Use Them 6
Additional UHC Services 7
Employee Assistance Plans 8
Understanding Health Savings Account (HSAs) 9
Flexible Spending Accounts (FSAs) 11
Dental Insurance 12
Vision Insurance 13
Basic Life and AD&D 14
Voluntary Life and AD&D and Dependent Life 14
Disability Insurance 15
Critical Illness Insurance 16
Accident Insurance 17
Hospital Indemnity Insurance 18
Glossary of Terms 19
Important Notices 20

CONTACT INFORMATION

If you have any questions regarding your benefits, please contact our carrier partners or your Columbia College Human Resources Department listed here.

Want to learn more?

Throughout this guide, you'll find clickable video and link icons that will take you to resources that provide additional info on your available benefits.

MEDICAL INSURANCE
UnitedHealthcare
www.myuhc.com
866-633-2446

DENTAL INSURANCE
Guardian
www.guardiananytime.com
888-482-7342

VISION INSURANCE
Guardian
www.guardiananytime.com
888-482-7342

BASIC LIFE/AD&D & DISABILITY INSURANCE AND VOLUNTARY PRODUCTS
Guardian
www.guardiananytime.com
888-482-7342

FLEXIBLE SPENDING ACCOUNTS
ASI Flex
www.asiflex.com
800-659-3035

EAP
WorkLifeMatters
https://worklife.uprisehealth.com/
800-386-7055

YOUR BENEFITS TEAM
Human Resources Department
humanresources@ccis.edu
573-875-7495

Medical Insurance

YOUR HEALTH PLAN OPTIONS

As a full-time employee of Columbia College, you have the choice between two medical plan options: a HDHP or a PPO Plan.

For each, your deductible will run from JANUARY 1 – DECEMBER 31.

While both plans give you the option of using out-of-network providers, you can save money by using in-network providers because UnitedHealthcare (UHC) has negotiated significant discounts with them. If you choose to go out-of-network, you'll be responsible for the difference between the actual charge and UHC's UCR (Usual, Customary and Reasonable) charge, plus your out-of-network deductible and coinsurance.

The HDHP offers you significantly lower premiums than the PPO plan, and you can establish a Health Savings Account (HSA) with the bank of your choice and contribute all or part of the premium savings into the HSA. These funds can be used to cover medical expenses, including deductibles, and they're yours forever — even if you leave Columbia College. Additionally, these funds are not forfeited at the end of each year.

Get the most out of your insurance by using **in-network providers.**

HOW TO GET STARTED

SELECT YOUR MEDICAL PLAN

HDHP PLAN
OFFERS SEVERAL BENEFITS:

- Lower premium contributions and potential maximum out-of-pocket expenses
- Routine preventive exams are covered at 100%
- Catastrophic coverage
- The HSA is owned by you
- You have more control over your health saving dollars

PPO PLAN
MAY BE FOR YOU IF ANY OF THE FOLLOWING IS TRUE:

- You are not eligible to establish a Health Savings Account
- You would rather know your out-of-pocket costs when you visit the doctor or pharmacy and be willing to pay more in monthly premiums
- You expect to incur medical expenses at the beginning of the year and having an FSA makes more sense as the total funds are available immediately.

FREQUENTLY ASKED QUESTIONS

Q. How many hours do I need to work to be eligible for insurance benefits?
You must be a full-time employee working a minimum of 30 hours per week on a regular basis.

Q. Will I receive a new Medical ID card?
You will receive an ID card in the mail if you are changing medical plans or making changes to your current medical plan election.

Q. Does the deductible run on a calendar year or policy year basis?
A calendar year basis.

Q. How long can I cover my dependent children?
Dependent children are eligible until the end of the year in which they turn age 26.

Q. I just got hired. When will my benefits become effective?
Your medical insurance benefit will begin on the 1st of the month following the first day of employment for regular full-time employees.

Medical Insurance

UnitedHealthcare	Option 1: HDHP Plan		Option 2: PPO Plan	
	Employee Cost Per Month (1/1/24—6/30/2024)	Employee Cost Per Month (7/1/24—12/31/2024)	Employee Cost Per Month (1/1/24—6/30/2024)	Employee Cost Per Month (7/1/24—12/31/2024)
Employee	$56	$61	$70	$77
Employee + Spouse	$310	$338	$340	$371
Employee + Child(ren)	$116	$126	$163	$178
Employee + Family	$458	$499	$481	$524
	IN-NETWORK		**IN-NETWORK**	
DEDUCTIBLE (1) **Individual / Family**	$2,000 / $4,000		$3,000 / $6,000	
COINSURANCE (Member Pays)	0%		20%	
OUT-OF-POCKET MAXIMUM (2) Individual / Family	$3,000 / $6,000		$6,000 / $12,000	
OFFICE VISITS				
Preventive Care	Covered at 100%		Covered at 100%	
Primary Care Physician / Specialist	Deductible then 0%		$40 / $80 copay	
Diagnostic Lab / X-Ray	Deductible then 0%		Deductible then 20%	
Urgent Care	Deductible then 0%		$60 copay	
HOSPITAL VISITS				
Inpatient Care (Facility / Physician)	Deductible then 0%		Deductible then 20%	
Outpatient Surgery	Deductible then 0%		Deductible then 20%	
Major Diagnostics & Imaging	Deductible then 0%		Deductible then 20%	
Emergency Room	Deductible then 0%		$300 copay	
PRESCRIPTION DRUG				
Deductible	Applies, then:		Does Not Apply	
Retail Tier 1 / 2 / 3 / 4 Copay	$10 / $30 / $50 / $50		$10 / $30 / $50 / $50	
Mail Order (90-day supply)	2 1/2 times retail copay		2 1/2 times retail copay	
	OUT-OF-NETWORK (3)		**OUT-OF-NETWORK (3)**	
DEDUCTIBLE Individual / Family	$4,000 / $8,000		$6,000 / $12,000	
COINSURANCE (Member Pays)	20%		40%	
OUT-OF-POCKET MAXIMUM Individual / Family	$8,000 / $16,000		$12,000 / $24,000	

IMPORTANT: Columbia College's HDHP includes a non-embedded family deductible for those enrolled in coverage with a dependent. All family members' out-of-pocket expenses count towards the $4,000 family deductible. This could mean one member incurs all the expenses to meet the deductible, or 2 or more family members split the expenses. Once the family deductible is satisfied, all family members move into coinsurance.

(1) HDHP: Family Deductible is non-embedded. (2) PPO: Family Deductible is embedded. Please see Glossary for an explanation of these two terms.

(2) Out-of-Pocket maximum includes all cost-sharing: deductible, coinsurance and copays

(3) All Out-of-Network services subject to deductible, coinsurance and balance billing

Premiums will be withheld from your paycheck on a pre-tax basis for Medical, Dental, and Vision insurance.

Your election can only be changed during the plan year if you experience a qualifying life status change. You must notify Human Resources within 30 days of the event.

Both plans are detailed in UHC's Summary Plan Description (SPD). This is a brief summary only. For exact terms and conditions, please refer to your SPD.

Care Options & When to Use Them

YOUR CARE OPTIONS

While we recommend that you seek routine medical care from your primary care physician whenever possible, there are alternatives available to you. Services may vary, so it's a good idea to visit the care provider's website. Be sure to check that the facility is in-network by calling the toll-free number on the back of your medical ID card, or by visiting

Primary Care vs. Urgent Care vs. ER

PRIMARY CARE

- Routine, primary/preventive care
- Non-urgent treatment
- Chronic disease management

For routine, primary/ preventive care or non-urgent treatment, we recommend going to your doctor's office.

Your doctor knows you and your health history best — and already has access to your medical records. You'll also likely pay the least amount out-of-pocket.

VIRTUAL VISITS

- Cold/flu
- Diarrhea
- Fever
- Rash
- Sinus problems

Virtual visits let you talk to a doctor anytime, anywhere from your mobile device or computer — no appointment necessary.

UHC partners with Amwell, Doctor on Demand and TelaDoc to bring you care from the comfort and convenience of your home or wherever you are.

CONVENIENCE CARE

- Common infections (ear infections, pink eye, strep throat & bronchitis)
- Flu shots & Vaccines
- Pregnancy tests
- Rashes
- Screenings

If you're unable to get to your doctor's office and your condition is not urgent/an emergency, these providers serve as a good alternative.

They are often located in malls or retail stores (such as CVS, Walgreens, Wal-Mart and Target), and generally serve patients 18 months of age or older without an appointment. Services may be provided at a lower out-of-pocket cost than an urgent care center.

URGENT CARE

- Sprains & Strains
- Small cuts
- Minor infections
- Sore throats
- Mild asthma attacks
- Back pain or strains

Sometimes you need medical care fast, but a trip to the emergency room may not be necessary. During office hours, you may be able to go to your doctor's office.

Outside regular office hours — or if you can't be seen by your doctor immediately — you may consider going to an Urgent Care Center where you can generally be treated for many minor medical problems faster than at an emergency room.

EMERGENCY ROOM

- Heavy bleeding
- Large open wounds
- Chest pain
- Spinal injuries
- Difficulty breathing
- Major burns
- Severe head injuries

An emergency medical condition is any condition (including severe pain) that you believe may result in serious injury or death without immediate medical care.

Emergency services are always considered in-network. If you receive treatment for an emergency in a non-network facility, you may be transferred to an in-network facility once your condition has been stabilized.

If you believe you are experiencing a medical emergency, go to the nearest emergency room or call 9-1-1, even if your symptoms are not described here.

Additional UHC Services

VIRTUAL VISITS

Retail Telehealth, or a "virtual visit," lets you see and talk to a doctor from your mobile device or computer without an appointment. UHC partners with American Well (Amwell), Doctor on Demand, and Teladoc to bring you care from the comfort and convenience of your home or wherever you are.

Most visits take about 10-15 minutes, and your doctor can write a prescription, if needed, that you can pick up at your local pharmacy.

GET STARTED TODAY!

To get started with a Virtual Visit, go to www.uhc.com/virtualvisits.

Conditions commonly Treated through a virtual visit:

- Bladder infection/ urinary tract infection
- Bronchitis
- Cold/flu
- Diarrhea
- Fever
- Migraine/headaches
- Pink eye
- Rash
- Sinus problems
- Sore throat

MYUHC.COM

A SINGLE SITE THAT DOES SO MUCH FOR YOU: With myuhc.com, you get a one-stop resources for medical information and tools to make the healthcare choices that are right for you.

- **CHECK** current and past claims status
- **REVIEW** benefits and coverage
- **FIND** network doctors and coverage
- **MANAGE** prescription drugs
- **COMPLETE** health surveys

UNITEDHEALTHCARE APP

Download in the Apple store or Google Play store for your mobile device

- **FIND** care and costs
- **REVIEW** plan information
- **ACCESS** health plan ID card
- **MANAGE** and pay claims
- **SEARCH** pharmacy, drug pricing and mail orders

Download on the App Store

GET IT ON Google Play

Employee Assistance Programs

Mental health includes your emotional, psychological, and social well-being. It can affect how you think, feel, and act. It also determines how you handle stress, relate to others, and make healthy life choices. Columbia College understands the importance of your mental health and offers the following resources:

EMPLOYEE ASSISTANCE PROGRAM - WORKLIFEMATTERS

The Employee Assistance Program (EAP) offers services to help promote well-being and enhance the quality of life for you and your family. If you are experiencing stress, having financial difficulties, struggling at work or home, please reach out to the following:

RESOURCES FOR EVERYONE

Phone: 1-800-386-7055 to speak with someone 24/7
Online: https://worklife.uprisehealth.com/; Access Code: worklife

COACHING

Online skill building for mental wellbeing and life issues. Members and household dependents (age 18+) can also schedule up to 3 coaching sessions per year.

SHORT-TERM COUNSELING

Members and household dependents can receive up to 3 in-person or virtual counseling sessions per issue.

LEGAL SERVICES

Unlimited telephonic support and free initial 30-minute consultation with an attorney, with a 25% discount on attorney services thereafter; online legal forms; extensive law library; identity theft.

WORK-LIFE MATTERS

Resources to help balance work and life responsibilities with family and caregiving, health and wellness, emotional wellbeing, daily living, and employee discounts (Perks at Work).

USE YOUR EAP ONLINE!

Get Started online with your Digitally Enabled EAP through Guardian/Uprise to access: Wellbeing Assessment, Coaching, Short-Term Counseling, 24-hour Crisis Help, Financial and Legal Support, Webinars & Trainings.

To Get Started:

1. Go to https://worklife.uprisehealth.com/
2. Enter your access code: worklife; After you login, go to the “Coaching” page for access.
3. You can also download the Uprise Health app on Google Play or the Apple App Store.

GET IT ON Google Play Download on the App Store

UHC EAP SERVICES

FOR EMPLOYEES ON THE MEDICAL PLAN

UnitedHealthcare

If you need guidance navigating mental health, financial or legal concerns, take advantage of the Employee Assistance Program (EAP) for 24/7 support — at no extra cost. ***You and your family members must be enrolled in one of the UHC medical plans in order to utilize these services.***

Reaching out to an EAP consultant is a good first step. They’re trained to understand your concerns so they can connect you with the consultant or service best able to help you:

- Address depression, anxiety or substance use issues.
- Improve relationships at home or work.
- Manage stress.
- Work through emotional issues or grief.
- Assistance with legal and financial concerns.

Call the member phone number on your health plan ID card and ask to speak to an EAP consultant.

Contact Information:
24/7 at 1-888-887-4114.

Health Savings Account (HSA)

UNDERSTANDING A HEALTH SAVINGS ACCOUNT (HSA)

THERE ARE TWO WAYS YOU CAN PUT MONEY INTO YOUR HSA:

1 **Regular payroll deductions** on a pre-tax basis

2 **Lump-sum contributions** made by you directly into your HSA account of any amount, anytime, up to the maximum limit. Recognize the same tax savings by claiming the deduction when filing your annual taxes.

WHAT IS AN HSA?

An HSA is exactly what it sounds like — a savings account where you can either direct pre-tax payroll deductions or deposit money to be used to pay for current or future qualified medical expenses for you and/or your dependents.

YOUR HSA CAN ALSO BE AN INVESTMENT OPPORTUNITY.

Depending upon your HSA balance, your account can grow tax-free in an investment of your choice (like an interest-bearing savings account, a money market account, a wide variety of mutual funds — or all three). Of course, your funds are always available if you need them for qualified health care expenses.

HSA FUNDS CAN BE USED FOR YOUR FAMILY.

Your HSA doesn't just benefit you. You can use the funds for your spouse and tax dependents for their eligible expenses, too — even if they're not covered by your medical plan.

YOUR FUNDS CAN CARRY OVER AND EVEN GROW OVER TIME.

The money in your HSA always belongs to you, and we mean always. Even if you leave the company or you don't use a lot of health services now, your funds will carry over from year to year and will always be there if you need them in the future — even after retirement.

CONTRIBUTE UP TO $4,150 SINGLE, OR $8,300 FAMILY

HSA CONTRIBUTIONS: COLUMBIA COLLEGE WILL CONTRIBUTE UP TO $250 FOR EMPLOYEE ONLY COVERAGE; $350 FOR EMPLOYEE/SPOUSE OR EMPLOYEE/CHILD(REN) COVERAGE; AND $400 FOR FAMILY COVERAGE—COLUMBIA COLLEGE WILL DO A DOLLAR FOR DOLLAR MATCH UP TO THESE MAXIMUMS!

WHAT ARE THE RULES?

- You must be covered under a Qualified High Deductible Health plan (QHDHP) in order to establish an HSA.
- You cannot establish an HSA if you or your spouse also have a medical FSA, unless it is a Limited Purpose FSA.
- You cannot be enrolled in Medicare or TRICARE due to age or disability.
- You cannot set up an HSA if you have insurance coverage under another plan, such as your spouse's employer, unless that secondary coverage is also a Qualified High Deductible Health Plan.
- You cannot be claimed as a dependent under someone else's tax return.

WHAT ELSE SHOULD I KNOW?

- You set up your HSA with the bank of your choice and communicate this information to Columbia College HR.
- You can invest up to the IRS's annual contribution limit. Contributions are based on a calendar year. The contribution limits for 2024 are $4,150 for Single and $8,300 for Family coverage. The annual maximum includes your contributions and your employer contributions. If you're age 55 or older, you are allowed to make an extra $1,000 contribution each year.
- The contributions grow tax-free and come out tax-free as long as you utilize the funds for approved services based on the IRS Publication 502, (medical, dental, vision expenses and over-the-counter medications, such as allergy medicine, cold and flu, pain relievers, and feminine hygiene)
- Your unused contributions roll over from year to year and can be taken with you if you leave your current job.
- If you use the money for non-qualified expenses, then the money becomes taxable and subject to a 20% excise tax penalty (like in an IRA account).
- There is no penalty for distributions following death, disability (as defined in IRC 72), or attainment of Medicare eligibility age, but taxes would apply for non-qualified distributions.
- If your health care expenses are more than your HSA balance, you need to pay the remaining cost another way. Save your receipts in case you are ever audited! You can request reimbursement later, after you have accumulated more money in your account.

Health Savings Account (HSA)

YOU CAN USE HSA FUNDS FOR IRS-APPROVED ITEMS SUCH AS:

- Doctor's office visits
- Dental services
- Eye exams, eyeglasses, laser surgery, contact lenses and solution
- Hearing aids
- Orthodontia, dental cleanings and fillings
- Prescription drugs and some over-the-counter medications (such as allergy medicine, cold and flu, pain relievers and feminine hygiene)
- Physical therapy, speech therapy and chiropractic expenses

More information about approved items, plus additional details about the HSA, is available at irs.gov.

IMPORTANT INFORMATION:

Every time you use your HSA, save your receipt in case the IRS asks you to prove your claim was for a qualified expense. If you use HSA funds for a non-qualified expense, you will pay tax and a penalty on those funds.

The HSA is your personal account and contains your personal funds. It can be considered an asset by a creditor and garnished as applicable.

As a health savings account holder, you will be required to file a Form 8889 with the IRS each year. This form identifies any contributions, distributions, or earned interest associated with your account.

THIS MAY BE THE BEST PLAN OPTION FOR YOU IF ANY OF THE FOLLOWING ARE TRUE:

- You do not incur a lot of medical and prescription medication expenses.
- You would like money in a savings account to pay for Qualified Expenses permitted under Federal Law.
- You would like the opportunity to contribute pre-tax income to a Health Savings Account.
- You are enrolled in the HDHP.

What Is a Health Savings Account?

FREQUENTLY ASKED QUESTIONS

Q. What will I pay at the pharmacy with the HSA qualified plan options?
You will pay the actual discounted cost of the drug until you satisfy your calendar year deductible in full.

Q. What will I pay at the physician's office with the HSA qualified plan?
You'll provide your ID card at the time of your visit and the physician's office will submit the claim to UHC. You will not owe anything at the time of your visit. Later you'll receive an Explanation of Benefits (EOB) from UHC that shows the charges discounted based on their contract with the physician. When you receive a bill from the physician's office, you pay the portion of the discounted cost you are responsible for as shown on the EOB.

Q. Where can I get a copy of an EOB?
You can access all of your EOB information, as well as obtain other important information, by logging on to www.myuhc.com.

Flexible Spending Accounts (FSA)

SELECT YOUR FSA ACCOUNTS

- *Health Care Flexible Spending Account*
- *Dependent Care Expense Account*

HEALTH CARE FLEXIBLE SPENDING ACCOUNT

- This account enables you to pay medical, dental, vision, and prescription drug expenses that may or may not be covered under your insurance program (or your spouse's) with pre-tax dollars. You can also pay for dependent health care, even if you choose single (vs. family) coverage. The total amount of your annual election is available to you up front, reducing your chance of incurring a large out-of-pocket expense early in the plan year. Be aware — any unused portion of the account at the end of the plan year is forfeited unless you have a balance of $640 or less, which may be rolled over.

ELIGIBLE EXPENSES EXAMPLES

- Coinsurance & copayments
- Contraceptives
- Crutches
- Dental expenses
- Dentures
- Diagnostic expenses
- Eyeglasses, including exam fee
- Handicapped care & support
- Nutrition counseling
- Hearing devices & batteries
- Hospital bills
- Deductible amounts
- Laboratory fees
- Licensed practical nurses
- Orthodontia
- Orthopedic shoes
- Oxygen
- Prescription drugs
- Psychiatric care
- Psychologist expenses
- Routine physical
- Seeing-eye dog expenses
- Prescribed vitamin supplements (medically necessary)

HOW THE HEALTH CARE FLEXIBLE SPENDING ACCOUNT WORKS

When you have out-of-pocket expenses (such as copayments and deductibles), you submit an FSA claim form with your receipt to pay for these qualified expenses at qualified providers to ASIFlex. Reimbursement is issued to you through direct deposit into your bank account, or by check. You have 90 days after the end of the Plan Year to turn in your receipts—so for 2023 claims, you have until March 31, 2024.

2024 MAXIMUM CONTRIBUTIONS

Health Care Flexible Spending account	$3,200 max
Dependent Care Expense account	$5,000 max

Full list of Health Care FSA Eligible Expenses

What is a Dependent Care FSA?

DEPENDENT CARE EXPENSE ACCOUNT

- This account gives you the opportunity to redirect a portion of your annual pay on a pre-tax basis to pay for dependent care expenses.
- An eligible dependent is any member of your household for whom you can claim expenses on your Federal Income Tax Form 2441, "Credit for Child and Dependent Care Expenses." Children must be under age 13.
- Qualified care centers include dependent care centers, preschool educational institutions, and qualified individuals (as long as the caregiver is not a family member and reports income for tax purposes).
- Before deciding to use the Dependent Care Expense Account, it would be wise to compare its tax benefit to that of claiming a child care tax credit when filing your tax return. You may want to check with your tax advisor to determine which method is best for you and your family.
- Any unused portion of your account balance at the end of the plan year is forfeited.

CONTACT INFORMATION

Request a full statement of your accounts at any time by calling 800-659-3035, or log on to www.asiflex.com to review your FSA balance. The address to mail claims to is P.O. Box 6044, Columbia, MO 65205-6044.

At www.asiflex.com, you can:

- View account information and activity
- File claims
- Manage your profile
- View notifications
- Access forms

Dental Insurance

REVIEW YOUR DENTAL PLAN

GUARDIAN IS THE DENTAL CARRIER FOR 2024

The dental plan is a PPO that offers coverage in- and out-of-network. It is to your advantage to utilize a network dentist in order to achieve the greatest cost savings. If you choose to go out-of-network, you will be responsible for any cost exceeding Guardian's negotiated fees, plus any deductible and coinsurance associated with your procedure.

Dependent children are eligible until the end of the year in which they turn age 26.

What is Dental Insurance?

In-Network Providers:
Provider is reimbursed based on contracted fees and cannot balance bill you.

Out-of-Network Providers:
Provider is reimbursed based on Reasonable and Customary standards and balance billing is possible.

DENTAL INSURANCE PLAN OPTIONS AND COSTS

Guardian	Employee Cost Month
Employee	$9.30
Employee + Spouse	$34.36
Employee + Child(ren)	$43.20
Employee + Family	$68.24

	In-Network	Out-of-Network	
Deductible Individual / Family	$50 / $150		Applies to Basic & Major Services
Annual Maximum	$1,000		Applies to Preventive, Basic & Major Services
Carrier Pays			
Diagnostic / Preventive Services	100%	100%	• Bitewing X-Rays • Full Mouth X-Rays • Cleanings—1 in any 6 consecutive month period • Oral Exams • Sealants
Basic Services	80%	80%	• Fillings • Scaling and Root Planing • Simple Extractions and Surgical Extractions
Major Services	50%	50%	• General Anesthesia • Dentures • Single Crowns
Orthodontia Services (Children and Adult)	50% up to the $1,500 lifetime maximum		• Diagnostics & Treatment
Rollover Benefits	If you do not use over $500 of Non-Orthodontic benefits in a Plan Year, you are eligible to "rollover" $350 towards your next year's Annual Maximum (if you used network providers and $250 if you use non-Network providers). The most you can "bank" or rollover is $1,000.		

FIND A DENTAL PROVIDER

To find a Guardian DentalGuard Dental Provider in your area, visit the website at www.guardiananytime.com.

- Click ""Find a Provider" from the top of the tool bar
- Click "Search Providers"
- Enter your Zip Code and then click "Search"
- Sort further by name, address, distance or specialty

REVIEW YOUR VISION PLAN

GUARDIAN IS THE VISION CARRIER FOR 2024

The vision plan offers coverage both in-network and out-of-network. It is to your advantage to utilize a network provider, which is the VSP Network—Signature Plan, in order to achieve the greatest cost savings. If you go out-of-network, your benefit is based on a reimbursement schedule.

In addition, if you are considering Lasik surgery or other non-covered benefits, there are discounts available with some providers. To find a participating provider, go to www.guardiananytime.com.

What is Vision Insurance?

VISION INSURANCE PLAN OPTIONS AND COSTS

Guardian	Employee Cost Per Month	
Employee	$9.50	
Employee + Spouse	$16.00	
Employee + Child(ren)	$16.30	
Employee + Family	$25.80	
	In-Network	**Out-of-Network**
Examination Copay	$20 copay	$20 copay
Frequency of Service		
Exam	Every 12 months	
Lenses	Every 12 months	
Frames	Every 12 months	
Lenses		**Reimbursement**
Single	$20 copay; 100% covered	Up to $48 after $20 copay
Bifocal	$20 copay; 100% covered	Up to $67
Trifocal	$20 copay; 100% covered	Up to $86
Lenticular	$20 copay; 100% covered	Up to $126
Frames	$0 copay; $130 allowance, 20% off balance over $130	**Reimbursement** Up to $48
Conventional Contacts	$0 copay; $130 allowance	**Reimbursement** Up to $130
Medically Necessary Contacts	$0	**Reimbursement** Up to $210

FIND A VISION PROVIDER

To find a Guardian Vision Provider (VSP Signature Network) in your area, visit the website at www.guardiananytime.com.

- Click “”Find a Provider” from the top of the tool bar
- Click “Search Providers”
- Select “Find a Vision Provider” Tab
- Click “Search VSP”
- Enter your Zip Code and then click “Search”
- Sort further by products or services

Life Insurance and AD&D

REVIEW YOUR LIFE INSURANCE POLICY

- *Add Your Spouse*
- *Add Your Dependents*
- *Increase Your Coverage*

BASIC LIFE AND AD&D

Columbia College provides 2x your annual earnings to a maximum of $250,000 in Basic Life and Accidental Death & Dismemberment (AD&D) insurance.

This coverage is offered through Guardian at no cost to you.

What is Life and AD&D Insurance?

VOLUNTARY LIFE AND AD&D AND DEPENDENT LIFE

You can purchase additional Life and AD&D Coverage beyond what Columbia College provides. Guardian guarantees issued coverage during your initial enrollment period — which means you can't be turned down for coverage based on medical history.

- Voluntary Employee Life & AD&D: minimum $10,000 to a maximum of $500,000, in $10,000 increments. Guarantee issue up to $150,000 (age reductions do apply starting at age 65).
- Optional Spouse Life & AD&D: minimum $5,000 up to $250,000 maximum in $5,000 increments. Guarantee issue up to $50,000 (Spouse Life coverage ends at age 70).
- Optional Child Life & AD&D: Flat $10,000. Guarantee issue is $10,000.

If you don't enroll in the Voluntary Life and AD&D plan during your initial enrollment period, you'll be required to complete an Evidence of Insurability form and be approved by Guardian before you're able to get coverage in the future.

You must be enrolled in voluntary life and/or AD&D coverage in order for your spouse, and/or eligible dependent children to enroll.

VOLUNTARY LIFE / AD&D AND DEPENDENT LIFE OPTIONS AND COSTS PER MONTH

VOL LIFE/AD&D GUARDIAN	Rates per $1,000 of coverage		
	Age	*Employee*	*Spouse*
Voluntary Life and AD&D Rates Combined (Spouse Premium is based on Employee's age)	<24	$0.10	$0.10
	25-29	$0.10	$0.10
	30-34	$0.11	$0.11
	35-39	$0.14	$0.14
	40-44	$0.18	$0.18
	45-49	$0.26	$0.26
	50-54	$0.38	$0.38
	55-59	$0.56	$0.56
	60-64	$0.81	$0.81
	65-69	$1.53	$1.53
	70-74	$2.83	$2.83
	75+	$2.83	$2.83
	Child(ren)	$0.212/month for $1,000 coverage	

This is a great time to check who you have listed as your beneficiaries!

REVIEW YOUR DISABILITY INSURANCE

- *Short-Term Disability*
- *Long-Term Disability*

VOLUNTARY SHORT-TERM DISABILITY INSURANCE

Short-Term Disability insurance is offered through Guardian. You pay 100% of the premium cost. The weekly benefit is a flat 60% of your weekly earnings up to $1,500.

Benefits are paid after a waiting period of 7 days for an accident and 7 days for sickness. Benefits can continue for up to 13 weeks.

Please note: *If you don't enroll in the Voluntary Short Term Disability plan during your initial enrollment period, you'll be required to complete an Evidence of Insurability form and be approved by Guardian before you're able to get coverage in the future.*

LONG-TERM DISABILITY INSURANCE

Long-Term Disability insurance is offered through Guardian. Columbia College pays 100% of the premium cost. The plan benefit is 60% of basic monthly earnings up to a maximum of $7,500 per month.

The benefits begin after a 90 day waiting period. Benefits can continue up to the Social Security Normal Retirement Age.

Definition of Disability: *You are disabled when Guardian determines—due to your injury, or illness—you are receiving appropriate care and treatment from a doctor on a continuing basis, while unable to perform one or more of the essential duties of the following: (1) Your occupation during the elimination period; (2)Youroccupation,forthefirst3year(s) following the elimination period, you will receive benefit payments while you are unable to work in your own occupation; or (3)After three years, you will continue to receive benefits if you cannot work in any occupation based on training, experience and education.*

VOLUNTARY STD — Rates per $10 of weekly benefit	
Age	***Employee***
15-29	$0.600
30-34	$0.826
35-39	$0.580
40-44	$0.389
45-49	$0.367
50-54	$0.395
55-59	$0.440
60-99	$.687

COULD YOU PAY THE BILLS IF YOU WEREN'T WORKING?

Less than 1/4 of U.S. consumers have enough emergency savings to cover six months or more of their expenses.

Nearly **70%** of workers that apply for Social Security Disability Insurance **are denied.**

WHY SHOULD YOU CONSIDER DISABILITY INSURANCE?

Many workers think these events are more likely than becoming disabled during their careers. Here are the actual odds:

.0000004% - *Winning Mega Millions*

.02% - *Being Struck by Lightning*

1% - Being audited by the *IRS*

3% - *Having twins*

25% - *Becoming disabled*

What is Short Term Disability?

What is Long Term Disability?

Voluntary Coverages

PROTECT YOUR FINANCES

- *Critical Illness Coverage*
- *Accident Insurance*

CRITICAL ILLNESS INSURANCE

While it is impossible to prepare for the physical and emotional consequences of being diagnosed with a critical illness, you can prepare for the consequences such an illness may have on your personal finances.

While major medical insurance may pay for a good portion of the costs associated with the illness, there are a lot of expenses that are just not covered — from deductibles and copays to living expenses.

This Critical Illness insurance policy from Guardian can help with the treatment costs of a covered critical illnesses — such as a heart attack or stroke. More importantly, it can help you focus on recuperation instead of the distraction of out-of-pocket costs.

With the Critical Illness plan, you receive cash benefits directly (unless otherwise assigned) — giving you the flexibility to help pay bills related to treatment or to help with everyday living expenses.

FEATURES:

- 100% employee paid
- Benefits are paid directly to you, unless you choose otherwise
- Fills in the gaps of other benefits, like the deductibles for the HDHP medical plan
- You can take your coverage with you if you change jobs or retire (with certain stipulations)
- **Pays a lump sum of $5,000 to $25,000 up diagnosis of eligible conditions: Cancer, Vascular (heart attack, stroke heart failure)**
- **Guarantee Issue Limits:** Employee — $20,000; Spouse — 10,000; Children — all amounts are guaranteed coverage.
- Please review the Guardian Certificate of Coverage for more detailed plan information
- **Health Screening Benefit—$50 per employee/spouse/child**

GROUP CRITICAL ILLNESS COVERAGE INCLUDES:

- Health Screening Benefit—$50 per employee/spouse/child
- Critical Illness Benefit payable for:
  - **Invasive Cancer**
  - **Carcinoma In Situ**
  - **Benign Brain Tumor**
  - **Skin Cancer**
  - **Heart Attack**
  - **Stroke**
  - **Heart Failure**
  - **Arteriosclerosis**
  - **Organ Failure**
  - **Kidney Failure**

See Guardian Enrollment Kit for rates.

What is Critical Illness Insurance?

HOW CRITICAL ILLNESS COVERAGE WORKS

1. **Critical illness coverage is selected**

2. You experience chest pains and numbness in your left arm

3. You visit the emergency room

4. A physician determines that you have suffered a heart attack

5. Guardian Critical Illness coverage pays you a First Occurrence Benefit

HOW ACCIDENT INSURANCE WORKS

1. You select "Accident Insurance"

2. You injure your leg in a covered accident and go to the hospital by ambulance

3. The ER doctor diagnoses a fracture and treats you

4. You leave the hospital on crutches

5. Guardian pays your benefit

ACCIDENT INSURANCE

If you're like most people, you don't budget for life's unexpected moments. One mishap can send you on an unexpected trip to your local emergency room — and leave you with a flurry of unexpected bills.

That's where Accident Insurance jumps in. In the event of a covered accident, the plan pays you cash benefits fast to help you pay for the costs associated with out-of-pocket expenses and bills — expenses major medical may not take care of.

GUARDIAN ACCIDENT INSURANCE COVERS THINGS LIKE THE FOLLOWING:

- Hospitalization
- Emergency room treatment
- X-rays
- Dislocations
- Fractures
- Lacerations

FEATURES:

- Coverage is guaranteed-issue (which means you may qualify for coverage without having to answer health questions)
- Benefits are paid directly to you (unless you choose otherwise)
- Coverage is available for you, your spouse, and your dependent children
- Coverage is portable (with certain stipulations). That means you can take it with you if you change jobs or retire
- Your accident coverage will cover injuries suffered while either on or off the job.
- **Health Screening Benefit—$50 per employee/spouse/child**

BENEFITS INCLUDE:

- Health Screening Benefit—$50 per employee/spouse/child
- Transportation and Lodging Benefits
- An Emergency Room Treatment Benefit
- A Rehabilitation Unit Benefit
- Coverage for certain serious conditions, such as coma and paralysis
- An Accidental-Death Benefit
- A Dismemberment Benefit
- Child Organized Sport Benefit

ACCIDENT Plan	Monthly Rates
Employee Only	$16.20
Employee Plus Spouse	$23.16
Employee Plus Children	$30.90
Family	$37.86

What is Accident Insurance?

Voluntary Coverages *(cont.)*

HOW HOSPITAL INDEMNITY INSURANCE WORKS

1. You select "Hospital Indemnity Insurance"

2. You experience chest pains and numbness in your left arm

3. A physician determines that you have suffered a heart attack

4. You are admitted to the hospital

5. Guardian pays a hospital admission benefit and/or hospital confinement benefit

HOSPITAL INDEMNITY INSURANCE

Focus on recovery during a hospital stay—not your out-of-pocket costs. A hospital confinement due to an illness or injury can happen to anyone. Staying in the hospital after an accident or illness can be costly. Hospital Indemnity insurance benefit payments are made directly to you, no matter what other coverage you may have, and can be used however you choose. Hospital Indemnity insurance through Guardian helps provide financial peace of mind.

GUARDIAN HOSPITAL INDEMNITY INSURANCE COVERS THINGS LIKE THE FOLLOWING:

- **Hospital/ICU Admission:** $1,000 per year, limited to 1 admission per benefit year.
- **Hospital/ICU Confinement:** $200/$400 per day up to 30 days
- **Pre-existing Limitation:** 12 month look back, 12 month exclusion
- **Child(ren) Age Limits**: Children age birth to 26 years
- **Health Screening Benefit**: $50 per employee/spouse/child

FEATURES:

- Coverage is guaranteed-issue (which means you may qualify for coverage without having to answer health questions)
- Benefits are paid directly to you (unless you choose otherwise)
- Coverage is portable (with certain stipulations). That means you can take it with you if you change jobs or retire
- **Health Screening Benefit—$50 per employee/spouse/child**

Hospital Indemnity Plan	Monthly Rates
Employee Only	$16.26
Employee Plus Spouse	$31.82
Employee Plus Children	$26.02
Family	$41.58

ELECT YOUR 403(B) CONTRIBUTION

COLUMBIA COLLEGE 403(B) PLAN

The retirement plan (Plan) is a defined contribution tax deferred 403(b)plan, set up under Internal Revenue Service Code 403(b), with its plan year beginning on July 1st each year and ending on June 30th. It is mandatory, both as a condition of employment, and as required by the Plan, that all eligible employees participate in the Plan.

REQUIREMENTS OF THE 403(B) RETIREMENT PLAN:

- The Columbia College 403(b) plan provides one of the best ways to save money for retirement while deferring current income taxes. The plan allows both voluntary and College contributions (for eligible employees).
- Employees must satisfy an eligibility waiting period of one (1) year, be 21 years of age, and worked at least 1,000 hours or more per Plan year in order to receive the College's contribution. Part-time employees are eligible for the College's contribution if they work 1,000 hours or more in a plan year. Adjunct Faculty are not eligible for the College's contribution.
- Employees who are at least 21 years of age and are projected to work at least 1000 hours in the Plan year are eligible to start self-contribution on their first day of employment.
- After the eligibility requirements are met, employees are able to enroll in the College's contribution in the first quarter following a year of service.
- At its discretion, the Columbia College may contribute a certain percentage of annual eligible wages to the retirement plan. Employees vest 20% in their account balance during the first year in the plan, and an additional 20% in each year of eligible service thereafter. Employees are fully vested in the retirement plan after 6 full years of continuous employment.
- It is mandatory for eligible employees to contribute to the retirement plan in order to receive a contribution from Columbia College. The College will provide a 100% match of up to 8%of eligible wages for eligible employees. The elective maximum percentage allowed is controlled by Internal Revenue Service regulations.

Other Benefits

VACATION

- Full-time Faculty are not eligible for vacation accrual.
- Full-time Administrative Staff (exempt) earn 20 days or 160 hours of vacation eave per Fiscal year (July 1–June 30).
- Full-time Support Staff (non-exempt) earn 10 days or 80 hours of vacation leave per fiscal year (July 1–June 30).
- Regular part-time staff earn a pro-rated portion of the full-time vacation leave calculated according to the staff's exemption status.
- Staff may carry-over one time their annual accrual from one fiscal year to the next (i.e., staff whose annual accrual is 10 days, may carryover up to 10 days from June 30th to July 1st).
- Accruals are prorated for employees that work full-time but less than 12 months.

SICK LEAVE

- All full-time faculty earn 10 days per academic year (August through May).
- All full-time staff earn 1 day (8 hours) leave per month for a total of 12 days per fiscal year (July 1–June 30).
- Sick leave (for regular part-time staff) is earned as a prorated portion of full-time sick leave.
- Maximum accruals of ninety (90) days for all regular full-time staff, and a prorated portion of the ninety (90) day maximum for all eligible regular part-time staff are allowed.
- Accruals are prorated for employees that work full-time but less than 12 months.

EMPLOYEE EDUCATION GRANT

The Employee Education Grant (EEG) is a benefit offered by the College after completion of their introductory period. Regular full-time employees, and their spouse or domestic partner, single children under the age of 25, and all Board of Trustees Members, unless in default of a federal student or parent loan or on academic probation, are eligible for EEG. All eligible members may access undergraduate in-seat classes tuition free, and online under graduate courses at a 75% tuition reduction. This is a taxable benefit.

Learn more about the EEG at ccis.edu/policies.

GRADUATE EDUCATIONAL GRANT

The Graduate Education Grant (GEG) is a benefit offered by the College to its regular full-time employees that allows enrollment in Columbia College graduate level courses at a reduced cost. Employees are eligible to apply for the GEG upon completion of their introductory period with Columbia College. This grant allows eligible employees to enroll in (in-seat and/ or online) graduate classes at Columbia College, at a 75% tuition reduction. Spouse or domestic partner, dependents, adjunct faculty and part-time employees are not eligible for the GEG. This is a taxable benefit.

Learn more about the GEG at ccis.edu/policies.

TUITION EXCHANGE

Full-time employees may be eligible to send their non-emancipated children to other member institutions with little or no tuition (fee/charge). A list of member institutions can be accessed via the following links:

- For a list of CIC Tuition Exchange (CIC) member institutions refer to www.cic.edu.
- For a list of Tuition Exchange (TE) member institutions refer to www.tuitionexchange.org.

Glossary of Terms

INSURANCE TERMS

Coinsurance—The plan's share of the cost of covered services which is calculated as a percentage of the allowed amount. This percentage is applied after the deductible has been met. You pay any remaining percentage of the cost until the out-of-pocket maximum is met. Coinsurance percentages will be different between in-network and out-of-network services.

Copays—A fixed amount you pay for a covered health care service. Copays can apply to doctor's office visits, as well as urgent care and emergency room services. Copays will not satisfy any part of the deductible. Copays should not apply to any preventive services.

Deductible—The amount of money you pay before services are covered. Services subject to the deductible will not be covered until it has been fully met. It does not apply to any preventive services, as required under the Affordable Care Act.

> **Non-Embedded Deductible (HDHP Medical Plan) –** The single team member deductible is *not embedded* into the family deductible, meaning one member can incur all the expenses to meet the deductible, or 2 or more family members split the expenses to meet the deductible.
>
> **Embedded Deductible (PPO Medical Plan) –** The individual deductible is *embedded* into the family deductible, meaning no one person covered under the plan can contribute more than the single deductible amount toward the family deductible.

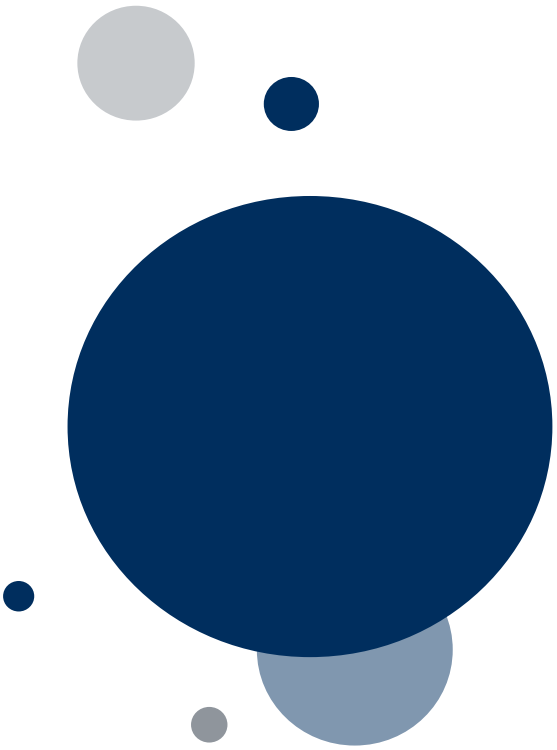
Lifetime Benefit Maximum—All plans are required to have an unlimited lifetime maximum.

Network Provider—A provider who has a contract with your health insurer or plan to provide services at set fees. These contracted fees are usually lower than the provider's normal fees for services.

Out-of-Pocket Maximum—The most you will pay during a set period of time before your health insurance begins to pay 100% of the allowed amount. The deductible, coinsurance and copays are included in the out-of-pocket maximum.

Preauthorization (also known as Prior Authorization (PA))—A process conducted by your health insurer or plan to determine if any service, treatment plan, prescription drug or durable medical equipment is medically necessary. This is sometimes called prior authorization, prior approval or precertification.

UCR (Usual, Customary and Reasonable)—The amount paid for medical services in a geographic area based on what providers in the area usually charge for the same or similar service.



MEDICAL TERMS

Prescription Drugs—Each plan offers its own unique prescription drug program. Specific copays apply to each tier and a medical plan can have one to five separate tiers. The retail pharmacy benefit offers a 30-day supply. Mail order prescriptions provide up to a 90-day supply. Sometimes the deductible must be satisfied before copays are applied.

Urgent Care—Care for an illness, injury or condition serious enough that a reasonable person would seek immediate care, but not so severe to require emergency room care.

Emergency Room—Services you receive from a hospital for any serious condition requiring immediate care.

Preventive Services—All services coded as Preventive must be covered 100% without a deductible, coinsurance or copayments.

Medically Necessary—Health care services or supplies needed to prevent, diagnose or treat an illness, injury, condition, disease or its symptoms, which meet accepted standards of medicine.

IMPORTANT NOTICES

MEDICARE PART D CREDITABLE COVERAGE

Important Notice from Columbia College 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 Columbia College 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. Columbia College has determined that the prescription drug coverage offered by the United Healthcare health 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 Columbia College coverage **may** be affected. You can keep this coverage if you elect Part D and this plan will coordinate with Part D coverage. If you do decide to join a Medicare drug plan and drop the Columbia College medical plan, **be aware that you and your dependents may not be able to get this coverage back**.

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

You should also know that if you drop or lose your current coverage with Columbia College 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 Columbia College changes. You also may request a copy of this notice at any time.

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

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

For more information about Medicare prescription drug coverage:

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

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

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

Date:	November 1, 2023
Name of Entity/Sender:	Columbia College
Contact--Position/Office:	Human Resources
Address:	1001 Rogers Street, Columbia, MO 65216
Phone Number:	573-875-7495

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, 2023. Contact your State for more information on eligibility –

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

GEORGIA – Medicaid	INDIANA – Medicaid
GA HIPP Website: https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp Phone: 678-564-1162, Press 1 GA CHIPRA Website: https://medicaid.georgia.gov/programs/third-party-liability/childrens-health-insurance-program-reauthorization-act-2009-chipra Phone: 678-564-1162, Press 2	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)	**KANSAS – Medicaid**
Medicaid Website: https://dhs.iowa.gov/ime/members Medicaid Phone: 1-800-338-8366 Hawki Website: http://dhs.iowa.gov/Hawki Hawki Phone: 1-800-257-8563 HIPP Website: https://dhs.iowa.gov/ime/members/medicaid-a-to-z/hipp HIPP Phone: 1-888-346-9562	Website: https://www.kancare.ks.gov/ Phone: 1-800-792-4884 HIPP Phone: 1-800-967-4660
KENTUCKY – Medicaid	**LOUISIANA – Medicaid**
Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP) Website: https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx Phone: 1-855-459-6328 Email: KIHIPP.PROGRAM@ky.gov KCHIP Website: https://kidshealth.ky.gov/Pages/index.aspx Phone: 1-877-524-4718 Kentucky Medicaid Website: https://chfs.ky.gov/agencies/dms	Website: www.medicaid.la.gov or www.ldh.la.gov/lahipp Phone: 1-888-342-6207 (Medicaid hotline) or 1-855-618-5488 (LaHIPP)
MAINE – Medicaid	**MASSACHUSETTS – Medicaid and CHIP**
Enrollment Website: https://www.mymaineconnection.gov/benefits/s/?language=en_US Phone: 1-800-442-6003 TTY: Maine relay 711 Private Health Insurance Premium Webpage: https://www.maine.gov/dhhs/ofi/applications-forms Phone: 1-800-977-6740 TTY: Maine relay 711	Website: https://www.mass.gov/masshealth/pa Phone: 1-800-862-4840 TTY: 711 Email: masspremassistance@accenture.com
MINNESOTA – Medicaid	**MISSOURI – Medicaid**
Website: https://mn.gov/dhs/people-we-serve/children-and-families/health-care/health-care-programs/programs-and-services/other-insurance.jsp Phone: 1-800-657-3739	Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005
MONTANA – Medicaid	**NEBRASKA – Medicaid**
Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084 Email: HHSHIPPProgram@mt.gov	Website: http://www.ACCESSNebraska.ne.gov Phone: 1-855-632-7633 Lincoln: 402-473-7000 Omaha: 402-595-1178

NEVADA – Medicaid	NEW HAMPSHIRE – Medicaid
Medicaid Website: http://dhcfp.nv.gov Medicaid Phone: 1-800-992-0900	Website: https://www.dhhs.nh.gov/programs-services/medicaid/health-insurance-premium-program Phone: 603-271-5218 Toll free number for the HIPP program: 1-800-852-3345, ext. 5218
NEW JERSEY – Medicaid and CHIP	**NEW YORK – Medicaid**
Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/ Medicaid Phone: 609-631-2392 CHIP Website: http://www.njfamilycare.org/index.html CHIP Phone: 1-800-701-0710	Website: https://www.health.ny.gov/health_care/medicaid/ Phone: 1-800-541-2831
NORTH CAROLINA – Medicaid	**NORTH DAKOTA – Medicaid**
Website: https://medicaid.ncdhhs.gov/ Phone: 919-855-4100	Website: https://www.hhs.nd.gov/healthcare Phone: 1-844-854-4825
OKLAHOMA – Medicaid and CHIP	**OREGON – Medicaid**
Website: http://www.insureoklahoma.org Phone: 1-888-365-3742	Website: http://healthcare.oregon.gov/Pages/index.aspx Phone: 1-800-699-9075
PENNSYLVANIA – Medicaid and CHIP	**RHODE ISLAND – Medicaid and CHIP**
Website: https://www.dhs.pa.gov/Services/Assistance/Pages/HIPP-Program.aspx Phone: 1-800-692-7462 CHIP Website: Children's Health Insurance Program (CHIP) (pa.gov) CHIP Phone: 1-800-986-KIDS (5437)	Website: http://www.eohhs.ri.gov/ Phone: 1-855-697-4347, or 401-462-0311 (Direct RIte Share Line)
SOUTH CAROLINA – Medicaid	**SOUTH DAKOTA - Medicaid**
Website: https://www.scdhhs.gov Phone: 1-888-549-0820	Website: http://dss.sd.gov Phone: 1-888-828-0059
TEXAS – Medicaid	**UTAH – Medicaid and CHIP**
Website: Health Insurance Premium Payment (HIPP) Program | Texas Health and Human Services Phone: 1-800-440-0493	Medicaid Website: https://medicaid.utah.gov/ CHIP Website: http://health.utah.gov/chip Phone: 1-877-543-7669
VERMONT– Medicaid	**VIRGINIA – Medicaid and CHIP**
Website: Health Insurance Premium Payment (HIPP) Program | Department of Vermont Health Access Phone: 1-800-250-8427	Website: https://coverva.dmas.virginia.gov/learn/premium-assistance/famis-select https://coverva.dmas.virginia.gov/learn/premium-assistance/health-insurance-premium-payment-hipp-programs Medicaid/CHIP Phone: 1-800-432-5924
WASHINGTON – Medicaid	**WEST VIRGINIA – Medicaid and CHIP**
Website: https://www.hca.wa.gov/ Phone: 1-800-562-3022	Website: https://dhhr.wv.gov/bms/ http://mywvhipp.com/ Medicaid Phone: 304-558-1700 CHIP Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)
WISCONSIN – Medicaid and CHIP	**WYOMING – Medicaid**
Website: https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm Phone: 1-800-362-3002	Website: https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/ Phone: 1-800-251-1269

To see if any other states have added a premium assistance program since July 31, 2023, 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)

This notice is a summary. For a full description of all of Columbia College's benefit plans, please refer to the Summary Plan Descriptions, located at: Human Resources.

INITIAL COBRA NOTICE

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."

Sometimes, filing a proceeding in bankruptcy under title 11 of the United States Code can be a qualifying event. If a proceeding in bankruptcy is filed with respect to [*enter name of employer sponsoring the Plan*], and that bankruptcy results in the loss of coverage of any retired employee covered under the Plan, the retired employee will become a qualified beneficiary. The retired employee's spouse, surviving spouse, and dependent children will also become qualified beneficiaries if bankruptcy results in the loss of their coverage under the Plan.

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;
- Commencement of a proceeding in bankruptcy with respect to the employer; or
- The employee's becoming entitled to Medicare benefits (under Part A, Part B, or both).

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

HOW IS COBRA CONTINUATION COVERAGE PROVIDED?

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

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

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

DISABILITY EXTENSION OF 18-MONTH PERIOD OF COBRA CONTINUATION COVERAGE

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

SECOND QUALIFYING EVENT EXTENSION OF 18-MONTH PERIOD OF CONTINUATION COVERAGE

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

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 https://www.medicare.gov/medicare-and-you.

IF YOU HAVE QUESTIONS

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

KEEP YOUR PLAN INFORMED OF ADDRESS CHANGES

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

PLAN CONTACT INFORMATION: HUMAN RESOURCES

MARKETPLACE COVERAGE OPTIONS

PART A: GENERAL INFORMATION

When key parts of the health care law take effect in 2014, there will be 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 begins in October 2013 for coverage starting as early as January 1, 2014.

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. [1]

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.[1]

HOW CAN I GET MORE INFORMATION?

For more information about your coverage offered by your employer, please check your summary plan description or contact Columbia College HR department.

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.

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

MARKETPLACE COVERAGE OPTIONS CONTINUED

PART B: INFORMATION ABOUT HEALTH COVERAGE OFFERED BY YOUR EMPLOYER

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

Employer Name: Columbia College	**Employer Identification Number (EIN):** 43-0655867
Employer Address: 1001 Rogers St., Columbia, MO 65216	**Employer Phone Number:** 573-875-8700
Who can we contact about employee health coverage at this job? **Jodi Johnson**	**Phone Number:** 573-875-7530 **Email Address:** jrjohnson@ccis.edu

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

- As your employer, we offer a health plan to:
  - ☐ All employees. Eligible employees are:
  - X Full time employees, working a minimum 30 hours per week on a regular basis. Employees will be effective the 1st day of the month, following the first day of employment.
  - ☐ Some employees. Eligible employees are:
- With respect to dependents:
  - X We do offer coverage. Eligible dependents are: Legal Spouses and children to age 26.
  - ☐ We do not offer coverage.

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

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

If you decide to shop for coverage in the Marketplace, **HealthCare.gov** will guide you through the process. Above is 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.

WOMEN'S HEALTH AND CANCER RIGHTS ACT OF 1998

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.
- Treatment of physical complications at all stages of the mastectomy, including lymphedemas.

These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under this plan. Therefore, the following deductibles and coinsurance apply: Please refer to your plan's Summary Plan Description for the deductibles and coinsurance that would apply. If you would like more information on WHCRA benefits, call your Plan Administrator at 573-875-7495.

IMPORTANT INFORMATION REGARDING 1095 FORMS

As an employer with 50 or more full-time employees, we are required to provide 1095-C forms to each employee who was employed as a full-time employee for at least one month during the calendar year, without regard to whether they were covered by our group health plan. These employees should expect to receive their Form 1095-C in early March 2024. We are also required to send a copy of your 1095-C form to the IRS.

The information reported on Form 1095-C is used in determining whether an employer owes a payment under the employer shared responsibility provisions under section 4980H. Form 1095-C is also used by you and the IRS to determine eligibility for the premium tax credit.

SPECIAL ENROLLMENT NOTICE

During the open enrollment period, eligible employees are given the opportunity to enroll themselves and dependents into our group health plans.

If you elect to decline coverage because you are covered under an individual health plan or a group health plan through your parent's or spouse's employer, you may be able to enroll yourself and your dependents in this plan if you and/or your dependents lose eligibility for that other coverage. You must request enrollment within 30 days after the other coverage ends. In addition, if you have a new dependent as a result of marriage, birth, adoption or placement for adoption, you may enroll any new dependent within 30 days of the event.

If you or your dependents become ineligible for Medicaid or CHIP, you may be able to enroll yourself and your dependents in the plan. You must request enrollment within 60 days.

If you or your dependents become eligible for premium assistance from Medicaid or CHIP, you may be able to enroll yourself and your dependents in the plan. You must request enrollment within 60 days.

To request special enrollment or obtain more information, contact Human Resources.

This notice is a summary. For a full description of all of Columbia College's benefit plans, please refer to the Summary Plan Descriptions, located at: Human Resources.

PROTECTIONS FROM DISCLOSURE OF MEDICAL INFORMATION

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

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

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

You may not be discriminated against in employment because of the medical information you provide as part of participating in the wellness program, nor may you be subjected to retaliation if you choose not to participate.

If you have questions or concerns regarding this notice, or about protections against discrimination and retaliation, please contact Human Resources at 573-875-7495.

NOTICE OF PRIVACY PRACTICES

Columbia College is subject to the HIPAA privacy rules. In compliance with these rules, it maintains a Notice of Privacy Practices. You have the right to request a copy of the Notice of Privacy Practices by contacting Human Resources.

NOTICE OF MATERIAL CHANGE (ALSO MATERIAL REDUCTION IN BENEFITS)

Columbia College has amended the Medical, Dental and Vision benefit plans. This benefit guide contains a summary of the modifications that were made. It should be read in conjunction with the Summary Plan Description or Certificate of Coverage, which is available to you by the carriers. If you would like a copy, please submit your request to Human Resources.

This notice is a summary. For a full description of all of Columbia College's benefit plans, please refer to the Summary Plan Descriptions, located at: Human Resources.

Your Notes

The purpose of this booklet is to describe the highlights of your benefit program. Your specific rights to benefits under the Plans are governed solely, and in every respect, by the official plan documents and insurance contracts, and not by this booklet. If there is any discrepancy between the description of the plans as described in this material and official plan documents, the language of the documents shall govern.