2026

Employee Benefits Guide

Columbia College
established 1851

2026 Benefits Overview

Welcome to the

2026 BENEFITS OPEN ENROLLMENT

It's that time of year again! The Columbia College annual insurance open enrollment period is about to begin.

We know that benefits are an integral part of the overall compensation package provided to all of our eligible employees, which is why we take great care to review all available benefits options on an annual basis. During this year's review, we focused not only on providing quality benefit plans but also on controlling the cost and financial risk for our employees. We continue to offer multiple options to meet the individual needs of our employees and their dependents.

For now, take the time to prepare by doing the following:

- Check that your personal information is accurate by reviewing your Total Compensation Statement on the Self-Service site.
- Review the benefits you are currently enrolled,
- Take a look at the changes for 2026, and
- Get a sneak peek at the plans being offered for the coming year.

Consider this booklet your open enrollment 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.

As always, we value you as a member of the Columbia College family and look forward to a healthy and safe 2026.

REMEMBER! Open enrollment is the one time of year you can make any adjustments you'd like for the upcoming plan year.

2026 UPDATES AT A GLANCE

- The medical carrier will be changing to UMR, and an additional HDHP plan will be offered.
- The dental carrier will be changing to Delta Dental of Missouri.
- The vision carrier will be changing to EyeMed.
- The Life/Disability, Critical Illness, Accident, and Hospital Indemnity plans will all be changing carriers to The Standard.

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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
UMR
www.UMR.com
800-826-9781

DENTAL INSURANCE
Delta Dental of Missouri
www.DeltaDentalMo.com
800-335-8266
service@deltadentalmo.com

BASIC LIFE/AD&D DISABILITY INSURANCE VOLUNTARY PRODUCTS
The Standard
https://www.standard.com
Life or AD&D: 800-368-8600
STD: 800-368-1135
LTD: 800-368-1135
Voluntary Accident, Critical Illness and Hospital Indemnity: 888-397-4783

VISION INSURANCE
EyeMed
www.EyeMed.com
866-939-3633

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

EAP
The Standard
www.HealthAdvocate.com
1-888-293-6948

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 three medical plan options: two HDHP plans and a PPO Plan.

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

While each plan gives you the option of using out-of-network providers, you can save money by using in-network providers because UMR 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 UMR's usual, customary and reasonable (UCR) charge, plus your out-of-network deductible and coinsurance.

Both HDHP plans offer you significantly lower premiums than the PPO plan, and, if eligible, 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, unlike a Flexible Spending Account (FSA), 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 PLANS
OFFER SEVERAL BENEFITS:

- You have more control over your health saving dollars.
- The HDHP High Plan offers Higher Deductibles in exchange for the lowest monthly premiums.
- The HDHP Low Plan offers a lower deductible and out of pocket maximum.

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?
Yes, everyone will be receiving a new UMR medical ID card for 1/1/26.

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 your first day of employment for regular full-time employees.

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.

Benefits Key Terms Explained

HDHP vs. PPO

HDHP with HSA

Medical Insurance

UMR	Option 1: HDHP High Plan Employee Cost per month	Option 2: HDHP Low Plan Employee Cost per month	Option 3: PPO Plan Employee Cost per month
Employee	$30	$96	$145
Employee + Spouse	$432	$481	$579
Employee + Child(ren)	$220	$245	$319
Employee + Family	$605	$674	$724
	IN NETWORK	IN NETWORK	IN NETWORK
DEDUCTIBLE (1) Type Individual / Family	Embedded $3,500 / $7,000	Aggregate $2,000 / $4,000	Embedded $3,500 / $7,000
COINSURANCE (Member Pays)	0%	0%	20%
OUT-OF-POCKET MAXIMUM(2) Individual / Family	$3,500 / $7,000	$3,000 / $6,000	$7,000 / $14,000
OFFICE VISITS Preventive Care Primary Care / Specialist Diagnostic Lab / X-Ray Urgent Care	 Covered at 100% Deductible then 0% Deductible then 0% Deductible then 0%	 Covered at 100% Deductible then 0% Deductible then 0% Deductible then 0%	 Covered at 100% $40 / $80 Copay Deductible then 20% $60 Copay
HOSPITAL VISITS Inpatient Care (Facility / Physician) Outpatient Surgery Major Diagnostics & Imaging Emergency Room	 Deductible then 0% Deductible then 0% Deductible then 0% Deductible then 0%	 Deductible then 0% Deductible then 0% Deductible then 0% Deductible then 0%	 Deductible then 20% Deductible then 20% Deductible then 20% $300 Copay
PRESCRIPTION DRUG Deductible Retail Tier 1 / 2 / 3 / 4 Copay Mail Order (90-day supply)	 Deductible then 0%	 Applies, then: $20 / $45 / $80 / $200 2 ½ times retail copay	 Does Not Apply $20 / $45 / $80 / $200 2 ½ times retail copay
	OUT-OF-NETWORK (3)	OUT-OF-NETWORK (3)	OUT-OF-NETWORK (3)
DEDUCTIBLE Individual / Family	$4,000 / $8,000	$4,000 / $8,000	$6,000 / $12,000
COINSURANCE (Member Pays)	20%	20%	40%
OUT-OF-POCKET MAXIMUM Individual / Family	$8,000 / $16,000	$8,000 / $16,000	$12,000 / $24,000

(1) HDHP Low Plan: Family Deductible is non-embedded. HDHP High and PPO: Family Deductible is embedded. 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 UMR's Summary Plan Description (SPD). This is a brief summary only. For exact terms and conditions, please refer to your SPD.

UMR Website and Teladoc

UMR WEBSITE

UMR ONLINE TOOLS

The UMR website is where you can access your health benefits in two clicks. At www.umr.com, there are no hassles and no waiting - just the answers you're looking for, anytime, night or day.

LOG IN NOW TO:

- Check your benefits and see what is covered
- Look up how much you owe and how much you've paid
- Find a doctor in your network
- Learn about medical conditions
- Access tools and resources to help you live a healthier life
- Request a new ID card
- Track Claims
- Utilize the health cost estimator
- Choose health center to find helpful apps, calculators, videos and health information in one place

NEW MEMBER REGISTRATION / LOGIN PROCESS!

Go to www.umr.com to login or register. **Click the Sign In** button in the upper–right corner. Make sure you have your ID card handy and follow the steps to get started.

Throughout the process, you will see "Learn more" and "Sign in help" to assist with any additional questions.

HERE'S HOW:

1. Select Log in / Register with HealthSafe ID
2. Follow the prompts to log in or register with HealthSafe ID

UMR MOBILE APP

Download the **UMR App** in the Apple store or Google Play store for your mobile device to find care, review plan information, access your health plan ID card, pay claims, and more.

Download on the App Store

GET IT ON Google Play

TELADOC™

Teladoc gives you to a U.S. board-certified doctor through the convenience of phone, video or mobile app visits. It is an affordable option for quality medical care.

TALK TO A DOCTOR ANYTIME

24 hours, 7 days a week

Teladoc.com or 1.800.Teladoc

HDHP : Covered at 100%

PPO : $0 copay

- Talk to a Dr. anytime, anywhere you happen to be
- Receive quality care via phone, video or mobile app
- Prompt treatment, median call back, in 10 minutes
- A network of doctors that can treat every member of the family
- Prescriptions sent to pharmacy of choice if medically necessary
- Teladoc is less expensive than the ER or urgent care

OPTUMRx Prescription Drug Program

PRESCRIPTION DRUG PROGRAM

Columbia College's prescription drug program is offered through OptumRx. OptumRx is one of the leading Pharmacy Benefit Management (PBM) companies in the country. The College's prescription drug program is part of the self-insurance plan, therefore whenever possible you should consider using a generic drug to help with your part in keeping the College's costs down.

Take advantage of all OptumRx has to offer!

- **Retail 90 Rx Program** — Specific retail pharmacies that are able to fill medication and other 90-day prescriptions. For a list of participating pharmacies go to www.UMR.com.

- **OptumRx Home Delivery**— OptumRx Home Delivery is a safe and reliable way to receive your prescriptions. You may pay less for your medication with a three-month supply through OptumRx. You will receive free standard shipping on medications delivered to your mailbox. You will have access to speak to a pharmacist who can answer your questions any time, any day.

MOBILE APP
Use your smartphone to access the mobile website through www.UMR.com. The mobile website lets you manage your prescription benefits from your smartphone. You can order refills, check your order status, set up medication reminders and more — anytime, anywhere. It's perfect for people on the go!

Here's How:
1. Ask your doctor to send an electronic prescription to OptumRx.
2. Visit optumrx.com and select "Get Started" or use the OptumRx app. From there, you can fill new prescriptions, transfer to home delivery and more.
3. Call the toll-free number on your member ID card to speak to a customer service advocate.
4. Once OptumRx receives your complete order for a new prescription, your medication should arrive within 10 business days. Completed refill orders should arrive in approximately seven days.

Optum Portal

As a UMR member, you can access your prescription information from the UMR website. Follow these steps to register:

1. Visit www.UMR.com.
2. In the left margin menu, select Members.
3. Login by entering your username and password in the top right login section. If you have not yet registered for a member account, select New user? Register here shown underneath username field.
4. Once successfully registered and/or logged in, select Pharmacy from the menu on the left. The website will redirect you to your online services home page.

Once on the pharmacy home page, click on OptumRx or the "Visit the Pharmacy" button to enter www.optumrx.com and begin to take advantage of the many tools and features that will help you manage your pharmacy benefit. On your first visit, you will also need to register at www.optumrx.com — just follow the simple instructions.

On-Site Tools

- Order Status— Check the status or your mail service orders
- Drug Pricing and Alternatives—Search prices for medications and find their lower-cost alternatives
- Your Benefits—See how much you've spent on medications, view your claims history and more
- Drug information—Find detailed information about thousands of prescription drugs
- Formulary (provider drug list) - Learn which medications are covered by your benefit plan
- Locate a Pharmacy—Enter your zip code and select go to find a retail pharmacy near you
- My Medicine Cabinet—This tab displays all of your medications, both mail service and retail, with pictures of your medications, refill statuses, medication reminders and past medications.

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 www.UMR.com.

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.

UMR partners with 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.

Finding Providers / Check Cost and Quality

LOOKING FOR A HEALTHCARE PROVIDER?

Simply use the online tool to find care!
Follow these easy steps!

1) Visit www.UMR.com
2) Select “Find a Provider”.
3) Choose to sign in as a member to enhance your search or search as a guest.
4) Select “Medical” under the “Search By” option.
5) Search for and select the UHC Choice Plus Network in the medical network search bar.
6) Select “Change your location” and enter your address or zip code. Click “Update Location”.
7) Use the search bar to search for a provider or service to find the care you need in the area you need it in.

Start shopping today!

Sign into www.umr.com and select the Find costs and care drop-down menu.

Then select Find a provider to search for medical or mental health providers!

Use UMR’s Care Finder Tool to Find the Care You Need!

Visit UMR.com to compare UnitedHealthcare network providers and get cost estimates for services—all in one convenient place.

Using the searchable directory helps you stay in-network, which means your benefits pay at the highest level and you save on out-of-pocket costs.

Check Cost and Quality

When searching for a doctor, look for two blue hearts beside their name—this indicates they are a UnitedHealthcare Premium Care Provider who meets high standards for quality and cost-effective care. You’ll also find star ratings reflecting patient satisfaction.

The provider search tool shows average costs for services in your area and highlights which providers are below, above, or at the local average cost.

For multi-step procedures, you can review total and step-by-step costs, including your estimated out-of-pocket expenses based on your plan’s deductible, copay, coinsurance, and payments to date—helping you know what to expect before your visit.

UMR Health Tools

2nd MD

Facing a new diagnosis or managing a chronic condition? Looking at possible surgery? A change in your medication? 2nd.MD provides a second opinion from doctors, who can help with advice before major health events or decisions. Within days, you and your family will be connected with a doctor by video or phone for a second opinion.

2nd MD's goal is to reduce healthcare waste through alternative diagnosis, improved treatment plans and expert- led pathways. Learn more by clicking here.

Call 1-866-269-3534 to get started.

NURSELINE

Call UMR's toll–free NurseLine to be connected to a team of registered nurses who can answer your questions and provide advice. The NurseLine is available anytime of day, seven days a week. Reach out by phone by dialing **877-950-5083** or live chat online at www.umr.com within the online health Center. Just look for the link that states "*I need to*…" within the health center.

DISEASE MANAGEMENT

UMR offers expert resources and one-on-one support to help those with chronic conditions gain control of their health. Even though participation is voluntary it is highly encouraged as all the resources are available to you at no cost. The program is open to medical plan members with one or more of the following conditions:

- Asthma or COPD
- Depression or anxiety
- Diabetes (types 1 or 2)
- Hypertension, heart failure or coronary artery disease
- HIV/AIDS, hepatitis C or sickle cell anemia
- Ulcerative colitis or Crohn's disease
- Asthma or COPD
- Chronic kidney disease
- ALS, multiple sclerosis, myasthenia gravis or rheumatoid arthritis
- Breast, prostate, colorectal or lung cancers

MATERNITY MANAGEMENT

If you are thinking about having a baby or are already expecting, UMR and your employer invite you to sign up for the Maternity management service. Enrolling in this program can help you learn how healthy lifestyle choice and proper medical care before and during your pregnancy can boost your odds of having a healthy, full–term baby. As a part of this free program, you may receive a $25 reward card for signing up in the first or second trimester. Visit the Health Center on www.umr.com, download the CARE app, or call UMR nurses at **888-438-8105** and start your enrollment today!

Real Appeal

Now's a great time to start taking small steps for lasting change, with Real Appeal®. This online weight management program is designed to help you create a healthier lifestyle that you can maintain with confidence. Click here for more information!

More support for more confidence

Real Appeal supports you every step of the way. It's available to you at no additional cost as part of your benefits.

- Supportive coaching and sessions
- Making behavior change possible
- Resources to stay motivated

Get started now at enroll.realappeal.com. Have your health insurance ID card when enrolling.

Kaia Health

Kaia Health offers a high-tech, low-cost in-home solution for musculoskeletal (MSK) pain management. The Kaia app helps employees address pain by providing virtual exercise therapy, motion analysis-guided physical exercises, one-on-one health coaching, tailored workouts, and bite-sized educational lessons. Its AI technology and real coaches ensure users perform exercises correctly, and the app adapts workouts daily to target specific pain areas. Kaia's holistic approach includes mental health support like breathing and relaxation techniques. Click here to learn more!

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 $4,400 SINGLE, OR $8,750 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 2026 are $4,400 for Single and $8,750 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.

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.UMR.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 $680 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 2025 claims, you have until March 31, 2026.

2026 MAXIMUM CONTRIBUTIONS

Health Care Flexible Spending account	$3,400 max
Dependent Care Expense account	$7,500 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

DELTA DENTAL OF MISSOURI IS THE DENTAL CARRIER FOR 2026

This dental plan allows employees and their eligible covered dependents to see any dentist they choose. To take advantage of the highest plan coverage and lowest out-of-pocket expenses, utilize a Delta Dental PPO network dentist as services from a Delta Dental PPO network dentist will be less expensive than services from an out-of- network dentist or a Delta Premier Network dentist.

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

Access your benefits 24/7 through your Delta Dental member portal

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

Delta Dental of Missouri	Employee Cost Per Month
Employee	$12.00
Employee + Spouse	$43.00
Employee + Child(ren)	$55.00
Employee + Family	$85.00

	Delta PPO and Delta Premier 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 (one set per benefit period) • Full Mouth X-Rays (once in a 60 month period) • Cleanings (twice in any benefit period) • Oral Exams (twice in any benefit period) • Sealants (for dependent children under age 16, once in 3 years)
Basic Services	80%	80%	• Fillings • Endodontics • Periodontics • Simple Extractions and Surgical Extractions • Stainless Steel Crowns (once in 24 months)
Major Services	50%	50%	• General Anesthesia • Bridges (once in 5 years) • Dentures (once every 5 years) • Implants (once every 5 years)
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.		

How to find Information about your Delta Dental plan!

To information about your dental plan, including **finding a provider**, **viewing your benefits**, **verifying eligibility** or **ordering/printing an ID card**, visit the website download the Delta Dental Mobile App or call Customer Service!

- Delta Dental Website: **www.DeltaDentalMo.com**
- Customer Service: 1-800-335-8266
- Mobile App: Download on the App Store GET IT ON Google Play

REVIEW YOUR VISION PLAN

EyeMed IS THE VISION CARRIER FOR 2026

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 EyeMed Insight Network, in order to achieve the greatest cost savings. You may be eligible for additional savings if you utilize a designated In-Network Plus Provider. 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.EyeMed.com.

VISION INSURANCE PLAN OPTIONS AND COSTS

EyeMed	Employee Cost Per Month
Employee	$8.91
Employee + Spouse	$15.01
Employee + Child(ren)	$15.29
Employee + Family	$24.20

	Plus Provider (In-Network)	Standard Provider (In-Network)	Out-of-Network
Examination Copay	$0 copay	$20 copay	**Reimbursement** Up to $40
Frequency of Service			
Exam	Every Calendar Year	Every Calendar Year	Every Calendar Year
Lenses	Every Calendar Year	Every Calendar Year	Every Calendar Year
Frames	Every Calendar Year	Every Calendar Year	Every Calendar Year
Lenses			**Reimbursement**
Single	$0 copay; 100% covered	$0 copay; 100% covered	Up to $30
Bifocal	$0 copay; 100% covered	$0 copay; 100% covered	Up to $50
Trifocal/Lenticular	$0 copay; 100% covered	$0 copay; 100% covered	Up to $70
Standard Progressive	$0 copay; 100% covered	$0 copay; 100% covered	Up to $50
Frames	$0 copay; 20% off balance over $200 allowance	$0 copay; 20% off balance over $150 allowance	**Reimbursement** Up to $75
Conventional Contacts	$0 copay; 15% off balance over $200 allowance	$0 copay; 15% off balance over $150 allowance	**Reimbursement** Up to $75
Medically Necessary Contacts	$0	$0	**Reimbursement** Up to $300

FIND A VISION PROVIDER

To find an EyeMed Insight Network Provider in your area or to check if your current provider is a Plus Provider, visit the website at Find a Vision Provider.

- Select “Insight Network”
- Fill the location field and search by zip or location
- ***PLUS Providers** are highlighted on the directory*

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 The Standard at no cost to you.

VOLUNTARY LIFE AND AD&D AND DEPENDENT LIFE

You can purchase additional Life and AD&D Coverage beyond what Columbia College provides. The Standard 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 (age reductions do apply starting at age 65).
- 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 The Standard before you're able to get coverage in the future.

Evidence of Insurability Form

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

One Time Enrollment Offering for 1/1/26: This plan includes the option for currently eligible and enrolled employees to increase their benefit elections up to the guarantee issue amount of $150,000 during the annual election period for a January 1st effective date. The annual increase feature also applies to spouse coverage. Enrollees may make either of these increases without providing evidence of insurability.

Future Open Enrollment Opportunities for Currently Eligible and Enrolled Employees: During the Annual Enrollment Period, all members, enrolled or eligible, may increase their benefit amount up to $50,000, not to exceed the guarantee issue amount, without providing evidence of insurability. Evidence of insurability is required for those whose evidence of insurability was not approved by The Standard during any prior period of eligibility.

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

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

VOL LIFE/AD&D THE STANDARD	Rates per $1,000 of coverage		
	Age	*Employee*	*Spouse*
Voluntary Life and AD&D Rates Combined (Spouse Premium is based on Spouse'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	$1.53	$1.53
	75+	$1.53	$1.53
	Child(ren)	$0.23/**$1,000 of coverage**	

Life & AD&D from the Standard

REVIEW YOUR DISABILITY INSURANCE

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

VOLUNTARY SHORT-TERM DISABILITY INSURANCE

Short-Term Disability insurance is offered through The Standard. 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 subject to a 60-day benefit waiting period for sickness or pregnancy during the first 12 months of the plan.*

SHORT-TERM DISABILITY INSURANCE

VOLUNTARY STD — Rates per $10 of weekly benefit per month	
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

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*

LONG-TERM DISABILITY

Long Term Disability insurance is offered through The Standard. 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 The Standard 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) Your occupation, for the first 3 year(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.*

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.**

Short Term Disability from The Standard

Voluntary Coverages

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 The Standard 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.

Critical Illness Insurance from The Standard

FEATURES:

- 100% employee paid
- **Employee Coverage: Purchased in increments of $5,000 to $25,000.**
- **Spouse Coverage: Purchased in increments of $2,500 to $12,500 (cannot be more than 50% of employee benefit).**
- **Children Coverage: 25% of the Employee Amount (no additional cost to add)**
- **Guarantee Issue Limits:** All benefit amounts.
- 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).
- Please review The Standard's 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:

* **Cancer**
* **End-Stage Renal Failure**
* **Major Organ Failure**
* **Heart Attack**
* **Stroke**
* **Coma**
* **Paralysis**
* **Advanced Alzheimer's Disease**
* **Advanced Multiple Sclerosis**
* **Advanced Parkinson's Disease**

See The Standard Enrollment Kit for rates

Please note: *The diagnosis of a covered critical illness must occur while the insured is covered under the group policy and after the effective date of coverage.*

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. The Standard Critical Illness coverage pays you a First Occurrence 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.

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. The Standard pays your benefit

THE STANDARD 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	$9.51
Employee Plus Spouse	$17.70
Employee Plus Children	$24.45
Family	$37.10

Accident Insurance from The Standard

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. The Standard 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 The Standard helps provide financial peace of mind.

The Standard HOSPITAL INDEMNITY INSURANCE COVERS THINGS LIKE THE FOLLOWING:

- **Hospital/ICU Admission:** $1,000 per year, limited to 2 admissions per benefit year.
- **Hospital/ICU Confinement:** $200 per day up to 30 days
- **Pre-existing Limitation:** None
- **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	$18.53
Employee Plus Spouse	$31.57
Employee Plus Children	$26.49
Family	$46.95

Hospital Indemnity from The Standard

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 – THE STANDARD

Connection to Resources, Support and Guidance You, your dependents (including children to age 26) and all household members can contact the program's master's level counselors 24/7. Reach out through the mobile EAP app, by phone, online, live chat and email. You can get referrals to support groups, a network counselor, community resources or your health plan. If necessary, you'll be connected to emergency services.

EAP services can help with:

- Depression, grief, loss, and emotional well-being
- Family, marital and other relationship issues
- Life improvement and goal-setting
- Addictions such as alcohol and drug abuse
- Stress or anxiety with work or family
- Financial and legal concerns
- Identity theft and fraud resolution
- Online will preparation and other legal documents

Phone: 1-888-293-6948 to speak with someone 24/7

Online: healthadvocate.com/standard3

ONLINE RESOURCES

- **Communications Center** – View a range of fliers, videos or other content.
- **Assessments** – Get insights into your risk levels and actionable steps to take.
- **Calculators** – Interactive, self-help financial tools to help you assess possible outcomes.
- **Legal Forms** – Common personal legal forms for everything from will making to rental agreements.
- **Locators** – Find Child Care, Adult Care, and other services.
- **Recipes** – Library of dietician-reviewed recipes that are healthy and delicious!
- **Trainings**– Personal and professional development training courses.
- **Webinars** – On-demand, expert-led talks.

SHORT-TERM COUNSELING

Members and household dependents can receive up to 3 counseling sessions per issue. Sessions can be done in person, on the phone or through video.

LIFE & WORK TOPICS

- **College Life** – Campus Life / Career Preparation/ College Preparation / Financial Aid
- **Relationships** – Caregiver and Elder Care Support / Disability Support / Family Life / Interpersonal Relationships
- **Emotional Health** – Anger Management / Anxiety Disorders / Attention-Deficit/Hyperactivity Disorder / Autism Spectrum Disorders
- **Financial** – Auto Center / Banking and Loands / Budgeting / Business Bankruptcy
- **Legal** – Advance Directives / Business Law / Consumer Protection / Criminal Law
- **Parenting** – Adoption / Babies and New Parent / Bullying / Child Care
- **Physical Health** – Allergies / Alternative Medicine / Autoimmune Diseases / Brain Health
- **Workplace** – Career Resources / Communication / Conflict Management / Diversity, Equity and Inclusion

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, 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 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 6% 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 leave 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.

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.

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.

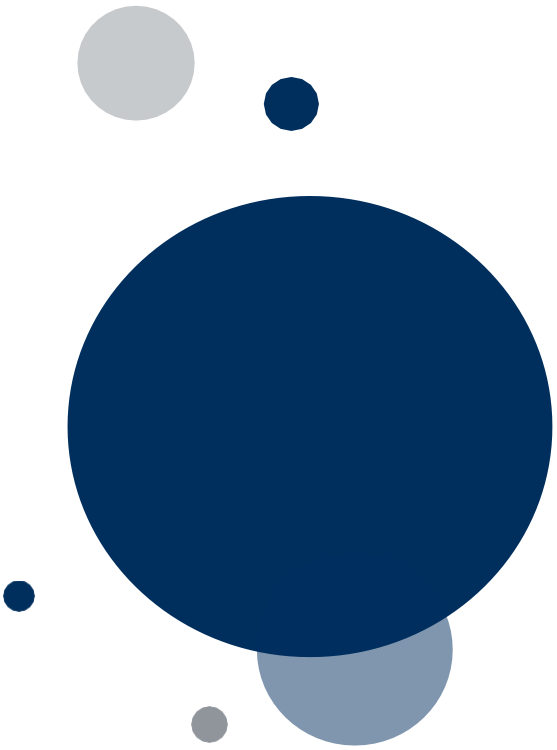
Lifetime Benefit Maximum—All plans are required to have an unlimited lifetime maximum.

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.

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 Columbia College Group Health Plan 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:	October 2, 2025
Name of Entity/Sender:	Columbia College
Contact--Position/Office:	Human Resources
Address:	1001 Rogers Street, Columbia, MO 65216
Phone Number:	573-875-7495

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.

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

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

GEORGIA – Medicaid	INDIANA – Medicaid
GA HIPP Website: https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp Phone: 678-564-1162, Press 1 GA CHIPRA Website: https://medicaid.georgia.gov/programs/third-party-liability/childrens-health-insurance-program-reauthorization-act-2009-chipra Phone: 678-564-1162, Press 2	Health Insurance Premium Payment Program All other Medicaid Website: https://www.in.gov/medicaid/ http://www.in.gov/fssa/dfr/ Family and Social Services Administration Phone: 1-800-403-0864 Member Services Phone: 1-800-457-4584
IOWA – Medicaid and CHIP (Hawki)	**KANSAS – Medicaid**
Medicaid Website: Iowa Medicaid | Health & Human Services Medicaid Phone: 1-800-338-8366 Hawki Website: Hawki - Healthy and Well Kids in Iowa | Health & Human Services Hawki Phone: 1-800-257-8563 HIPP Website: Health Insurance Premium Payment (HIPP) | Health & Human Services (iowa.gov) HIPP Phone: 1-888-346-9562	Website: https://www.kancare.ks.gov/ Phone: 1-800-792-4884 HIPP Phone: 1-800-967-4660
KENTUCKY – Medicaid	**LOUISIANA – Medicaid**
Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP) Website: https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx Phone: 1-855-459-6328 Email: KIHIPP.PROGRAM@ky.gov KCHIP Website: https://kynect.ky.gov Phone: 1-877-524-4718 Kentucky Medicaid Website: https://chfs.ky.gov/agencies/dms	Website: www.medicaid.la.gov or www.ldh.la.gov/lahipp Phone: 1-888-342-6207 (Medicaid hotline) or 1-855-618-5488 (LaHIPP)
MAINE – Medicaid	**MASSACHUSETTS – Medicaid and CHIP**
Enrollment Website: https://www.mymaineconnection.gov/benefits/s/?language=en_US Phone: 1-800-442-6003 TTY: Maine relay 711 Private Health Insurance Premium Webpage: https://www.maine.gov/dhhs/ofi/applications-forms Phone: 1-800-977-6740 TTY: Maine relay 711	Website: https://www.mass.gov/masshealth/pa Phone: 1-800-862-4840 TTY: 711 Email: masspremassistance@accenture.com
MINNESOTA – Medicaid	**MISSOURI – Medicaid**
Website: https://mn.gov/dhs/health-care-coverage/ Phone: 1-800-657-3672	Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005

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

TEXAS – Medicaid	UTAH – Medicaid and CHIP
Website: Health Insurance Premium Payment (HIPP) Program | Texas Health and Human Services Phone: 1-800-440-0493	Utah's Premium Partnership for Health Insurance (UPP) Website: https://medicaid.utah.gov/upp/ Email: upp@utah.gov Phone: 1-888-222-2542 Adult Expansion Website: https://medicaid.utah.gov/expansion/ Utah Medicaid Buyout Program Website: https://medicaid.utah.gov/buyout-program/ CHIP Website: https://chip.utah.gov/
VERMONT– Medicaid	**VIRGINIA – Medicaid and CHIP**
Website: Health Insurance Premium Payment (HIPP) Program | Department of Vermont Health Access Phone: 1-800-250-8427	Website: https://coverva.dmas.virginia.gov/learn/premium-assistance/famis-select https://coverva.dmas.virginia.gov/learn/premium-assistance/health-insurance-premium-payment-hipp-programs Medicaid/CHIP Phone: 1-800-432-5924
WASHINGTON – Medicaid	**WEST VIRGINIA – Medicaid and CHIP**
Website: https://www.hca.wa.gov/ Phone: 1-800-562-3022	Website: https://dhhr.wv.gov/bms/ http://mywvhipp.com/ Medicaid Phone: 304-558-1700 CHIP Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)
WISCONSIN – Medicaid and CHIP	**WYOMING – Medicaid**
Website: https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm Phone: 1-800-362-3002	Website: https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/ Phone: 1-800-251-1269

To see if any other states have added a premium assistance program since July 31, 2025, or for more information on special enrollment rights, contact either:

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

U.S. Department of Health and Human Services
Centers for Medicare & Medicaid Services
www.cms.hhs.gov
1-877-267-2323, Menu Option 4, Ext. 61565

Paperwork Reduction Act Statement

According to the Paperwork Reduction Act of 1995 (Pub. L. 104-13) (PRA), no persons are required to respond to a collection of information unless such collection displays a valid Office of Management and Budget (OMB) control number. The Department notes that a Federal agency cannot conduct or sponsor a collection of information unless it is approved by OMB under the PRA, and displays a currently valid OMB control number, and the public is not required to respond to a collection of information unless it displays a currently valid OMB control number. See 44 U.S.C. 3507. Also, notwithstanding any other provisions of law, no person shall be subject to penalty for failing to comply with a collection of information if the collection of information does not display a currently valid OMB control number. See 44 U.S.C. 3512.

The public reporting burden for this collection of information is estimated to average approximately seven minutes per respondent. Interested parties are encouraged to send comments regarding the burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to the U.S. Department of Labor, Employee Benefits Security Administration, Office of Policy and Research, Attention: PRA Clearance Officer, 200 Constitution Avenue, N.W., Room N-5718, Washington, DC 20210 or email ebsa.opr@dol.gov and reference the OMB Control Number 1210-0137.

OMB Control Number 1210-0137 (expires 1/31/2026)

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.

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.

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.