This publication contains important information about your employee benefit program. Please read thoroughly.
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## WELCOME TO COLUMBIA COLLEGE!

Columbia College is committed to enhancing the health and well-being of our valued employees. We view benefits as an important part of your overall compensation package, and we strive to offer our employees comprehensive and affordable benefits. Our benefits program is designed to enhance your financial security by offering you plans that provide health care and wellness benefits, disability and survivor protection, as well as savings avenues. As a full-time employee, you have the opportunity to enroll in the benefits offered by Columbia College.

This benefits guide will help familiarize you with the benefits program. We encourage you to review it and share with your family. Doing so will enable you to choose the benefit plans and options which best meet your particular needs.
ENROLLMENT DETAILS

Newly hired employees have 30 days from your date of hire to enroll. If you do not enroll in benefits during your new-hire period, you will not be eligible to enroll in benefits until annual enrollment, unless you experience a qualifying life event.

MAKING CHANGES (QUALIFYING LIFE EVENTS)
A qualifying life event is a change in your personal life or employment which may impact your eligibility or dependent’s eligibility for benefits. The following special circumstances are some reasons you may change your benefits during the year. For a full list of qualifying life events, please contact Human Resources.

- Marriage
- Divorce or legal separation
- Birth, adoption, or placement of a child for adoption
- Termination or commencement of your spouse’s coverage in general when coverage is maintained through the spouse’s plan
- Shift from part-time to full-time status (or vice versa) by you or your spouse
- Death of a spouse or dependent
- When a dependent satisfies or ceases to satisfy eligibility requirements
- Taking an unpaid leave of absence (you or your spouse)
- A change in residence that causes loss of eligibility

These life event changes will allow you to make plan changes at the time during the year in which the life event occurs. If such a change occurs, you must notify human resources and make a change to your benefits within 31 days of the life event change. If you do not request a change in status (alongside requested documentation) you may need to wait until the next annual enrollment opportunity to make your change.

Changes which are requested due to a “change of mind” cannot be allowed until the next benefits enrollment period.
MEDICAL

The HDHP option is a type of plan that actually consists of two parts—a High-Deductible Health Plan (HDHP) that is paired with a Health Savings Account (HSA)*. HSAs have been around for over a decade, so you have probably read about them, or perhaps you know someone who has been covered by one. A majority of employers offer HSAs now and their popularity has skyrocketed over the past few years. We believe an HSA can provide the flexibility you want in providers and protection against big medical bills, plus a unique way to save for your medical expenses now and in the future.

<table>
<thead>
<tr>
<th>HDHP-Premiums</th>
<th>You Pay</th>
<th>Monthly Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Employee Only</td>
<td>$27.64</td>
<td>$587.40</td>
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<tr>
<td>Employee + Spouse</td>
<td>$254.42</td>
<td>$1,143.91</td>
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<tr>
<td>Employee + Child(ren)</td>
<td>$85.54</td>
<td>$857.91</td>
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<tr>
<td>Family</td>
<td>$399.17</td>
<td>$1,412.71</td>
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</table>

High Deductible Health Plan – HDHP

<table>
<thead>
<tr>
<th>Medical Benefits</th>
<th>Network</th>
<th>Non-Network</th>
</tr>
</thead>
<tbody>
<tr>
<td>Individual Deductible</td>
<td>$2,000</td>
<td>$4,000</td>
</tr>
<tr>
<td>Family Deductible</td>
<td>$4,000</td>
<td>$8,000</td>
</tr>
<tr>
<td>Coinsurance (% you pay)</td>
<td>0%</td>
<td>20%</td>
</tr>
<tr>
<td>Individual Out-of-Pocket Maximum</td>
<td>$3,000</td>
<td>$8,000</td>
</tr>
<tr>
<td>Family Out-of-Pocket Maximum</td>
<td>$6,000</td>
<td>$16,000</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Covered Services</th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Do Medical copays count towards Out-of-Pocket Maximums?</td>
<td>Not Applicable</td>
<td></td>
</tr>
<tr>
<td>Primary Care Office Visit</td>
<td>Deductible, then 100%</td>
<td>Deductible, then 100%</td>
</tr>
<tr>
<td>Specialist Office Visit</td>
<td>Deductible, then 100%</td>
<td>Deductible, then 100%</td>
</tr>
<tr>
<td>Urgent Care Services</td>
<td>Deductible, then 100%</td>
<td>Deductible, then 100%</td>
</tr>
<tr>
<td>Emergency Services</td>
<td>Deductible, then 100%</td>
<td>Deductible, then 100%</td>
</tr>
</tbody>
</table>

* NOTE: HSA’s are not subject to ERISA.
MEDICAL

An HDHP is a lot like other medical plans.

You have:

**Flexibility** to see any doctor and receive benefits if you use in-network or out-of-network doctors or hospitals—of course, you’ll receive better benefits by sticking in-network. An annual deductible you must meet before the plan covers a majority of the costs.

**Discounted rates** for services that have been negotiated with the providers—you’re not paying retail. Limits on the total amount you’ll have to spend each year—your out-of-pocket maximum.

But with an HDHP, you also get:

**Lower monthly costs.** It costs you less per month in premium. On the flip side, you’ll assume a little more responsibility for out-of-pocket costs in the form of higher office visit, prescription costs and larger deductibles.

**Help building a nest egg** for qualified health care expenses. With this plan, you can open a tax-advantaged HSA. Use it to pay for qualified health care expenses that count toward meeting your deductible. You contribute to the account with pretax payroll deductions or lump-sum deposits.

**Preventive care covered 100%**. Preventive care services such as annual check-ups, immunizations and age-appropriate screenings are covered 100%.
MEDICAL

PLAN OVERVIEWS & OPTIONS

IN-NETWORK BENEFITS

Our medical plan allows you the freedom to choose any provider you wish; however, you will typically pay less and will receive a greater benefit when you visit in-network doctors and hospitals. When you obtain services “in the network,” you cost-share with the medical plan to pay for eligible expenses; UnitedHealthcare, our plan administrator, reimburses your physician, hospital and other providers at the allowances identified in your plan summaries.

In-network treatment is encouraged whenever possible to take advantage of the deepest discounts and highest benefit levels.

OUT-OF-NETWORK BENEFITS

When you obtain services “out-of-the-network,” the plan still shares the cost for eligible services, but you as the member will be responsible for paying a greater share of the cost. Non-network providers are only reimbursed up to the applicable allowance. Also note a higher annual deductible and higher coinsurance payment applies to all eligible medical and most supplemental services out-of-network.

NOTE

Deductions for medical premiums are taken on a pre-tax basis.
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; the individual deductible does not apply in this situation.

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.
PREVENTIVE CARE SERVICES

REGULAR WELL CHECKS CAN HELP YOU GET AND STAY HEALTHY
You want to understand how your body changes as you get older. That’s what preventive exams do for you. They give you and your doctor a snapshot of your health. And they give you a chance to talk to your doctor and see if you need to make any changes. They also keep your doctor updated about your health. That way you can get better care if problems come up later.

WHAT TO EXPECT
Most preventive exams start with a talk about your health history and any problems. After that, most doctors will talk to you about things like:

- Medicines you take
- How you eat—and how you can eat better
- How active you are—and whether you should be more active
- Stress in your life or signs of depression
- Drinking, smoking and drug use
- Safety measures like wearing your seat belt and using sunscreen
- Your sexual habits and any risks they pose
- Tests and vaccines you may need

WHAT’S THE DIFFERENCE BETWEEN PREVENTIVE CARE AND DIAGNOSTIC CARE?

Some tests can help you stay healthy, catch problems early on and even save your life. These are called preventive care because that can help prevent some health problems. They’re different from diagnostic tests, which help diagnose a health problem. Diagnostic tests are for when someone has symptoms of a health problem and the doctor wants to find out why.

It’s important to know the difference. For example, your doctor might want you to get a colonoscopy (a test that checks your colon). If it’s because of your age or because your family has a history of colon problems, that’s called preventive care. But if it’s because you’re having pain or other symptoms of a problem, that’s diagnostic care.

For more information on preventive care, visit UHC’s preventive care website to identify your age and gender specific preventive care guidelines, based on recommendations of the U.S. Preventive Services Task Force and other health organizations. Use the recommendations provided on the website to talk with your doctor about the preventive health screenings that are right for you.
PHARMACY

Prescription benefits are included within the HDHP. Once you are enrolled in a HDHP, you will first need to satisfy your deductible before a copay can be applied. However, the deductible is waived if you are taking an approved maintenance medication.

Mail Order Program—“3 months for 2.5” Copays

HDHP participants can use the mail order program to obtain valuable savings when ordering up to 90-day supplies of maintenance medications. Under this program, you pay an amount equal to two and a half times the retail copay for a 90-day supply of your prescription.

Not all drugs will qualify for the mail order drug program.

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<th>HDHP-Option Prescription Drug Benefits</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
</tr>
<tr>
<td><strong>Retail</strong></td>
</tr>
<tr>
<td>(up to 31-day supply)</td>
</tr>
<tr>
<td>Deductible: Same as Medical</td>
</tr>
<tr>
<td>Tier 1 - Generic: after deductible - $10</td>
</tr>
<tr>
<td>Tier 2 - Preferred Brand: after deductible - $30</td>
</tr>
<tr>
<td>Tier 3 - Non-Preferred Brand: after deductible - $50</td>
</tr>
<tr>
<td>Specialty drugs: $50</td>
</tr>
<tr>
<td>Do prescription copays count towards Out-of-Pocket Max?: Yes</td>
</tr>
<tr>
<td><strong>Mail</strong></td>
</tr>
<tr>
<td>(90- day supply)</td>
</tr>
<tr>
<td>Deductible: Same as Medical</td>
</tr>
<tr>
<td>Tier 1 - Generic: after deductible - $25</td>
</tr>
<tr>
<td>Tier 2 - Preferred Brand: after deductible - $75</td>
</tr>
<tr>
<td>Tier 3 - Non-Preferred Brand: after deductible - $125</td>
</tr>
<tr>
<td>Specialty drugs: N/A</td>
</tr>
</tbody>
</table>
TO BE ELIGIBLE FOR AN HSA, THE FOLLOWING MUST BE TRUE.

1. You must have coverage under a Columbia College qualified HDHP.
2. You cannot have coverage under a non-qualified plan, including traditional, non-HDHP family coverage through your spouse or a traditional health flexible spending account (either through Columbia College or through your spouse’s employer). For example, you cannot open and contribute money to an HSA if you are contributing money to the traditional health flexible spending account (FSA).
3. You cannot be claimed as a dependent on another person’s tax return
4. If you are enrolled in Medicare or Tricare.
5. You cannot have received VA Medical benefits within the last three months.

Health savings accounts (HSAs) are tax advantaged bank accounts. If you enroll in a Columbia College HDHP medical plan, you may be eligible to open an HSA. The contributions you make to the HSA are not subject to federal income, social security, Medicare, and most state income tax. The earnings on the account are tax free. In addition, withdrawals can be made from HSAs on a tax-free basis as long as they are used for qualified health expenses. If you enroll in the HSA plan and meet all eligibility requirements set by the IRS, you may contribute to an HSA account.

Note: employees who sign up for the HDHP must take action and open up a health savings account.

CONTRIBUTING TO YOUR HSA

When you enroll in a HDHP and you open a HSA, you can make pre-tax contributions to your HSA through payroll deductions. It’s your choice to contribute or not. The IRS limits the amount of pre-tax dollars you can contribute to your HSA each year. For 2021, you can contribute up to $3,600 for single coverage and $7,200 for family coverage. If you enroll mid-year, you still can contribute the total allowable amount for that year; however, to take advantage of the tax savings, you must:

- Stay enrolled in a qualifying high-deductible health plan for the following 12 months.
- Not have other health care coverage that would make you ineligible to contribute to an HSA.

How much can I contribute?

As noted by federal law, the annual contributions limits are:

<table>
<thead>
<tr>
<th>Type of Coverage</th>
<th>2021 Employee Voluntary Maximum Annual Contribution</th>
<th>2021 Maximum Annual Contribution*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Employee Only(EE)</td>
<td>$3,600</td>
<td>$3,600</td>
</tr>
<tr>
<td>EE + Spouse</td>
<td>$7,200</td>
<td>$7,200</td>
</tr>
<tr>
<td>EE + Child(ren)</td>
<td>$7,200</td>
<td>$7,200</td>
</tr>
<tr>
<td>Family</td>
<td>$7,200</td>
<td>$7,200</td>
</tr>
</tbody>
</table>

*Individuals aged 55 or older may be eligible to make a catch-up contribution of $1,000 in 2021.
HEALTH SAVINGS ACCOUNT

HOW PAYING FOR NETWORK CARE WORKS WITH AN HSA

1. First you put money in your HSA. Contributions cannot be made until the bank account is established.

2. Money invested from your account has the ability to grow tax-free; the money rolls from plan year to plan year (at most banks, a certain level of funding in the account must be reached to be eligible for investing).

3. You can use your HSA to pay your deductible, coinsurance, or prescription drug copays.*

*Qualified health expenses which may be reimbursed from an HSA on a tax-free basis are listed in IRS publication 502 and include out-of-pocket medical, dental, and vision expenses for you and your dependents.

Some Miscellaneous rules: *For specifics, please refer to IRS Publication 969 Health Savings Accounts and Other Tax-Favored Health Plans.*

- **Catch-up contributions** are allowed for participants that are 55 or older ($1,000)
- **Rules for married individuals:** If each spouse has family coverage, the contribution limit for 2021 is $7,200 per household.
- **Each spouse** who is an eligible individual who wants an HSA must open a separate HSA account. You can’t have a joint HSA.
- **HSA accounts** are employee-owned bank accounts, and it is the responsibility of the employee to keep track of contribution limits.
- If you are enrolled or become enrolled in Medicare or Tricare, you cannot contribute money to an HSA and you are responsible to notify Human Resources immediately to stop contributions.
**DENTAL**

### Dental Premiums (Monthly)

<table>
<thead>
<tr>
<th></th>
<th>You Pay</th>
<th>Monthly Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Employee Only</td>
<td>$9.30</td>
<td>$30.74</td>
</tr>
<tr>
<td>Employee + Spouse</td>
<td>$34.36</td>
<td>$60.85</td>
</tr>
<tr>
<td>Employee + Child(ren)</td>
<td>$43.20</td>
<td>$71.51</td>
</tr>
<tr>
<td>Family</td>
<td>$68.24</td>
<td>$101.64</td>
</tr>
</tbody>
</table>

VISION

Columbia College offers vision coverage through Guardian. This is a Full Feature plan, offering you the nation’s largest vision network of Eye Specialists and access to retail providers (e.g. Pearle Vision, Costco, Visionworks and more). The vision plan covers routine eye exams and also pays for a portion of the cost of glasses or contact lenses. To find an in-network vision provider, please visit www.GuardianAnytime.com, and click on “Find a Vision Provider” tab in the middle of the page. Your network is identified as “VSP Network Signature Plan”.

<table>
<thead>
<tr>
<th>Vision Premiums (Monthly)</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Employee Only</td>
<td>$13.31</td>
</tr>
<tr>
<td>Employee + Spouse</td>
<td>$21.29</td>
</tr>
<tr>
<td>Employee + Child(ren)</td>
<td>$21.74</td>
</tr>
<tr>
<td>Family</td>
<td>$35.05</td>
</tr>
</tbody>
</table>
Basic group term life and accidental death and dismemberment (AD&D) insurance is provided to you at no cost through Guardian. This benefit is equal to 200% of your annual salary, up to $250,000. Your basic AD&D coverage amount equals your basic life benefit.

EVIDENCE OF INSURABILITY (EOI)

EOI is medical underwriting for supplemental life coverage. It is required if amounts over the guarantee issue are requested or if you are enrolling outside the normal enrollment periods.

Your supplemental life purchases which exceed $150,000 require EOI. No EOI is required for spouse or children if timely enrolled.

Life insurance purchase amounts requiring EOI do not become effective (and therefore premiums are not deducted from your pay) until approval is obtained from Guardian or the effective date of your benefits, whichever comes later.

If you have applied for supplemental life insurance and you do not provide a statement of good health, or if such evidence is not accepted by Guardian as satisfactory, the amount of your supplemental coverage will not be more than the amount for which you were covered immediately prior to the date on which any such increase would have become effective.
SUPPLEMENTAL LIFE INSURANCE SPECIFICS

• You must be enrolled for supplemental life benefits in order to be eligible for supplemental dependent life coverage.
• Supplemental dependent life insurance coverage may be purchased in the following amounts:
  • Spouse—$5,000 increments to a maximum benefit of $250,000; the amount cannot exceed 50% of the employee’s supplemental coverage.
  • Children
    • 14 days to 26 years
    • Election can be one of the following: $1,000; $5,000; $10,000 increments
• You must name a beneficiary—the person or persons who would receive your life insurance benefit; if you do not name a beneficiary, the benefit will be paid to your estate.

During your initial new-hire eligibility period, Guardian will allow you to elect coverage up to the guaranteed issue amounts without submitting evidence of insurability. If you want to increase your election beyond the guaranteed issue amounts, evidence of insurability will be required before Guardian will finalize and approve your election.

Guaranteed issue amounts are as follows:

• Employee guaranteed issue amount = $150,000
• Spouse guaranteed issue amount = $50,000
• Child(ren) guaranteed issue amount = $10,000
GUARDIAN WORKSITE PLANS

CRITICAL ILLNESS
Optional, supplemental benefits

- 100% employee paid
- Fills in the gaps of other benefits, like the HDHP
- Pays the policyholder cash. You spend the money, and you get to choose how.

Pays a lump sum of $5,000 to $25,000 upon diagnosis of eligible conditions
- Cancer
- Vascular (heart attack, stroke, heart failure)
- Other (organ failure, kidney failure)

Includes a health screening benefit ($50 per EE/spouse/child)

ACCIDENT INSURANCE
Covers accidents on and off the job

- Common injuries (e.g. Chipped tooth and poison ivy...etc.)

Benefits:
- Wellness benefit: $50
- Initial physician’s office or urgent care visit: $75
- Hospital Admission: $1,000
- ER visit

HOSPITAL INDEMNITY
Covers sickness and injury

- Hospital/ICU Admission pays: $1000 per admission to a maximum of 1 admission per year, per insured, with a maximum of 2 admissions per year, per covered family.
- Hospital/ICU Confinement pays: $200/$400 per day to a maximum of 30 days per year, per insured.
- These benefits are paid directly to the insured when they need it most and can be used however they choose to help pay for out-of-pocket medical expenses like co-pays and deductible or non-medical expenses such as childcare and transportation.
- Portability allow the employee to take the coverage with them even if employment has ended.
We recognize the hardship a non-work related injury or illness resulting in lost time from work can have for you and your family. In order to have protection for lost income due to an extended absence from work, you are offered Voluntary Short Term Disability in the amount of $200 to $1500.

If you meet the definition of disability as determined by Guardian, you are eligible to receive a benefit, chosen by you, per week for 13 weeks. Your STD benefits may be reduced by the amount of other income you receive for the same disability. The elimination period—the length of time of continuous disability which must be satisfied before you are eligible to receive benefits—is seven days.

**DEFINITION OF DISABILITY**

You are considered to have a disability when Guardian determines—due to your injury or illness—you are unable to perform the duties of your job and earning less than 20% of your pre-disability earnings.

**LONG TERM DISABILITY (LTD)**

You will be eligible to receive a monthly LTD benefit if you meet the definition of a disability (see below). LTD benefits begin after 90 consecutive days of disability, and are equivalent to 60% of your monthly earnings to $7,500. The maximum duration for receiving LTD benefits is to age 65 or your 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.

- Your occupation during the elimination period
- 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.
- After three years, you will continue to receive benefits if you cannot work in any occupation based on training, experience and education.
WHAT IS A SECTION 125 FLEXIBLE SPENDING (REIMBURSEMENT) ACCOUNT?
Columbia College sponsors a Section 125 flexible spending plan which lets you redirect a portion of your pay through payroll deduction into healthcare and dependent care reimbursement accounts. You may be reimbursed from your accounts as you incur eligible dependent care expenses as well as expenses not covered by health, dental, or vision insurance. The money which goes into your FSAs is deducted on a pre-tax basis, which means it is deducted from your pay before federal and Social Security taxes are calculated. Because you do not pay taxes on money which goes into your FSA, you decrease your payroll tax liability and potentially reduce your Federal income tax liability, thus increasing your net money.

HOW DO FSA CONTRIBUTIONS WORK?
How much money should you put into your accounts each pay period? That depends on your eligible expenses. The best way to estimate your expenses for the upcoming year is by looking over the eligible expenses you incurred over the past few years. Divide the total predictable expenses by the number of pay periods in the plan year. The resulting number represents the amount you should consider contributing each pay period to your reimbursement accounts.

HEALTHCARE FSA
A healthcare FSA provides you the ability to save money on a pre-tax basis for any IRS-allowed health expenses not covered by your healthcare coverage. These expenses include deductibles, copays and coinsurance payments, routine physicals, uninsured dental expenses, vision care expenses (e.g., eyeglasses or contact lenses), and hearing care expenses (e.g., a hearing exam or a hearing aid).

ASI (www.ASIflex.com) is the third-party administrator of the FSA plans.

Per IRS guidelines, you may deposit up to $2,750 (pre-tax) for the 2021 plan year into your healthcare FSA to cover you and your dependents during the plan year. Pre-tax contributions are withheld from each paycheck. It is important to estimate carefully.

Participants in the HDHP plan can participate in the Limited-Purpose FSA.
DEPENDENT CARE FLEXIBLE SPENDING ACCOUNT

A Dependent Care FSA provides you with the ability to save money on a pre-tax basis for daycare expenses for your child, disabled parent or spouse. Generally, expenses will qualify for reimbursement if they are the result of care for the following circumstances.

- Your children, under the age of 13, for whom you are entitled to a personal exemption on your federal income tax return
- Your spouse or other dependents, including parents, who are physically or mentally incapable of self-care and rely on you for financial support
- Eligible expenses include payments to daycare centers, preschool costs (up to, but not including, first grade), after school care, and elderly care. The cost of babysitting in a home is permitted—as long as the person providing the care is not one of your own children under age 19 or anyone else you claim as tax exemption on your federal income tax return. You must provide the Social Security or tax ID number of the care provider to be reimbursed from your dependent care FSA.

You may deposit up to $5,000 (pre-tax) into your dependent care FSA. Pre-tax contributions are withheld from each paycheck. Unlike the healthcare account, *money is only reimbursed up to the total balance of the account.*

HSA participants may also participate in the Dependent Care FSA.
WorkLifeMatters Employee Assistance Program offers services to help promote well-being and enhance the quality of life for you and your family.

Support and guidance is available for assistance with family and personal issues online at www.ibhworklife.com and by phone at 1-800-386-7055.

Help with Health
- Healthy Living
- Stress Management
- Mental Health
- Diet and Fitness
- Overall Wellness

Help with Family
- Parenting Support
- Child and Elder Care
- Learning Programs
- Special Needs Help

Help with Legal & Financial
- Legal Issues
- Will Preparation
- Taxes
- Debt
- Financial Planning Tools and Assistance

Connect to a counselor for free support services:
Email: eapcounselor@ibhcorp.com
Phone: 1-800-386-7055
Available 24 hours a day, 7 days a week*
Web: www.ibhworklife.com
(User name: Matters Password: wlm70101)
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. This amount will be determined annually by the Board of Trustees and will be announced at the beginning of each plan year on July 1. 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 not mandatory that an employee contribute to the retirement plan. However, for retirement purposes, he/she may elect to contribute up to a certain maximum percentage of his/her annual wages (excluding the College’s contribution) toward his/her retirement. The elective maximum percentage allowed is controlled by Internal Revenue Service regulations.
OTHER BENEFITS

EMPLOYEE EDUCATIONAL 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 undergraduate 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). The organization maintains stringent rules to keep the tuition exchanges in balance between member institutions. A list of member institutions can be accessed via the following links:

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

VACATION

• 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 employees earn a pro-rated portion of the full-time vacation leave calculated according to the employee’s exemption status.
• Employees may carry-over one time their annual accrual from one fiscal year to the next (i.e., An employee whose annual accrual is 10 days, may carryover up to 10 days from June 30th to July 1st.)

SICK LEAVE

• All full-time employees 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 employees) is earned as a prorated portion of full-time sick leave.
• Maximum accruals of ninety (90) days for all regular full-time employees, and a prorated portion of the ninety (90) day maximum for all eligible regular part-time employees are allowed.
CONTACT INFORMATION

Please call or email the Human Resources department for any specific questions.

HUMAN RESOURCES
(573) 875-7495
humanresources@ccis.edu
This benefit guide describes the highlights of Columbia College’s benefits program and various coverage options. Your specific rights to benefits under the plan are governed solely, and in every respect, by the official plan documents, and not the information in this benefits guide. If there is any discrepancy between the description of the program elements as described in this document or other materials you receive and the official plan documents, the language in the official plan documents shall prevail as accurate.

Please refer to the plan-specific documents published by each of the respective carriers for detailed plan information. You should be aware that any and all elements of Columbia College’s benefits program may be modified in the future, at any time, to meet legislative or compliance-related requirements, or otherwise as decided by Columbia College.

Columbia College is required to provide you certain protections administered by the Internal Revenue Service and the United States Department of Labor. This benefit plan is classified by the Department of Labor as a “welfare plan” and by the IRS as a “specific fringe benefit plan” under IRC s.6039 (D). The Plan is also governed by Internal Revenue Code Section 125. Plan participants are entitled to certain protections and directions for recourse in the event of mistreatment by the Plan, its sponsor, or administrator. Since these protections are essentially the same as federal law, this Statement of Rights is published here for your information. The employer identification number assigned to Columbia College is 43-0655867. You should refer to these numbers in any correspondence about the plan.

**PLAN YEAR**
Columbia College’s benefits plan year is January 1st through December 31st. This Benefits Guide outlines the benefits which apply to the plan year unless otherwise noted.
Legal Notices

Summaries of Benefits and Coverage
To help you be better informed of your health plan, you can review the Summaries of Benefits and Coverage (SBC), which summarize important information about the options in a standard format. The SBCs can be found on the Columbia College SharePoint site. Paper copies are also available free of charge, by contacting the Human Resources Department at (573) 875-7495 or humanresources@ccis.edu.

Compliance with Applicable Laws
The Plan Sponsor (Columbia College) will administer the Benefit Plans in compliance with federal and state laws. The Plan Sponsor will administer the Benefit Plans in compliance with:

1. The Mental Health Parity Act (MHPA) and The Mental Health Parity and Addiction Equity Act (MHPAEA) ERISA § 712, requiring parity in certain mental health and substance use disorder benefits;
2. The Women’s Health and Cancer Rights Act of 1998 (WHCRA) ERISA § 713(a), imposing requirements for coverage of reconstructive surgery and other complications in connection with mastectomy;
3. ERISA § 609(c) coverage for adopted children;
4. ERISA § 609(d) coverage of costs of pediatric vaccines;
5. The Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA);
6. The Health Insurance Portability and Accountability Act of 1996 (HIPAA) (applies to any group health plan sponsored by the Plan Sponsor);
7. The Newborns’ and Mothers’ Health Protection Act of 1996 (NMHPA);
8. The Genetic Information Nondiscrimination Act (GINA);
9. The Health Information Technology for Economic and Clinical Health Act (HITECH);
10. Michelle’s Law; and,

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; and
- Treatment of physical complications of the mastectomy, including lymphedema.

These benefits will be provided subject to the same deductible and co-insurance particulars that are applicable to other medical and surgical benefits provided under this Plan. Columbia College has provided the detailed information regarding deductible and co-insurance for the Columbia College Group Health Plan. For more information or to get a copy of the Summary Plan Description containing these details contact the Human Resources Department at (573) 875-7495 or humanresources@ccis.edu.
Legal Notices

Newborns’ Act Disclosure
This Plan does not restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. Federal law generally does not prohibit the mother’s or newborn’s attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under Federal law, require that a provider obtain authorization from the plan or the insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours). Additional information including State Rights required are described in detail in the applicable Benefit Plan Descriptions.

HIPAA Special Enrollment Rights
If you do not enroll yourself and your dependents in a group health plan after you become eligible or during annual enrollment, you may be able to enroll under the special enrollment rules under the Health Insurance Portability and Accountability Act of 1996 (“HIPAA”) that apply when an individual declines coverage and later wishes to elect it.

Generally, special enrollment is available if (i) you declined coverage because you had other health care coverage that you have now lost through no fault of your own (or employer contributions to your other health care coverage terminate); or (ii) you have acquired a new dependent (through marriage or the birth or adoption of a child) and wish to cover that person. In either case, as long as you meet the necessary requirements, you can enroll both yourself and all eligible dependents in the group health plan if you provide notice to the Plan Administrator within 30 days after you lose your alternative coverage (or employer contributions to your alternative coverage cease) or the date of your marriage or the birth, adoption, or placement for adoption of your child.

Additionally, if you and your eligible dependents are not already enrolled in the Plan, you may be able to enroll yourself and your eligible dependents if (i) you or your dependents lose coverage under a state Medicaid or children’s health insurance program (CHIP), or (ii) you or your dependents become eligible for premium assistance under state Medicaid or CHIP, as long as you request enrollment no more than 60 days from the date of the Medicaid/CHIP event.

To request special enrollment or obtain more information, contact the Human Resources Department at (573) 875-7495 or humanresources@ccis.edu.

The Genetic Nondiscrimination Act of 2008 (GINA)
GINA prohibits a group health plan from adjusting group premium or contribution amounts for a group of similarly situated individuals based on the genetic information of members of the group. GINA prohibits a group health plan from requesting or requiring an individual or a family member of an individual to undergo genetic tests. Genetic information means information about an individual’s genetic tests, the genetic tests of family members of the individual, the manifestation of a disease or disorder in family members of the individual or any request for or receipt of genetic services, or participation in clinical research that includes genetic services by the individual or a family member of the individual. The term genetic information includes, with respect to a pregnant woman (or a family member of a pregnant woman) genetic information.
Legal Notices

Michelle’s Law
The law allows for continued coverage for dependent children who are covered under your group health plan as a student if they lose their student status because of a medically necessary leave of absence from school. This law applies to medically necessary leaves of absence that begin on or after January 1, 2010.

If your child is no longer a student, as defined in your Certificate of Coverage, because he or she is on a medically necessary leave of absence, your child may continue to be covered under the plan for up to one year from the beginning of the leave of absence. This continued coverage applies if your child was (1) covered under the plan and (2) enrolled as a student at a post-secondary educational institution (includes colleges, universities, some trade schools and certain other post-secondary institutions).

Your employer will require a written certification from the child’s physician that states that the child is suffering from a serious illness or injury and that the leave of absence is medically necessary.

COBRA Rights
Under the Consolidated Omnibus Budget Reconciliation Act (COBRA), federal law makes it possible for certain employees and their eligible dependents to continue participating in health care plans if coverage would otherwise terminate. If you enroll in medical, dental or vision coverage, or the Health Care Flexible Spending Account, you should be aware of your rights under COBRA. Among other things, COBRA mandates that an employer give employees the ability to continue those same coverages after leaving employment. You can review your rights under COBRA in the Summary Plan Description (located in the SharePoint site).

HIPAA Notice
The Health Insurance Portability and Accountability Act of 1996 (HIPAA) notice explains your rights under HIPAA and the requirements of the Plan to protect the Protected Health Information (“PHI”) obtained about you relating to your health coverage, and how the Plan may use and disclose this information. PHI includes individually identifiable information which relates to your past, present or future health, treatment or payment for health care services. Columbia College strongly believes in protecting the confidentiality and security of information received about you during the course of administering the Plan.

This notice is found in the Summary Plan Description (located in the SharePoint site).
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 (https://www.medicaid.gov/chip/state-program-information/index.html), 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).

Please refer to information for each state in SharePoint. If you live in one of the listed states, you may be eligible for assistance paying your employer health plan premiums. Contact your state for more information on eligibility.

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

Important Notice From Columbia College About Your Prescription Drug Coverage If You Are Eligible for 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 United Healthcare 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 will not be affected. See below for more information about what happens to your current coverage if you join a Medicare drug plan.

If you do decide to join a Medicare drug plan and drop your current Columbia College coverage, be aware that you and your dependents will be able to get this coverage back at the next open enrollment. You should compare your current coverage, including which drugs are covered, with the coverage and cost of the plans offering Medicare prescription drug coverage in your area.
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 Human Resources Department at (573) 875-7495 or humanresources@ccis.edu 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 the 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).
This publication is only a partial summary of benefits and is provided for information purposes only. It does not describe all elements of the summarized programs. For complete information regarding the benefits, plan provision, limitations and exclusions, and for a description of claims procedures, refer to the plan’s Summary Plan Descriptions. In the event of a discrepancy or conflict between the information contained in this publication and the official benefit plan provisions, the official plan documents and insurance contracts will govern. No rights shall accrue to you and/or your dependents because of any statement, error or omission in this publication.