



Health Insurance Marketplace Coverage Options and Your Health Coverage

PART A: General Information

Even if you are offered health coverage through your employment, you may have other coverage options through the Health Insurance Marketplace ("Marketplace"). To assist you as you evaluate options for you and your family, this notice provides some basic information about the Health Insurance Marketplace and health coverage offered through your employment.

What is the Health Insurance Marketplace?

The Marketplace is designed to help you find health insurance that meets your needs and fits your budget. The Marketplace offers "one-stop shopping" to find and compare private health insurance options in your geographic area.

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

You may qualify to save money and lower your monthly premium and other out-of-pocket costs, but only if your employer does not offer coverage, or offers coverage that is not considered affordable for you and doesn't meet certain minimum value standards (discussed below). The savings that you're eligible for depends on your household income. You may also be eligible for a tax credit that lowers your costs.

Does Employment-Based Health Coverage Affect Eligibility for Premium Savings through the Marketplace?

Yes. If you have an offer of health coverage from your employer that is considered affordable for you and meets certain minimum value standards, you will not be eligible for a tax credit, or advance payment of the tax credit, for your Marketplace coverage and may wish to enroll in your employment-based health plan. However, you may be eligible for a tax credit, and advance payments of the credit that lowers your monthly premium, or a reduction in certain cost-sharing, if your employer does not offer coverage to you at all or does not offer coverage that is considered affordable for you or meet minimum value standards. If your share of the premium cost of all plans offered to you through your employment is more than 9.12% of your annual household income, or if the coverage through your employment does not meet the "minimum value" standard set by the Affordable Care Act, you may be eligible for a tax credit, and advance payment of the credit, if you do not enroll in the employment-based health coverage. For family members of the employee, coverage is considered affordable if the employee's cost of premiums for the lowest-cost plan that would cover all family members does not exceed 9.02% of the employee's household income.

Note: If you purchase a health plan through the Marketplace instead of accepting health coverage offered through your employment, then you may lose access to whatever the employer contributes to the employment-based coverage. Also, this employer contribution-as well as your employee contribution to employment-based coverage-is generally excluded from income for federal and state income tax purposes. Your payments for coverage through the Marketplace are made on an after-tax basis. In addition, note that if the health coverage offered through your employment does not meet the affordability or minimum value standards, but you accept that coverage anyway, you will not be eligible for a tax credit. You should consider all of these factors in determining whether to purchase a health plan through the Marketplace.

When Can I Enroll in Health Insurance Coverage through the Marketplace?

You can enroll in a Marketplace health insurance plan during the annual Marketplace Open Enrollment Period. Open Enrollment varies by state but generally starts November 1 and continues through at least December 15.

Outside the annual Open Enrollment Period, you can sign up for health insurance if you qualify for a Special Enrollment Period. In general, you qualify for a Special Enrollment Period if you've had certain qualifying life events, such as getting married, having a baby, adopting a child, or losing eligibility for other health coverage. Depending on your Special Enrollment Period type, you may have 60 days before or 60 days following the qualifying life event to enroll in a Marketplace plan.

In addition, if you or your family members are enrolled in Medicaid or CHIP coverage, it is important to make sure that your contact information is up to date to make sure you get any information about changes to your eligibility. To learn more, visit [HealthCare.gov](https://www.healthcare.gov) or call the Marketplace Call Center at 1-800-318-2596. TTY users can call 1-855-889-4325.

What about Alternatives to Marketplace Health Insurance Coverage?

If you or your family are eligible for coverage in an employment-based health plan (such as an employer-sponsored health plan), you or your family may also be eligible for a Special Enrollment Period to enroll in that health plan in certain circumstances, including if you or your dependents were enrolled in Medicaid or CHIP coverage and lost that coverage.

Confirm the deadline with your employer or your employment-based health plan.

Alternatively, you can enroll in Medicaid or CHIP coverage at any time by filling out an application through the Marketplace or applying directly through your state Medicaid agency. Visit <https://www.healthcare.gov/medicaid-chip/getting-medicaid-chip/> for more details.

How Can I Get More Information?

For more information about your coverage offered by your employer, please check your summary plan description at <https://www.coloradocollege.edu/offices/humanresources/benefits/> or contact Gina Lujan (719-389-6104) or Cameron Martin (719-389-6194).

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

PART B: Information about Health Coverage Offered by Your Employer

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

1. Employer name: The Colorado College
 2. Employer Identification Number (EIN): 84-0402510
 3. Employer address: 14 E. Cache La Poudre Street
 4. Employer phone number: 719-389-7660
 5. City: Colorado Springs
 6. State: Colorado
 7. Zip: 80903-3294
 8. Whom can we contact about employee health coverage at this job? Gina Lujan / Cameron Martin
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9. Phone number: 719-389-6104 / 719-389-6194
 10. Email address: elujan@coloradocollege.edu / cmartin2024@coloradocollege.edu

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

•As your employer, we offer a health plan to:

- ✓ Some employees. Eligible employees include regular employees who work at least 1,000 hours per year

● **With respect to dependents:**

✓ We do offer coverage. Eligible dependents are spouses, domestic partners, dependent children/stepchildren/adopted children

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

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

If you decide to shop for coverage in the Marketplace, HealthCare.gov will guide you through the process. Here's the employer information you'll enter when you visit HealthCare.gov to find out if you can get a tax credit to lower your monthly premiums.

HIPAA SPECIAL ENROLLMENT NOTICE

If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance or group health plan coverage, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing toward you or your dependents' other coverage). However, you must request enrollment within 30 days after you or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage).

[REDACTED]

In addition,
if you have a
new

dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents. However, you must request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption.

To request special enrollment or obtain more information, contact:

Gina Lujan
Benefits Manager
Tel: 719-389-6104
Email: elujan@coloradocollege.edu

NOTICE OF PRIVACY PRACTICES REGARDING PROTECTED HEALTH

Colorado College Notice of Privacy Practices
Effective Date of this Notice: May 1, 2026

**THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED
AND DISCLOSED AND HOW YOU CAN ACCESS THIS INFORMATION.
PLEASE REVIEW THIS NOTICE CAREFULLY.**

Colorado College offers healthcare benefits to its employees and retirees, and their eligible family members. These benefits include a self-funded group health plan with Colorado College directly paying the claims and a separate self-funded plan that provides dental benefits. This notice describes the privacy practices established by Colorado College for its self-funded benefits (referred to as "We," "Us" or "The Plan"). The Plan is managed for Colorado College by business associates, which are third party

administrators that interact with the healthcare providers and handle members' claims.

Colorado College also offers fully insured group vision insurance with an insurer assuming the financial risk of paying for covered vision benefits. The notice of privacy practices for vision insurance is available directly from the insurance carrier. Please go to:

<https://www.coloradocollege.edu/offices/humanresources/benefits/> for a current list of benefits.

Colorado College is committed to protecting the privacy of your PHI

Colorado College is committed to protecting the privacy of your protected health information or "PHI." PHI refers to health information that we create or receive that relates to your physical or mental health, your healthcare, or payment for your healthcare. In most cases, the business associate that serves as the third-party administrator for the Plan maintains your PHI, but Colorado College may also hold health-related information. Generally, Colorado College-held information is limited to enrollment data, but in limited instances, it may include information you provide to designated Colorado College staff to help with coordination of benefits or resolving complaints.

The privacy protections described in this notice reflect the requirements of federal regulations issued under the Health Insurance Portability and Accountability Act (HIPAA). HIPAA requires us to:

- Comply with HIPAA privacy rules and other federal laws;
- Take steps to protect your PHI;
- Give you this notice of our legal duties and privacy practices with respect to your PHI; and
- Follow the terms of the notice that is currently in effect.

How we will use and disclose your Protected Health Information

The following sections describe different ways that we might use and disclose your PHI. Not every use or disclosure will be listed. All of the ways that we are permitted to use and disclose PHI, however, will fall within one of the categories. Use and disclosure of some PHI, such as certain drug and alcohol information, HIV information and mental health information, is further restricted.

- **Treatment.** We may use and disclose your PHI to doctors, nurses, technicians, and other personnel who are involved in providing you with medical treatment or services. For instance, a doctor or health care facility involved in your care may request your personal health information in our possession to assist in your care.
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- **Payment.** We may use and disclose your PHI in the course of activities that involve reimbursement for healthcare, such as determination of eligibility for coverage, claims processing, billing, obtaining and payment of premium, utilization review, medical necessity determinations and pre-certifications.
 - **Healthcare operations.** We may use and disclose your PHI to carry out business operations. For example, we may disclose your PHI to a business associate who handles claims processing or administration, data analysis, utilization review, quality assurance benefit management, practice management, or referrals to specialists, or provides legal, actuarial, accounting, consulting, data aggregation, management, or financial services.
 - **Plan sponsor.** The Plan may disclose summary health information (that is, claims data that is stripped of most individual identifiers) to Colorado College in its role as plan sponsor in order to obtain bids for health insurance coverage or to facilitate modifying, amending, or terminating benefits. The Plan may also provide Colorado College enrollment or disenrollment information. In addition, if you request help from Colorado College to coordinate your benefits or to resolve a complaint, the Plan may disclose your PHI to designated Colorado College staff, but no PHI may be disclosed to facilitate employment-related actions or decisions or for matters involving other benefits or benefit plans. Colorado College may not further disclose any PHI that is disclosed to it in these limited instances, except as you authorize.
 - **As required by law.** We will disclose your PHI if required to do so by federal, state, or local law or regulation.
 - **To avert a serious threat to health or safety.** We may disclose your PHI when necessary, to prevent or

lessen a serious threat to your health and safety or the health and safety of the public or another person. Any disclosure, however, would only be to someone able to help prevent the threat.

- **Military and Veterans.** If you are or were in the military forces, we may release your PHI to military officials as authorized or required by law. We may also release medical information about foreign military personnel to the appropriate military authority as authorized or required by law.
 - **Research.** In limited circumstances, we may use and disclose PHI for research purposes, subject to the confidentiality provisions of state and federal law. Your PHI may be important to further research efforts and the development of new knowledge. All research projects conducted by Colorado College must be approved through a special review process to protect member safety, welfare, and confidentiality.
 - **Workers' Compensation.** We may release PHI for workers' compensation or similar programs as permitted or required by law. These programs provide benefits for work-related injuries or illness.
 - **Health oversight activities.** We may disclose PHI to governmental, licensing, auditing, and accrediting agencies as authorized or required by law.
 - **Legal proceedings.** We may disclose PHI to courts, attorneys, and court employees in the course of conservatorship and certain other judicial or administrative proceedings.
 - **Lawsuits and disputes.** If you are involved in a lawsuit or other legal proceeding, we may disclose your PHI in response to a court or administrative order, or in response to a subpoena, discovery request, warrant, summons, or other lawful process. If the lawsuit or proceeding is in regard to reproductive health, however, no information will be disclosed.
 - **Law enforcement.** If authorized or required by law, we may disclose your PHI under limited circumstances to a law enforcement official in response to a warrant or similar process, to identify or locate a suspect, or to provide information about the victim of a crime.
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- **National security and intelligence activities.** If authorized or required by law, we may release your PHI to authorized federal officials for intelligence, counterintelligence, and other national security activities.
 - **Protective services for the United States President and others.** We may disclose your PHI to authorized federal and state officials so they may provide protection to the President, other authorized persons, or foreign heads of state, or conduct special investigations, as authorized or required by law.
 - **Inmates.** If you are an inmate of a correctional institution or under the custody of a law enforcement official, we may release your PHI to the correctional institution or law enforcement official, as authorized or required by law. This release would be necessary for the institution to provide you with healthcare; to protect your health and safety or the health and safety of others; or for the safety and security of the correctional institution.

Required Disclosures

We may be required to disclose your PHI to the Department of Health and Human Service if the Secretary is conducting a compliance audit.

Your Rights

You have the following rights regarding the PHI that we maintain about you:

- **Right to inspect and copy.** With certain exceptions, you have the right to inspect and obtain a copy of your PHI that is maintained by or for The Plan. To inspect and obtain a copy of The PHI, you must submit your request in writing to Colorado College, Office of Human Resources, 14 E Cache La Poudre Street, Colorado Springs, CO, 80903, attention: HIPAA Privacy Officer. You may be charged a fee for the costs of copying, mailing or other supplies associated with your request. We may deny your request to inspect and/or obtain a copy in certain limited circumstances. For example, HIPAA does not permit you to access or obtain copies of psychotherapy notes. If your request is denied, you will be informed in writing, and you may request that the denial be reviewed. The person conducting the review will not be the person who denied your request. The Plan will comply with the outcome of the review.

- **Right to request an amendment.** If you believe that the PHI that we maintain is incorrect or incomplete, you may request that The Plan amend the information. You have the right to request an amendment for as long as the information is kept by or for The Plan. A request for an amendment should be made in writing and submitted to Colorado College, Office of Human Resources, 14 E Cache La Poudre Street, Colorado Springs, CO 80903 attention: HIPAA Privacy Officer. In addition, you must provide the reasons that support your request.
 - We may deny your request for an amendment if it is not in writing or does not include any reason to support the request. In addition, The Plan may deny your request if you ask to amend information that was not created by the plan; is not part of the PHI maintained by or for The Plan; is not part of the information that you would be permitted to inspect and copy under the law; or if the information is accurate and complete. If the request is granted, the plan will forward your request to other entities that you identify that you want to receive the corrected information. For example, if your PHI has been disclosed to our staff so that it may help to coordinate benefits or resolve a complaint, you may direct The Plan to share the correction with the designated staff members.
 - **Right to an accounting of disclosures.** You have the right to receive an "accounting of disclosures," which is a list of disclosures such as those that were made of PHI about you, with the exception of certain documents including those relating to treatment, payment,
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and healthcare operations and disclosures made to you or consistent with your authorization. To request an accounting of disclosures, you must submit your request in writing to Colorado College, Office of Human Resources, 14 E Cache La Poudre Street, Colorado Springs, CO 80903 attention: HIPAA Privacy Officer. Your request must state a time period, which may not be longer than six years and may not include dates before April 14, 2003. Your request should indicate in what form you want the list (for example, on paper or electronically). The first list you request within a 12-month period will be free. For additional lists, we may charge you for the costs of providing the list. You will be notified of any costs involved and you may choose to withdraw or modify your request at that time before any costs are incurred.

- **Right to request restrictions.** You have the right to request a restriction or limitation on the use and disclosure of your PHI for treatment, payment, or healthcare operations, or to request a restriction on the PHI that the plan may disclose about you to someone who is involved in your care or the payment for your care, such as a family member or friend. We are not required to agree to your request. If we agree to your request, we will comply with the requested restriction unless the information is needed to provide you emergency treatment or to assist in disaster relief efforts. To request a restriction, you must submit your request in writing to Colorado College, Office of Human Resources, 14 E. Cache La Poudre Street, Colorado Springs, CO 80903 attention: HIPAA Privacy Officer. Your request should state the information you want to limit; whether you want to limit the plan's use, disclosure, or both; and to whom you want the limits to apply, for example, disclosures to your spouse.
- **Right to Request Confidential Communications.** You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. For example, you can ask that we only contact you at work or by mail to a specific address. To request confidential communications, you must submit your request in writing to Colorado College, Office of Human Resources, 14 E. Cache La Poudre Street, Colorado Springs, CO 80903, attention: HIPAA Privacy Officer. The Plan will accommodate all reasonable requests and will not ask you the reason for your request. Your request must specify how or where you wish to be contacted.
- **Right to a Paper Copy of this notice.** You may ask us to give you a copy of this notice at any time. To obtain a paper copy of this notice, contact the Colorado College, Office of Human Resources, 14 E. Cache La Poudre Street, Colorado Springs, CO, 80903 attention: HIPAA Privacy Officer. A copy is also available on the benefits website: <https://www.coloradocollege.edu/offices/humanresources/benefits/>.
- **Other uses of medical information.** Other uses and disclosures of PHI not covered by this notice will be made only with your written permission. This includes most uses and disclosures of psychotherapy notes, uses and disclosures of PHI for marketing purposes, and uses and disclosures of PHI that constitute a sale of PHI. If you provide us permission to use or disclose your PHI, you may revoke that permission, in writing, at any time. If you revoke your permission, The Plan will no longer use or disclose your PHI for the reasons stated in your written authorization. Please understand that The Plan cannot take back any disclosures already made with your permission.
- **Breach.** You have the right to be notified of the discovery of a breach of unsecured PHI.
- **Genetic information is Protected Health Information.** In accordance with the Genetic Information Nondiscrimination Act (GINA), we will not use or disclose genetic information for underwriting purposes, which includes eligibility determinations, premium computations, applications of any pre-existing condition exclusions, and any other activities related to the creation, renewal, or replacement of a contract of health insurance or health benefits.

Changes to this Notice

We reserve the right to change this notice and to make the revised or changed notice effective for PHI your plan already maintains on you as well as any information the plan receives or creates in the future. A copy of the current notice will be posted at the Colorado College website at:

<https://www.coloradocollege.edu/offices/humanresources/benefits/>.

The notice will contain the effective date on the first page, in the top right-hand corner. In addition, a copy of the notice that is currently in effect will be given to new health plan members and thereafter

MEDICARE PART D COVERAGE DISCLOSURE NOTICE

available upon
request.

Complaints

If you believe your privacy rights have been violated, you may file a complaint with the Colorado College Office of Human Resources or with the Secretary of the Department of Health and Human Services. To file a complaint with us, contact Colorado College, Office of Human Resources, 14 E. Cache La Poudre Street, Colorado Springs, CO 80903, attention: HIPAA Privacy Officer. Email will not be accepted; all complaints must be submitted in writing.

You will not be retaliated against for filing a complaint.

Questions

If you have questions or for further information regarding this privacy notice, contact Colorado College, Office of Human Resources at 719-389-6104.

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with The Colorado 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. Please share this information with any other family member who is covered under the plan and who may be eligible for Medicare Part D.

There are two important things you should 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. The Colorado College has determined that the prescription drug coverage offered by The Colorado College health plan is, on average for all plan participants, expected to pay out as much as the 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 through 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 Colorado College coverage will be affected. See below for more information about what happens to your current coverage if you join a Medicare drug plan.

The benefit plan options that affect Part D eligible individuals (or their dependents) that are related to Part D and their benefit plan may include:

- that individuals can retain their existing coverage and choose not to enroll in a Part D plan; or
- that individuals can enroll in a Part D plan as a supplement to, or in lieu of, the other coverage.

If you decide to join a Medicare drug plan and drop your Colorado College prescription drug coverage, 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 coverage with The Colorado College and do not 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 19 months without creditable coverage, your premium may consistently be at least 19% higher than the base Medicare 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 Office of Human Resources.

NOTE: You will get this notice each year. 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 may receive a copy of the handbook in the mail from Medicare and it is available at www.medicare.gov. You may also be contacted directly by Medicare drug plans.

For
about
prescription drug coverage:

NEWBORNS' ACT DISCLOSURE NOTICE

more information
Medicare

- 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:	May 1, 2026
Name of Entity/Sender:	The Colorado College
Contact--Position/Office:	Cameron Martin
Address:	14 East Cache La Poudre Street Colorado Springs, CO 80903
Phone Number:	(719) 389-6194

Group health plans and health insurance issuers generally may not, under Federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section.

However, Federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under Federal law, require that a provider obtain authorization from the plan or the insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

NEWBORNS' ACT DISCLOSURE NOTICE

WOMEN'S HEALTH AND CANCER RIGHTS ACT

If you have had or are going to have a mastectomy, you may be entitled to certain benefits under the Women's Health and Cancer Rights Act of 1998 (WHCRA). For individuals receiving mastectomy-related benefits, coverage will be provided in a manner determined in consultation with the attending physician and the patient, for:

Notice Regarding The Rights Of Pregnant Workers

- All stages of reconstruction

of the breast on which the mastectomy was performed;

- Surgery and reconstruction of the other breast to produce a symmetrical appearance;
- Prostheses; and
- Treatment of physical complications of the mastectomy, including lymphedema.

These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under this plan. See information on deductibles and coinsurance at: <https://www.coloradocollege.edu/offices/humanresources/benefits/>

If you would like more information on WHCRA benefits, call your benefits manager at 719-389-6104.

Effective August 10, 2016, pursuant to C.R.S. §24-34-402.3, et seq., all employees, and applicants for employment in the State of Colorado have the right to be free from discriminatory or unfair employment practices because of pregnancy, a health condition related to pregnancy, or the physical recovery from childbirth. In addition, all employers shall:

Provide reasonable accommodations to perform the essential functions of the job to an applicant for employment or an employee for health conditions related to pregnancy or the physical recovery from childbirth, if the applicant or employee requests the reasonable accommodations, unless the accommodation would impose an undue hardship on the employer's business;

Not take adverse action against an employee who requests or uses a reasonable accommodation related to pregnancy, physical recovery from childbirth, or a related condition;

Not deny employment opportunities to an applicant or employee based on the need to make a reasonable accommodation related to the applicant's or employee's pregnancy, physical recovery from childbirth, or a related condition;

Not require an applicant or employee affected by pregnancy, physical recovery from childbirth, or a related condition to accept an accommodation that the applicant or employee has not requested or an accommodation that is unnecessary for the applicant or employee to perform the essential functions of the job; and

Not require an employee to take leave if the employer can provide another reasonable accommodation for the employee's pregnancy, physical recovery from childbirth, or related condition.

An employer may require an employee or applicant to provide a note stating the necessity of a reasonable accommodation from a licensed health care provider before providing such accommodation.

If an applicant or employee requests an accommodation, the employer and applicant or employee shall engage in a timely, good faith, and interactive process to determine effective, reasonable accommodations for the applicant or employee for conditions related to pregnancy, physical recovery from childbirth, or a related condition.

If you need an accommodation, please contact Human Resources at (719) 389-7659.

CHILDREN'S HEALTH INSURANCE PROGRAM REAUTHORIZATION

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 January 31, 2026. Contact your State for more information on eligibility –

ALABAMA – Medicaid	ALASKA – Medicaid
Website: http://myalhipp.com/ Phone: 1-855-692-5447	The AK Health Insurance Premium Payment Program Website: http://myakhipp.com/ Phone: 1-866-251-4861 Email: CustomerService@MyAKHIPP.com Medicaid Eligibility: https://health.alaska.gov/dpa/Pages/default.aspx
ARKANSAS – Medicaid	CALIFORNIA – Medicaid
Website: http://myarhipp.com/ Phone: 1-855-MyARHIPP (855-692-7447)	Health Insurance Premium Payment (HIPP) Program Website: http://dhcs.ca.gov/hipp Phone: 916-445-8322 Fax: 916-440-5676 Email: hipp@dhcs.ca.gov
COLORADO – Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)	FLORIDA – Medicaid

Health First Colorado Website: https://www.healthfirstcolorado.com/ Health First Colorado Member Contact Center: 1-800-221-3943/State Relay 711 CHP+: https://hcpf.colorado.gov/child-health-plan-plus CHP+ Customer Service: 1-800-359-1991/State Relay 711 Health Insurance Buy-In Program (HIBI): https://www.mycohibi.com/ HIBI Customer Service: 1-855-692-6442	Website: https://www.flmedicaidtprecovery.com/flmedicaidprecovery.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: KIHIPPPROGRAM@ky.gov KCHIP Website: https://kynect.ky.gov Phone: 1-877-524-4718 Kentucky Medicaid Website: https://chfs.ky.gov/agencies/dms	Louisiana Medicaid Website: https://www.ldh.la.gov/healthy-louisiana Medicaid Customer Service Line: 1-888-342-6207 Louisiana Medicaid email: healthy@la.gov Louisiana Health Insurance Premium Program (LaHIPP) Website: https://www.ldh.la.gov/lahipp LaHIPP phone: 1-877-697-6703 LaHIPP email: La.HIPP@la.gov LaHIPP fax: 1-888-716-9787 LaHIPP mailing address: 100 Crescent Centre Parkway, Suite 1000 Tucker, GA 30084
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: HSHIPPProgram@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.nifamilycare.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 Rlte 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-MyWVHIP (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 January 31, 2026, 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 ebbsa.opr@dol.gov and reference the OMB Control Number 1210-0137.
OMB Control Number 1210-0137 (expires 4/30/2026)

403(B) UNIVERSAL AVAILABILITY NOTICE

The Colorado College Retirement & Investment Plans

Required Notice, Information Only

The Colorado College sponsors the Colorado College Retirement Benefit Plan (the "Plan"). See plan document and summary plan document (<https://www.coloradocollege.edu/offices/humanresources/benefits/>) or request a copy from the CC Office of Human Resources (contact information at bottom of notice). The Plan includes a mandatory benefit and a voluntary benefit.

Eligibility

You are not eligible to participate in the Plan if you are:

- A person providing services as an independent contractor;
- A person providing services as a leased employee; or
- A student employee.

In addition, you are not required to make Mandatory Contributions to your Plan account, and therefore will not be eligible to receive Employer Contributions if you are:

- An employee hired after March 31, 2005 and classified by the College as a paraprofessional; except that beginning 7/1/16 any employee classified as a "paraprofessional" will be an eligible employee for purposes of the plan;
- An employee who is not benefit eligible pursuant to personnel policies established by the College; or,
- An employee whose employment with the College is governed by the terms of a collective bargaining agreement.

Voluntary Benefit: Generally, all common law employees of the College are eligible to contribute a portion of compensation to the Plan as voluntary elective contributions. Elective contributions will be invested in the funding vehicles selected by the employee. If the employee does not select a funding vehicle, contributions will be invested in the Qualified Default Investment Alternative (QDIA). See <https://www.coloradocollege.edu/offices/humanresources/benefits/> for a copy of the QDIA notice or request a paper copy from the Office of Human Resources.

Mandatory Benefit: Except for those employees noted above as ineligible for the mandatory benefit under the Plan, all eligible employees will participate when they reach age 29 and have a year of service to the College or a year of service immediately preceding their employment with the College at a tax-exempt 501(c)(3) organization or a public entity. The employee is required as a condition of employment to contribute 5% of pay to their own retirement account and receives a contribution from the college to their retirement account (currently 10%).

Eligible employees under age 29 with a year of service may make a 5% voluntary contribution election to the mandatory plan and receive the College's contribution.

See plan documents at <https://www.coloradocollege.edu/offices/humanresources/benefits/> for full details on eligibility and other plan details.

Contributions

An employee can elect to voluntarily defer a portion of his or her compensation to the Plan on a pre-tax and/or post-tax (Roth) basis.

Pre-tax Contributions: Pre-tax contributions are taken out of your pay before your income is taxed. Pre-tax contributions and their earnings will grow tax-free while they are held in your Funding Vehicles and will be taxed when they are withdrawn. In addition, penalties may apply if withdrawn prior to age 59-1/2.

Post-tax (Roth) Contributions - Roth contributions are taken out of your pay after your income is taxed. Like pre-tax contributions, Roth contributions and their earnings grow tax-free while they are held in your Funding Vehicles. However, distributions of Roth contributions are not subject to tax if they are withdrawn after you have reached age 59 ½ (or after your death or disability) so long as you have had a designated Roth account in the Plan for at least 5 years. If you elect to make after-tax Roth Elective Contributions to your Funding Vehicles, you cannot later re-characterize those contributions as pre-tax Elective Contributions. Likewise, you generally cannot re-characterize pre-tax Elective Contributions as after-tax Roth Elective Contributions.

Employee contributions to the Plan can be allocated among the investment options offered through TIAA. Employees are 100% vested in their accounts under the Plan at all times. The investment options are available from TIAA, on the Human Resources website under Benefits & Wellness/Retirement Plan Committee, or from the Human Resources office.

Contribution Limits

Annual contributions to the Plan are limited per IRS regulations. The contribution limits for the 2023 and 2024 calendar years are listed below.

Year	Basic Elective Contribution Limit	Age 50+ Catch-up Contribution	15 Years of Service Catch-up Contribution
2025	\$23,500	\$7,500	\$3,000*
2026	\$24,500	\$8,000	\$3,000*

* The 15 years of service catch-up contribution applies before the age 50+ catch-up and is based on a formula that considers all past contributions to the Plan and the employee's total years of service to the College. The maximum 15 years of service catch-up available is \$3,000 per year up to a \$15,000 lifetime benefit, but an employee's actual catch-up may be lower than this maximum. If you wish to defer more than \$23,500 (\$31,000 if age 50 or older) for 2025, please contact TIAA to determine if you are eligible for the 15 years of service catch-up.

To Enroll in the Voluntary Benefit

Eligible employees may begin participating in the voluntary portion of the Plan at any time, may change their elections at any time, and may stop contributions at any time. The change will take effect as soon as administratively convenient after receipt of an updated Voluntary Salary Reduction Agreement Form (SRA). To enroll in the Plan, an employee must complete an SRA and turn it into the Office of Human Resources. The form may be found on the benefits website: <https://www.coloradocollege.edu/offices/humanresources/benefits/>. Contributions may be designated as a percent of salary or as a flat dollar amount. The SRA will apply only to amounts earned after enrolling in the Plan, and an employee's election under the SRA will continue until the SRA is modified or revoked by the employee.

To Modify a Voluntary Deferral Election

Employees may increase, decrease, or stop their voluntary contributions to the Plan at any time. Employees may also change the investment direction of their contributions at any time by calling TIAA or accessing the TIAA portal (see bottom of page for contact details).

To Enroll in the Mandatory Benefit

After one year of service and attainment of age 29, eligible Colorado College employees are automatically enrolled in the mandatory plan. Both the employee's contribution and the College's contribution will be funded to a TIAA account in the employee's name and the employee will have the right to direct the investments. The default for mandatory employee contributions is pre-tax. The funds are 100% vested to the employee when applied. If the employee does not make investment directions, the funds will be applied to the Qualified Default Investment Alternative (QDIA). Employees who are eligible due to covered service at a 501(c) (3) or public entity immediately prior to their CC employment should contact the Office of Human Resources to enroll when hired.

Employees who have a year of service but are under age 29 may participate in the mandatory portion of the plan by making a voluntary election. This entitles the employee to the College's contribution. Contact the Office of Human Resources for the special election form if you are an eligible employee, under age 29, and interested in participating.

Approved Vendor

The current approved vendor under the Plan is TIAA. TIAA offers a wide range of fixed and variable annuities and mutual funds as Plan investment options. If a participant does not select investment options, the funds will be invested in the Qualified Default Investment Alternative (QDIA). See QDIA notice and the current array of investments available on the benefits website: <https://www.coloradocollege.edu/offices/humanresources/benefits/> or request a paper copy from the Office of Human Resources.

More Information

Contact the College's Human Resources office or TIAA directly with questions or for help enrolling in the Plan. A paper copy of this notice is also available from the Office of Human Resources.

Colorado College Office of Human Resources

Email: elujan@coloradocollege.edu / cmartin2024@coloradocollege.edu

Telephone: 719-389-6104 / 719-389-6194

TIAA

Tel: 1-800-842-2252

Web: www.TIAA.org/ColoradoCollege

This notice is provided as a source of information and does not constitute legal, tax, or other professional advice. If legal advice, tax advice, or other professional assistance is required, the services of a professional advisor should be sought. Every effort has been made to make this notice as thorough and accurate as possible. However, there are other legal documents, laws, and regulations that govern the operation of the Plan. It is understood that in the event of any conflict, the terms of the Plan document, applicable laws, and regulations will govern.

GENERAL NOTICE OF COBRA CONTINUATION

This notice contains important information about your right to COBRA continuation coverage. It generally explains how COBRA continuation coverage works, when it may become available to you and your family, and what you and they need to do to protect the right to receive it.

Introduction

You are receiving this notice because you recently enrolled in, or may enroll in, group health plan coverage as an employee of Colorado College. This notice has important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan. When you become eligible for COBRA, you may also become eligible for other coverage options that may cost less than COBRA continuation coverage.

The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage can become available to you and other members of your family when group health coverage would otherwise end. For more information about your rights and obligations under the Plan and under federal law, you should review the Summary Plan Descriptions or contact the Plan Administrator. The Summary Plan Descriptions may be found at the Benefits website: <https://www.coloradocollege.edu/offices/humanresources/benefits/> or by contacting the Office of Human Resources.

You may have other options available to you when you lose group health coverage.

For example, you may be eligible to buy an individual plan through the Health Insurance Marketplace. By enrolling in coverage through the Marketplace, you may qualify for lower costs on your monthly premiums and lower out-of-pocket costs. Additionally, you may qualify for a 30-day special enrollment period for another group health plan for which you are eligible (such as a spouse's plan), even if that plan generally does not accept late enrollees.

What is COBRA continuation coverage?

COBRA continuation coverage is a continuation of group Plan coverage when it would otherwise end because of a life event. This is also called a "qualifying event." Specific qualifying events are listed later in this notice. After a qualifying event, COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." You, your spouse, and your dependent children could become qualified beneficiaries if coverage under the Plan is lost because of the qualifying event. Under the Plan, qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage.

If you are an employee, you will become a qualified beneficiary if you lose your coverage under the Plan because of the following qualifying events:

- Your hours of employment are reduced so that you are no longer eligible for coverage, or
- Your employment ends for any reason other than your gross misconduct.

If you are the spouse of an employee, you will become a qualified beneficiary if you lose your coverage under the Plan because of the following qualifying events:

- Your spouse or domestic partner (DP) dies; Your spouse's/DP's hours of employment are reduced so that she/he/they (and thus you) are no longer eligible for coverage under the plan;
- Your spouse's/DP's employment ends for any reason other than his or her gross misconduct;
- Your spouse/DP becomes entitled to Medicare benefits (under Part A, Part B, or both); or
- You become divorced or legally separated from your spouse/DP.

Your dependent children will become qualified beneficiaries if they lose coverage under the Plan because of the following qualifying events:

- The parent-employee dies;
- The parent-employees' hours of employment are reduced so that she/he/they (and thus dependent child) is no longer eligible for coverage under the plan;
- The parent-employee's employment ends for any reason other than his/her/their gross misconduct;
- The parent-employee becomes entitled to Medicare benefits (Part A, Part B, or both);
- The parents become divorced or legally separated; or
- The child stops being eligible for coverage under the Plan as a "dependent child."
- Sometimes, filing a proceeding in bankruptcy under title 11 of the United States Code can be a qualifying event. If a proceeding in bankruptcy is filed with respect to Colorado College, and that bankruptcy results in the loss of coverage of any retired employee covered under the plan, the retired employee will become a qualified beneficiary. The retired employee's spouse, surviving spouse, DP and dependent children will also become qualified beneficiaries if bankruptcy results in the loss of their coverage under the plan.

When is COBRA continuation coverage available?

The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Plan Administrator has been notified that a qualifying event has occurred. The employer must notify the Plan Administrator of the following qualifying events:

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

For all other qualifying events (divorce or legal separation of the employee and spouse or a dependent child's losing eligibility for coverage as a dependent child), you must notify the Plan Administrator within 60 days after the qualifying event occurs. You must provide this notice to: Colorado College, Human Resources - Attn: Benefits Manager, 14 E. Cache La Poudre Street, Colorado Springs, CO 80903-3294, Tel: 719-389-6104.

How is COBRA continuation coverage provided?

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

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

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

Disability extension of 18-month period of COBRA continuation coverage

If you or anyone in your family covered under the Plan is determined by Social Security to be disabled and you notify the Plan Administrator in a timely fashion, you and your entire family may be entitled to get up to an additional 11 months of COBRA continuation coverage, for a

maximum of 29 months. The disability would have to have started at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period of COBRA continuation coverage.

Second qualifying event extension of 18-month period of continuation coverage

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

Are there other coverage options besides COBRA Continuation Coverage?

Yes. Instead of enrolling in COBRA continuation coverage, there may be other coverage options for you and your family through the Health Insurance Marketplace, Medicaid, or other group health plan coverage options (such as a spouse's/DP's plan) through what is called a "special enrollment period." Some of these options may cost less than COBRA continuation coverage. You can learn more about many of these options at www.HealthCare.gov.

If you have questions

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

Keep your Plan informed of address changes

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

Plan contact information

Gina Lujan, Benefits Manager
Human Resources
Colorado College
14 E. Cache La Poudre Street
Colorado Springs, CO 80903-3294
Tel: 719-389-6104
Email: elujan@coloradocollege.edu

HEALTH PLAN SUMMARY ANNUAL REPORT

For THE COLORADO COLLEGE MEDICAL AND DENTAL PLAN

This is a summary of the annual report of The Colorado College Medical and Dental Plan, EIN 84-0402510, Plan No. 501, for period 07/01/2024 through 06/30/2025. The annual report has been filed with the Employee Benefits Security Administration, U.S. Department of Labor, as required under the Employee Retirement Income Security Act of 1974 (ERISA). The Colorado College has committed itself to pay certain self-insured Medical and Dental claims incurred under the terms of the plan.

Insurance Information

The plan has contracts with MetLife Legal Plans and ComPsych Corporation to pay Employee Assistance Program and Legal claims incurred under the terms of the plan. The total premiums paid for the plan year ending 06/30/2025 were \$47,564.

Your Rights to Additional Information

You have the right to receive a copy of the full annual report, or any part thereof, on request. The items listed below are included in that report:

- insurance information, including sales commissions paid by insurance carriers;

To obtain a copy of the full annual report, or any part thereof, write or call the office of The Colorado College at 14 East Cache La Poudre Street, Colorado Springs, CO, 80903 or by telephone at 719-389-6194.

You also have the legally protected right to examine the annual report at the main office of the plan (The Colorado College, 14 East Cache La Poudre Street, Colorado Springs, CO, 80903) and at the U.S. Department of Labor in Washington, D.C., or to obtain a copy from the U.S. Department of Labor upon payment of copying costs. Requests to the Department should be addressed to: Public Disclosure Room, Room N1513, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue, N.W., Washington, D.C. 20210.

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 less than one minute per notice (approximately 3 hours and 11 minutes per plan). 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, Office of the Chief Information Officer, Attention: Departmental Clearance Officer, 200 Constitution Avenue, N.W., Room N-1301, Washington, DC 20210 or email DOL_PRA_PUBLIC@dol.gov and reference the OMB Control Number 1210-0040.
OMB Control Number 1210-0040 (expires 03/31/2026)

SUMMARY ANNUAL REPORT For THE COLORADO COLLEGE VISION PLAN

This is a summary of the annual report of The Colorado College Vision Plan, EIN 84-0402510, Plan No. 509, for period 07/01/2024 through 06/30/2025. The annual report has been filed with the Employee Benefits Security Administration, U.S. Department of Labor, as required under the Employee Retirement Income Security Act of 1974 (ERISA).

Insurance Information

The plan has contracts with EyeMed Vision Care on Behalf of Fidelity Security Life Insurance Co. to pay Vision claims incurred under the terms of the plan. The total premiums paid for the plan year ending 06/30/2025 were \$109,572.

Your Rights to Additional Information

You have the right to receive a copy of the full annual report, or any part thereof, on request. The items listed below are included in that report:

- insurance information, including sales commissions paid by insurance carriers;

To obtain a copy of the full annual report, or any part thereof, write or call the office of THE COLORADO COLLEGE at 14 EAST CACHE LA POUDE STREET, COLORADO SPRINGS, CO, 80903 or by telephone at 719-389-6194.

You also have the legally protected right to examine the annual report at the main office of the plan (THE COLORADO COLLEGE, 14 EAST CACHE LA POUDE STREET, COLORADO SPRINGS, CO, 80903) and at the U.S. Department of Labor in Washington, D.C., or to obtain a copy from the U.S. Department of Labor upon payment of copying costs. Requests to the Department should be addressed to: Public Disclosure Room, Room N1513, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue, N.W., Washington, D.C. 20210.

Paperwork Reduction Act Statement

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The public reporting burden for this collection of information is estimated to average less than one minute per notice (approximately 3 hours and 11 minutes per plan). 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, Office of the Chief Information Officer, Attention: Departmental Clearance Officer, 200 Constitution Avenue, N.W., Room N-1301, Washington, DC 20210 or email DOL_PRA_PUBLIC@dol.gov and reference the OMB Control Number 1210-0040.

OMB Control Number 1210-0040 (expires 03/31/2026)

RETIREMENT BENEFIT PLAN SUMMARY ANNUAL REPORT

For Colorado College Retirement Benefit Plan

For Colorado College Retirement Benefit Plan

This is a summary of the annual report Form 5500 Annual Return/Report of Employee Benefit Plan for Colorado College Retirement Benefit Plan, EIN 84-0402510, Plan No. 001, for period January 1, 2024 through December 31, 2024. The Form 5500 annual report has been filed with the Employee Benefits Security Administration, as required under the Employee Retirement Income Security Act of 1974 (ERISA). Your plan is a single-employer defined contribution plan.

Basic Financial Statement

Benefits under the plan are provided by insurance and a trust fund. Plan expenses were \$25,358,309. These expenses included \$276,719 in administrative expenses, \$25,080,932 in benefits paid to participants and beneficiaries, and \$658 in other expenses. A total of 1,897 persons were participants in or beneficiaries of the plan at the end of the plan year, although not all of these persons had yet earned the right to receive benefits.

The value of plan assets, after subtracting liabilities of the plan, was \$381,542,052 as of December 31, 2024, compared to \$352,507,200 as of January 1, 2024. During the plan year the plan experienced an increase in its net assets of \$29,034,852. This increase includes unrealized appreciation and depreciation in the value of plan assets; that is, the difference between the value of the plan's assets at the end of the year and the value of the assets at the beginning of the year or the cost of assets acquired during the year. The plan had total income of \$54,393,161, including employer contributions of \$6,006,457, employee contributions of \$5,526,466, other contributions of \$1,800,073, earnings from investments of \$40,608,074, and other income of \$452,091.

Your Rights To Additional Information

You have the right to receive a copy of the full annual report, or any part thereof, on request. The items listed below are included in that report:

- An accountant's report;
- Financial information;
- Information on payments to service providers;
- Assets held for investment;
- Insurance information, including sales commissions paid by insurance carriers;
- Information regarding any common or collective trusts, pooled separate accounts, master trusts or 103-12 investment entities in which the plan participates.

To obtain a copy of the full annual report, or any part thereof, write or call the office of Colorado College in care of Lori Seager who is Plan Administrator at 14 E. Cache La Poudre Street, Colorado Springs, CO 80903, or by telephone at (719) 389-6194. The charge to cover copying costs will be \$0.25 per page.

You also have the right to receive from the plan administrator, on request and at no charge, a statement of the assets and liabilities of the plan and accompanying notes, or a statement of income and expenses of the plan and accompanying notes, or both. If you request a copy of the full annual report from the

plan administrator, these two statements and accompanying notes will be included as part of that report. The charge to cover copying costs given above does not include a charge for the copying of these portions of the report because these portions are furnished without charge.

You also have the legally protected right to examine the annual report at the main office of the plan (Colorado College, 14 E. Cache La Poudre Street, Colorado Springs, CO 80903) and at the U.S. Department of Labor in Washington, D.C., or to obtain a copy from the U.S. Department of Labor upon payment of copying costs. Requests to the Department should be addressed to: Public Disclosure Room, Room N-1513, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue, N.W., Washington, D.C. 20210.

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OMB Control Number 1210-0040 (expires 03/31/2026)

COLORADO SPRINGS FINE ARTS CENTER 403(B) SAVINGS PLAN

For Colorado Springs Fine Arts Center 403(b) Savings Plan

Please Note that this is a frozen retirement plan formerly offered to employees of the Colorado Springs Fine Arts Center.

This is a summary of the annual report Form 5500-SF Annual Return/Report of Small Employee Benefit Plan for Colorado Springs Fine Arts Center 403(b) Savings Plan, EIN 84-0406947, Plan No. 001, for period January 1, 2025 through December 31, 2025. The Form 5500-SF annual report has been filed with the Employee Benefits Security Administration, as required under the Employee Retirement Income Security Act of 1974 (ERISA). Your plan is a single-employer defined contribution plan.

Basic Financial Statement

Plan expenses were \$80,122. These expenses included \$265 in administrative expenses and \$79,857 in benefits paid to participants and beneficiaries. A total of 20 persons were participants in or beneficiaries of the plan at the end of the plan year.

The value of plan assets, after subtracting liabilities, was \$688,135 as of December 31, 2025, compared to \$704,407 as of January 1, 2025. During the plan year, the plan experienced a decrease in its net assets of \$16,272. The plan had total income of \$63,850, including earnings from investments.

Your Rights To Additional Information

You have the right to receive a copy of the full annual report, or any part thereof, on request. The items listed below are included in that report:

- financial information;
- assets held for investment;

To obtain a copy of the full annual report, or any part thereof, write or call the office of Colorado Springs Fine Arts Center in care of Lori Seager who is Plan Administrator at 14 E. Cache La Poudre Street, Colorado Springs, CO 80903, or by telephone at (719) 634-5581. The charge to cover copying costs will be \$3.00 for the full annual report, or \$0.25 per page for any part thereof.

You also have the right to receive from the plan administrator, on request and at no charge, a statement of the assets and liabilities of the plan and accompanying notes, or a statement of income and expenses of the plan and accompanying notes, or both. If you request a copy of the full annual report from the plan administrator, these two statements and accompanying notes will be included as part of that report. The charge to cover copying costs given above does not include a charge for the copying of these portions of the report because these portions are furnished without charge.

You also have the legally protected right to examine the annual report at the main office of the plan (Colorado Springs Fine Arts Center, 14 E. Cache La Poudre Street, Colorado Springs, CO 80903) and at the U.S. Department of Labor in Washington, D.C., or to obtain a copy from the U.S. Department of Labor upon payment of copying costs. Requests to the Department should be addressed to: Public Disclosure Room, Room N-1513, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue, N.W., Washington, D.C. 20210.

Small Plan Audit Waiver

The plan has met the requirements to waive the annual examination and report of an independent qualified public accountant. As of the end of the plan year, the following regulated financial

institution(s) held or issued plan assets that qualified under the waiver:

Equitable

704,407

You have the right, upon request of the Plan Administrator and without charge, to examine or receive copies of statements from the regulated financial institutions describing the qualifying plan assets. If you are unable to examine or obtain these documents, contact the Employee Benefits Security Administration (EBSA) Regional Office for assistance. Information about contacting EBSA regional offices can be found on the Internet at <http://www.dol.gov/ebsa>.

Paperwork Reduction Act Statement

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OMB Control Number 1210-0040 (expires 03/31/2026)

EMERITI PLAN SUMMARY ANNUAL REPORT

SUMMARY ANNUAL REPORT FOR EMERITI RETIREE HEALTH PLAN

FOR THE COLORADO COLLEGE

This is a summary of the annual report of the EMERITI RETIREE HEALTH PLAN FOR THE COLORADO COLLEGE, a health and dental plan (Employer Identification Number 84-0402510, Plan Number 510), for the plan year 01/01/2024 through 12/31/2024. The annual report has been filed with the Employee Benefits Security Administration, as required under the Employee Retirement Income Security Act of 1974 (ERISA).

Insurance Information

The plan has insurance contracts with AETNA LIFE INSURANCE COMPANY to pay all Dental, Prescription drug, PPO contract claims incurred under the terms of the plan. The total premiums paid for the plan year ending 12/31/2024 were \$256,693.

Basic Financial Statement

The value of plan assets, after subtracting liabilities of the plan, was \$12,638,587 as of the end of plan year, compared to \$11,559,465 as of the beginning of the plan year. During the plan year the plan experienced a change in its net assets of \$1,079,122. This change includes unrealized appreciation and depreciation in the value of plan assets; that is, the difference between the value of the plan's assets at the end of the year and the value of the assets at the beginning of the year or the cost of assets acquired during the year. During the plan year, the plan had total income of \$1,891,686 including employer contributions of \$386,139, employee contributions of \$265,268, gains/(losses) of \$0 from the sale of assets, and earnings from investments of \$1,240,279. Plan expenses were \$812,564. These expenses included \$88,495 in administrative expenses, \$724,069 in benefits paid to participants and beneficiaries, and \$0 in other expenses.

Your Rights to Additional Information

You have the right to receive a copy of the full annual report, or any part thereof, on request. The items listed below are included in that report:

1. An accountant's report.
2. Financial information and information on payments to service providers.
3. Assets held for investment.
4. Insurance information, including sales commissions paid by insurance carriers.

To obtain a copy of the full annual report, or any part thereof, write or call the plan administrator, at 14 EAST CACHE LA POUDE STREET, COLORADO SPRINGS, CO 80903 and phone number, 719-389-6422.

You also have the right to receive from the plan administrator, on request and at no charge, a statement of the assets and liabilities of the plan and accompanying notes, or a statement of income and expenses of the plan and accompanying notes, or both. If you request a copy of the full annual report from the plan administrator, these two statements and accompanying notes will be included as part of that report.

You also have the legally protected right to examine the annual report at the main office of the plan: 14 EAST CACHE LA POUDE STREET, COLORADO SPRINGS, CO 80903, and at the U.S. Department of Labor in Washington, D.C., or to obtain a copy from the U.S. Department of Labor upon payment of copying costs. Requests to the Department should be

addressed to: Public Disclosure Room, Room N-1513, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue, N.W., Washington, D.C. 20210. The annual report is also available online at the Department of Labor website www.efast.dol.gov.

COLORADO FAMILY AND MEDICAL LEAVE INSURANCE

COLORADO FAMILY AND MEDICAL LEAVE INSURANCE

Beginning 1/1/2024, The Colorado Family and Medical Leave Plan became effective.

Beginning 1/1/24, most Colorado workers within the state will be eligible to take paid family and medical leave during covered circumstances:

- To care for a new child, including adopted and fostered children
- To care for themselves if they have a serious health condition
- To make arrangements for a family member's military deployment
- To address the immediate safety needs and impact of domestic violence and/or sexual assault

Most workers are eligible to receive up to 12 weeks of paid family and medical leave. Those who experience pregnancy or childbirth complications may receive an additional four weeks.

The college meets its obligation to provide Colorado Family and Medical Leave through a private plan administered through Sun Life.

SunLife makes it easy to file a claim or request leave.

Step 1: Know when it's time to file a claim or request a leave

If you're absent from work, we can advise you on when to file a claim or request a leave. If your absence is scheduled, such as an upcoming hospital stay, call us 30 days prior to your last day of work. If unscheduled, please call us as soon as possible.

Step 2: Have this information ready

- Name, address and other key identification information
- Name of your department and last full day of active work
- The nature of your claim or leave request
- Your treating physician's name, address, phone and fax numbers
- Your manager's name and phone number
- **The Colorado College Policy Number: 996298**

Step 3: Make the call or file online

With your information handy, call Sunlife at 1-800-3247-6875 or file online at Sunlife.com/pfml. You'll be assisted by a caring professional who'll take your information, answer your questions and file your claim or process your leave request.

The Colorado College Employee Benefit Plan (The Plan) has been established to provide welfare benefits for its eligible employees.

The Employee Retirement Income Security Act of 1974 (ERISA) requires that the Plan Administrator provide you with a Summary Plan Description which discloses required information about the employee benefit plan. The following section entitled "Summary Plan Description" is not part of the Group Insurance Policy. The information in the Summary Plan Description is provided by the Plan Administrator who is the Policyholder and is included in this Certificate for your convenience. This Summary Plan Description applies only to the benefits under the Plan to the extent they are funded by the Group Insurance Policy issued by Sun Life Assurance Company of Canada. Sun Life Assurance Company of Canada assumes no responsibility for the accuracy or sufficiency of the information in the Summary Plan Description.

SUMMARY PLAN DESCRIPTION

Plan Sponsor: The Colorado College
14 E Cache La Poudre St
Colorado Springs, CO 80903

Plan Administrator and Named Fiduciary:
The Colorado College
14 E Cache La Poudre St
Colorado Springs, CO 80903

The Plan Administrator has authority to control and manage the operation and administration of the Plan, except that Sun Life Assurance Company of Canada makes all benefit claim determinations under the Group Insurance Policy.

Agent for Service of Legal Process for the Plan:

The Colorado College
14 E Cache La Poudre St
Colorado Springs, CO 80903

Service of Legal Process for Sun Life:

General Counsel
1 Sun Life Executive Park
Wellesley Hills, MA 02481

Employer Identification Number (EIN): 84-0402510

Plan Number: Life: 506, LTD:502

End of Plan Year: June 30th

Type of Administration: The Plan is administered by the Plan Administrator. The benefits provided by the Group Insurance Policy issued by Sun Life Assurance Company of Canada are included in the Plan. Sun Life Assurance Company of Canada is the claims administrator for those benefits and has full authority to make all benefit claim determinations.

Participants: The insured employees described in the Sun Life Assurance Company of Canada Certificate.

Plan Changes and Termination: The Plan Administrator may amend, modify or terminate the Plan.

Contributions: The cost of the insurance premiums are paid for by your employer and (if applicable) includes the cost of any insurance premiums contributed by you.

Funding: The benefits under the Plan are funded, at least in part, by the Group Insurance Policy issued by Sun Life Assurance Company of Canada. Those insurance benefits are described in your Certificate.

Claims Procedure: When you or your beneficiary wish to file a claim under the Plan, you should contact your personnel office for claim forms and instructions for filing. Your Certificate explains the procedure for filing a claim under the Group Insurance Policy.

If your claim for benefits is denied in whole or in part, you will receive a written notice within the time required by ERISA from the date you filed your claim, stating the reasons why your claim was denied. You will then have the right, upon written notice from you or your authorized representative, to review that claim denial. The claim denial notice will include the name and address of the person you may ask for such a review. Additional information about claims submitted and review procedures may be obtained by contacting your Plan Administrator.

Your Rights under ERISA:

As a participant in the Plan, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all plan participants shall be entitled to:

Receive Information About Your Plan and Benefits

- Examine, without charge, at the Plan Administrator's office and at other specified locations, such as worksites and union halls, all documents governing the Plan, including insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.
- Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the Plan, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) and updated summary plan description. The Plan Administrator may make a reasonable charge for the copies.
- Receive a summary of the plan's annual financial report, if required by ERISA. The Plan Administrator is required by law to furnish each participant with a copy of this summary annual report.

Prudent Actions by Plan Fiduciaries

In addition to creating rights for Plan participants, ERISA imposes duties upon the people who are responsible for the operation of the Plan. The people who operate your plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of you and other Plan participants and beneficiaries. No one, including your employer, your union, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a benefit or exercising your rights under ERISA.

Enforce Your Rights

If your claim for a benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules.

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of Plan Documents or the latest annual report from the Plan and do not receive them within 30 days, you may file suit in a Federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to \$110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Plan Administrator.

If you have a claim for benefits which is denied or ignored, in whole or in part and if you have exhausted the claims and appeal procedures described in the Certificate, you may file suit in a state or Federal court. If it should happen that Plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance of the U.S. Department of Labor, or you may file suit in a Federal court. The court will decide who should pay court costs and legal fees. If you are successful the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

Assistance with Your Questions

If you have questions about your Plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Plan Administrator, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue, N.W., Washington, DC 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

The Colorado College Employee Benefit Plan (The Plan) has been established to provide welfare benefits for its eligible employees.

The Employee Retirement Income Security Act of 1974 (ERISA) requires that the Plan Administrator provide you with a Summary Plan Description which discloses required information about the employee benefit plan. The following section entitled "Summary Plan Description" is not part of the Group Insurance Policy. The information in the Summary Plan Description is provided by the Plan Administrator who is the Policyholder and is included in this Certificate for your convenience. This Summary Plan Description applies only to the benefits under the Plan to the extent they are funded by the Group Insurance Policy issued by Sun Life Assurance Company of Canada. Sun Life Assurance Company of Canada assumes no responsibility for the accuracy or sufficiency of the information in the Summary Plan Description.

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14 E Cache La Poudre St
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Colorado Springs, CO 80903

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Agent for Service of Legal Process for the Plan:

The Colorado College
14 E Cache La Poudre St
Colorado Springs, CO 80903

Service of Legal Process for Sun Life:

General Counsel
1 Sun Life Executive Park
Wellesley Hills, MA 02481

Employer Identification Number (EIN): 84-0402510

Plan Number: Life: 506, LTD:502

End of Plan Year: June 30th

Type of Administration: The Plan is administered by the Plan Administrator. The benefits provided by the Group Insurance Policy issued by Sun Life Assurance Company of Canada are included in the Plan. Sun Life Assurance Company of Canada is the claims administrator for those benefits and has full authority to make all benefit claim determinations.

Participants: The insured employees described in the Sun Life Assurance Company of Canada Certificate.

Plan Changes and Termination: The Plan Administrator may amend, modify or terminate the Plan.

Contributions: The cost of the insurance premiums are paid for by your employer and (if applicable) includes the cost of any insurance premiums contributed by you.

Funding: The benefits under the Plan are funded, at least in part, by the Group Insurance Policy issued by Sun Life Assurance Company of Canada. Those insurance benefits are described in your Certificate.

Claims Procedure: When you or your beneficiary wish to file a claim under the Plan, you should contact your personnel office for claim forms and instructions for filing. Your Certificate explains the procedure for filing a claim under the Group Insurance Policy.

If your claim for benefits is denied in whole or in part, you will receive a written notice within the time required by ERISA from the date you filed your claim, stating the reasons why your claim was denied. You will then have the right, upon written notice from you or your authorized representative, to review that claim denial. The claim denial notice will include the name and address of the person you may ask for such a review. Additional information about claims submitted and review procedures may be obtained by contacting your Plan Administrator.

Your Rights under ERISA:

As a participant in the Plan, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all plan participants shall be entitled to:

Receive Information About Your Plan and Benefits

- Examine, without charge, at the Plan Administrator's office and at other specified locations, such as worksites and union halls, all documents governing the Plan, including insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.
- Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the Plan, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) and updated summary plan description. The Plan Administrator may make a reasonable charge for the copies.
- Receive a summary of the plan's annual financial report, if required by ERISA. The Plan Administrator is required by law to furnish each participant with a copy of this summary annual report.

Prudent Actions by Plan Fiduciaries

In addition to creating rights for Plan participants, ERISA imposes duties upon the people who are responsible for the operation of the Plan. The people who operate your plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of you and other Plan participants and beneficiaries. No one, including your employer, your union, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a benefit or exercising your rights under ERISA.

Enforce Your Rights

If your claim for a benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules.

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of Plan Documents or the latest annual report from the Plan and do not receive them within 30 days, you may file suit in a Federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to \$110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Plan Administrator.

If you have a claim for benefits which is denied or ignored, in whole or in part and if you have exhausted the claims and appeal procedures described in the Certificate, you may file suit in a state or Federal court. If it should happen that Plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance of the U.S. Department of Labor, or you may file suit in a Federal court. The court will decide who should pay court costs and legal fees. If you are successful the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

Assistance with Your Questions

If you have questions about your Plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Plan Administrator, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue, N.W., Washington, DC 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

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Service of Legal Process for Sun Life:

General Counsel
1 Sun Life Executive Park
Wellesley Hills, MA 02481

Employer Identification Number (EIN): 84-0402510

Plan Number: Life: 506, LTD:502

End of Plan Year: June 30th

Type of Administration: The Plan is administered by the Plan Administrator. The benefits provided by the Group Insurance Policy issued by Sun Life Assurance Company of Canada are included in the Plan. Sun Life Assurance Company of Canada is the claims administrator for those benefits and has full authority to make all benefit claim determinations.

Participants: The insured employees described in the Sun Life Assurance Company of Canada Certificate.

Plan Changes and Termination: The Plan Administrator may amend, modify or terminate the Plan.

Contributions: The cost of the insurance premiums are paid for by your employer and (if applicable) includes the cost of any insurance premiums contributed by you.

Funding: The benefits under the Plan are funded, at least in part, by the Group Insurance Policy issued by Sun Life Assurance Company of Canada. Those insurance benefits are described in your Certificate.

Claims Procedure: When you or your beneficiary wish to file a claim under the Plan, you should contact your personnel office for claim forms and instructions for filing. Your Certificate explains the procedure for filing a claim under the Group Insurance Policy.

If your claim for benefits is denied in whole or in part, you will receive a written notice within the time required by ERISA from the date you filed your claim, stating the reasons why your claim was denied. You will then have the right, upon written notice from you or your authorized representative, to review that claim denial. The claim denial notice will include the name and address of the person you may ask for such a review. Additional information about claims submitted and review procedures may be obtained by contacting your Plan Administrator.

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- Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the Plan, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) and updated summary plan description. The Plan Administrator may make a reasonable charge for the copies.
- Receive a summary of the plan's annual financial report, if required by ERISA. The Plan Administrator is required by law to furnish each participant with a copy of this summary annual report.

Prudent Actions by Plan Fiduciaries

In addition to creating rights for Plan participants, ERISA imposes duties upon the people who are responsible for the operation of the Plan. The people who operate your plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of you and other Plan participants and beneficiaries. No one, including your employer, your union, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a benefit or exercising your rights under ERISA.

Enforce Your Rights

If your claim for a benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules.

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of Plan Documents or the latest annual report from the Plan and do not receive them within 30 days, you may file suit in a Federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to \$110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Plan Administrator.

If you have a claim for benefits which is denied or ignored, in whole or in part and if you have exhausted the claims and appeal procedures described in the Certificate, you may file suit in a state or Federal court. If it should happen that Plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance of the U.S. Department of Labor, or you may file suit in a Federal court. The court will decide who should pay court costs and legal fees. If you are successful the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

Assistance with Your Questions

If you have questions about your Plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Plan Administrator, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue, N.W., Washington, DC 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

The Colorado College Employee Benefit Plan (The Plan) has been established to provide welfare benefits for its eligible employees and their eligible dependents.

The Employee Retirement Income Security Act of 1974 (ERISA) requires that the Plan Administrator provide you with a Summary Plan Description which discloses required information about the employee benefit plan. The following section entitled "Summary Plan Description" is not part of the Group Insurance Policy. The information in the Summary Plan Description is provided by the Plan Administrator who is the Policyholder and is included in this Certificate for your convenience. This Summary Plan Description applies only to the benefits under the Plan to the extent they are funded by the Group Insurance Policy issued by Sun Life Assurance Company of Canada. Sun Life Assurance Company of Canada assumes no responsibility for the accuracy or sufficiency of the information in the Summary Plan Description.

SUMMARY PLAN DESCRIPTION

Plan Sponsor: The Colorado College
14 E Cache La Poudre St
Colorado Springs, CO 80903

Plan Administrator and Named Fiduciary:
The Colorado College
14 E Cache La Poudre St
Colorado Springs, CO 80903

The Plan Administrator has authority to control and manage the operation and administration of the Plan, except that Sun Life Assurance Company of Canada makes all benefit claim determinations under the Group Insurance Policy.

Agent for Service of Legal Process for the Plan:

The Colorado College
14 E Cache La Poudre St
Colorado Springs, CO 80903

Service of Legal Process for Sun Life:

General Counsel
1 Sun Life Executive Park
Wellesley Hills, MA 02481

Employer Identification Number (EIN): 84-0402510

Plan Number: Life: 506, LTD:502

End of Plan Year: June 30th

Type of Administration: The Plan is administered by the Plan Administrator. The benefits provided by the Group Insurance Policy issued by Sun Life Assurance Company of Canada are included in the Plan. Sun Life Assurance Company of Canada is the claims administrator for those benefits and has full authority to make all benefit claim determinations.

Participants: The insured employees described in the Sun Life Assurance Company of Canada Certificate.

Plan Changes and Termination: The Plan Administrator may amend, modify or terminate the Plan.

Contributions: The cost of the insurance premiums are paid for by you.

Funding: The benefits under the Plan are funded, at least in part, by the Group Insurance Policy issued by Sun Life Assurance Company of Canada. Those insurance benefits are described in your Certificate.

Claims Procedure: When you or your beneficiary wish to file a claim under the Plan, you should contact your personnel office for claim forms and instructions for filing. Your Certificate explains the procedure for filing a claim under the Group Insurance Policy.

If your claim for benefits is denied in whole or in part, you will receive a written notice within the time required by ERISA from the date you filed your claim, stating the reasons why your claim was denied. You will then have the right, upon written notice from you or your authorized representative, to review that claim denial. The claim denial notice will include the name and address of the person you may ask for such a review. Additional information about claims submitted and review procedures may be obtained by contacting your Plan Administrator.

Your Rights under ERISA:

As a participant in the Plan, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all plan participants shall be entitled to:

Receive Information About Your Plan and Benefits

- Examine, without charge, at the Plan Administrator's office and at other specified locations, such as worksites and union halls, all documents governing the Plan, including insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.
- Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the Plan, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) and updated summary plan description. The Plan Administrator may make a reasonable charge for the copies.
- Receive a summary of the plan's annual financial report, if required by ERISA. The Plan Administrator is required by law to furnish each participant with a copy of this summary annual report.

Prudent Actions by Plan Fiduciaries

In addition to creating rights for Plan participants, ERISA imposes duties upon the people who are responsible for the operation of the Plan. The people who operate your plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of you and other Plan participants and beneficiaries. No one, including your employer, your union, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a benefit or exercising your rights under ERISA.

Enforce Your Rights

If your claim for a benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules.

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of Plan Documents or the latest annual report from the Plan and do not receive them within 30 days, you may file suit in a Federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to \$110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Plan Administrator.

If you have a claim for benefits which is denied or ignored, in whole or in part and if you have exhausted the claims and appeal procedures described in the Certificate, you may file suit in a state or Federal court. If it should happen that Plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance of the U.S. Department of Labor, or you may file suit in a Federal court. The court will decide who should pay court costs and legal fees. If you are successful the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

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Short Term Disability Income Plan

The Colorado College

BOOKLET

PLAN EFFECTIVE DATE: 07/01/26

The Plan is a self-funded welfare benefit plan (the “Plan”) providing Short Term Disability benefits (“STD”) to eligible participants under the terms and conditions of the Plan. Sun Life Assurance Company of Canada (“Sun Life”) is the Claims Administrator and provides certain claim administration services to the Plan. The Plan Administrator, *Colorado College*, retains discretion to make the final claim decision. The Plan is not insured by Sun Life and Sun Life has not issued any insurance policy to fund benefits under the Plan, nor is Sun Life responsible for the payment of any benefits under the Plan. All benefits are funded by *Colorado College*.

This booklet is intended to provide a summarized explanation of the current Plan benefits. The description of Eligible Classes in the Schedule of Benefits will help you determine what benefits apply to you. In the event of any changes in benefits or Plan provisions, the Plan Administrator will provide you with a new booklet that describes any changes.

Possession of this booklet does not necessarily mean you are covered under the Plan. The requirements for becoming eligible for coverage under the Plan and the dates your coverage begins or ceases are explained within this booklet.

This booklet uses terms and phrases that are listed in the Definitions Section.

For information, please contact your Human Resources contact at *Colorado College* or Sun Life at (877) 786-3652.

**THE PLAN MAY BE AMENDED OR
TERMINATED BY *Colorado College*
AT ANY TIME AND FOR ANY REASON.**

READ THIS DOCUMENT CAREFULLY

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BENEFITS FOR YOU

Short Term Disability Coverage

The Plan pays you a portion of your income earnings as a benefit for a period of Short-Term Disability caused by an Illness or Injury that occurs while your coverage is in effect and so long as you meet all requirements under the Plan to receive benefits. You must provide the Plan, at your own expense, satisfactory Proof of Disability before benefits will be paid.

Coverage under this Plan is non-occupational. Only non-occupational injuries and non-occupational illnesses are covered.

Please refer to the following provisions for more details about your coverage.

BENEFIT HIGHLIGHTS

Eligible Employee's

All Full Time and Part Time Active Employee's in the United States regularly scheduled to work between 1000- 1400 hours or more per fiscal year (or a minimum of 20 hours per week)

Eligibility Waiting Period

First of the month coincident with or next following date of employment

Elimination Period

7 days for injury or illness

Note: Benefits will begin on the first day following the completion of the Elimination Period.

Gross Disability Benefit

100% of weekly Covered Earnings

For any partial week of Disability, payment is made at the daily rate of 1/5th of the weekly benefit payable.

Maximum Benefit Payable Period

The earlier of:

- a. end of the Disability; or
- b. 26 weeks

Benefits Actually Payable

Any benefit actually payable to you will be reduced by Other Income Benefits or Other Income Earnings

Covered Earnings means your wage or salary as reported by the Employer for work performed for the Employer as in effect just prior to the date your Disability begins. Covered Earnings are determined initially on the date an Employee applies for coverage. A change in the amount of Covered Earnings is effective immediately if the Employer gives us written notice of the change and the required premium is paid. It does not include earnings received from commissions, bonuses, overtime pay, or other extra compensation.

Any increase in your Covered Earnings will not be effective during a period of continuous Disability.

ELIGIBILITY AND EFFECTIVE DATES

Eligibility Requirements for Plan Benefits

The eligibility requirements for Plan benefits are shown in the Benefit Highlights.

When is the Employee Eligible for Plan Benefits?

The Employee is initially eligible for Plan benefits on the latest date of:

1. This Plan's effective date; or
2. The day after the Employee completes the Eligibility Waiting Period shown in the Benefit Highlights.

Plan Eligibility Effective Date

Eligibility will be effective at 12:01 A.M. MT

determined as follows, but only if the Employee's application or enrollment is made in a form or format satisfactory to the Plan.

An Employee is covered on his Eligibility Date.

When Does a Change in benefits Start?

If the Employee is in Active Service, any increase in benefits will start:

1. Immediately upon the date of change, if the Employee transfers to a different class of eligible Employees; or
2. Immediately upon the date of change, for an increase in the Employee's Covered Earnings.

Delayed Effective Date

The effective date of any initial, increased or additional coverage will be delayed for an individual if he is not in Active Service because of Injury or Illness. The initial, increased or additional coverage will begin on the date the individual returns to Active Service.

DISABILITY INCOME BENEFITS

Disability Benefit

When Sun Life receives Proof that a Covered Person is Disabled due to Injury or Illness and requires the Appropriate and Continuing Care by a Physician, the Plan will pay the Covered Person a Weekly Benefit after the end of the Elimination Period, subject to any other provisions of this Plan. The benefit will be paid for the period of Disability if the Covered Person gives to Sun Life Proof of continued:

1. Disability;
2. Appropriate and Continuing Care by a Physician; and
3. Appropriate Available Treatment.

The Proof must be given upon the Plan's request and at the Covered Person's expense. In determining whether the Covered Person is Disabled, the Plan will not consider employment factors including, but not limited to, interpersonal conflict in the workplace, recession, job obsolescence, pay cuts, job sharing and loss of a professional or occupational license or certification.

For purposes of determining Disability, the Injury must occur and Disability must begin while the Employee is covered under the Plan.

The Weekly Benefit will not:

1. Exceed the Covered Person's Amount of Coverage; or
2. Be paid for longer than the Maximum Benefit Period.

The Amount of Coverage and the Maximum Benefit Period are shown in the Benefit Highlights.

Amount of Disability Weekly Benefit

To figure the amount of Weekly Benefit:

1. Take the lesser of:
 - a. The Covered Person's Covered Earnings multiplied by the benefit percentage shown in the Benefit Highlights; or
 - b. The Maximum Weekly Benefit shown in the Benefit Highlights; and then
2. Deduct Other Income Benefits and Other Income Earnings, (shown in the Other Income Benefits and Other Income Earnings provision of this Plan), from this amount.

Minimum Benefit

The Plan will pay the Minimum Benefit regardless of any reductions made for Other Income Benefits. However, if there is an overpayment due, this benefit may be reduced to recover the overpayment.

Return to Work Incentive Benefit Calculation

You may work for wage or profit while Disabled. In any week in which you work and a Disability Benefit is payable, the Return-to-Work Incentive Benefit Calculation applies.

For each week that Disability Benefits are payable, your benefits are calculated as follows:

1. Add your Gross Disability Benefit (Weekly STD benefit) and Covered Earnings (part-time weekly earnings).
2. Compare the sum from 1 to your Covered Earnings.
3. If the sum from 1 exceeds **100%** of your Covered Earnings, then subtract the Covered Earnings from the sum in 1.
4. Your Gross Disability Benefit will be reduced by the difference from 3, as well as by Other Income Benefits.
5. If the sum from 1 does not exceed **100%** of your Covered Earnings, your Gross Disability Benefit will be reduced by the Other Income Benefits.

The Plan will review your status from time to time and will require satisfactory proof of earnings, and continued Disability.

No Disability Benefits are paid, and participation will end if the Plan determines you are able to work under a modified work arrangement and you refuse to do so without Good Cause.

Other Income Benefits

If Disability Benefits are payable to you under this Plan, you may be eligible for benefits from Other Income Benefits. If so, the Plan may reduce the Disability Benefits by the amount of such Other Income Benefits.

Other Income Benefits include:

1. Benefits under Unemployment Compensation Law, or any other act or law of like intent;
2. **The amount from any mandated benefits act or law that you may receive or be eligible to receive, including all Paid Medical Leave, or state disability mandated temporary disability benefits required by law and where such reduction is not prohibited by law;**

3. An automobile insurance policy providing disability wage loss benefits;
4. Any labor management trustee, union or employee benefit plans that are funded in whole or in part by your Employer;
5. Any disability income benefits under:
 - a. any other group plan of your Employer; or
 - b. any governmental retirement system as a result of your job with your Employer;
6. The amount you receive from any sick leave paid to you by your Employer; or
7. The amount you receive from any salary continuation paid to you by your Employer. Other Income Benefits includes only the amount of such benefits which, when combined with your Disability Benefit, exceeds 100% of your Covered Earnings. The amount in excess of 100% of Covered Earnings are used to reduce your benefit.

Dependents include any person who receives (or is assumed to receive*) benefits under any applicable law because of your entitlement to benefits.

* See the Assumed Receipt of Benefits provision.

Increases in Other Income Benefits

Any increase in Other Income Benefits during a period of Disability due to a cost of living adjustment are considered in calculating your Disability Benefits after the first reduction is made for any Other Income Benefits. This section does not apply to any cost of living adjustment for Covered Earnings.

Lump Sum Payments

Other Income Benefits or earnings paid in a lump sum are prorated over the period for which the sum is given. If no time is stated, the lump sum is prorated over five years.

If no specific allocation of a lump sum payment is made, then the total payment will be an Other Income Benefit.

Assumed Receipt of Benefits

The Plan will assume you and your dependents are receiving benefits for which you are eligible from Other Income Benefits. The Plan will reduce your Disability Benefits by the amount from Other Income Benefits it estimates are payable to you and your dependents.

The Plan will waive Assumed Receipt of Benefits, except for Covered Earnings for work you perform while Disability Benefits are payable, if you:

1. Provide satisfactory proof of application for Other Income Benefits;
2. Sign a Reimbursement Agreement;
3. Provide satisfactory proof that all appeals for Other Income Benefits have been made unless the Plan determines that further appeals are not likely to succeed; and
4. Submit satisfactory proof that Other Income Benefits were denied.

The Plan will not assume receipt of any pension or retirement benefits that are actuarially reduced according to applicable law, until you actually receive them.

The Plan may limit its waiver of Assumed Receipt of Benefits at its discretion.

Recovery of Overpayment

The Plan has the right to recover any benefits it has overpaid. The Plan may use any or all of the following to recover an overpayment:

1. Request a lump sum payment of the overpaid amount;

2. Reduce any amounts payable under this Plan; and/or
3. Take any appropriate collection activity available to it.

The Minimum Benefit amount will not apply when Disability Benefits are reduced in order to recover any overpayment.

If an overpayment is due when you die, any benefits payable under the Plan are reduced to recover the overpayment.

Right of Recovery

The Plan has the right to recover any overpayment of benefits caused by, but not limited to, the following:

1. Fraud;
2. Any error made in processing a claim;
3. The Covered Person's receipt of any Other Income Benefits.

The Plan may recover and overpayment by, but not limited to, the following:

1. Requesting a lump sum payment of the overpaid amount;
2. Reducing any benefits payable under this Plan;
3. Taking any appropriate collection activity available including any legal action needed; and

It is required that full reimbursement be made to the Plan.

Successive Periods of Disability

A separate period of Disability is considered continuous:

1. If it results from the same or related causes as a prior Disability for which weekly benefits were payable; and
2. If, after receiving Disability Benefits, you return to work in your Regular Occupation for less than 30 consecutive days; and
3. If you earn less than the percentage of Covered Earnings that would still qualify you to meet the definition of Disability/Disabled during at least one week.

Any later period of Disability, regardless of cause, that begins when you are eligible for participation under another group disability plan provided by any employer will not be considered a continuous period of Disability.

For any separate period of disability, which is not considered continuous, you must satisfy a new Elimination Period.

EXCLUSIONS AND LIMITATIONS

Disability Benefit Exclusions

The Plan will not pay any Disability Benefits for a Disability that result, directly or indirectly, from:

1. Suicide, attempted suicide, or self-inflicted injury while sane or insane.
2. War or any act of war, whether or not declared.
3. Active participation in a riot.
4. Commission of a felony.
5. The revocation, restriction or non-renewal of your license, permit or certification necessary to perform the duties of your occupation unless due solely to Injury or Illness otherwise covered by the Plan.
6. Any cosmetic surgery or surgical procedure that is not Medically Necessary. "Medically Necessary" means the surgical procedure is: (a) prescribed by a Physician as required treatment of the Injury or Sickness; and (b) appropriate according to conventional medical practice for the Injury or Illness in the locality in which the surgery is performed. The Plan will pay benefits if you donating an organ in a non-experimental organ transplant procedure cause the Disability.
7. An Injury or Illness for which the Employee is entitled to benefits from Workers' Compensation or occupational disease law.

In addition, the Plan will not pay Disability Benefits for any period of Disability during which the Employee is incarcerated in a penal or corrections institution.

Disability Benefit Limitations

No benefit is payable to you under the Plan for any period of Disability or other loss:

1. While you are not under the Continuing Care of a Physician for the Injury or Illness causing your Disability, unless you have reached your maximum point of recovery and are still Disabled;
2. For any period you do not submit to any medical examination or clinical assessment requested by The Plan.

TERMINATION PROVISIONS

Termination of Disability Benefits

Benefits will end on the earliest of the following dates:

1. The date you earn more than the percentage of Covered Earnings set forth in the definition of Disability from any occupation.
2. The date the Plan determines you are not Disabled.
3. The end of the Maximum Benefit Period.
4. The date you die.
5. The date you are no longer receiving Appropriate Care.
6. The date you fail to cooperate with the Plan in the administration of the claim. Such cooperation includes, but is not limited to, providing any information or documents needed to determine whether benefits are payable or the actual benefit amount due.

Termination of Plan Participation

Your participation will end on the earliest of the following dates:

1. The date you are eligible for participation under a plan intended to replace this Plan.
2. The date the Plan terminates.

3. The date you are no longer in an eligible class.
4. The day after the end of the period for which you cease to make your contribution to the Plan, if applicable.
5. The date you are no longer in Active Service.
6. The date benefits end for failure to comply with the terms and conditions of the Plan.

CONTINUATION AND REINSTATEMENT OF PLAN PARTICIPATION

Continuation of Plan Participation

If the Employee is absent due to an Injury or Illness, the Employee's Plan Participation will continue during the Elimination Period.

While the Plan is in force and subject to the conditions stated in the Plan, the Employer may continue the Employee's coverage for any of the following reasons: Layoff – up to 1 month

- Leave of Absence – up to 1 month
- Vacation – up to 3 months

While the Plan is in force, the Employee may be eligible to continue their coverage pursuant to the Family and Medical Leave Act (FMLA) of 1993, as amended or continue coverage pursuant to a state required continuation period (if any).

While the Plan is in force, the Employee may be eligible to continue their insurance pursuant to the Uniformed Services Employment and Reemployment Rights Act (USERRA), as amended.

Reinstatement of Plan Participation

Your participation may reinstate if it ends because you are on an unpaid leave of absence.

Your participation may be reinstated only if a written request for reinstatement is received by the Plan within 31 days from the date you return to Active Service from an Employer approved unpaid leave of absence or from the military service pursuant to the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA). For participation to be reinstated the following conditions must be met.

1. You must be in a Class of Eligible Employees.
2. The required contribution must be paid, if applicable.

Reinstated participation will be effective on the date you return to Active Service. If you did not fully satisfy the Eligibility Waiting Period before participation ended due to an unpaid leave of absence, credit will be given for any time that was satisfied.

GENERAL PROVISIONS

Claimant Cooperation Provision

Your failure to cooperate with the Plan in the administration of the claim may result in termination of the claim. Such cooperation includes, but is not limited to, providing any information or documents needed to determine whether benefits are payable or the actual benefit amount due.

Proof of Loss

Written proof of loss must be given to the Plan within 90 days after the date of the loss for which a claim is made. If written proof of loss is not given in that time, the claim will not be invalidated nor reduced if it is shown that written proof of loss was given as soon as was reasonably possible. In any case, written proof must be given not more than a year after that 90 day period. If written proof of loss is provided

outside of these time limits, the claim will be denied. These time limits will not apply while the person making the claim lacks legal capacity.

Within 30 days of a request, written proof of continued Disability and Appropriate Care by a Physician must be given to the Plan.

The Plan reserves the right to determine if the Covered Person's Proof of loss is satisfactory.

Notice of Claim

Notice of claim must be given to the Plan within 30 days of the date of the loss on which the claim is based. If that is not possible, the Plan must be notified as soon as it is reasonably possible to do so. Such notice of claim must be received in a form or format satisfactory to the Plan.

When written notice of claim is applicable and has been received by the Plan the Covered Person will be sent claim forms. If the forms are not received within 15 days after written notice of claim is sent, the Covered Person can send The Plan written Proof of claim without waiting for the forms.

Time of Payment

Disability Benefits will be paid at regular intervals of not less frequently than once a week. Any balance, unpaid at the end of any period for which the Plan is liable, will be paid at that time.

Physical Examination and Autopsy

The Plan, at its expense, will have the right to examine any person for whom a claim is pending as often as it may reasonably require. The Plan may require an autopsy unless prohibited by law at its expense.

Physician/Patient Relationship

You will have the right to choose any Physician who is practicing legally. The Plan will in no way disturb the Physician/patient relationship.

Legal Proceedings

A claimant or the claimant's authorized representative cannot start any legal action:

1. Until 60 days after Proof of claim has been given; or
2. More than three years after the time Proof of claim is required.

Legal Action

You must use and exhaust this Plan's administrative claims and appeals procedures before bringing a lawsuit. Any legal action brought to recover payment of any benefit under this Plan must be initiated before the earlier to occur of the following:

- Two years after the date of the final decision on the final appeal of the denial of your claim;
- Three years from the date your claim for benefits was first denied.

Payment of Claims

The benefit is payable to the Covered Person. But, if a benefit is payable to a Covered Person's estate, a Covered Person who is a minor, or who is not competent, The Plan has the right to pay up to \$2,000 to any of the Covered Person's relatives or any other person whom the Plan considers entitled thereto by reason of having incurred expense for the maintenance, medical attendance or burial of the Covered Person. If the Plan in good faith pays the benefit in such a manner, any such payment shall fulfill the Plan's responsibility for the amount paid.

Subrogation and Reimbursement

When a Covered Person's Injury appears to be someone else's fault, benefits otherwise payable under this Plan for loss of time as a result of that Injury will not be paid unless the Covered Person or his legal representative agree(s):

1. To repay the Plan for such benefits to the extent they are for the losses for which compensation is paid to the Covered Person by or on behalf of the person at fault;
2. To allow the Plan a lien on such compensation and to hold such compensation in trust for the Plan and
3. To execute and give to the Plan any instruments needed to secure the rights under 1. and 2. Above.

Further, when the Plan has paid benefits to or on behalf of the injured Covered Person, the Plan will be subrogated to all rights of recovery that the Covered Person has against the person at fault. These subrogation rights will extend only to recovery of the amount the Plan has paid. The Covered Person must execute and deliver any instruments needed and do whatever else is necessary to secure those rights to The Plan.

DEFINITIONS

Active Service

If you are an Employee, you are in Active Service on a day which is one of the Employer's scheduled work days if either of the following conditions are met:

1. You are performing your Regular Occupation for the Employer on a full-time basis. You must be working at one of the Employer's usual places of business or at some location to which the Employer's business requires you to travel.
2. The day is a scheduled holiday or vacation day and you were performing your Regular Occupation on the preceding scheduled day.

You are in Active Service on a day which is not one of the Employer's scheduled work days only if you were in Active Service on the preceding scheduled work day.

Appropriate Care means the determination of an accurate and medically supported diagnosis of your Disability by a Physician, or a plan established by a Physician of ongoing medical treatment and care of the Disability that conforms to generally accepted medical standards, including frequency of treatment and care.

Continuing Care means the Employee visits a Physician whose medical specialty is the most appropriate specialty to evaluate, manage, or treat their Injury or Illness. The Employee receives care and treatment as frequently as is medically necessary according to the generally accepted medical standards.

Disability or Disabled means the Covered Person, as a result of Injury or Sickness, is unable to perform the Material and Substantial Duties of his Regular Occupation.

Eligibility Date means the date an Employee becomes eligible for insurance under this plan. Eligibility Requirements are shown in the Schedule of Benefits.

Eligibility Waiting Period means the continuous length of time an Employee must be in Active Service in an eligible class to reach his Eligibility Date.

Elimination Period means the period of time you must be continuously Disabled before Disability Benefits are payable. The Elimination Period is shown in the Schedule of Benefits.

A period of Disability is not continuous if separate periods of Disability result from unrelated causes.

Employee

For eligibility purposes, you are an Employee if you work for the Employer and are in one of the Classes of Eligible Employees. Otherwise, you are an Employee if you are an employee of the Employer who participates under this Plan.

Employer

The Employer and any affiliates or subsidiaries covered under the Plan.

Full-time

Full-time means the number of hours set by the Employer as a regular workday for Employees in your eligibility class.

Good Cause means a medical reason preventing the Employee's participation in the Return to Work Incentive Plan. The Employee must provide satisfactory Proof of Good Cause to The Plan. **Illness** means any physical or mental illness or disease including pregnancy or complications of pregnancy.

Injury means any accidental loss or bodily harm which results directly or indirectly of all other causes from an Accident.

Material and Substantial Duties means responsibilities that are normally required to perform the Covered Person's Regular Occupation and cannot be reasonably eliminated or modified.

Mental Illness means a psychiatric or psychological condition classified as such in the most current edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM) regardless of the underlying cause of the Mental Illness. If the DSM is discontinued, Sun life will use the replacement chosen or published by the American Psychiatric Association.

Physician means a licensed doctor practicing within the scope of his or her license and rendering care and treatment to you that is appropriate for your condition and locality. The term does not include you, your spouse, the immediate family (including parents, children, siblings or spouses of any of the foregoing, whether the relationship derives from blood or marriage), of you or spouse, or a person living in your household.

It does not include a Covered Person, any family member or domestic partner.

Plan

Refers to the Short Term Disability benefits provided by the Employer as an in effect from time to time.

Regular Occupation means the occupation you routinely perform at the time the Disability begins. In evaluating Disability, the Plan will consider the duties of the occupation as it is normally performed in the general labor market in the national economy. It is not work tasks that are performed for a specific employer or at a specific location.

Treatment means consulting, receiving care or services provided by or under the direction of a Physician including diagnostic measures, being prescribed drugs and/or medicines, whether the

Covered Person chooses to take them or not, and taking drugs and/or medicines.

Weekly Benefit means the weekly amount payable by the Plan to the Disabled or Partially Disabled Covered Person.

CLAIMS APPEAL AND REVIEW PROCESS

Claim Determinations

The Claims Administrator will make notification of a claim determination as soon as possible but not later than 45 calendar days after the claim is made. The Claims Administrator may determine that due to matters beyond its control an extension of this 45 calendar days claim determination period is required. Such an extension, of not longer than 30 additional calendar days, will be allowed if the Claims Administrator notifies you within the first 45 calendar days period. If prior to the end of the first 30 calendar days extension period, the Claims Administrator again determines that due to matters beyond its control a decision cannot be made within that extension period, the claim determination period may be extended for an additional 30 calendar days. The Claims Administrator must notify you, prior to the end of the first extension period, of the circumstance requiring the extension and the date by which a decision can be expected.

The notice of any extension by the Claims Administrator shall specifically explain:

- the standards on which entitlement to a benefit is based;
- the unresolved issues that prevent a decision on the claim; and
- the additional information needed to resolve those issues.

The claimant will have 45 calendar days, from the date of the notice, to provide the Claims Administrator with the required information.

What if my claim is denied?

If your claim is denied in whole or in part, you will be notified in writing, in a culturally and linguistically appropriate manner, which will inform you of:

1. the specific reason(s) for the denial, and the Plan provisions on which the denial is based;
2. the identity of any medical or vocational experts whose advice was obtained in connection with the claim, regardless of whether the advice was relied upon to deny the claim;
3. if applicable, why we did not agree with or follow: 1) the views of healthcare professionals treating you or vocational professionals who evaluated you; 2) the views of medical or vocational experts whose advice we obtained, without regard to whether we relied upon that advice; and 3) a disability determination made by the Social Security Administration, if applicable.
4. the identity of (and upon request, the right to receive a copy of) any internal rule, guideline, protocol or other similar criterion relied upon to deny the claim; or a statement that such does not exist;
5. your right to request and receive, at no charge, copies of the information relevant to your benefits claim;
6. a description of any additional material or information needed to prove entitlement to benefits and an explanation of why such material or information is necessary;

7. a description of the appeal procedures and time limits;
8. your right to bring a civil action under ERISA, §502(a) following an adverse determination on review;

Appeals of Adverse Benefit Determinations

You may submit an appeal if the Claims Administrator gives notice of an adverse benefit determination.

You have 180 calendar days following the receipt of notice of an adverse benefit determination to request your appeal. Your appeal must be submitted in writing and should include:

- Your name;
- Your reasons for making the appeal; and
- Any other information you would like to have considered.

You may submit written comments, documents, records, and other information relating to your claim, whether or not the comments, documents, records, or information were submitted in connection with the initial claim. You may also request that the Plan provide you, free of charge, copies of all documents, records, and other information relevant to the claim.

Send in your appeal to the address shown on the notice of adverse benefit determination.

You may also choose to have another person (an authorized representative) make the appeal on your behalf by providing written consent to the Claims Administrator.

Appeal Procedure

The Claims Administrator shall issue a decision within 45 calendar days of receipt of the request for an appeal. If The Claims Administrator determines that due to special circumstances an extension of time for claim processing is required, such an extension, if not longer than 45 additional calendar days, will be allowed if the Claims Administrator notifies you within the first 45 calendar day period. The extension notice shall indicate the special circumstances requiring an extension of time and the date by which a decision can be expected.

What if my claim is denied on appeal?

If your claim is denied in whole or in part, you will be notified in writing, in a culturally and linguistically appropriate manner, which will inform you of:

1. the specific reason(s) for the denial, and the Plan provisions on which the denial is based;
2. your right to request and receive, at no charge, copies of the information relevant to your benefits claim;
3. your right to bring a civil action under ERISA, §502(a), and the time in which you have to bring such an action, including the calendar date upon which such time expires;
4. the identity of (and upon request, the right to receive a copy of) any internal rule, guideline, protocol or other similar criterion relied upon to deny the claim; or a statement that such does not exist;
5. the identity of any medical or vocational experts whose advice was obtained for the appeal, regardless of whether the advice was relied upon to deny the claim on appeal; and
6. if applicable, why we did not agree with or follow: 1) the views of healthcare professionals

treating you or vocational professionals who evaluated you; 2) the views of medical or vocational experts whose advice we obtained, without regard to whether we relied upon that advice; and 3) a disability determination made by the Social Security Administration, if applicable.

YOUR RIGHTS AS SET FORTH BY ERISA

As a participant in this Plan you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all Plan participants shall be entitled to:

Receive Information About Your Plan and Benefits

Examine, without charge, at the Plan Administrator's office and at other specified locations, such as worksites and union halls, all documents governing the Plan, including insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefit Security Administration.

Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the Plan, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) and updated summary plan description. The administrator may make a reasonable charge for the copies.

Receive a summary of the Plan's annual financial report. The Plan Administrator is required by law to furnish each participant with a copy of this summary annual report.

Prudent Actions by Plan Fiduciaries

In addition to creating rights for Plan participants ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plan. The people who operate your Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of you and other Plan participants and beneficiaries. No one, including your employer, your union, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a disability benefit or exercising your rights under ERISA.

Enforce Your Rights

If your claim for a disability benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules.

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of Plan documents or the latest annual report from the Plan and do not receive them within 30 days, you may file suit in a Federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to \$110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or Federal court. If it should happen that Plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a Federal court. The court will decide who should pay court costs and legal fees. If you are successful the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

Assistance with Your Questions

If you have any questions about your Plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Plan Administrator, you should contact the nearest office of the Employee Benefit Security Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefit Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefit Security Administration.

This Plan is designed to provide you with short term disability income benefits in the event of your covered Disability. Every effort has been made to assure the accuracy of this Summary Plan Description. To the extent that the terms of the Plan Document differ from this Summary Plan Description, the Plan Document will prevail.

PLAN ADMINISTRATION

The Plan is established and maintained by THE COLORADO COLLEGE.

The Employer Identification Number (EIN) is 84-0402510.

The Plan Number is 502.

The Plan Administrator is:
THE COLORADO COLLEGE
14 E. Cache La Poudre St.
Colorado Springs, CO 80903

Service of Legal Process may be made upon the Plan Administrator. The Plan Administrator has authority to control and manage the operation and administration of the plan.

This plan of benefits is self-insured by the Employer and its cost is financed by the Employer.
Date of the end of the Plan Year: June 30th

PLAN TERMINATION: The right is reserved in the Plan for the Employer to terminate, suspend, withdraw or amend the plan in whole or in part at any time.