BENEFIT GUIDE

2022

OGLETHORPE
UNIVERSITY

Welcome To Oglethorpe Open Enrollment

This Employee Benefit Guide is an overview of the benefits available to you as well as the cost that will be deducted from your paycheck should you choose to elect. Please read it carefully in order to make the best choices for you and your family in the 2022 Plan Year, which will run January 1, 2022 through December 31, 2022.

At this time, Oglethorpe invites you to choose the benefits that best fit your needs. We greatly value our employees and are committed to providing competitive benefits. We are pleased to offer you a wide-ranging package of benefits for 2022. We recognize the important role your benefits play and continue to make every effort to target the best quality benefit plans for our employees and their families. Our program offers a variety of plans to meet the needs of our diverse workforce. Oglethorpe's benefits are designed to assist in providing for the health, well-being and financial security of you and your covered dependents.

Open Enrollment is your opportunity to enroll in benefits or make changes to current benefits. You will need to enroll online at www.paycomonline.com.

Summary of Benefits

Oglethorpe is offering a comprehensive suite of benefits which includes the following:

- Medical plans will be offered by Cigna for a total of three plan options. An OAP (Open Access Plus) with HSA (Health Savings Account), OAP Standard, and OAP Premium.
- Employer HSA match contribution increased to $30 per paycheck.
- Employees can enroll in a Medical and Dependent Care Flexible Spending Account (FSA) if they do not enroll in the OAP with a HSA.
- Dental plans will continue to be offered by Cigna.
- EyeMed will continue to be our vision carrier.
- All eligible employees will receive Basic Life and AD&D insurance through Cigna at no cost to the employee. Additional voluntary employee, spouse and/or child life insurance will be offered at a discounted group rate.
- Employees have access to an Employee Assistance Program (EAP) through Cigna.
- Long Term Disability (LTD) benefits are provided to the employee at no cost. Voluntary Short-Term Disability (STD) benefits are available to you on a voluntary basis.
- Accident and Critical Illness Insurance policies are also available to supplement other medical benefit coverages.
- Medical, dental and vision premiums will be deducted from your paycheck on a pre-tax basis.
- Employees have access to benefit counselors through Cigna One Guide. These Benefit Counselors will be able to help you navigate through your medical, dental, life & disability options.
- A 403(b) plan is offered through Lincoln Financial to provide you with the tools and flexibility you need to prepare for retirement.

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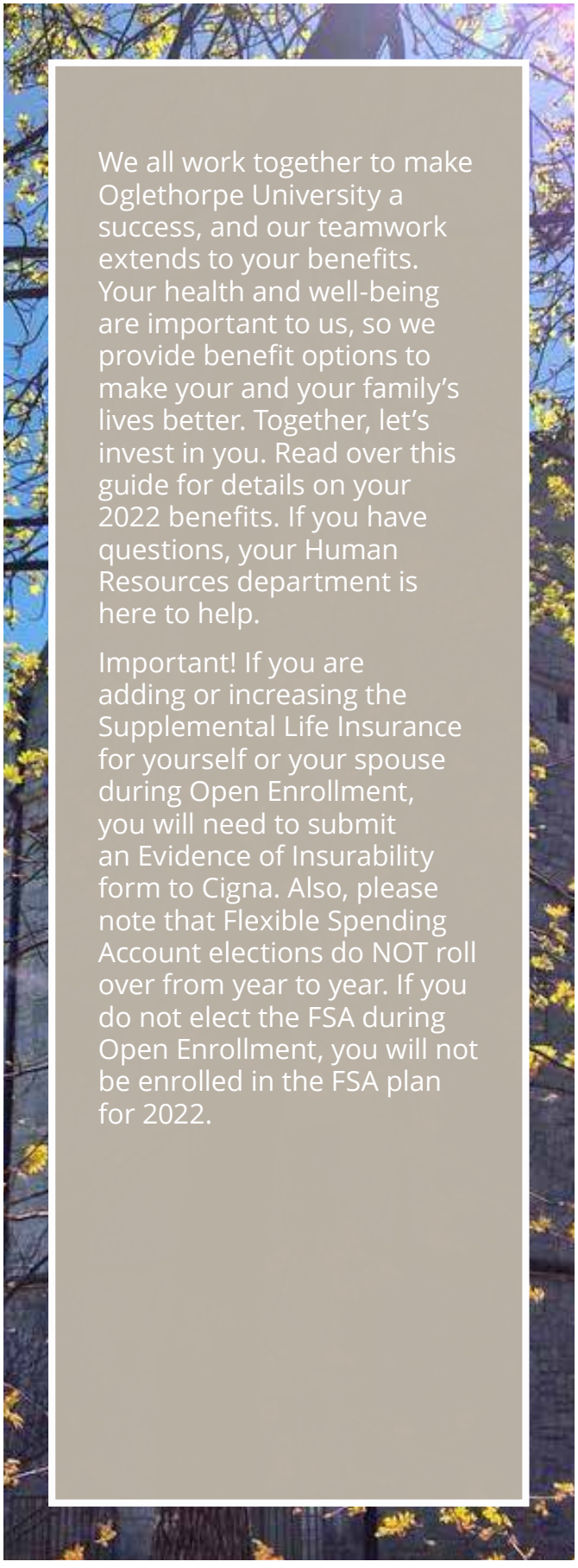


We all work together to make Oglethorpe University a success, and our teamwork extends to your benefits. Your health and well-being are important to us, so we provide benefit options to make your and your family's lives better. Together, let's invest in you. Read over this guide for details on your 2022 benefits. If you have questions, your Human Resources department is here to help.

Important! If you are adding or increasing the Supplemental Life Insurance for yourself or your spouse during Open Enrollment, you will need to submit an Evidence of Insurability form to Cigna. Also, please note that Flexible Spending Account elections do NOT roll over from year to year. If you do not elect the FSA during Open Enrollment, you will not be enrolled in the FSA plan for 2022.

See **page 42** for important information concerning Medicare Part D coverage.

In this Guide, we use the term company to refer to Oglethorpe University. This Guide is intended to describe the eligibility requirements, enrollment procedures and coverage effective dates for the benefits offered by the company. It is not a legal plan document and does not imply a guarantee of employment or a continuation of benefits. While this Guide is a tool to answer most of your questions, full details of the plans are contained in the Summary Plan Descriptions (SPDs), which govern each plan's operation. Whenever an interpretation of a plan benefit is necessary, the actual plan documents will be used.

EMPLOYEE CONTRIBUTIONS

	BI-WEEKLY
MEDICAL - OAP WITH HSA	
EMPLOYEE ONLY	$25.25
EMPLOYEE + SPOUSE	$187.28
EMPLOYEE + CHILD(REN)	$173.08
EMPLOYEE + FAMILY	$281.14
MEDICAL - OAP STANDARD	
EMPLOYEE ONLY	$45.80
EMPLOYEE + SPOUSE	$263.10
EMPLOYEE + CHILD(REN)	$244.11
EMPLOYEE + FAMILY	$394.91
MEDICAL - OAP PREMIUM	
EMPLOYEE ONLY	$119.46
EMPLOYEE + SPOUSE	$443.45
EMPLOYEE + CHILD(REN)	$401.18
EMPLOYEE + FAMILY	$654.98
DENTAL	
EMPLOYEE ONLY	$16.40
EMPLOYEE + SPOUSE	$34.62
EMPLOYEE + CHILD(REN)	$38.72
EMPLOYEE + FAMILY	$59.11
VISION	
EMPLOYEE ONLY	$3.17
EMPLOYEE + SPOUSE	$6.01
EMPLOYEE + CHILD(REN)	$6.33
EMPLOYEE + FAMILY	$9.30

ACCIDENT COVERAGE

BI-WEEKLY CONTRIBUTIONS

EMPLOYEE ONLY	$5.76
EMPLOYEE + SPOUSE	$10.52
EMPLOYEE + CHILD(REN)	$13.82
EMPLOYEE + FAMILY	$18.59

CRITICAL ILLNESS COVERAGE

BI-WEEKLY CONTRIBUTIONS - $10,000 BENEFIT

AGE	EMPLOYEE ONLY	EMPOYEE + SPOUSE	EMPOYEE + CHILDREN	EMPLOYEE + FAMILY
0-29	$2.22	$4.48	$4.71	$6.97
30-39	$3.51	$7.32	$6.00	$9.81
40-49	$6.48	$13.53	$8.98	$16.02
50-59	$12.57	$26.79	$15.06	$29.28
60-69	$19.86	$41.68	$22.36	$44.17
70-79	$31.08	$63.84	$33.57	$66.33
80+	$53.89	$121.18	$56.38	$123.67

BI-WEEKLY CONTRIBUTIONS - $20,000 BENEFIT

AGE	EMPLOYEE ONLY	EMPOYEE + SPOUSE	EMPOYEE + CHILDREN	EMPLOYEE + FAMILY
0-29	$4.43	$8.95	$9.42	$13.95
30-39	$7.02	$14.63	$12.01	$19.62
40-49	$12.97	$27.06	$17.96	$32.05
50-59	$25.14	$53.58	$30.13	$58.56
60-69	$39.73	$83.35	$44.72	$88.34
70-79	$62.15	$127.67	$67.14	$132.66
80+	$107.78	$242.35	$112.76	$247.35

Premiums are based on the Employee's age on the effective date of coverage. Even if the Spouse is in a different age band, the rates are driven off of the employee's age. Children are covered at no additional cost when you elect Employee coverage.

VOLUNTARY LIFE INSURANCE

RATES/$1,000 (MONTHLY)

AGE (AS OF JANUARY 1, 2022)	EMPLOYEE	AGE (AS OF JANUARY 1, 2022)	SPOUSE
Under 25	$0.06	Under 25	$0.06
25-29	$0.06	25-29	$0.06
30-34	$0.08	30-34	$0.08
35-39	$0.09	35-39	$0.09
40-44	$0.12	40-44	$0.12
45-49	$0.20	45-49	$0.20
50-54	$0.28	50-54	$0.28
55-59	$0.57	55-59	$0.57
60-64	$0.68	60-64	$0.68
65-69	$1.27	65-69	$1.27
70-74	$2.06	70-74	$2.06
75+	$2.06	75+	$2.06

CHILD VOLUNTARY LIFE INSURANCE

RATE/$1,000 (MONTHLY)
$0.20

VOLUNTARY STD

AGE (AS OF JANUARY 1, 2022)

AGE RANGE	STD
<30	$0.325
30-34	$0.325
35-39	$0.325
40-44	$0.325
45-49	$0.325
50-54	$0.325
55-59	$0.398
60-64	$0.470
65+	$0.515

ELIGIBILITY & ENROLLMENT

Oglethorpe University offers a variety of benefits to support you and your family's needs. Choose options that cover what's important to your unique lifestyle.

Eligibility

If you are a full-time Employee of Oglethorpe University who is regularly scheduled to work at least 30 hours per week, you are eligible to participate in the **medical, dental, vision, life and disability plans and additional benefits.**

When Does Coverage Begin?

Your elections are effective on the first of the month following your date of hire. You won't be able to change your benefits until the next enrollment period unless you experience a qualifying life event.

Eligible Dependents

Dependents eligible for coverage in the Oglethorpe University benefits plans include:

- Your legal Spouse (or common-law spouse where recognized).
- Children up to age 26 (includes birth children, stepchildren, legally adopted children and children for whom legal guardianship has been awarded to you or your Spouse).
- Dependent children 26 or more years old, unmarried and primarily supported by you and incapable of self-sustaining employment by reason of mental or physical disability which arose while the child was covered as a dependent under this plan (periodic certification may be required).

Verification of dependent eligibility is required upon enrollment.

How to Enroll in Benefits

To enroll in benefits, all eligible employees should log on to Paycom. Use the link below for single sign on access, which allows you to use your OU username and password.

Employee site:
https://www.paycomonline.net/v4/ee/web.php/sso/index/0NB36

Thoughts & Tips: **You CANNOT change your benefit selections during the plan year unless you have a qualifying life event, such as marriage and/or the birth or adoption of a child.**

Enroll Now. You've Got One Shot!

What are **Qualifying Life Events?**

Most people know you can change your benefits when you start a new job or during Open Enrollment. But did you know that changes in your life may permit you to update your coverage at other points in the year? Qualifying Life Events (QLEs) determined by the IRS could allow you to enroll in health insurance or change your elections outside of the annual time.

Common qualifying events include:

A change in your employment status from full time to part time, or part time to full time, resulting in a gain or loss of eligibility

A change in your legal marital status (marriage, divorce or legal separation)

Entitlement to Medicare or Medicaid

A change in the number of your dependents (for example, through birth or adoption, or if a child is no longer an eligible dependent)

Eligibility for coverage through the Marketplace

A change in your spouse's employment status (resulting in a loss or gain of coverage)

Changes in your address or location that may affect the coverage for which you are eligible

Some lesser-known qualifying events are:

Turning 26 and losing coverage through a parent's plan

Changes that make you no longer eligible for Medicaid or the Children's Health Insurance Program (CHIP)

Death in the family (leading to change in dependents or loss of coverage)

When a Qualifying Life Event occurs, you have 30 days to request changes to your coverage. Keep in mind your change in coverage must be consistent with your change in status.

Questions regarding specific life events and your ability to request changes should be directed to Oglethorpe University's Human Resources. Don't miss out on a chance to update your benefits!

PREPARING FOR OPEN ENROLLMENT

As a committed partner in your health, Oglethorpe University absorbs a significant amount of your benefit costs. Your contributions for medical, dental and vision benefits are deducted on a pre-tax basis, lessening your tax liability. Please note that Employee contributions vary depending on level of coverage. Typically, the more coverage you have, the higher your portion.

You may select any combination of medical, dental and/or vision plan coverage. For example, you could select medical coverage for you and your entire family, but select dental and vision coverage only for yourself. The only requirement is that you, as an eligible Employee of Oglethorpe University, must elect coverage for yourself in order to elect any dependent coverage.

Open Enrollment To-Do

Update your personal information.

If you've experienced a qualifying life event in the last year, you may need to change your elections or update your details.

Double-check covered and restricted medications.

If you make any changes to your plan, consider how it affects your prescription coverage.

Review available plans' deductibles.

Take a look at your options – if you foresee a lot of medical needs this year, you might want a lower deductible. If not, you could switch to a higher deductible and enjoy lower premiums.

Consider your HSA or FSA.

An HSA or FSA can help cover healthcare costs including dental and vision services and prescriptions. Adding one of these accounts to your benefits can help with your long-term financial goals – and your employer may contribute.

Check to see if your pharmacy is in-network.

Going in-network often saves you money. Check for any plan changes to make sure your favorite pharmacy is still your best bet and is covered in-network.

How to Pick a Plan

Which plan is right for you? When deciding, consider any medical needs you foresee for the upcoming plan year, your overall health, and any medications you currently take. For additional information about the three health insurance plans, please copy the unique link into your address bar: https://www.benefitseducationcigna.com/5e91cbc9b343b3a5139a005ddb3ce3d0/Home

How does an OAP (Open Access Plus) Standard or Premium Plan work?

You'll pay more in premiums out of your paycheck, but perhaps less at the time of service.

You're able to choose from a network of providers who offer a fixed copay for services.

Lower Calendar Year Deductibles and Out-of-Pocket Maximums

How does an OAP (Open Access Plus) with HSA (Health Savings Account) work?

You'll pay less in premiums. (Think less money from your paycheck.)

You'll pay for the full cost of non-preventive medical services until you reach your deductible.

You can also use a Health Savings Account in conjunction, which provides a safety net for unexpected medical costs and tax advantages.

If you expect to mostly use preventive care (which is covered), this plan could be for you.

CIGNA ONE GUIDE SERVICE

We are very excited to add a new benefit for employees to be able to connect to a benefit specialist to help you make better and more informed decisions. Cigna is making it easier than ever to get the coverage you actually need. Their benefit specialists make insurance easier to understand.

Choose a Cigna Plan with Confidence

Whether you have been, are a current customer or considering Cigna for the first time, we understand how confusing and overwhelming it can be to review your health plan options. And we want to help by providing the resources you need to make a decision with confidence. That's why **Cigna One Guide® is available to you now**.

Call a Cigna One Guide representative during pre-enrollment to get personalized, useful guidance.

Your personal guide will help you:

- Easily understand the basics of health coverage
- Identify the types of health plans available to you that best meet the needs of you and your family
- Check if your doctors are in-network to help you avoid unnecessary costs
- Get answers on any other questions you may have about the plans or provider networks available to you

The best part is, during the enrollment period, your personal guide is just a call away.*

Don't wait until the last minute to enroll.
Call **888-806-5094** to speak with a Cigna One Guide representative today.*

After enrollment, the support continues for Cigna customers.

Your Cigna One Guide representative will be there to guide you through the complexities of the health care system, and help you avoid costly missteps. Our goal is a simpler health care journey for you and your family.

Cigna One Guide service provides personalized assistance to help you:

- Resolve healthcare issues
- Save time and money
- Get the most out of your plan
- Find the right hospitals, dentists and other healthcare providers in your plan's network
- Get cost estimates and avoid surprise expenses
- Understand your bills

Access Cigna One Guide – after enrollment – in the way that's most convenient for you:

App

Chat

Phone

*During enrollment, personal guides available Monday through Friday, 8:00 am–9:00 pm EST. Once your coverage begins, call the number on your ID card to speak with a personal guide. Additional customer service representatives are available 24/7.

MEDICAL BENEFITS

Medical benefits are provided through Cigna. Choose the plan that works best for your life. Consider the physician networks, premiums and out-of-pocket costs for each plan. Keep in mind your choice is effective for the entire 2022 plan year, unless you have a qualifying life event.

Medical Premiums

Premium contributions for medical are deducted from your paycheck on a pre-tax basis. Your level of coverage determines your bi-weekly contributions. Contribution plan options include Open Access Plus with Health Savings Account (OAP with HSA), OAP Standard, and OAP Premium.

	OAP WITH HSA	OAP STANDARD	OAP PREMIUM
BI-WEEKLY CONTRIBUTIONS			
EMPLOYEE ONLY	$25.25	$45.80	$119.46
EMPLOYEE + SPOUSE	$187.28	$263.10	$443.45
EMPLOYEE + CHILD(REN)	$173.08	$244.11	$401.18
EMPLOYEE + FAMILY	$281.14	$394.91	$654.98

How to Find a Provider

Visit myCigna.com or call Customer Care at 866-494-2111 for a current list of Cigna network providers.

STEP 1: Click on "Find a Doctor" at the top of the screen. Then, under "How are you Covered?" select "Employer." (If you're already a Cigna customer, log in to myCigna.com or the myCigna® app to search your current plan's network. To search other networks, use the Cigna.com directory.)

STEP 2: Change the geographic location to the city/state or zip code you want to search. Select the search type and enter a name, specialty or other search term. Click on one of our suggestions or the magnifying glass icon to see your results.

STEP 3: Answer any clarifying questions, and then verify where you live (as that will determine the networks available).

STEP 4: Select "Open Access Plus, OA Plus, Choice Fund OA Plus."

That's it! You can also refine your search results by distance, years in practice, specialty, languages spoken and more.

Thoughts & Tips: **Most preventive care offered by an in-network physician is covered at 100%.**

Medical Plan Summary

This chart summarizes the 2022 medical coverage provided by Cigna. All covered services are subject to medical necessity as determined by the plan. Please be aware that all out-of-network services are subject to Reasonable and Customary (R&C) limitations.

	OAP WITH HSA	OAP STANDARD	OAP PREMIUM	
	IN-NETWORK ONLY	IN-NETWORK ONLY	IN-NETWORK	OUT-OF-NETWORK
CALENDAR YEAR DEDUCTIBLE				
INDIVIDUAL	$2,900	$1,000	$1,500	$3,500
FAMILY	$5,800	$2,000	$3,000	$7,000
COINSURANCE (PLAN PAYS)	100%*	90%*	90%*	70%*
CALENDAR YEAR OUT-OF-POCKET MAXIMUM (MAXIMUM INCLUDES DEDUCTIBLE)				
INDIVIDUAL	$2,900	$3,500	$4,000	$8,000
FAMILY	$5,800	$7,000	$8,000	$16,000
COPAYS/COINSURANCE				
PREVENTIVE CARE	100%	100%	100%	70%*
PRIMARY CARE	100%*	$25	$30	70%*
SPECIALIST SERVICES	100%* referrals required	$35	$40 referrals required	70%*
URGENT CARE	100%*	$50	$60	70%*
EMERGENCY ROOM	100%*	$250, waived if admitted	$250, waived if admitted	

*After Deductible

On the OAP Standard and OAP Premium plans, the individual deductible amount must be met by each member enrolled under your medical coverage. If you have several covered dependents, all charges used to apply toward a "per individual" deductible amount will also be applied toward the "per family" deductible amount. When the family deductible amount is reached, no further individual deductibles will have to be met for the remainder of that plan year. No member may contribute more than the individual deductible amount to the "per family" deductible amount. The same typically applies for the out-of-pocket maximum.

On the OAP with HSA plan, each covered individual is not required to meet the individual deductible. The OAP with HSA has an aggregate deductible, meaning the family deductible amount will include all combined eligible expenses that you and your covered dependents incur. The family deductible amount may be satisfied by one member or a combination of two or more members covered under your medical plan. The same typically applies for the out-of-pocket maximum.

OUT-OF-POCKET COSTS

Deductible

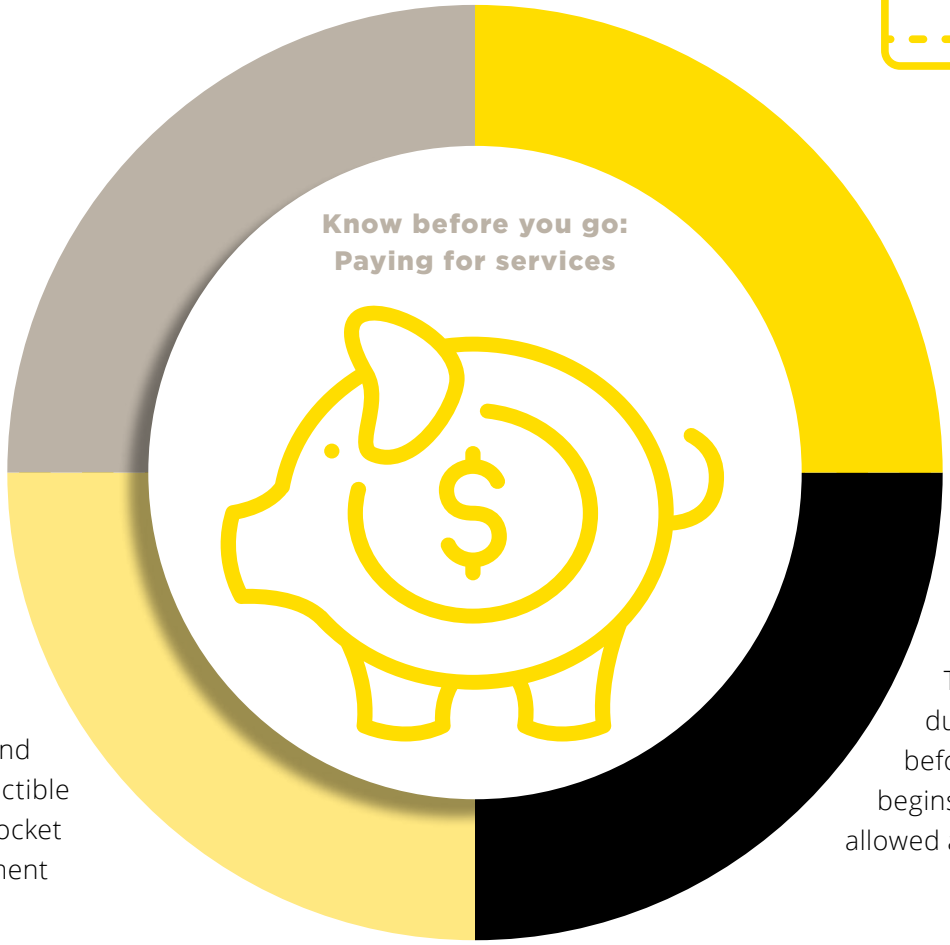
The amount you must pay for covered services before your insurance starts paying its portion.

UP TO DEDUCTIBLE

YOU PAY 100%

Copay

The fixed amount you pay for healthcare services at the time you receive them.



Coinsurance

Your percentage of the cost of a covered service. If your office visit is $100 and your coinsurance is 20% (and you've met your deductible but not your out-of-pocket maximum), your payment would be $20.

% YOU PAY

% PLAN PAYS

UP TO THE OUT-OF-POCKET MAXIMUM

AFTER DEDUCTIBLE IS REACHED

Out-of-Pocket Maximum

The most you will pay during the plan year before your insurance begins to pay 100% of the allowed amount.

AFTER OUT-OF-POCKET MAXIMUM IS REACHED

PLAN PAYS **100%** THROUGH END OF PLAN YEAR

Healthcare Cost Transparency

With options like the OAP with HSA Plan and Flexible Spending Accounts, your healthcare spending is in your control. But with so many providers and varying costs for services, how do you decide where to go? Healthcare cost transparency tools are online services available through most health insurance carriers that allow consumers to compare costs for medical services, from prescriptions to major surgeries, to make choices easier. To learn more, visit www.myCigna.com or call 866-494-2111.

Rising Costs of Healthcare

The cost of healthcare in the U.S. has been steadily growing each year. Why? Some of the factors include an aging population, increased demand for care (resulting in higher prices for premiums and prescription drugs) and an increase in chronic illnesses. **Oglethorpe University wants to help keep you healthy, so we do our best to keep your healthcare costs reasonable.** Make sure you're informed about your options so you can make the best healthcare choices for you and your family. Placing an importance on preventive care, making healthy choices, and managing costs will help keep your health — and wallet — in control in the long run.

Thoughts & Tips: **The cost of an MRI can vary between $300 and $3,000 — even within your area. It's your healthcare with options, so shop around for the best option in your area.**

PREVENTIVE CARE

Most health plans are required to cover a set of preventive services — at no cost to you!

Screening tests and routine checkups are considered preventive, which means they're often paid at 100%. Keep up to date with your primary care physician to save time and money and keep yourself healthier in the long run. Under the U.S. Patient Protection and Affordable Care Act (PPACA), some common covered services include:

- Wellness visits, physicals and standard immunizations
- Screenings for blood pressure, cancer, cholesterol, depression, obesity and diabetes
- Pediatric screenings for hearing, vision, obesity and developmental disorders

- Anemia screenings, breastfeeding support and pumps for pregnant and nursing women
- Iron supplements (for children ages 6 to 12 months at risk for anemia)

Take advantage of these covered services. However, remember that diagnostic care to identify health risks is covered according to plan benefits, even if done during a preventive care visit. This means if your doctor finds a new condition or potential risk during your appointment, the services may be billed as diagnostic medicine and result in some out-of-pocket costs. Read over your benefit summary to see what specific preventive services are provided to you.

WHERE TO GO FOR CARE

You think you may be sick, but your primary care physician is booked through the end of the month. You have a question about the side effects of a new medication, but the pharmacy is closed. Instead of immediately choosing an expensive trip to the emergency room or relying on questionable information from the internet, take a look below at various care center resources and the types of care they provide.

PRIMARY CARE CENTER

When would I use this?

You need routine care or treatment for a current health issue. Your primary doctor knows you and your health history, can access your medical records, provide routine care, and manage your medications.

What type of care would they provide?*

- Routine checkups
- Preventive services
- Immunizations
- Manage your general health

What are the costs and time considerations?**

- Often requires a copay and/or coinsurance
- Normally requires an appointment
- Usually little wait time with scheduled appointment

NURSE LINE

When would I use this?

You need a quick answer to a health issue that does not require immediate medical treatment or a physician visit.

What type of care would they provide?*

Answers to questions regarding:

- Symptoms
- Medications and side effects
- Self-care home treatments
- When to seek care

What are the costs and time considerations?**

- Nurse lines are usually available 24 hours a day, 7 days a week.
- This service is usually free as part of your medical insurance.

VIRTUAL MEDICINE

When would I use this?

You need care for minor illnesses and ailments, but would prefer not to leave home. These services are available by phone and online (via webcam).

What type of care would they provide?*

- Cold & flu symptoms
- Allergies
- Bronchitis
- Urinary tract infection
- Sinus problems

What are the costs and time considerations?**

- There is usually a first-time consultation fee and a flat fee or copay for any visit thereafter.
- Access to care is usually immediate.
- Some states may not allow for prescriptions through telemedicine or virtual visits.

URGENT CARE CENTER

When would I use this?

You need care quickly, but it is not a true emergency. Urgent care centers offer treatment for non-life-threatening injuries or illnesses.

What type of care would they provide?*

- Strains, sprains
- Minor broken bones (e.g., finger)
- Minor infections
- Minor burns
- X-rays

What are the costs and time considerations?**

- Often requires a copay and/or coinsurance that is usually higher than an office visit
- Walk-in patients welcome, but waiting periods may be longer as patients with more urgent needs will be treated first

DO YOUR HOMEWORK

What may seem like an urgent care center could actually be a standalone ER. These newer facilities come with a higher price tag, so ask for clarification if the word "emergency" appears in the company name.

EMERGENCY ROOM

What are the costs and time considerations?**

- Often requires a much higher copay and/or coinsurance
- Open 24/7, but waiting periods may be longer because patients with life-threatening emergencies will be treated first

When would I use this?

You need immediate treatment for a serious life-threatening condition. If a situation seems life threatening, call 911 or your local emergency number right away.

What type of care would they provide?*

- Heavy bleeding
- Chest pain
- Major burns
- Spinal injuries
- Severe head injury
- Broken bones

*This is a sample list of services and may not be all-inclusive.

**Costs and time information represent averages only and are not tied to a specific condition or treatment.

VIRTUAL MEDICINE

When you're sick, the last thing you want to do is leave the cozy comfort of your home. Or sometimes you're just too on the go to pop in for a visit. Virtual medicine is a convenient and easy way to talk to a doctor fast.

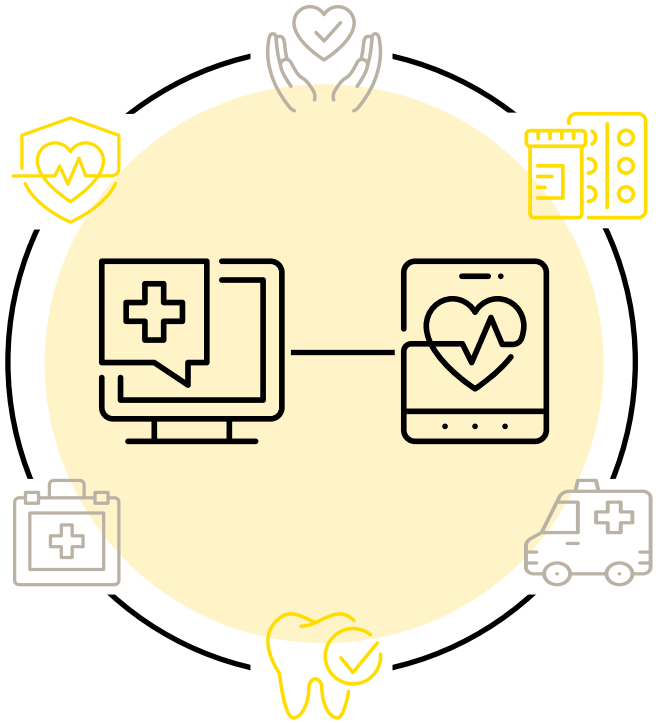
Telemedicine

We provide a telemedicine benefit through Cigna to you and your dependents. Cigna offers on-demand access to board-certified doctors through online video, telephone or secure email. You and your family can be treated for general health issues at home. Telemedicine is useful for after-hours non-emergency care, when your primary care doctor is unavailable, if you need prescriptions or refills or if you're traveling. Please note that some states do not allow physicians to prescribe medications via telemedicine. For more information, visit www.myCigna.com.

The cost for these services depend on the medical plan elected. If considered a preventive appointment, insurance will cover 100% of the appointment fee. Cigna partners with MDLive. MDLive provides cost transparency for the customer at the point of entry into MDLive before an appointment.

Cigna doctors can treat many medical conditions, including:

- Cold & flu
- Bronchitis
- Urinary tract infection
- Respiratory infection
- Sinus problems



Virtual Visits

A virtual visit with Cigna lets you see and talk to a doctor from your phone, tablet or computer without an appointment. Most visits take about 10-15 minutes, and doctors can write a prescription (in participating states). Try a virtual visit when your doctor is not available or you're traveling.

Doctors can diagnose and treat a wide range of non-emergency medical conditions, including:

- Bladder infection/ Urinary tract infection
- Bronchitis
- Cold/flu
- Pink eye
- Rash
- Sinus problems
- Sore throat
- Stomach ache

Access Virtual Visits

Visit www.myCigna.com to request a virtual visit. Once you register and request a consult, you will pay your portion of the service costs according to your medical plan, and then enter a virtual waiting room. During your visit you can talk to a doctor about your health concerns, symptoms and treatment options. The cost for these services depend on the medical plan elected. If considered a preventive appointment, insurance will cover 100% of the appointment fee. Cigna partners with MDLive. MDLive provides cost transparency for the customer at the point of entry into MDLive before an appointment.

Virtual visits aren't good for conditions requiring an exam or test, complex or chronic problems, or emergencies, including sprains or broken bones.

PHARMACY BENEFITS

Prescription Drug Coverage for Medical Plans

Our Prescription Drug Program is coordinated through Cigna. That means you will only have one ID card for both medical care and prescriptions. Information on your benefits coverage and a list of network pharmacies is available online at www.myCigna.com or by calling the Customer Care number on your ID Card. Your cost is determined by the tier assigned to the prescription drug product. Products are assigned as Generic, Preferred Brand, Non-Preferred Brand or Non-Preferred Specialty.

	OAP WITH HSA	OAP STANDARD	OAP PREMIUM	
	IN-NETWORK ONLY	IN-NETWORK ONLY	IN-NETWORK	OUT-OF-NETWORK
RETAIL RX (30-DAY SUPPLY)				
GENERIC	100%*	$25	$25	$25
PREFERRED BRAND	100%*	$40	$40	$40
NON-PREFERRED BRAND	100%*	$55	$55	$55
NON-PREFERRED SPECIALTY	100%*	80% up to $300 max	80% up to $300 max	80% up to $300 max
MAIL ORDER RX (90-DAY SUPPLY)				
GENERIC	100%*	$50	$50	Not Covered
PREFERRED BRAND	100%*	$80	$80	Not Covered
NON-PREFERRED BRAND	100%*	$110	$110	Not Covered
NON-PREFERRED SPECIALTY	100%*	80% up to $300 max	80% up to $300 max	Not Covered

*After Deductible

Generic Drugs

Looking to save money on medication costs? You've most likely heard that generic prescription drugs are a more affordable option. Generic drugs are versions of brand-name drugs with the exact same dosage, intended use, side effects, route of administration, risks, safety and strength. Because they are the same medicine, generic drugs are just as effective as brand-name drugs and undergo the same rigid FDA standards. But on average, **a generic version costs 80% to 85% less than the brand-name equivalent.** To find out if there is a generic equivalent for your brand-name drug, visit www.fda.gov.

You can find a cost comparison tool at www.myCigna.com to assist in comparing medical and pharmacy prices. The OAP with HSA plan will cover certain preventive generic prescription drugs at no cost to you. All other prescription drugs covered by the OAP with HSA plan are covered at 100% after reaching your deductible. The OAP Standard and OAP Premium plans cover prescription drugs with either a copay or 80% up to $300 maximum depending on drug tier. Prescription drug prices are negotiated by Cigna and will provide savings over paying at full retail costs.

Note: Apps such as GoodRx and RxSaver let you compare prices of prescription drugs and find possible discounts. If you use these tools, make sure to check the price against the cost through your insurance to get the best deal. Note that these discounts can't be combined with your benefit plan's coverage. As a result, if you choose to use a discount card from an app such as GoodRx or RxSaver, the amount you pay will not count toward your deductible or out-of-pocket maximum under the benefit plan.

HEALTH SAVINGS ACCOUNT

Need funds to help cover out-of-pocket healthcare expenses? Consider a Health Savings Account (HSA). **An HSA is a personal healthcare bank account used to pay for qualified medical expenses and funded by you, and in some cases your employer too.** HSA contributions and withdrawals for qualified healthcare expenses are tax free. You must be enrolled in the OAP with HSA to participate.

Your HSA can be used for qualified expenses for you, your spouse and/or tax dependent(s), even if they are not covered by your plan. If you are not currently enrolled in the OAP with HSA but you have unused HSA funds from a previous account, those funds can still be used for qualified expenses.

WEX will issue you a debit card, giving you direct access to your account balance. Use your debit card to pay for qualified medical expenses, with no need to submit receipts for reimbursement. You must have a balance in your HSA account to use the card.

Eligible expenses include doctors' visits, eye exams, prescription expenses, laser eye surgery, menstrual products, over-the-counter medications and more. Check out IRS Publication 502 on www.irs.gov for a complete list of eligible expenses.

Eligibility

You are eligible to contribute to an HSA if:

- You are enrolled in an HSA-eligible Health Plan.
- You are not covered by your Spouse's non-HDHP.
- Your Spouse does not have a healthcare Flexible Spending Account or Health Reimbursement Account.
- You are not eligible to be claimed as a dependent on someone else's tax return.
- You are not enrolled in Medicare or TRICARE.
- You have not received Department of Veterans Affairs medical benefits in the past 90 days for non-service-related care. (Service-related care will not be taken into consideration.)

Your Money. Your Account.

Your HSA is a personal bank account that you own and administer. It's up to you how much you contribute, when to use the money for medical services, and when to reimburse yourself. You can save and roll over HSA funds to the next year if you don't spend them all in the calendar year. You can even let funds accumulate year-over-year to use in retirement. HSA funds are also portable if you change jobs. There are no vesting requirements or forfeiture provisions.

Understanding Your HSA Benefit

The example that follows illustrates how an HSA can help you save taxes by lowering income when you make pre-tax contributions.

Angela is an employee with Oglethorpe University. Assume that she:

- Enrolls herself in the OAP w/HSA
- Contributes $3,650 to her HSA, and
- Has an annual income of $75,000.

Angela would save $927 on taxes while growing her HSA.

	ANGELA DOES NOT CONTRIBUTE TO HER HSA	ANGELA MAKES PRE-TAX HSA CONTRIBUTIONS
ANNUAL INCOME	$75,000	$75,000
ANGELA'S PRE-TAX CONTRIBUTIONS TO HER HSA	$0	$3,650
ADJUSTED INCOME	$75,000	$71,350
TAXES*	$15,178	$14,251
TAX SAVINGS	$0	$927

*Based on federal income tax rates for 2021 assuming Angela is married, filing jointly, take the standard deduction, claims two examples, and has no other income. Social Security and Medicare taxes are based on a combined 7.65% tax rate. The state tax rate is assumed to be 3% per year.

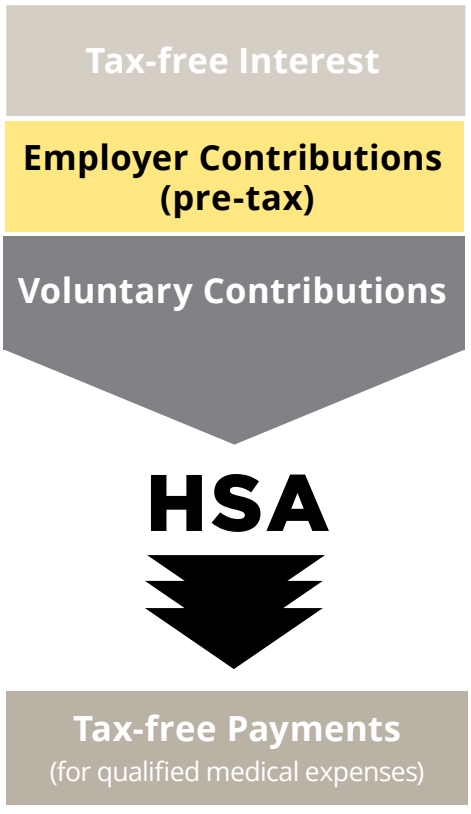
How to Enroll

To enroll in the company-sponsored HSA, you must elect the OAP with HSA with Oglethorpe University. Complete all HSA enrollment materials and designate the amount to contribute on a pre-tax basis. Oglethorpe University will establish an HSA account in your name and send in your contribution once bank account information has been provided and verified.

Plan. Spend. Save.

Contributions to an HSA can be made through payroll deduction on a pre-tax basis when you open an account with WEX. **The money in this account (including interest and investment earnings) grows tax free.** When the funds are used for qualified medical expenses, they are spent tax free.

If you withdraw funds from the account for non-medical expenses, you will be subject to a penalty. At age 65, however, any unused funds in your HSA can be withdrawn without penalty for non-medical purposes. If you withdraw the funds in your HSA after age 65, you would be subject to normal income tax on the money in the account, but you would not be limited to using the money for just medical-related expenses.



HSA Funding Limits

The IRS places an annual limit on the maximum amount that can be contributed to HSAs. For 2022, contributions (which include any employer contribution) are limited to the following:

HSA FUNDING LIMITS	
EMPLOYEE	$3,650
FAMILY	$7,300
CATCH-UP CONTRIBUTION (AGES 55+)	$1,000

Oglethorpe University will match employee contributions dollar for dollar up to $780 per year or $30 per paycheck.

EMPLOYER HSA CONTRIBUTION
MATCH
$1 for $1 up to $780

Any matching contributions will become available on a per pay period basis.

HSA contributions in excess of the IRS annual contribution limits ($3,650 for individual coverage and $7,300 for family coverage for 2022) are not tax deductible and are generally subject to a 6% excise tax.

You are responsible for making sure your contributions are within IRS limits, and depending on your situation, those limits may change throughout the year.

If you've contributed too much to your HSA this year, you have two options:

- Remove the excess contributions and the net income attributable to the excess contribution before you file your federal income tax return (including extensions). You'll pay income taxes on the excess removed from your HSA.
- Leave the excess contributions in your HSA and pay 6% excise tax on excess contributions. Next year consider contributing less than the annual limit to your HSA to make up for the excess contribution during the previous year.

The Oglethorpe University HSA is established with WEX. You may be able to roll over funds from another HSA. For more enrollment information, contact Human Resources or visit www.wexinc.com.

FLEXIBLE SPENDING ACCOUNTS

Flex your spending power! A Flexible Spending Account (FSA) is a special tax-free account you put money into to pay for certain out-of-pocket expenses.

Healthcare Flexible Spending Account

You can contribute up to $2,750 annually for qualified medical expenses (deductibles, copays, coinsurance, menstrual products, over-the-counter medications, etc.) with pre-tax dollars, reducing your taxable income and increasing your take-home pay. You can even pay for eligible expenses with an FSA debit card at the same time you receive them without waiting for reimbursement.

Thoughts & Tips: **Your FSA money can cover the cost of going to a chiropractor or acupuncturist, if your insurance doesn't already cover it.**

Dependent Care Flexible Spending Account

In addition to the Healthcare FSA, you may opt to participate in the Dependent Care FSA — whether or not you elect any other benefits. You can set aside pre-tax funds into a Dependent Care FSA for expenses associated with caring for elderly or child dependents. Unlike the Healthcare FSA, reimbursement from your Dependent Care FSA is limited to the total amount that is deposited in your account at that time.

- With the Dependent Care FSA, you can set aside up to $5,000 to pay for child or elder care expenses on a pre-tax basis.
- Eligible dependents include children under 13 and a spouse or other individual who is physically or mentally incapable of self-care and has the principal place of residence as the employee for more than half the year may be a qualifying individual.
- Expenses are reimbursable if the provider is not your dependent.
- You must provide the tax identification number or Social Security number of the party providing care to be reimbursed.

This account covers dependent day care expenses that are necessary for you and your Spouse to work or attend school full time. Examples of eligible dependent care expenses include:

- In-home babysitting services (not provided by a tax dependent)
- Care of a preschool child by a licensed nursery or day care provider
- Before- and after-school care
- Day camp
- In-house dependent day care

Due to federal regulations, expenses for your domestic partner and your domestic partner's children may not be reimbursed under the FSA programs. Check with your tax advisor to determine if any exceptions apply.

How to Use the Account

You can use your FSA debit card at doctor and dentist offices, pharmacies and vision service providers. It cannot be used at locations that do not offer services under the plan, unless the provider has also complied with IRS regulations. The transaction will be denied if you attempt to use the card at an ineligible location.

Once you incur an eligible expense, submit a claim form along with the required documentation. Contact WEX with reimbursement questions. If you need to submit a receipt, you will be notified by WEX. Always retain a receipt for your records.

While FSA debit cards allow you to pay for services at point of sale, they do not remove the IRS regulations for substantiation. Always keep receipts and Explanation of Benefits (EOBs) for any debit card charges. Without proof that an expense was valid, your card could be turned off and your expense deemed taxable.

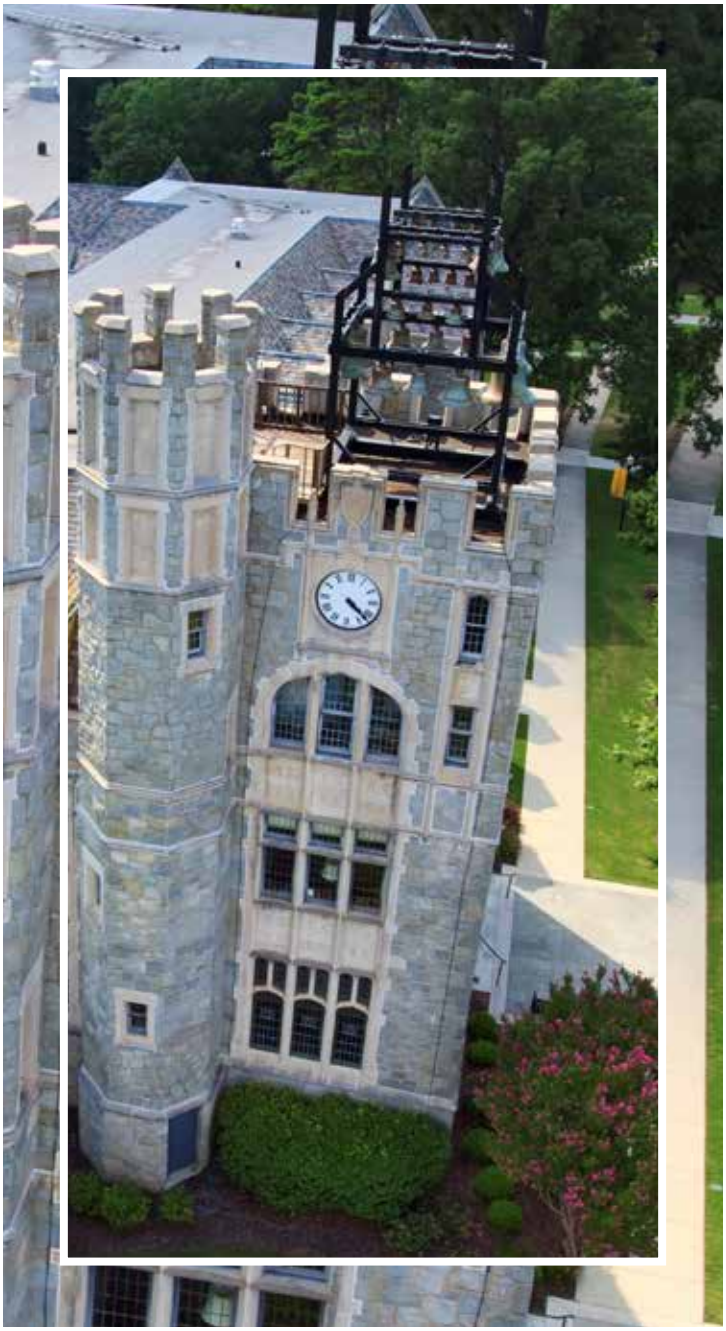
General Rules and Restrictions

The IRS has the following rules and restrictions for Healthcare and Dependent Care FSAs:

- Expenses must be incurred during the 2022 plan year.
- Dollars cannot be transferred between FSAs.
- You cannot participate in a Dependent Care FSA and claim a dependent care tax deduction at the same time.
- You must "use it or lose it" — any unused funds will be forfeited.
- You cannot change your FSA election in the middle of the plan year unless you experience a qualifying life event.
- Terminated employees have ninety (90) days following the date of termination to submit their FSA claims for reimbursement.
- Those considered highly compensated employees (family gross earnings were $125,000 or more last year) may have different FSA contribution limits. Visit irs.gov for more information.

Grace Period

- FSA participants may have an additional 2½-month grace period to incur expenses after the plan year ends (December 31, 2022).
- If an expense is incurred during the grace period between January 1, 2023 and March 15, 2023, AND submitted for reimbursement on or before March 31, 2023, any remaining balance in the previous 2022 plan year that ended December 31, 2022 will be paid out from the claim, even though the service was provided in the NEW 2023 plan year.
- The grace period applies to both the Dependent Care and Healthcare FSAs.



FSA vs HSA

Flexible Spending Accounts (FSAs) and Health Savings Accounts (HSAs) are both ways to save pre-tax money to pay for your eligible healthcare costs. Which one is right for you?

	FSA	HSA
OWNERSHIP	Your employer owns your FSA. If you leave your employer, you lose access to the account unless you have a COBRA right.	You own your HSA. It is a savings account in your name and you always have access to the funds, even if you change jobs.
ELIGIBILITY & ENROLLMENT	You're eligible for an FSA if it's offered by your employer. You can elect a Healthcare FSA even if you waive other coverage. You cannot make changes to your contribution during the Plan Year without a Qualifying Life Event. You cannot be enrolled in both a Healthcare FSA and an HSA.	1. You must be enrolled in a Qualified High Deductible Health Plan to be eligible to contribute money to your HSA. You cannot be covered by a Spouse's non-High Deductible plan or eligible for a Spouse's FSA or enrolled in Medicare or TRICARE. 2. You can change your contribution at any time during the Plan Year.
TAXATION	Contributions are tax free via payroll deduction. However, the funds spent are not tax free.	For Federal tax purposes, the money in the account is "triple tax free," meaning: 1. Contributions are tax free. 2. The account grows tax free. 3. Funds are spent tax free (if used for qualified expenses).
CONTRIBUTIONS	Both you and your employer can contribute to the account according to IRS limits. The contribution limit for the Healthcare FSA for 2022 is $2,750.	Both you and your employer can contribute to the account according to IRS limits. The contribution limit for 2022 is $3,650 for individuals and $7,300 for families. This amount includes the employer contribution. If you are 55 or older, you may make a "catch-up" contribution of $1,000 per year.
PAYMENT	Some plans include an FSA debit card to pay for eligible expenses. If not, you pay up front and submit your receipts for reimbursement.	Many HSAs include a debit card, ATM withdrawal or checkbook to pay for qualified expenses directly. You can also use online bill payment services from the HSA financial bank. You decide when to use the money in your HSA to pay for qualified expenses, or if you want to use another account to pay for services and save the money in your HSA for future expenses or retirement.
ROLL OVER OR GRACE PERIOD	You must use the money in the account by end of Plan Year. A Healthcare FSA or Dependent Care FSA may include a 2.5-month grace period after the end of the Plan Year for any extra expenses to be incurred and reimbursed. Any unclaimed funds at the end of the run out are lost and returned to your employer.	The money in the account rolls over from year to year. Funds are always yours and may be used for future qualified expenses — even in retirement years.
QUALIFIED EXPENSES	Physician services, hospital services, prescriptions, menstrual products, over-the-counter medications, dental care and vision care. A full listing of eligible expenses is available at www.irs.gov.	Physician services, hospital services, prescriptions, menstrual products, over-the-counter medications, dental care, vision care, Medicare Part D plans, COBRA premiums and long-term care premiums. A full listing of eligible expenses is available at www.irs.gov.
OTHER TYPES	Other types of FSAs include: • Dependent Care FSA - Allows you to set aside pre-tax dollars for elder or child dependent care and covers expenses such as day care and before- and after-school care.	There is only one type of HSA.

Please refer to your Summary Plan Description or plan certificate for your plan's specific FSA or HSA benefits.

WELLNESS

In addition to your Employee Assistance Program through Cigna, your medical provider has resources for your overall wellness and mental health. Your mind and body are connected. Your thoughts, feelings and actions affect your overall well-being. We're committed to helping you achieve and maintain optimal mental, physical, and emotional health.

Through the Cigna MotivateMe® program, your employer provides you with financial rewards for the healthy actions you take. The goal is to keep you motivated to get your annual check-up, know your key health numbers and, ultimately, take control of your health. Cigna MotivateMe® is a voluntary wellness program available to all employees, administered according to federal rules permitting employer-sponsored wellness programs that seek to improve employee health or prevent disease.

Below are some of the simple activities you can complete to start earning rewards.

1. Get your annual preventive check-up.

Your annual preventive check-up can help catch health issues before they become more serious. Most medical plans cover annual check-ups at 100% when received from an in-network health care provider.*

2. Complete your online health assessment.

The online health assessment is an easy-to-answer, online questionnaire that provides a snapshot of your health, and recommends steps for improvement. It should take about 15 minutes to complete.

To complete your online health assessment, log in to myCigna.com and select the "Wellness" tab. Then find the Health Assessment.

Don't have a primary care provider?

Find an in-network provider near you by logging in to myCigna.com and clicking "Find Care & Costs."

Quick Tip

Get your annual preventive check-up before taking the online health assessment because you will be asked to enter your validated biometric numbers.

For a full list of activities to complete to earn rewards:**

1. Log in to myCigna.com
2. Click the "Wellness" tab
3. Select "Incentive Awards" in the navigation bar

*Plans may vary and not all preventive care services are covered. For example, most immunizations for travel are generally not covered. For the details of your specific medical plan and a complete list of covered preventive care services, see your plan materials.
** For all participants – if you think you might be unable to meet a standard for the reward under this wellness program, you might qualify for an opportunity to earn the same reward by different means. Contact Cigna at the number on your Cigna ID card and we will work with you and, if you wish, with your doctor. For participants who may have an impairment – if you are unable to participate in any of the program events, activities or goals because of a disability, you may be entitled to a reasonable accommodation for participation, or an alternative standard for rewards. For worksite accommodations, please contact your human resources manager or Benefits Administrator. For accommodations with online, phone or other Cigna programs, please contact Cigna at the number on your Cigna ID card.

Notice Regarding Wellness Program

Cigna MotivateMe is a voluntary wellness program available to all employees. The program is administered according to federal rules permitting employer-sponsored wellness programs that seek to improve participant health or prevent disease, including the Americans with Disabilities Act of 1990, the Genetic Information Nondiscrimination Act of 2008, and the Health Insurance Portability and Accountability Act, as applicable, among others. If you choose to participate in the wellness program you may be asked to complete a voluntary health risk assessment or "HRA" that asks a series of questions about your health-related activities and behaviors and whether you have or had certain medical conditions (e.g., cancer, diabetes, or heart disease). You may also be asked to complete a biometric screening, which may include a blood test for total cholesterol, HDL, LDL, triglycerides, glucose, and cotinine screening. Your blood pressure, height, weight, and waist circumference may also be measured. You are not required to complete the HRA or to participate in the blood test or other medical examinations.

However, individuals who choose to participate in the wellness program may qualify for the CIGNA reward incentives by earning program credit by completing the Cigna online health assessment and other MotivateMe activities to earn rewards.

Although you are not required to complete the HRA or participate in the biometric screening, only participants who do so may qualify for the CIGNA reward incentives.

Additional incentives may be available for participants who participate in certain health-related activities or achieve certain health outcomes. If you are unable to participate in any of the health-related activities or achieve any of the health outcomes required to earn an incentive, you may be entitled to a reasonable accommodation or an alternative standard. You may request a reasonable accommodation or an alternative standard by contacting Human Resources at 404-364-8325.

The information from your HRA and the results from your biometric screening may be used to provide you with information to help you understand your current health and potential risks, and may also be used to offer you services through the wellness program, such as wellness programming and content. You also are encouraged to share your results or concerns with your own doctor.

Protections from Disclosure of Medical Information

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

Your health information will not be sold, exchanged, transferred, or otherwise disclosed except to the extent permitted by law to carry out specific activities related to the wellness program, and you will not be asked or required to waive the confidentiality of your health information as a condition of participating in the wellness program or receiving an incentive. Anyone who receives your information for purposes of providing you services as part of the wellness program will abide by the same confidentiality requirements. In order to provide you with services under the wellness program, your personally identifiable health information may be shared with one or more of the following: Lockton Companies, Cigna.

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

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

If you have questions or concerns regarding this notice, or about protections against discrimination and retaliation, please contact Human Resources at 404-364-8325.

SUPPLEMENTAL HEALTH BENEFITS

Oglethorpe University offers several ways for you to supplement your medical plan coverage. This additional insurance can help cover unexpected expenses, regardless of any benefit you may receive from your medical plan. Coverage is available for yourself and your dependents and is offered at discounted group rates.

Accident Coverage

Accidents happen. You can't always prevent them, but you can take steps to reduce the financial impact. Accident coverage, available through Cigna, provides benefits for you and your covered family members if you have expenses related to an accident that occurs outside of work. Health insurance helps with medical expenses, but this coverage is an additional layer of protection that can help you pay deductibles, copays, and even typical day-to-day expenses such as a mortgage or car payment. Benefits under this plan are payable to you, to use as you wish.

BI-WEEKLY CONTRIBUTIONS	
EMPLOYEE ONLY	$5.76
EMPLOYEE + SPOUSE	$10.52
EMPLOYEE + CHILD(REN)	$13.82
EMPLOYEE + FAMILY	$18.59

Accident Coverage

SUMMARY OF BENEFITS*	
HOSPITAL ADMISSION	$1,000 + $200 per day
INTENSIVE CARE UNIT STAY	$400 per day
DISLOCATIONS AND FRACTURES	up to $8,000
AMBULANCE	Ground: $400 / Air: $1,600
EMERGENCY CARE BENEFIT - EMERGENCY ROOM / PHYSICIAN'S OFFICE / URGENT CARE	$200
DIAGNOSTIC EXAM (X-RAY OR LAB)	$50
FOLLOW UP PHYSICIAN OFFICE VISIT	$75 (max 10/accident)
FOLLOW UP PHYSICAL THERAPY VISITS	$50 (max 10/accident)
BURNS	up to $10,000
CONCUSSION	$150
COMA	$10,000
ABDOMINAL OR THORACIC SURGERY	$1,250
TENDON, LIGAMENT, ROTATOR CUFF, OR KNEE SURGERY	Repair: $400 / Exploratory: $150
RUPTURED DISC SURGERY (REPAIR)	$750
BLOOD / PLASMA / PLATELETS	$200

*This list is a summary. Refer to plan documents for a comprehensive list of covered benefits.

Critical Illness Coverage

Critical Illness coverage through Cigna pays a lump-sum benefit if you are diagnosed with a covered disease or condition. You can use this money however you like; for example: to help pay for expenses not covered by your medical plan, lost wages, child care, travel, home health care costs or any of your regular household expenses.

Plan Highlights

- Guaranteed Issue Coverage (no medical questions)
- Benefits are payable based on the date of the covered event occurring or the date of diagnosis. Illnesses or occurrences prior to the effective date of coverage will not be payable events
- $50 annual Wellness Benefit is payable for each covered member for completing certain wellness screenings such as a pap test, cholesterol test, mammogram, colonoscopy or stress test (once per year per covered person)

Coverage Amounts:

- Employee: $10,000 or $20,000
- Spouse: 100% of Employee Benefit
- Children: 100% of Employee Benefit

BI-WEEKLY CONTRIBUTIONS ($10,000 BENEFIT)				
AGE	EMPLOYEE ONLY	EMPOYEE + SPOUSE	EMPOYEE + CHILDREN	EMPLOYEE + FAMILY
0-29	$2.22	$4.48	$4.71	$6.97
30-39	$3.51	$7.32	$6.00	$9.81
40-49	$6.48	$13.53	$8.98	$16.02
50-59	$12.57	$26.79	$15.06	$29.28
60-69	$19.86	$41.68	$22.36	$44.17
70-79	$31.08	$63.84	$33.57	$66.33
80+	$53.89	$121.18	$56.38	$123.67

BI-WEEKLY CONTRIBUTIONS ($20,000 BENEFIT)				
AGE	EMPLOYEE ONLY	EMPOYEE + SPOUSE	EMPOYEE + CHILDREN	EMPLOYEE + FAMILY
0-29	$4.43	$8.95	$9.42	$13.95
30-39	$7.02	$14.63	$12.01	$19.62
40-49	$12.97	$27.06	$17.96	$32.05
50-59	$25.14	$53.58	$30.13	$58.56
60-69	$39.73	$83.35	$44.72	$88.34
70-79	$62.15	$127.67	$67.14	$132.66
80+	$107.78	$242.35	$112.76	$247.35

Premiums are based on the Employee's age on the effective date of coverage. Even if the Spouse is in a different age band, the rates are driven off of the employee's age. Children are covered at no additional cost when you elect Employee coverage.

Covered Conditions and Benefit Amounts*

A covered employee and a covered dependents each have the full benefit amount illustrated below.

	COVERED CONDITIONS AND BENEFIT AMOUNTS*
CANCER CONDITIONS	
INVASIVE CANCER	100%
CARCINOMA IN SITU	25%
SKIN CANCER	$250
VASCULAR CONDITIONS	
HEART ATTACK	100%
STROKE	100%
CORONARY ARTERY DISEASE	25%
AORTIC & CEREBRAL ANEURYSM	25%
NERVOUS SYSTEMS CONDITIONS	
ADVANCED STAGE ALZHEIMER'S DISEASE	25%
AMYOTROPHIC LATERAL SCLEROSIS (ALS)	25%
PARKINSON'S DISEASE	25%
MULTIPLE SCLEROSIS	25%
INFECTIOUS CONDITIONS	
SEVERE SEPSIS	25%
CHILDHOOD CONDITIONS	
CEREBRAL PALSY	100%
CYSTIC FIBROSIS	100%
MUSCULAR DYSTROPHY	100%
POLIOMYELITIS	100%
HEART WALL MALFORMATION	100%
SICKLE CELL	100%
OTHER SPECIFIED CONDITIONS	
BENIGN BRAIN TUMOR	100%
BLINDNESS	100%
COMA	25%
END-STAGE RENAL (KIDNEY) DISEASE	100%
MAJOR ORGAN FAILURE	100%
PARALYSIS	100%

*This is a summary. Refer to plan document for details including definitions, plan exclusions and limitations.

DENTAL BENEFITS

Brushing your teeth and flossing are great, but don't forget to visit the dentist too! Oglethorpe University offers affordable plan options for routine care and beyond. Coverage is available from Cigna.

Network Dentists

If you use a dentist who doesn't participate in your plan's network, your out-of-pocket costs will be higher, and you are subject to any charges beyond the Reasonable and Customary (R&C). To find a network dentist, visit Cigna at www.cigna.com and search for providers in the Cigna DPPO Advantage network.

Dental Premiums

Premium contributions for dental are deducted from your paycheck on a pre-tax basis. Your tier of coverage determines your bi-weekly premium.

Dental Plan Summary

This chart summarizes the 2022 dental coverage provided by Cigna.

	DENTAL	
BI-WEEKLY CONTRIBUTIONS		
EMPLOYEE ONLY	$16.40	
EMPLOYEE + SPOUSE	$34.62	
EMPLOYEE + CHILD(REN)	$38.72	
EMPLOYEE + FAMILY	$59.11	
	IN-NETWORK	**OUT-OF-NETWORK**
CALENDAR YEAR DEDUCTIBLE		
INDIVIDUAL	$50	$50
FAMILY	$150	$150
CALENDAR YEAR MAXIMUM		
PER PERSON	$2,000	$2,000
COVERED SERVICES		
PREVENTIVE SERVICES Oral Exams, Routine Cleanings, Bitewing X-rays, Fluoride Applications, Sealants, Space Maintainers, Panoramic X-rays	100%	100%
BASIC SERVICES Full Mouth X-rays, Fillings, Oral Surgery, Simple Extractions	90%*	90%*
MAJOR SERVICES Oral Surgery, Complex Extractions, Denture Adjustments and Repairs, Root Canal Therapy, Periodontics, Crowns, Dentures, Bridges	60%*	60%*
ORTHODONTICS Dependent Child(ren) Only	50%	
ORTHODONTIC LIFETIME MAXIMUM	$1,000 per person	

*After Deductible

Thoughts & Tips: **Only 60% of adults ages 20 to 64 have been to the dentist in the past year. Take advantage of your dental coverage to keep your smile healthy.**

Routine Dental Care Does More Than Just Brighten Your Smile

Research shows that individuals who get recommended preventive dental care save, on average, 31% on future dental costs. For individuals who don't get recommended preventive care, their future dental costs increase by an average of 43%. A healthier mouth offers savings you can smile about.

The Cigna DPPO Advantage network makes it easy to protect your health – and your smile – with the right dental care at the right price. You can choose a dentist from one large network directory that is easily accessible and available online. Our online tools allow you to make more informed decisions about your dentist and your dental care.

Understand How Your Plan Works

When you choose a network dentist, your coverage includes a wide range of eligible services after you satisfy any waiting period and meet your deductible.

Your plan includes coverage for preventive dental care services, including cleanings, x-rays and more, at no additional cost or at a reduced cost to you.*

*Most plans limit cleanings and bitewing x-rays to two per calendar year, and full mouth/panorex x-rays to one every three calendar years. See your plan documents for a list of covered and non-covered services under your specific plan.

Important Factors to Consider

- For procedures other than diagnostic or preventive services, you will usually pay a percentage of the cost – or coinsurance amount – to the dentist at the time of service.
- You don't need an ID card to receive dental care.
- You don't need to select a primary care dentist.
- You don't need a referral to receive care from a specialist.

Your Access – Thousands of Dentists, One Directory

Cigna's DPPO Advantage network provides access to a large number of dentists and offers greater discounts with higher benefit levels compared to out-of-network dentists. This means more convenience and more ways for you to save.

IN-NETWORK	OUT-OF-NETWORK
Select a dentist or specialist from the Cigna DPPO Advantage network	Select any dentist or specialist
» By choosing a DPPO Advantage dentist, you receive a higher network benefit coverage than you would with a DPPO dentist. This may result in lower out-of-pocket expenses. » You'll pay less for covered services because network dentists have agreed to offer services at lower negotiated rates. » You may save on out-of-pocket costs for many services not covered under your plan. Network dentists have agreed to offer our customers discounted fees for all procedures on their fee schedules. (Not available in all states.) » Network dentists will submit claims for you. » All network dentists have met Cigna credentialing requirements based on national standards, and we repeat the process every three years.	» Your out-of-pocket expenses will generally be higher because out-of-network dentists have not agreed to offer Cigna plan customers negotiated rates. » Depending on your plan design, out-of-network dentists may bill you for the difference between the payment they receive from Cigna and their usual fees. » You may have to file your own claims.

VISION BENEFITS

Don't wear glasses? Even you shouldn't skip an annual eye exam! Oglethorpe University provides you and your family access to quality vision care with a comprehensive vision benefit through EyeMed.

Vision Premiums

Premium contributions for vision are deducted from your paycheck on a pre-tax basis. Your tier of coverage determines your Bi-weekly premium.

Vision Plan Summary

This chart summarizes the 2022 vision coverage provided by EyeMed.

	VISION		
BI-WEEKLY CONTRIBUTIONS			
EMPLOYEE ONLY	$3.17		
EMPLOYEE + SPOUSE	$6.01		
EMPLOYEE + CHILD(REN)	$6.33		
EMPLOYEE + FAMILY	$9.30		
	IN-NETWORK	**OUT-OF-NETWORK**	**FREQUENCY**
EXAMS			
COPAY	$10 Copay	Up to $30	Once every 12 months
LENSES			
SINGLE VISION	$20 Copay	Up to $25	Once every 12 months
BIFOCAL	$20 Copay	Up to $40	
TRIFOCAL	$20 Copay	Up to $60	
LENTICULAR	Standard: $85 Premium: $85 Copays plus 20% discount on additional charges	Up to $40	
CONTACTS (IN LIEU OF LENSES AND FRAMES)			
FITTING AND EVALUATION	Standard: Up to $40 Copay Specialty: $50 Retail Allowance	Not Covered	Once every 12 months
ELECTIVE	$130 Retail Allowance, 15% discount on additional charges (no discount for disposable lenses)	Up to $104	
FRAMES			
ALLOWANCE	$130 Retail Allowance, 20% discount on additional charges	Up to $65	Once every 24 months

Thoughts & Tips: **More than 150 million Americans use corrective eye wear to compensate for refractive errors.**

SURVIVOR BENEFITS

It's difficult to think about what would happen if something ever happened to you, but it's important to have a plan in place to make sure your family is provided for. Survivor benefits provide financial protection and security. Securing Life insurance now ensures your family will be protected for the future.

Basic Life and Accidental Death and Dismemberment (AD&D) Insurance

Oglethorpe University provides Employees with Basic Life and AD&D insurance as part of your basic coverage through Cigna, which guarantees that loved ones, such as a Spouse or other designated survivor(s), continue to receive part of an Employee's benefits after death.

Your Basic Life and AD&D insurance benefit is 1 times annual compensation to the next $1,000, up to $200,000. If you are a full-time Employee, you automatically receive Life and AD&D insurance even if you elect to waive other coverage. **Basic life insurance reduces to 65% at age 65 and 50% at age 70.**

What's a beneficiary? Your beneficiary is the person you designate to receive your Life insurance benefits in the event of your death. This includes any benefits payable under Basic Life offered by Oglethorpe University. You receive the benefit payment for a dependent's death under the Cigna insurance.

Name a primary and contingent beneficiary to make your intentions clear. Make sure to indicate their full name, address, Social Security number, relationship, date of birth and distribution percentage. Please note that in most states, benefit payments cannot be made to a minor. If you elect to designate a minor as beneficiary, all proceeds may be held under the beneficiary's name and will earn interest until the minor reaches majority age at 18. If you need assistance, contact Human Resources or your own legal counsel.

Voluntary Life Insurance

Life and AD&D benefits are an important part of your family's financial security. The basic benefits provided to you by Oglethorpe University may not be enough to cover expenses in a time of need. Therefore, extra coverage is available to protect you and your family. Eligible Employees may purchase additional Voluntary Life insurance. Premiums are paid through payroll deductions. **Basic life insurance reduces to 65% at age 65 and 50% at age 70.**

BASIC EMPLOYEE LIFE/AD&D	
COVERAGE AMOUNT	1 times annual compensation to the next $1,000
WHO PAYS	Oglethorpe University
BENEFITS PAYABLE	If you die, lose a limb or suffer paralysis in an accident
MAXIMUM BENEFIT	$200,000
EVIDENCE OF INSURABILITY (EOI) REQUIRED	No
VOLUNTARY EMPLOYEE LIFE	
COVERAGE AMOUNT	Increments of $1,000
WHO PAYS	Employee
BENEFITS PAYABLE	In the event of your death. This benefit is in addition to the Basic Life benefit.
MAXIMUM BENEFIT	5 times annual compensation or $500,000
EVIDENCE OF INSURABILITY (EOI) REQUIRED	For amounts over $100,000
VOLUNTARY SPOUSE LIFE	
COVERAGE AMOUNT	Increments of $5,000
WHO PAYS	Employee
BENEFITS PAYABLE	In the event of your spouse's death
MAXIMUM BENEFIT	Up to 50% of the employee benefit or $100,000
EVIDENCE OF INSURABILITY (EOI) REQUIRED	For amounts over $30,000
VOLUNTARY CHILD LIFE	
COVERAGE AMOUNT	Increments of $2,500
WHO PAYS	Employee
BENEFITS PAYABLE	In the event of your child's death
MAXIMUM BENEFIT	Up to $10,000
EVIDENCE OF INSURABILITY (EOI) REQUIRED	No

Annual Enrollment

Employees and Spouses currently enrolled in the Voluntary Life plan may increase their benefit by one increment up to the guarantee issue amount without supplying Evidence of Insurability (EOI). EOI will be required for any increases above one increment (or if the increment increase exceeds the guarantee issue) as well as for all elections outside of the initial eligibility period. The EOI must be approved by Cigna prior to the benefit becoming active.

VOLUNTARY LIFE INSURANCE

RATES/$1,000 (MONTHLY)

AGE (AS OF JANUARY 1, 2022)	EMPLOYEE	AGE (AS OF JANUARY 1, 2022)	SPOUSE
Under 25	$0.06	Under 25	$0.06
25-29	$0.06	25-29	$0.06
30-34	$0.08	30-34	$0.08
35-39	$0.09	35-39	$0.09
40-44	$0.12	40-44	$0.12
45-49	$0.20	45-49	$0.20
50-54	$0.28	50-54	$0.28
55-59	$0.57	55-59	$0.57
60-64	$0.68	60-64	$0.68
65-69	$1.27	65-69	$1.27
70-74	$2.06	70-74	$2.06
75+	$2.06	75+	$2.06

CHILD VOLUNTARY LIFE INSURANCE

RATE/$1,000 (MONTHLY)
$0.20

TO CALCULATE HOW MUCH YOUR VOLUNTARY LIFE COVERAGE WILL COST:

$	÷ 1,000 =	$	x Age Based Rate =	$
Benefit Elected				Monthly Premium

INCOME PROTECTION

Oglethorpe University offers disability coverage to protect you financially in the event you cannot work as a result of a debilitating injury. A portion of your income is protected until you can return to work or until you reach retirement age.

Voluntary Short Term Disability (STD) Insurance

Short Term Disability (STD) benefits are available to you on a voluntary basis. STD insurance replaces 60% of your income if you become partially or totally disabled for a short time. Certain exclusions, along with pre-existing condition limitations, may apply. Review your plan documents or talk with Human Resources for more details.

WEEKLY MAXIMUM BENEFIT	$1,500
ELIMINATION PERIOD	7 days
MAXIMUM BENEFIT PERIOD	90 days

VOLUNTARY STD	
AGE (AS OF JANUARY 1, 2022)	
AGE RANGE	**STD**
<30	$0.325
30-34	$0.325
35-39	$0.325
40-44	$0.325
45-49	$0.325
50-54	$0.325
55-59	$0.398
60-64	$0.470
65+	$0.515

Long Term Disability (LTD) Insurance

Long Term Disability (LTD) benefits are provided by the Company at no cost to you. LTD insurance replaces 60% of your income if you become partially or totally disabled for an extended time. Certain exclusions, along with pre-existing condition limitations, may apply. Review your plan documents or talk with Human Resources for more details.

MONTHLY MAXIMUM BENEFIT	$10,000
ELIMINATION PERIOD	90 days
MAXIMUM BENEFIT PERIOD	Payments will last for as long as you are disabled or until you reach your Social Security Normal Retirement Age, whichever is sooner.

Thoughts & Tips: **Nearly 6% of working Americans will experience a short term disability due to illness, injury or pregnancy on average every year.**

TO CALCULATE HOW MUCH YOUR STD COVERAGE WILL COST:

$	÷ 52 =	$	x 60% =	$	x Rate =	$	÷ $10 =	$
Annual Salary		Weekly Income		Weekly Benefit		Amount		Monthly Premium

CALCULATION EXAMPLE (USING 45 AGE RANGE)

$50,000.00	÷ 52 =	$961.54	x 60% =	$576.92	x Rate =	$187.50	÷ $10 =	$18.75
$80,000.00	÷ 52 =	$1,538.46	This amount is over the weekly maximum benefit					
$80,000.00	÷ 52 =	$1,500.00	x 60% =	$900.00	x Rate =	$292.50	÷ $10 =	$29.25
Annual Salary		Weekly Income		Weekly Benefit		Amount		Monthly Premium

RETIREMENT PLANNING

Whether you're just starting out in your career or you've been in the workforce for years, it's always a good time to plan for retirement.

Contributing to a 403(b) account now can help keep you financially secure later in life. The Oglethorpe University 403(b) plan provides you with the tools and flexibility you need to prepare.

PLAN AT A GLANCE	
PLAN NAME	Oglethorpe University 403(b) Plan
RECORD KEEPER	Lincoln Financial 403(b) Plan
WEBSITE	www.lincolnfinancial.com/retirement
ELIGIBILITY	as of the 1st day of the month following thirty (30) days of service
COMPANY MATCH	There is no minimum contribution required to participate in the retirement plan. However, to receive the university's matching contributions, eligible employees must contribute a minimum of 5% of their annual salary. Oglethorpe University offers a 7% match of annual salary. Oglethorpe University will notify participants of any changes to the matching contribution at least 30 days prior to the payroll period the matching contribution will become effective. An employee's gross pay is used for this calculation.

What is a 403(b)? This employer-sponsored retirement account can help build and create choices for your future self by saving money — tax free — from your paycheck. Due to the value of compounding interest, the sooner you participate in a 403(b), the better.

Eligible Employees can invest for retirement while receiving certain tax advantages. Administrative and record-keeping services for this plan are provided by Lincoln Financial 403(b) Plan. You may start making pre-tax contributions into the plan as of the 1st day of the month following thirty (30) days of service.

Pre-tax vs. 403(b): What's the difference? If you contribute to your 403(b) pre-tax, your contributions will be taken out before taxes each pay period. However, you'll have to pay taxes on the funds when you withdraw them during retirement. If you choose the available 403(b) Roth, contributions will be deducted from your paycheck after taxes — so you won't pay taxes when you withdraw during retirement. Once you retire, you might be in a higher tax bracket, so contributing after taxes now could save you money in the long run.

Thoughts & Tips: **When you retire, you'll need at least 70% of your pre-retirement earnings to maintain your standard of living.**

Contributing to the Plan

The deferred contribution limit set annually by the IRS is $19,500 for 2022.

If you are age 50 or older this calendar year and you already contribute the maximum allowed to your 403(b) account, you may also make a "catch-up contribution." This additional deposit accelerates your progress toward your retirement goals. The maximum catch-up contribution is $6,500 for 2022 — for a combined total contribution allowance of $26,000. See your plan administrator for details.

Think you might be getting close to the annual contribution limit? Our payroll system tracks how much you've contributed. If you started at the company mid-year, let the Payroll Department know how much you contributed at your previous employer so that can be factored in.

How Much Should I Be Saving?

Industry standards suggest saving, at a minimum, 12% to 15% of your income, inclusive of Oglethorpe University's generous matching contribution. There is no minimum contribution required to participate in the retirement plan. However, to receive the university's matching contributions, employees must contribute a minimum of 5% of their annual salary. Oglethorpe University offers a 7% match of annual salary. Oglethorpe University will notify participants of any changes to the matching contribution at least 30 days prior to the payroll period the matching contribution will become effective. An employee's gross pay is used for this calculation. If you cannot afford to save much right now, at least make sure to be saving up to the matching amount so you are not leaving free money behind.

Changing or Stopping Your Contributions

You may change the amount of your contributions any time. All changes are effective as soon as administratively feasible and remain in effect until you modify them. You may also discontinue your contributions and start them again at any time.

Consolidating Your Retirement Savings

If you have an existing qualified retirement plan (pre-tax) with a previous employer, you may transfer that account into the plan any time. Visit Lincoln Financial 403(b) Plan at www.lincolnfinancial.com/retirement for details.

Regardless of which retirement account you choose or how much you contribute, it's important to think of it as a long-term strategy. Dipping into the account early will jeopardize the quality of your retirement and rack up penalties from the IRS.

Investing in the Plan

It's up to you how to invest the assets in your account. The Oglethorpe University 403(b) plan offers a selection of investment options for you to choose from. You may change your investment choices any time. For more details, refer to your 403(b) Enrollment Guide or visit www.lincolnfinancial.com/retirement.

Vesting - 100% Immediately

The term "vested" refers to how much of your 403(b) funds you can take with you if or when you leave Oglethorpe University. With our vesting schedule, you immediately own 100% of the company's matching contributions. You always own and are fully vested in your own personal 403(b) contributions.

VESTING SCHEDULE	
YEARS OF SERVICE	**PERCENTAGE VESTED**
Immediate	100%

ADDITIONAL BENEFITS

Oglethorpe University cares about you and wants you to succeed in all aspects of life, so we offer a variety of additional benefits to help make your day-to-day easier.

Employee Assistance Program

We know life is complicated, and sometimes we all just need a little help. Our Employee Assistance Program (EAP) helps manage your and your family's total health, including mental, emotional and physical. And it comes at no cost to you — whether you're enrolled in a company-sponsored medical plan or not.

Through this program, you have access to mental health assistance and legal and financial help from a number of professionals. You have 24-hour access to helpful resources by phone, and the EAP benefit includes three face-to-face visits per issue with a licensed professional. All services provided are confidential and will not be shared with Oglethorpe University. You may access information, benefits, educational materials and more either by phone at 800-538-3543 or online at www.cignabehavioral.com/cgi.

The Program provides referrals to help with:

- Emotional health and well-being
- Alcohol or drug dependency
- Marriage or family relationship problems
- Job pressures
- Stress, anxiety, depression
- Grief and loss
- Financial or legal advice

Holidays

Oglethorpe University observes the following ten holidays during the year:

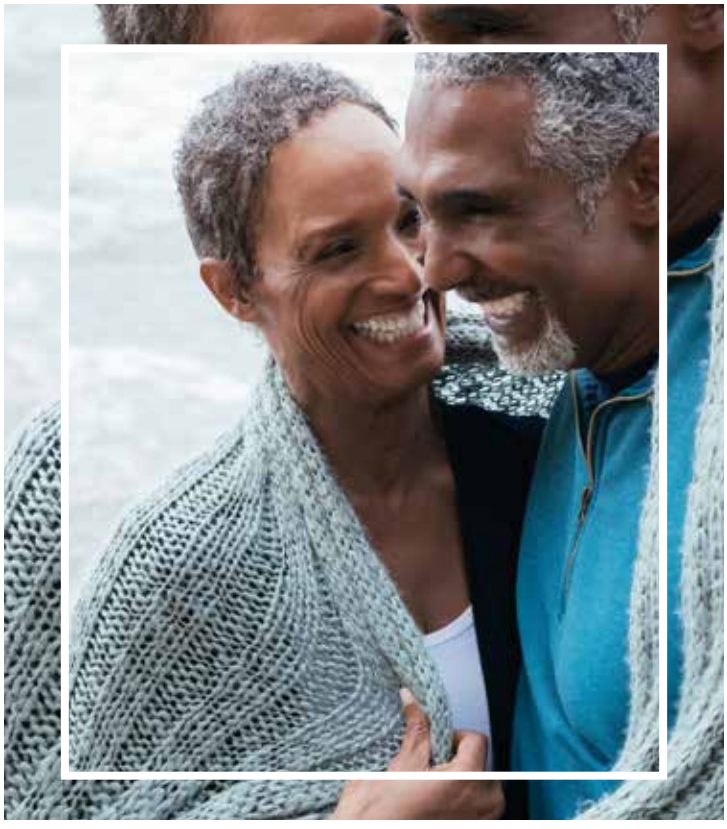
- New Year's Day
- Martin Luther King, Jr. Day
- Memorial Day
- Juneteenth
- Independence Day
- Labor Day
- Thanksgiving Day
- Friday Following Thanksgiving
- Christmas Eve
- Christmas Day

In addition, the University typically closes for winter break each year.

Vacation

For regular, full-time employees (with the exception of faculty) vacation time begins to accrue immediately and may be used after 3 months of continuous employment.

An employee may accrue up to 120 hours of vacation. At that point, accruals will stop until hours fall below 120 (with the exception of employees with 12 or more years of service). Occasional exceptions to this cap may be approved for unusual situations such as the need to cover unplanned absences or special projects in a department. Exceptions must be approved by your supervisor and the Human Resources Director.



Sick Leave

Regular full-time employees (with the exception of faculty and nine-month staff) are eligible for 10 days of paid sick leave each anniversary year. Nine-month staff are eligible for seven and a half paid sick days. Sick leave may be used:

- When unable to work because of illness or injury.
- When the employee or dependent has a scheduled medical or dental appointment.
- To care for an ill family member (spouse, parent, child, grandparents or grandchildren).

Although full-time Faculty do not receive regular sick days, they do accrue up to two weeks of FMLA leave each year to a maximum of 640 hours (16 weeks) for use with illness or other events which meet the definition of FMLA leave.

Each pay period, sick leave is accrued for staff at a rate of 3.08 hours for regular, full-time employees and at a rate of 2.31 hours for nine-month staff, and is considered "available" on the first workday of the next month. The accrual rate is based on actual hours worked in a pay period—when working less than a normal schedule, the accrual rate will be lower for that pay period.

Any accrued unused sick days are "banked" at the end of the year into a special account called a Family Medical Leave Act (FMLA) account. Once banked, sick days can only be used for events classified as FMLA leave. A maximum of 480 hours (12 weeks) can be banked into the FMLA account for staff.

Sick leave may not be "saved" by taking time off without pay. If an employee is absent and has exceeded his or her available sick leave balance, he or she may use vacation, if available, to cover the absence.

The employee is responsible for managing his or her sick leave and monitoring the sick leave balance which appears on each paycheck. Remember that sick time may only be used when there is a balance available.

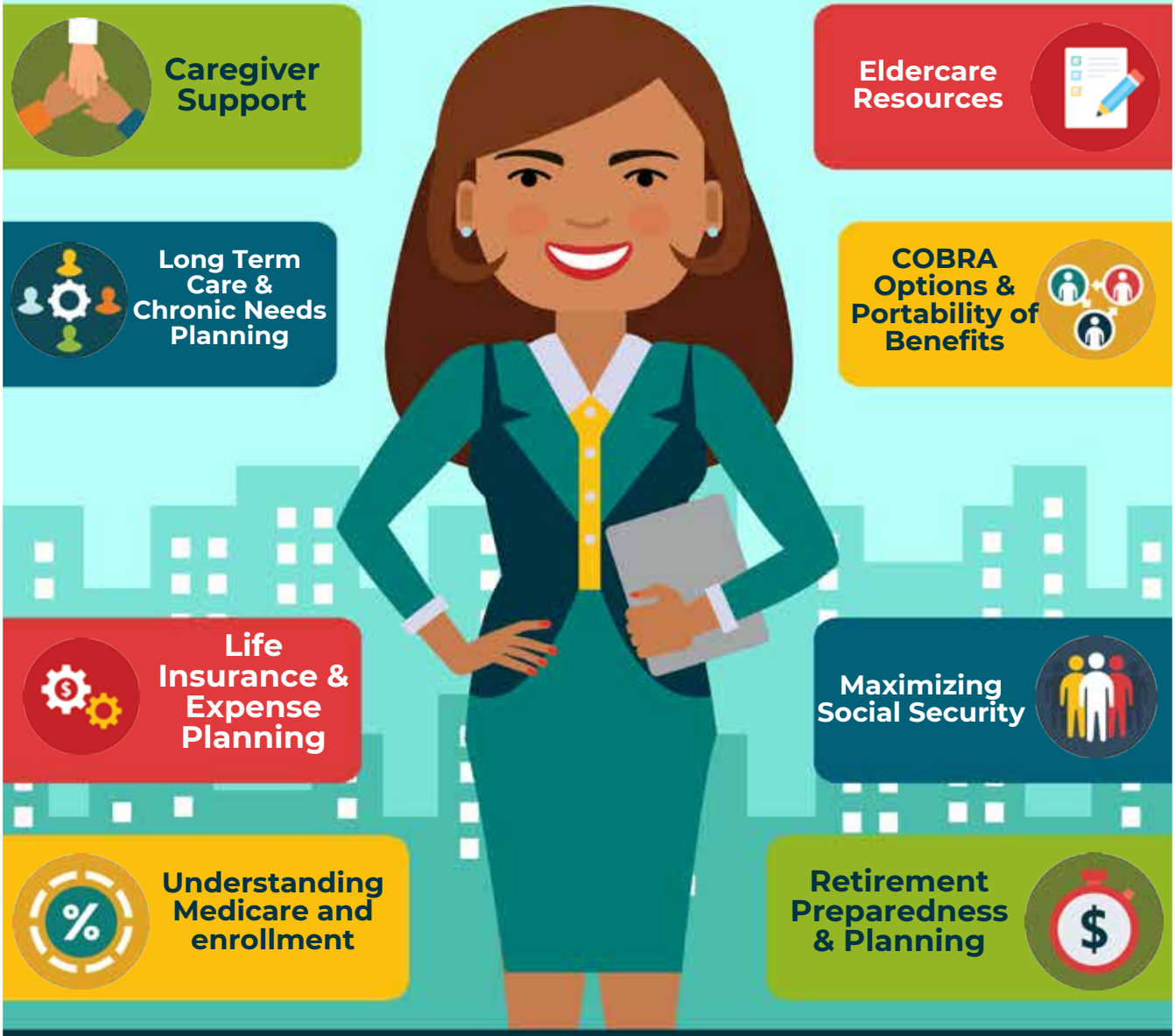
Unused sick leave is not paid upon termination of employment or upon transferring to a non-benefits eligible position. Once an employee gives notice of resignation, sick leave requests will no longer be approved.

Transitions
Retiree Benefit Group

800-935-1405

Support for your entire workforce

With a name like Transitions Retiree Benefit Group it is important to understand how we support all employees and their families through our services.



- Caregiver Support
- Eldercare Resources
- Long Term Care & Chronic Needs Planning
- COBRA Options & Portability of Benefits
- Life Insurance & Expense Planning
- Maximizing Social Security
- Understanding Medicare and enrollment
- Retirement Preparedness & Planning

VA Benefits | Prescription Planning | Assisted Living Services

A Benefit for all ages and stages of life

Feel free to share this information with your loved one, all they need is your name and the name of your employer. From there they will have access to our services and our national network of providers. Welcome to the Transitions RBG family!

GLOSSARY

Balance Billing – When you are billed by a provider for the difference between the provider's charge and the allowed amount. For example, if the provider's charge is $100 and the allowed amount is $60, you may be billed by the provider for the remaining $40.

Coinsurance – Your share of the cost of a covered healthcare service, calculated as a percent of the allowed amount for the service, typically after you meet your deductible.

Copay – The fixed amount, as determined by your insurance plan, you pay for healthcare services received.

Deductible – The amount you owe for healthcare services before your health insurance begins to pay its portion. For example, if your deductible is $1,000, your plan does not pay anything until you've paid $1,000 for covered services. This deductible may not apply to all services, including preventive care.

Explanation of Benefits (EOB) – A statement from your insurance carrier that explains which services were provided, their cost, what portion of the claim was paid by the plan, and what portion is your liability, in addition to how you can appeal the insurer's decision.

Flexible Spending Accounts (FSAs) – A special tax-free account you put money into that you use to pay for certain out-of-pocket healthcare costs. You'll save an amount equal to the taxes you would have paid on the money you set aside. FSAs are "use it or lose it," meaning that funds not used by the end of the plan year will be lost. Some Healthcare FSAs do allow for a grace period or a rollover into the next plan year.

- Healthcare FSA – A pre-tax benefit account used to pay for eligible medical, dental, and vision care expenses that aren't covered by your insurance plan. All expenses must be qualified as defined in Section 213(d) of the Internal Revenue Code.
- Dependent Care FSA – A pre-tax benefit account used to pay for dependent care services. For additional information on eligible expenses, refer to Publication 503 on the IRS website.

Healthcare Cost Transparency – Also known as market transparency or medical transparency. Online cost transparency tools, available through health insurance carriers, allow you to search an extensive national database to compare varying costs for services.

Health Savings Account (HSA) – A personal healthcare bank account funded by your or your employer's tax-free dollars to pay for qualified medical expenses. You must be enrolled in a HDHP to open an HSA. Funds contributed to an HSA roll over from year to year and the account is portable, so if you change jobs your account goes with you.

High Deductible Health Plan (HDHP) – A plan option that provides choice, flexibility and control when it comes to healthcare spending. Most preventive care is covered at 100% with in-network providers, there are no copays and all qualified employee-paid medical expenses count toward your deductible and your out-of-pocket maximum.

Network – A group of physicians, hospitals and other healthcare providers that have agreed to provide medical services to a health insurance plan's members at discounted costs.

- In-Network – Providers that contract with your insurance company to provide healthcare services at the negotiated carrier discounted rates.
- Out-of-Network – Providers that are not contracted with your insurance company. If you choose an out-of-network provider, services will not be covered at the in-network negotiated carrier discounted rates.
- Non-Participating – Providers that have declined entering into a contract with your insurance provider. They may not accept any insurance and you could pay for all costs out of pocket.

Open Enrollment – The period set by the employer during which employees and dependents may enroll for coverage, make changes or decline coverage.

Out-of-Pocket Maximum – The most you pay during a policy period (usually a 12-month period) before your health insurance begins to pay 100% of the allowed amount. This does not include your premium, charges beyond the Reasonable & Customary, or healthcare your plan doesn't cover. Check with your carrier to confirm what applies to the maximum.

Over-the-Counter (OTC) Medications – Medications available without a prescription.

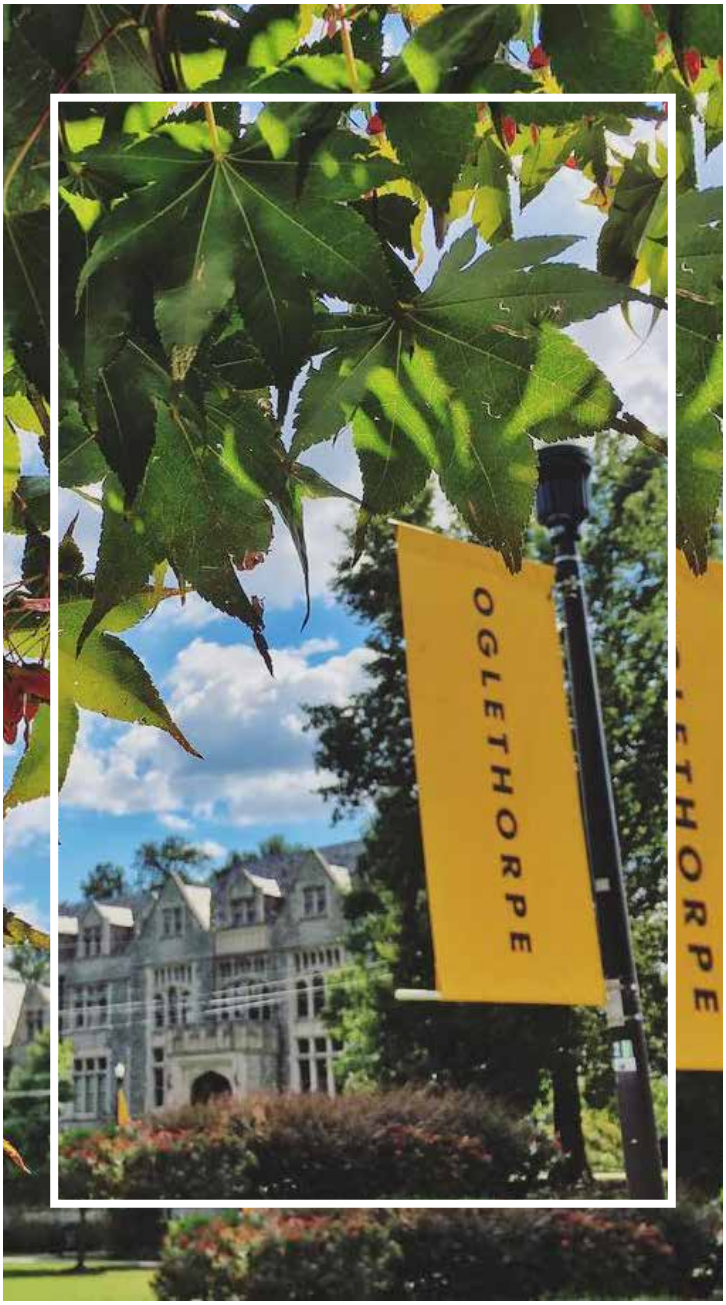
Prescription Medications – Medications prescribed by a doctor. Cost of these medications is determined by their assigned tier: generic, preferred, non-preferred or specialty.

- **Generic Drugs –** Drugs approved by the U.S. Food and Drug Administration (FDA) to be chemically identical to corresponding preferred or non-preferred versions. Usually the most cost-effective version of any medication.
- **Preferred Drugs –** Brand-name drugs on your provider's approved list (available online).
- **Non-Preferred Drugs –** Brand-name drugs not on your provider's list of approved drugs. These drugs are typically newer and have higher copayments.
- **Specialty Drugs –** Prescription medications used to treat complex, chronic and often costly conditions. Because of the high cost, many insurers require that specific criteria be met before a drug is covered.
- **Prior Authorization –** A requirement that your physician obtain approval from your health insurance plan to prescribe a specific medication for you.

Reasonable and Customary Allowance (R&C) – Also known as the UCR (Usual, Customary, and Reasonable) amount. The amount paid for a medical service in a geographic area based on what providers in the area usually charge for the same or similar medical service. The R&C amount is sometimes used to determine the allowed amount.

Summary of Benefits and Coverage (SBC) – Mandated by healthcare reform, your insurance carrier provides you with a summary of your benefits and plan coverage.

Summary Plan Description (SPD) - The document(s) that outline the rights, obligations, and material provisions of the plan(s) to all participants and their beneficiaries.



Required Notices

Important Notice from Oglethorpe University About Your Prescription Drug Coverage and Medicare under the OAP Plan(s)

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with Oglethorpe University and about your options under Medicare's prescription drug coverage. This information can help you decide whether or not you want to join a Medicare drug plan. If you are considering joining, you should compare your current coverage, including which drugs are covered at what cost, with the coverage and costs of the plans offering Medicare prescription drug coverage in your area. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice.

There are two important things you need to know about your current coverage and Medicare's prescription drug coverage:

1. Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.

2. Oglethorpe University has determined that the prescription drug coverage offered by the OAP plan(s) is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

When Can You Join A Medicare Drug Plan?

You can join a Medicare drug plan when you first become eligible for Medicare during a seven-month initial enrollment period. That period begins three months prior to your 65th birthday, includes the month you turn 65, and continues for the ensuing three months. You may also enroll 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 current Oglethorpe University coverage will not be affected. For most persons covered under the Plan, the Plan will pay prescription drug benefits first, and Medicare will determine its payments second. For more information about this issue of what program pays first and what program pays second, see the Plan's summary plan description or contact Medicare at the telephone number or web address listed herein.

If you do decide to join a Medicare drug plan and drop your current Oglethorpe University coverage, be aware that you and your dependents will not be able to get this coverage back.

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

You should also know that if you drop or lose your current coverage with Oglethorpe University and don't join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later.

If you go 63 continuous days or longer without creditable prescription drug coverage, your monthly premium may go up by at least 1% of the Medicare base beneficiary premium per month for every month that you did not have that coverage. For example, if you go nineteen months without creditable coverage, your premium may consistently be at least 19% higher than the Medicare base beneficiary premium. You may have to pay this higher premium (a penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following October to join.

For More Information about This Notice or Your Current Prescription Drug Coverage…

Contact the person listed at the end of these notices for further information. **NOTE:** You'll get this notice each year. You will also get it before the next period you can join a Medicare drug plan, and if this coverage through Oglethorpe University changes. You also may request a copy of this notice at any time.

For More Information about Your Options under Medicare Prescription Drug Coverage…

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

For more information about Medicare prescription drug coverage:

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

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

Remember: Keep this Medicare Part D 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:	January 1, 2022
Name of Entity/Sender:	Oglethorpe University
Contact—Position/Office:	Human Resources
Address:	4484 Peachtree Road, NE Atlanta, GA 30319
Phone Number:	404-364-8325

Women's Health and Cancer Rights Act

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

- All stages of reconstruction of the breast on which the mastectomy was performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance;
- Prostheses; and
- Treatment of physical complications of the mastectomy, including lymphedema.

These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under this plan. For deductibles and coinsurance information applicable to the plan in which you enroll, please refer to the summary plan description. If you would like more information on WHCRA benefits, please contact Human Resources at 404-364-8325.

HIPAA Privacy and Security

The Health Insurance Portability and Accountability Act of 1996 deals with how an employer can enforce eligibility and enrollment for health care benefits, as well as ensuring that protected health information which identifies you is kept private. You have the right to inspect and copy protected health information that is maintained by and for the plan for enrollment, payment, claims and case management. If you feel that protected health information about you is incorrect or incomplete, you may ask your benefits administrator to amend the information. For a full copy of the Notice of Privacy Practices, describing how protected health information about you may be used and disclosed and how you can get access to the information, contact Human Resources at 404-364-8325.

HIPAA Special Enrollment Rights

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 later 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 towards your or your dependents' other coverage).

Loss of eligibility includes but is not limited to:

- Loss of eligibility for coverage as a result of ceasing to meet the plan's eligibility requirements (i.e. legal separation, divorce, cessation of dependent status, death of an employee, termination of employment, reduction in the number of hours of employment);
- Loss of HMO coverage because the person no longer resides or works in the HMO service area and no other coverage option is available through the HMO plan sponsor;
- Elimination of the coverage option a person was enrolled in, and another option is not offered in its place;
- Failing to return from an FMLA leave of absence; and
- Loss of coverage under Medicaid or the Children's Health Insurance Program (CHIP).

Unless the event giving rise to your special enrollment right is a loss of coverage under Medicaid or CHIP, you must request enrollment within 30 days after your or your dependent's(s') other coverage ends (or after the employer that sponsors that coverage stops contributing toward the coverage).

If the event giving rise to your special enrollment right is a loss of coverage under Medicaid or the CHIP, you may request enrollment under this plan within 60 days of the date you or your dependent(s) lose such coverage under Medicaid or CHIP. Similarly, if you or your dependent(s) become eligible for a state-granted premium subsidy towards this plan, you may request enrollment under this plan within 60 days after the date Medicaid or CHIP determine that you or the dependent(s) qualify for the subsidy.

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 Human Resources at 404-364-8325.

IMPORTANT CONTACTS

MEDICAL
Cigna
866-494-2111
(General Account Questions)
www.myCigna.com
Policy #: 0631217

SUPPLEMENTAL HEALTH (ACCIDENT AND CRITICAL ILLNESS)
Cigna
800-244-6224
www.mycigna.com

VIRTUAL VISITS
Cigna partner MDLIVE
www.myCigna.com

DENTAL
Cigna
800-362-4462
www.cigna.com
Policy #: 3343297

VISION
EyeMed
866-299-1358
www.eyemed.com
Policy #: 9836370

HEALTH SAVINGS ACCOUNT
WEX
866-451-3399
www.wexinc.com

FLEXIBLE SPENDING ACCOUNTS
WEX
866-451-3399
www.wexinc.com

LIFE AND AD&D
Cigna
800-362-4462
www.cigna.com
Policy #: SGM-605732

DISABILITY
Cigna
800-362-4462
www.cigna.com
Policy #: STD: VDT-601702
LTD: SGD-605840

RETIREMENT
Lincoln Financial 403(b) Plan
www.lincolnfinancial.com/retirement

EMPLOYEE ASSISTANCE PROGRAM
Cigna
800-538-3543
www.cignabehavioral.com/cgi
Policy #: SGD-605840

OGLETHORPE UNIVERSITY HUMAN RESOURCES
4484 Peachtree Road NE
Atlanta, GA 30319
404-364-8325

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