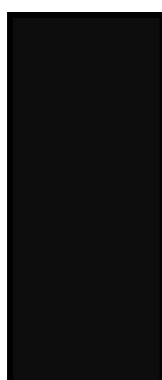
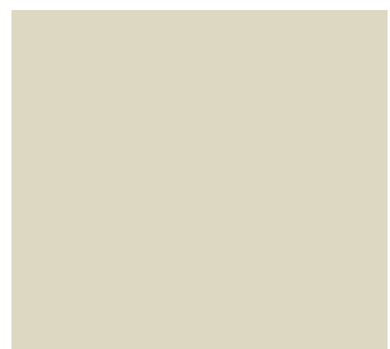
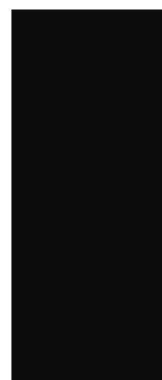
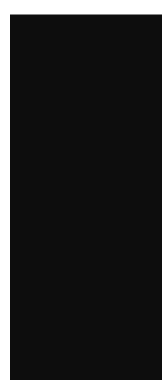
2016 Summary of Employee Benefits





Welcome to your 2016 Employee Benefits Guide

We recognize the important role employee benefits plays as a critical component of your overall compensation. Oglethorpe University continues to make every effort to target the best quality benefit plans for our employees and their families. Our program offers a range of plan options to meet the needs of our diverse workforce. We know that your benefits are important to you and your family. This program is designed to assist you in providing for the health, well being and financial security of you and your covered dependents. Helping you understand the benefits Oglethorpe University offers is important to us, and that is why we have created this Employee Benefits Guide.

Benefits Guide Overview

Oglethorpe University is proud to offer a high quality assortment of benefit choices, and the freedom to select coverage that will fit your needs and your budget. This Benefits Guide, along with your Benefit Summaries provides a full explanation of the benefits available to you and your family.

The coverage you elect during the annual open enrollment period becomes effective on January 1 of the following year. If you are a new employee, your coverage will begin the first of the month following your date of hire.

This is your enrollment opportunity. At this time, you may elect to enroll in the benefit programs offered. Options selected during this enrollment period will remain in place until December 31, 2016 unless you or your dependents experience a qualified life event (See box below).

Changing Benefits During the Year

The IRS states that eligible employees may only make elections to the plan during their initial eligibility period or once a year at open enrollment. The following circumstances are the only reasons you may change your benefit elections during the year:

Marriage	Spouse Loss of Coverage
Divorce	Death of a Dependent
Birth or Adoption	Loss of Dependent Status
Change in employment Status, Addition of a New Benefits Package, and Open Enrollment for a Spouse.	

These special circumstances, often referred to as life event changes, allow you to make plan changes at any time during the year when they occur. You must inform your Human Resources Department within 30 days of the event in order to make a qualified change. All other changes will be deferred to open enrollment.

WHAT'S NEW IN 2016?

Medical Plan Changes

Oglethorpe University will continue to offer the HDHP with HSA, HMO, and Multi-Choice plans through Kaiser Permanente for 2016. The HDHP with HSA and Multi-Choice benefits are not changing for 2016, but the HMO benefits have been altered slightly. Changes to the HMO plan are:

- Co-insurance decreases from 100% to 90%.
- Out of Pocket Maximum decreases from $6,350 single/$12,700 family to $3,000 single/$6,000 family.
- Specialist Copay decreases from $35 to $30.
- Non Preferred Brand Name Drugs are not covered unless determined by a physician to be medically necessary.

Please see pages 4-6 of this Benefits Guide for more information on the medical plans.

Dental Plan—Carrier Change

Beginning January 1, 2016, Guardian will be the new dental insurance carrier. Employees will still have the opportunity to select between two plans. See page 11 for plan benefits, but note that the NAP plan pays out of network providers at a higher reimbursement level than the Value plan—for employees who visit a dentist who does not participate in the Guardian network, the NAP plan will reimburse the provider at a higher level and, subsequently, reduce the portion of the charges subject to balance billing.

As an added benefit, both Guardian plans allow for an annual maximum rollover benefit. See page 12 for details on the rollover benefit.

New for 2016—Voluntary Short Term Disability

Oglethorpe University will offer a voluntary Short Term Disability (STD) plan through Cigna for coverage to commence on January 1, 2016. The Short Term Disability plan through Cigna does not require employees to complete any kind of medical underwriting. There is a 12 month pre-existing condition exclusion for any condition that has been treated in the 3 months before the plan becomes effective—in other words, if you have seen your doctor for any kind of treatment in the past 3 months, you would be ineligible for any kind of STD benefit related to that treatment during the first 12 months of the policy. Benefits begin on the 8th day of accident or sickness and can last up to 12 weeks. Please note that Cigna requires at least 25% of eligible employees to participate—if less than 25% of employees enroll in the STD plan, Oglethorpe University will not be able to offer this plan through Cigna for 2016.

Please see page 16 of this guide for rate information and how to calculate your monthly cost for coverage.

STEPS FOR ENROLLMENT

1. Read this Benefits Guide carefully.

2. Meet with a Colonial Life enrollment counselor in person or via phone and make your 2016 elections. New hires who will be enrolling in benefits after Open Enrollment has ended will need to complete and return a paper enrollment form to HR.

3. Verify that your deductions are correct on your first 2016 paycheck.

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 at open enrollment, you will not be enrolled in the plan for 2016.

UNDERSTANDING YOUR MEDICAL PLAN

Medical Questions? Need to Locate a Provider?
Contact Kaiser Permanente
1-888-865-5813 or www.kp.org
Group #: 10022
Plan Name: Oglethorpe University

Oglethorpe University's medical benefits are insured through Kaiser Permanente. Employees may select either the High Deductible Health Plan with Health Savings Account (HDHP with HSA), the traditional HMO, the Multi-Choice PPO, or waive coverage altogether.

For enrolled members, Register on the kp.org website and**:**

-Find in network providers and facilities
-Track claims and account activity
-Get answers to coverage questions
-Find health advice
And much more

Follow these easy steps to locate a doctor, hospital or health facility participating with Kaiser.

For members enrolled in the HDHP or HMO plan:

STEP 1: Go to www.kp.org. Select "Georgia" as your region. Click on "Find a Doctor."
STEP 2: Search for a Physician, Hospital, or Health Care Facility by name or zip code.
STEP 3: Click on the link for "More Search Options" and under plan type, select "HMO or EPO"

For members enrolled in the Multi-Choice Plan:

STEP 1 and **STEP 2** same as above.
STEP 3: Click on the link for "More Search Options" and under plan type, select "Multi-Choice or POS"

Members can also search the PHCS Multi-Choice network at www.multiplan.com. Select the "PHCS" Logo and then search by either provider or facility.

UNDERSTANDING YOUR MEDICAL PLAN

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Group #: 10022
Plan Name: Oglethorpe University

High Deductible Health Plan with Health Savings Account (HDHP with HSA)	
	In Network Only
Overview	Participants must visit a Kaiser provider or facility to receive benefits. Use a non-Kaiser provider or facility and no benefits will be paid by Kaiser.
Calendar Year Deductible	
Individual	$2,500
Family	$5,000
Annual Out of Pocket Maximum *(includes Deductible, Co-insurance, and all Co-pays)*	
Individual	$2,500
Family	$5,000
Co-insurance	100% after Deductible
Lifetime Maximum Benefit	Unlimited
Primary Care Physician Office Visits	Plan pays 100% after Deductible
Specialist Office Visits	Plan pays 100% after Deductible *(referrals required from PCP)*
Preventive Care Services - as determined by the US Preventive Services Task Force	Covered at 100%, not subject to deductible or Co-pays
Hospital Inpatient Expenses *(Must be Pre-Certified)*	Plan pays 100% after Deductible
Hospital Outpatient Expenses	Plan pays 100% after Deductible
Diagnostic Lab / X-Ray *(not performed in Doctor's office)*	Plan pays 100% after Deductible
Emergency Room (Accidental Injury and Medical Emergency Care)	Plan pays 100% after Deductible
Urgent Care	Plan pays 100% after Deductible
Durable Medical Equipment	Plan pays 100% after Deductible
Chiropractic Services *(20 visit maximum per calendar year)*	Plan pays 100% after Deductible
Rehabilitation Benefits *(includes physical, occupational and speech therapy)*	Plan pays 100% after Deductible Limited to 20 visits per calendar year
Prescription Drugs	
Kaiser Pharmacy (30-day Supply)	Plan pays 100% after Deductible
Network Pharmacy (30-day Supply)	Plan pays 100% after Deductible
Mail Order Program (90-day Supply)	Plan pays 100% after Deductible

A Health Savings Account, or HSA is an individual account that can be used to save for future medical expenses. You must be enrolled in the HDHP plan above in order to open a Health Savings Account. Contributions to an HSA can be made by you or your employer, or a combination of the two, but the money in the account will always belong to you—even if you terminate employment with Oglethorpe University. Oglethorpe University will match employee HSA contributions dollar for dollar up to $40 per month. Employees who open an HSA can take advantage of tax savings—contributions made to your HSA are pre-tax and, as long as you are using the account for qualified medical expenses, withdrawals from the account are tax-free. See page 8 for more information on Health Savings Accounts.

UNDERSTANDING YOUR MEDICAL PLAN

Medical Questions? Need to Locate a Provider?
Contact Kaiser Permanente
1-888-865-5813 or www.kp.org
Group #: 10022
Plan Name: Oglethorpe University

HMO	
	In Network Only
Overview	Participants must visit a Kaiser provider or facility to receive benefits. Use a non-Kaiser provider or facility and no benefits will be paid by Kaiser.
Calendar Year Deductible	
Individual	$1,000
Family	$2,000
Annual Out of Pocket Maximum *(includes Deductible, Co-insurance, and all Co-pays)*	
Individual	$3,000
Family	$6,000
Co-insurance	90% after Deductible
Lifetime Maximum Benefit	Unlimited
Primary Care Physician Office Visits	$20 Co-pay
Specialist Office Visits	$30 Co-pay
Preventive Care Services - as determined by the US Preventive Services Task Force	Covered at 100%, not subject to deductible or Co-pays
Hospital Inpatient Expenses *(Must be Pre-Certified)*	Plan pays 90% after Deductible
Hospital Outpatient Expenses	Plan pays 90% after Deductible
Diagnostic Lab / X-Ray *(not performed in Doctor's office)*	Plan pays 90% after Deductible
Emergency Room **(Accidental Injury and Medical Emergency Care)**	$200 Co-pay, waived if admitted
Urgent Care	$40 Co-pay
Durable Medical Equipment	Plan pays 100% after Deductible
Chiropractic Services *(20 visit maximum per calendar year)*	$30 Co-pay
Rehabilitation Benefits *(includes physical, occupational and speech therapy)*	Plan pays 90% after Deductible Limited to 20 visits per calendar year
Prescription Drugs	
Kaiser Pharmacy (30-day Supply)	$5 for Preventive drugs $15 for Generic drugs $30 for Preferred Brand drugs 30% to a $300 max for Specialty Drugs *Non Preferred Brand drugs not covered unless medically necessary*
Network Pharmacy (30-day Supply)	$15 for Preventive drugs $25 for Generic drugs $40 for Preferred Brand drugs 30% for Specialty Drugs *Non Preferred Brand drugs not covered unless medically necessary*
Mail Order Program (90-day Supply)	2 Co-pays per 90 day supply

UNDERSTANDING
YOUR MEDICAL PLAN

Medical Questions? Need to Locate a Provider?
Contact Kaiser Permanente
1-888-865-5813 or www.kp.org
Group #: 10022
Plan Name: Oglethorpe University

Multi-Choice - Kaiser/PHCS Plan			
	In and Out of Network Benefits		
Overview	Participants will receive the highest level of benefits if they visit a Kaiser provider or facility (Tier 1). Participants will receive a lower level of benefits if they visit a PHCS PPO provider or facility (Tier 2). Participants will receive the lowest level of benefits if they visit an non-network provider or facility (Tier 3).		
Calendar Year Deductible	**Kaiser Providers Tier 1**	**PPO Providers (PHCS) Tier 2**	**Non-Participating Providers Tier 3**
Individual	$1,000	$2,000	$3,000
Family	$3,000	$6,000	$9,000
Annual Out of Pocket Maximum *(includes Deductible, Co-insurance, and all Co-pays. Tier 1 and Tier 2 Out of Pocket Maximums will cross accumulate)*			
Individual	$2,000	$4,000	$7,000
Family	$6,000	$12,000	$21,000
Co-insurance	90% after Deductible	80% after Deductible	60% after Deductible
Lifetime Maximum Benefit	Unlimited		
Primary Care Physician Office Visits	$20 Co-pay	$40 Co-pay	Plan pays 60% after Deductible
Specialist Office Visits	$35 Co-pay *(referrals required from PCP)*	$50 Co-pay	Plan pays 60% after Deductible
Preventive Care Services - as determined by the US Preventive Services Task Force	Covered at 100%, not subject to deductible or Co-pays		Plan pays 60% after Deductible
Hospital Inpatient Expenses *(Must be Pre-Certified)*	Plan pays 90% after Deductible	Plan pays 80% after Deductible	Plan pays 60% after Deductible
Hospital Outpatient Expenses	Plan pays 90% after Deductible	Plan pays 80% after Deductible	Plan pays 60% after Deductible
Diagnostic Lab / X-Ray *(not performed in Doctor's office)*	Plan pays 90% after Deductible	Plan pays 80% after Deductible	Plan pays 60% after Deductible
Emergency Room (Accidental Injury and Medical Emergency Care)	$200 Co-pay, waived if admitted	$200 Co-pay, waived if admitted	$200 Co-pay, waived if admitted
Urgent Care	$60 Co-pay	$70 Co-pay	Plan pays 60% after Deductible
Durable Medical Equipment	Plan pays 90% after Deductible	Plan pays 80% after Deductible	Plan pays 60% after Deductible
Chiropractic Services *(20 visit maximum per calendar year)*	$35 Co-pay	Not Covered	Not Covered
Rehabilitation Benefits *(includes physical, occupational and speech therapy)*	Plan pays 90% after Deductible Limited to 20 visits per calendar year	Plan pays 80% after Deductible Limited to 20 visits per calendar year	Plan pays 60% after Deductible Limited to 20 visits per calendar year
Prescription Drugs			
Kaiser Pharmacy (30-day Supply)	$15 for Generic drugs $30 for Preferred Brand drugs $45 for Non Preferred Drugs	N/A	N/A
Network Pharmacy (30-day Supply)	$25 for Generic drugs $40 for Preferred Brand drugs $55 for Non Preferred Drugs	$20 for Generic drugs $50 for Preferred Brand drugs $75 for Non Preferred Drugs	$20 for Generic drugs $50 for Preferred Brand drugs $75 for Non Preferred Drugs
Mail Order Program (90-day Supply)	2 Co-pays per 90 day supply	3 Co-pays per 90 day supply	

Medical Questions? Need to Locate a Provider?
Contact Kaiser Permanente
1-888-865-5813 or www.kp.org
Group #: 10022
Plan Name: Oglethorpe University

Frequently Asked Questions…

Kaiser Multi-Choice Plan

Can I continue to see a non-Kaiser Permanente provider if I enroll in the Multi-Choice plan?

Yes. You will simply need to inform your provider that you are enrolled in the Kaiser Multi-Choice medical plan and the plan utilizes the PHCS physician's network. If your provider is contracted with the PHCS PPO network, you'll receive the Tier 2 level of benefits that are listed in the Multi-Choice benefit summary. If your physician is not contracted with PHCS, you will receive the Tier 3 level of benefits that are listed in the Multi-Choice benefits summary.

How do I identify myself as a Kaiser Permanente Multi-Choice member?

Simply show your Kaiser Permanente medical ID card whenever you get medical care. Included on your ID card is a logo for the PHCS network—a non-Kaiser provider will recognize that logo and understand that you are enrolled in the Multi-Choice plan.

Am I restricted to one location or physician for my care?

No, The Multi-Choice plan is all about choice. Each time you need to care, you can choose either a Kaiser provider (Tier 1 benefits), a PHCS provider (Tier 2 benefits), or a Non Participating PPO Provider (Tier 3 benefits).

Deductible and Out-of-Pocket

How does my family deductible and out-of-pocket maximum work with the HDHP plan? With the HMO and Multi-Choice plan?

The family deductible and out-of-pocket maximum for the HDHP is "aggregate" while the family deductible and out-of-pocket maximum for the HMO and Multi-Choice plan is "embedded". With the HDHP plan, an employee with individual coverage must meet the entire calendar year deductible before Kaiser will begin paying any co-insurance for covered services (except for preventive care). For family coverage (two or more members enrolled), the entire calendar year family deductible must be met before Kaiser will begin paying any co-insurance for any family member enrolled in the plan.

On the HMO and Multi-Choice plans, the family deductible and out-of-pocket maximum are embedded. While these plans have a cap on how much a family can spend, no one family member will be responsible for more than the individual deductible or individual out-of-pocket maximum. For example, the family deductible on the HMO plan is $3,000 and the family out-of-pocket maximum is $6,000, but no one family member will have to meet more than the individual deductible ($1,000) before Kaiser begins paying co-insurance for that family member. Likewise, no one family member will have to meet more than the individual out-of-pocket maximum ($3,000) before Kaiser will cover all additional, eligible charges for that family member at no cost.

Questions?
Contact Discovery Benefits
1-866-451-3399
www.discoverybenefits.com
Plan Name: Oglethorpe University

If you enroll in the Kaiser High Deductible Health Plan (HDHP)— you are eligible to open and contribute to a Health Savings Account (HSA).

An HSA is an employee-owned account that allows you to set aside money for your eligible medical expenses (including vision and dental expenses) incurred this year or in future years. Your contributions to the account are tax exempt, so you can save on taxes when you contribute. Unlike a Flexible Spending Account, any unused balance in your HSA rolls over from year to year—there is no "use it or lose it" rule.

You must be enrolled in a Qualified High Deductible Health Plan in order to contribute to an HSA. In future years, if you decide to dis-enroll from the HDHP plan, you can continue to use any money in your HSA for qualified medical expenses, but you are ineligible to contribute any additional funds to the account.

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.

Oglethorpe University employees can open an HSA through Discovery Benefits. You can select any amount (up to the annual limit) to contribute to your HSA each pay period, but Oglethorpe University will match your HSA contribution dollar for dollar up to $40 per month.

Once you have set up your HSA, you will receive a debit card for easy access to your funds. You can use this debit card to pay for qualified medical expenses without having to file any paperwork for reimbursement—this card can be used at doctor's offices, pharmacies, hospitals, and other healthcare provider locations. It is recommended to save the receipts for every purchase you make with the card as you may need the receipts to verify expenses should you ever be audited.

There are limits to how much you can contribute to your HSA each calendar year. For 2016, the contribution limits are:

		*Age 55+
Individual	$3,350	$4,350
Family	$6,750	$7,750

*If you are over age 55, you can contribute an additional $1,000 to your HSA for 2016 as a "catch-up" contribution.

Please use the list on the next page as a guide to help you determine whether a medical expense is qualified or not for an HSA distribution.

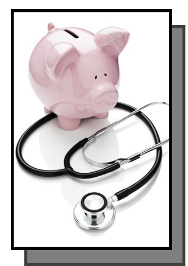
UNDERSTANDING YOUR FSA BENEFIT

Questions?
Contact Discovery Benefits
1-866-451-3399
www.discoverybenefits.com
Plan Name: Oglethorpe University

A Flexible Spending Account (FSA) is an arrangement that permits you to pay for certain out-of-pocket expenses with funds that you have set aside, by payroll deduction, on a tax-free basis. Oglethorpe University offers two types of Flexible Spending Accounts: The Health Care Reimbursement Account is for out-of-pocket medical expenses including medical, dental, vision, and drug expenses for you and your dependents. Prescription drugs as well as over-the-counter drugs with a doctor's prescription are qualified expenses. The Dependent Care Assistance Account is designed to help you pay for daycare services so that you and your spouse (if married) can work or be a full-time student.

Important! Employees who enroll in the HDHP plan are ineligible to open BOTH a Health Savings Account and a FSA Health Care Reimbursement account. Employees with an HSA, however, can still enroll in the Dependent Care Assistance Account.

Account Type	Examples of Eligible Expenses	Contribution Limits	Access to Funds	Pre Tax Benefits
Health Care	· Medical Plan Deductibles · Most Insurance Co-payments · Prescription Drugs · Some OTC medicines (Only if prescribed by your doctor) · Vision Exams/Eyeglasses/Contacts · Laser Eye Surgery · Acupuncture · Weight Loss Programs · Dental and Orthodontia (Braces) · Birth Control Pills/Devices/Procedures · Chiropractic	Maximum annual contribution is $2,500	Allows immediate access to the entire contribution amount from the 1st day of the benefit year, before all scheduled contributions have been made.	Save 20% - 40% on your health care expenses. Save on purchases not covered by insurance. Reduces your taxable income.
Dependent Care	· Daycare · Day Camp · Eldercare · Before and After School Care	Minimum contribution is $100 per year. Maximum contribution is $5,000 per year ($2,500 if married and file separate	You will be able to submit claims up to your year-to-date accumulated amount in your account (You will only be reimbursed based on your acumulated contribution amounts)	Save 20% - 40% on your dependent care expenses. Reduces your taxable income.
"Use it or Lose it" Rule	You should plan your contributions carefully. According to IRS guidelines, any money in your FSA at the end of the year must be forfeited. At the end of the plan year, you may continue to incur claims for expenses during the "Grace Period". The Grace Period extends two and a half months after the end of the plan year. Any monies left at the end of your Grace Period must be forfeited. See below for important claims filing deadlines.			
Eligibility	You are eligible for the FSA benefits the first of the month following your date of hire. You may incur claims beginning January 1 - December 31 of the current year. You may continue to incur claims during the Grace Period of the following year (January 1 - March 15). All current year claims must be submitted between January 1 of the current year and March 31 of the following year.			



UNDERSTANDING YOUR HSA/FSA BENEFIT

Questions?
Contact Discovery Benefits
1-866-451-3399
www.discoverybenefits.com
Plan Name: Oglethorpe University

The following items are qualified medical expenses and may be paid for using your HSA or FSA:

- Ambulance
- Annual Physical
- Artificial Limb
- Artificial Teeth
- Nursing Home (for medical care)
- Thermometers
- Abortion
- Acupuncture
- Bandages
- Birth Control Pills
- Blood Pressure Monitor
- Blood Sugar Test Kit
- Blood Tests
- Body Scan
- Braille Books
- Breast Pump/Supplies
- Breast Reconstruction
- Christian Science (fees to practitioners for care)
- Cold/Hot Pack for medical care
- Condoms
- Contact Lenses and supplies
- Contraceptives
- Crutches
- Dental Treatment
- Dentures and cleaners
- Dermatologist
- Diabetic Supplies
- Diagnostic Devices
- Doctor's fees not covered by insurance
- Drug Addiction (inpatient treatment)
- Drugs (with prescription)
- Eye Exams
- Eye Surgery (including laser eye surgery)
- Eyeglasses
- Fertility Enhancement
- First Aid Supplies
- Flu Shot
- Guide Dog (including maintenance costs)
- Gynecologist
- Hearing Aids (including batteries and repair)
- Homeopathic Care
- Immunizations
- Laboratory Fees
- Lactation Expenses
- Medical Alert Bracelet
- Operations (non cosmetic)
- Optometrist
- Orthopedist
- Orthotic Inserts
- Osteopath
- Out-of-Network charges
- Oxygen for medical condition
- Physical Examination
- Pregnancy Test Kit
- Prosthesis
- Psychiatric Care
- Psychoanalysis
- Psychologist
- Splints
- Sterilization
- Therapy
- Vasectomy
- Wheelchair
- X-Ray

The following are NOT qualified medical expenses:

- Babysitting
- Controlled Substances
- Cosmetic Surgery
- Cosmetics
- CPR Class
- Dancing Lessons
- Dental Floss
- Diaper Service
- Diet Foods
- Electrolysis
- Exercise Equipment
- Facial Tissues
- Funeral Expenses
- Health Club Dues
- Household Help
- Illegal Treatments
- Marijuana
- Maternity Clothes
- Medigap Premiums
- Swimming Lessons
- Teeth Whitening
- Veterinary Fees

UNDERSTANDING YOUR DENTAL PLAN

Dental Questions? Need to Locate a Provider?
Contact Guardian
1-888-600-1600 or www.guardiananytime.com
Group #: 00518964

Oglethorpe University's dental benefits are insured by Guardian. Employees can enroll in either the Value Plan or the NAP Plan. Both plans are passive PPO plans so employees are free to utilize any provider they wish. Although you can visit any dentist you would like, in or out of network, staying in network excludes any possibility of balance billing.

The NAP Plan pays out of network providers at a higher reimbursement level than the Value Plan. For those employees who visit a dentist that does not participate in the Guardian PPO network, enrolling in the NAP plan will assure that your dentist receives the highest possible reimbursement from Guardian and will help mitigate any additional charges due to balance billing.

Value Plan		
	In-Network	**Out-of-Network** *Subject to Negotiated Fee Schedule
Deductible	Single: $50 Family: $150	Single: $50 Family: $150
Annual Maximum Benefit Per Individual	$2,000	$2,000
Preventive Services *(Oral exams, cleanings, X-Rays)*	100% *(deductible waived)*	100% *(deductible waived)**
Basic Services *(Fillings, periodontics, simple extractions, root canals)*	100% after deductible	100% after deductible*
Major Services *(Crowns, dentures, complex extractions, inlays and veneers)*	60% after deductible	60% after deductible*
Orthodontia *(children to age 26 and adults)*	Covered at 50%; $1,000 Lifetime Benefit Maximum	
NAP Plan		
	In-Network	**Out-of-Network** *Subject to 90th Percentile of Usual and Customary
Deductible	Single: $50 Family: $150	Single: $50 Family: $150
Annual Maximum Benefit Per Individual	$2,000	$2,000
Preventive Services *(Oral exams, cleanings, X-Rays)*	100% *(deductible waived)*	100% *(deductible waived)**
Basic Services *(Fillings, periodontics, simple extractions, root canals)*	80% after deductible	80% after deductible*
Major Services *(Crowns, dentures, complex extractions, inlays and veneers)*	50% after deductible	50% after deductible*
Orthodontia *(children to age 26 and adults)*	Covered at 50%; $1,000 Lifetime Benefit Maximum	
Annual Maximum Rollover	Available with both Value and NAP plan: If members receive at least one cleaning per year and use a total benefit of less than $800, they will be rewarded with a $400 increase in the next year's benefit maximum, to a maximum of an additional $1,500.	

Dental Questions? Need to Locate a Provider?
Contact Guardian
1-888-600-1600 or www.guardiananytime.com
Group #: 00518964

DENTAL MAXIMUM ROLLOVER—save your unused claim dollars for when you need them most!

Guardian will roll over a portion of your unused annual maximum into your personal Maximum Rollover Account (MRA). If your reach your Plan Annual Maximum in future years, you can use money from your MRA. To qualify for an MRA, you must have paid a claim (not just a visit) and must not have exceeded the paid claims threshold during the benefit year. Your MRA may not exceed the MRA limit. You can view your annual MRA statement detailing your account and those of your dependents on www.guardiananytime.com

Here's how the benefits work:

Plan Annual Maximum	Threshold	Maximum Rollover Amount	Max Rollover Account Limit
$2,000	$800	$400	$1,500
Max Claims Reimbursement	Claims amount that determines eligibility	Additional dollars added to Plan Annual Max in future years	Plan Annual Maximum plus Max Rollover cannot exceed $3,500

YEAR ONE: Jane starts with a $2,000 Plan Annual Maximum. She submits $150 in dental claims. Since she did not reach the $800 Threshold, she receives a $400 rollover that will be applied to Year Two.

YEAR TWO: Jane now has an increased Plan Annual Maximum of $2,400. This year, she submits $50 in claims and receives an additional $400 rollover added to her Plan Annual Maximum.

YEAR THREE: Jane now has an increased Plan Annual Maximum of $2,800. This year, she submits $2,500 in claims. All claims are paid due to the amount accumulated in her Maximum Rollover Account.

YEAR FOUR: Jane's Plan Annual Maximum is $2,300 ($2,000 Plan Annual Maximum + $300 remaining in her Maximum Rollover Account).

FINDING A PROVIDER IN THE GUARDIAN DENTALGUARD PREFERRED NETWORK

Follow these easy steps to search for a dentist in the Guardian network.

STEP 1: Go to www.guardiananytime.com. At the top of the page, click on "Find a Provider".

STEP 2: On the next page, click on "Find a Dentist".

STEP 3: In the drop down menu to Select your Dental Plan, choose "**PPO**". Enter either the location you'd like to search or the provider name you'd like to search.

STEP 4: Towards the bottom of the page, in the drop down menu to Select your Dental Network, choose "**DentalGuard Preferred**"

UNDERSTANDING
YOUR VISION PLAN

Vision Questions? Need to Locate a Provider?
Contact EyeMed
1-866-299-1358 or www.eyemed.com
Group #: 9836370

EyeMed offers complete, high quality vision care to Oglethorpe University employees through their Select network. The plan includes benefits for eye exams, frames, eyeglasses and contact lenses. In addition, members receive discounts for Lasik surgery and preferred pricing for frames.

Members can find in network providers by clicking on the "Find a Provider" link at www.eyemed.com and choosing the "Select" network.

Network Providers Include: *Lenscrafters, Pearle Vision, JC Penney, Sears, Macy's, Target, For Eyes*	**Select Network Providers**	**Out of Network Providers**
Eye Exam	**Once every 12 months**	
	$10 Co-pay	Up to $30
Prescription Lenses	**Once every 12 months**	
Single	$20 Co-pay	Up to $25
Bifocal	$20 Co-pay	Up to $40
Trifocal	$20 Co-pay	Up to $60
Progressive	Standard: $85 Co-pay Premium: $85 Co-pay plus 20% discount on additional charges	Up to $40
Frames	**Once every 24 months**	
	$130 Retail Allowance plus 20% discount on additional charges	Up to $65
Contact Lenses *(in lieu of glasses)*	**Once every 12 months**	
	$130 Retail Allowance, 15% discount on additional charges (no discount for disposable lenses)	Up to $104
Contact Lens Fitting	Standard: Up to $40 Co-pay Specialty: $50 Retail Allowance	Not Covered

Questions?
Contact Cigna
1-800-362-4462
www.cigna.com
Group ID: Oglethorpe University

Your Life and Disability benefits are insured through Cigna. Oglethorpe University provides benefits through Cigna at no cost to employees. Basic Life and Accidental Death & Dismemberment Insurance, Long Term Disability Insurance, and the Cigna Employee Assistance Program are all benefits that are 100% paid for by the University. In addition to these University paid benefits, employees can elect Voluntary Short Term Disability Insurance for themselves, as well as Supplemental Life for themselves and any eligible dependents .

BASIC LIFE AND ACCIDENTAL DEATH & DISMEMBERMENT INSURANCE (AD&D)

Basic Life and AD&D insurance coverage are important parts of your financial well being. Oglethorpe University provides basic life and AD&D at no cost to you. Basic Life insurance is equal to 1 times annual compensation to the next $1,000, to a maximum benefit of $200,000. Benefits are reduced to 65% at the age of 65 and 50% at the age of 70.

AD&D insurance provides benefits to you and your beneficiary if you suffer loss of life or limb due to an accident. Basic AD&D insurance is equal to 1 times annual compensation rounded to the next $1,000, up to a maximum of $200,000.

LONG TERM DISABILITY

Oglethorpe University provides company paid Long Term Disability insurance that begins after 90 days of disability for approved claims. The program replaces 60% of your covered earnings up to $10,000 per month. If an employee continues to meet the definition of disabled, Long Term Disability benefits can last until Social Security Normal Retirement Age (SSNRA).

EMPLOYEE ASSISTANCE PROGRAM (EAP)

Cigna offers an Employee Assistance Program (EAP) at no cost to you. The EAP is designed to help with a wide range of issues including stress and depression, conflicts at work or home, family and relationship problems, alcohol and drug related issues, anger management, grief and much more.

When you call the EAP, you'll be talking to a trained expert who will offer confidential advice and practical solutions. The website provides additional information and resources ranging from health and wellness to caring for an elderly parent to legal assistance.

For more information, call 1-800-538-3543 or visit www.cignabehavioral.com/cgi.

VOLUNTARY SHORT TERM DISABILITY

Employees can purchase Short Term Disability coverage from Cigna. The program replaces 60% of your covered earnings up to $1,500 per week. The benefits begin on the 8th day of illness or injury and can last up to 12 weeks. For new enrollees, the Short Term Disability plan has a 12 month pre-existing condition exclusion for any treatment that was received in the 3 months prior to enrolling in the plan.

SUPPLEMENTAL EMPLOYEE AND DEPENDENT LIFE

Employees can purchase additional life insurance for themselves and dependent spouses and children. Employees must elect Supplemental Life Insurance for themselves in order to also elect the benefit for a spouse or child.

Employee Benefit—in increments of $1,000, up to 5 times annual compensation or $500,000. Evidence of Insurability is required for amounts over $100,000.

Spouse Benefit—in increments of $5,000, up to 50% of the employee benefit or $100,000. Evidence of Insurability is required for amounts over $30,000.

Child(ren) Benefit—in increments of $2,500, up to $10,000.

2016 EMPLOYEE CONTRIBUTIONS

**All costs shown per pay period*

Medical Insurance - HDHP with H.S.A			
	9 Month Semi-Monthly	12 Month Semi-Monthly	Hourly Bi-Weekly
Employee Only	$17.47	$13.11	$12.10
Employee + Spouse	$209.67	$157.25	$145.15
Employee + Child(ren)	$199.18	$149.39	$137.89
Employee + Family	$314.49	$235.87	$217.73
Medical Insurance - HMO			
	9 Month Semi-Monthly	12 Month Semi-Monthly	Hourly Bi-Weekly
Employee Only	$41.42	$31.06	$28.67
Employee + Spouse	$306.49	$229.87	$212.19
Employee + Child(ren)	$291.17	$218.38	$201.58
Employee + Family	$459.74	$344.80	$318.28
Medical Insurance - Multi-Choice			
	9 Month Semi-Monthly	12 Month Semi-Monthly	Hourly Bi-Weekly
Employee Only	$128.41	$96.31	$88.90
Employee + Spouse	$523.92	$392.94	$362.72
Employee + Child(ren)	$497.73	$373.29	$344.58
Employee + Family	$785.88	$589.41	$544.07

Dental Insurance - Value Plan			
	9 Month Semi-Monthly	12 Month Semi-Monthly	Hourly Bi-Weekly
Employee Only	$24.00	$18.00	$16.62
Employee + Spouse	$50.67	$38.00	$35.08
Employee + Child(ren)	$56.67	$42.50	$39.23
Employee + Family	$86.50	$64.88	$59.88
Dental Insurance - NAP Plan			
	9 Month Semi-Monthly	12 Month Semi-Monthly	Hourly Bi-Weekly
Employee Only	$24.00	$18.00	$16.62
Employee + Spouse	$50.67	$38.00	$35.08
Employee + Child(ren)	$56.67	$42.50	$39.23
Employee + Family	$86.50	$64.88	$59.88

Vision Insurance - EyeMed Select			
	9 Month Semi-Monthly	12 Month Semi-Monthly	Hourly Bi-Weekly
Employee Only	$4.49	$3.37	$3.11
Employee + Spouse	$8.97	$6.73	$6.21
Employee + Child(ren)	$8.52	$6.39	$5.90
Employee + Family	$13.19	$9.89	$9.13

2016 EMPLOYEE CONTRIBUTIONS

**All costs shown per month*

Supplemental Employee Life Insurance		cost per $1,000 of coverage
Formula for calculating the cost: (Annual Base Salary rounded to next highest $1,000)/$1,000 X Premium = Deduction per month		
Age as of 1/1/2016		
	<30	$0.06
	30-34	$0.08
	35-39	$0.09
	40-44	$0.12
	45-49	$0.20
	50-54	$0.28
	55-59	$0.57
	60-64	$0.68
	65-69	$1.27
	70+	$2.06
Supplemental Dependent Life Insurance		
	Coverage for your spouse *(cannot exceed 50% of employee election)*	Rates are the same as the Supplemental Employee Life Insurance above using the Spouse's age as of 1/1/2016 and the following formula: (Coverage Amount/1,000) X Premium=Deduction Per Month
	Coverage for your child	$0.50 per $2,500 of coverage
Supplemental Short-Term Disability Insurance		cost per $10 of weekly benefit
To calculate: (Weekly Earnings (not to exceed $1,500) X .6 X Premium) / 10 = Deduction per month		
Age as of 1/1/16		
	<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

403(b) PLAN

Oglethorpe University has established and maintains a 403(b) plan to allow eligible employees a tax-leveraged means of supplementing their retirement planning. All full-time employees are eligible and encouraged to participate in the university's retirement program, which is affiliated with Lincoln Financial.

For elective deferrals, all eligible employees may begin participation in the Elective Deferral portion of the plan as of the 1st day of the month following thirty (30) days of service with the university. For Matching Contributions, all eligible employees may begin participation as of the 1st day of the first complete payroll period after completing one year of eligible service.

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 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.

Individual payments upon retirement depend upon contributions to the Lincoln Financial program. The university provides eligible employees covered by its plans with summary plan description booklets and other materials regarding these retirement plans as appropriate.

COLONIAL VOLUNTARY BENEFITS—ACCIDENT AND CRITICAL ILLNESS

Available through Colonial Life, Oglethorpe University offers employees the opportunity to purchase Accident and Critical Illness and Cancer Insurance.

The Colonial Accident plan is designed to help cover the gaps in traditional medical insurance when an employee or dependent needs medical care for injury related to an accident. The Colonial Accident plan will reimburse enrolled members a lump sum for fractures, dislocations, burns, concussions, and other accidental injuries. Employees who enroll in the Accident plan can also receive lump sums to help cover surgery, hospitalization, and physical therapy related to accidents. The Colonial Accident plan also includes a $50 wellness payment if a covered member has a preventive health screening during the plan year.

The Colonial Critical Illness and Cancer plan will reimburse an employee a lump sum (between $5,000 and $20,000) if an employee is diagnosed with cancer or end stage renal failure or if an employee suffers a stroke or heart attack. Employees can use the lump sum to help cover the cost of medical treatment, travel expenses, child care, or everyday living expenses.

CBIZ EMPLOYEE ADVOCATE

Oglethorpe University understands that healthcare and benefits can be difficult to navigate. If you have questions about any of your insurance plans or need additional clarification on a benefit, please feel free to reach out to your Dedicated Employee Advocate, Traci Blake, at 770-858-4511 or tblake@cbiz.com. Traci can assist if you:

- Believe that a claim has not been paid properly
- Need further clarification on an insurance matter
- Have questions regarding a bill
- Have a question about a benefit
- Need help solving a benefit related problem
- Need help determining whether a provider is in-network

ADDITIONAL
BENEFIT INFORMATION

HOLIDAYS

Oglethorpe University observes the following eight holidays during the year:

New Year's Day	Memorial Day	Labor Day	Friday following Thanksgiving
Martin Luther King, Jr. Day	Independence Day	Thanksgiving Day	Christmas Day

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 cabinet members and 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 cleared by a supervisor.

Effective July 1, 2006—an accrual rate is the amount of vacation hours earned each pay period and is determined by position at the university and length of service in a benefits-eligible position.

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, domestic partner, parent or child).

Each pay period, sick leave is accrued at a rate of 3.33 hours for regular, full-time employees (3.08 hours for non-exempt employees) and at a rate of 2.5 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.

To qualify for paid sick leave benefits when unable to report to work, the employee must follow departmental guidelines for supervisor notification. As much notice as possible should be given for the use of sick leave. For scheduled absences such as doctor's appointments, sick leave should be scheduled in advance according to departmental practices. Medical and dental appointments (whether an employee's or an immediate family member's) should be scheduled outside of regular work hours if at all possible to minimize disruption to the workplace. Sick leave balance will appear on each paystub.

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.

* Women’s Health and Cancer Rights Act of 1998

Your medical plan, as required by the Women’s Health and Cancer Rights Act of 1998, provides benefits for mastectomy – related services, including reconstruction and surgery to achieve symmetry between the breasts, prosthesis, and complications resulting from a mastectomy (including lymphedema).

Please call your plan administrator for more information. These benefits may be subject to annual deductibles, co-insurance provisions or copays that are appropriate and consistent with other benefits under your plan.

* The Genetic Information Nondiscrimination Act (GINA)

The Genetic Information Nondiscrimination Act of 2008, also referred to as GINA, is federal law that protects Americans from being treated unfairly because of differences in their DNA that may affect their health. The law prevents discrimination from health insurers and employers.

Who needs protection from genetic discrimination?

Everyone should care about the potential for genetic discrimination. Every person has dozens of DNA differences that could increase or decrease his or her chance of getting a disease such as diabetes, heart disease, cancer or Alzheimer’s. It’s important to remember that these DNA differences don’t always mean someone will develop a disease, just that the risk to get the disease may be greater.

More and more tests are being developed to find DNA differences that affect our health. These tests (called genetic tests) will become a routine part of health care in the future. Health care providers will use information about each person’s DNA to develop more individualized ways of detecting, treating and preventing disease. But unless this DNA information is protected, it could be used to discriminate against people.

Why was the law needed?

The law was needed to help ease concerns about discrimination that might keep some people from getting genetic tests that could benefit their health. The law also enables people to take part in research studies without fear that their DNA information might be used against them in health insurance or the workplace.

* Patient Protection Model Disclosure

Kaiser Permanente generally requires the designation of a primary care provider. You have the right to designate any primary care provider who participates in our network and who is available to accept you or your family members. Until you make this designation, Kaiser Permanente designates one for you. For information on how to select a primary care provider, and for a list of the participating primary care providers, contact Kaiser Permanente at 1-866-865-5813. For children, you may designate a pediatrician as the primary care provider. You do not need prior authorization from Kaiser Permanente or from any other person (including a primary care provider) in order to obtain access to obstetrical or gynecological care from a health care professional in our network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals. For a list of participating health care professionals who specialize in obstetrics or gynecology, contact the Kaiser Permanente at 1-866-865-5813.

Important Notice from Oglethorpe University About Your Prescription Drug Coverage and Medicare

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with 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 Kaiser is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

When Can You Join A Medicare Drug Plan?
You can join a Medicare drug plan when you first become eligible for Medicare and each year from October 15th 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 may be affected.

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

When Will You Pay A Higher Premium (Penalty) To Join A Medicare Drug Plan?
You should also know that if you drop or lose your 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 November to join.

For More Information About This Notice Or Your Current Prescription Drug Coverage…
Contact the person listed below for further information. **NOTE:** You'll get this notice each year. You will also get it before the next period you can join a Medicare drug plan, and if this coverage changes through Oglethorpe University. You also may request a copy of this notice at any time.

For More Information About Your Options Under Medicare Prescription Drug Coverage…
More detailed information about Medicare plans that offer prescription drug coverage is in the "Medicare & You" handbook. You'll get a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare drug plans.

For more information about Medicare prescription drug coverage:

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

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

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

Name of Entity/Sender:	Oglethorpe University
Contact--Position/Office:	Sandy Butler, HR Director
Address:	4484 Peachtree Road, NE, Atlanta, GA 30319
Phone Number:	404-364-8325

New Health Insurance Marketplace Coverage Options and Your Health Coverage

Form Approved
OMB No. 1210-0149
(expires 1-31-2017)

PART A: General Information

When key parts of the health care law take effect in 2014, there will be a new way to buy health insurance: the Health Insurance Marketplace. To assist you as you evaluate options for you and your family, this notice provides some basic information about the new Marketplace and employment-based health coverage offered by your employer.

What is the Health Insurance Marketplace?

The Marketplace is designed to help you find health insurance that meets your needs and fits your budget. The Marketplace offers "one-stop shopping" to find and compare private health insurance options. You may also be eligible for a new kind of tax credit that lowers your monthly premium right away. Open enrollment for health insurance coverage through the Marketplace begins in October 2013 for coverage starting as early as January 1, 2014.

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

You may qualify to save money and lower your monthly premium, but only if your employer does not offer coverage, or offers coverage that doesn't meet certain standards. The savings on your premium that you're eligible for depends on your household income.

Does Employer Health Coverage Affect Eligibility for Premium Savings through the Marketplace?

Yes. If you have an offer of health coverage from your employer that meets certain standards, you will not be eligible for a tax credit through the Marketplace and may wish to enroll in your employer's health plan. However, you may be eligible for a tax credit that lowers your monthly premium, or a reduction in certain cost-sharing if your employer does not offer coverage to you at all or does not offer coverage that meets certain standards. If the cost of a plan from your employer that would cover you (and not any other members of your family) is more than 9.5% of your household income for the year, or if the coverage your employer provides does not meet the "minimum value" standard set by the Affordable Care Act, you may be eligible for a tax credit.[1]

Note: If you purchase a health plan through the Marketplace instead of accepting health coverage offered by your employer, then you may lose the employer contribution (if any) to the employer-offered coverage. Also, this employer contribution -as well as your employee contribution to employer-offered coverage- is often excluded from income for Federal and State income tax purposes. Your payments for coverage through the Marketplace are made on an after-tax basis.

How Can I Get More Information?

For more information about your coverage offered by your employer, please check your summary plan description or contact Sandy Butler at 404-364-8325.

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

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

PART B: Information About Health Coverage Offered by Your Employer

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

3. Employer name		4. Employer Identification Number (EIN)
Oglethorpe University		58-0568698
5. Employer address		6. Employer phone number
4484 Peachtree Road NE		404-364-8325
7. City	8. State	9. ZIP code
Atlanta	GA	30319
10. Who can we contact about employee health coverage at this job?		
Sandy Butler		
11. Phone number (if different from above)	12. Email address	
	Sbutler1@oglethorpe.edu	

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

- As your employer, we offer a health plan to:
  - ☐ All employees. Eligible employees are:
  - ☒ Some employees. Eligible employees are:

    Full Time Employees who work at least 30 hours per week.
- With respect to dependents:
  - ☒ We do offer coverage. Eligible dependents are:
    - Legal Spouses
    - Children up to age 26 to include: natural born children, step children, legally adopted children, grandchildren if employee has court ordered power of attorney. Handicapped dependent children are also eligible beyond age 26.
  - ☐ We do not offer coverage.

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

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

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

Premium Assistance Under Medicaid and the Children's Health Insurance Program (CHIP)

If you or your children are eligible for Medicaid or CHIP and you're eligible for health coverage from your employer, your state may have a premium assistance program that can help pay for coverage, using funds from their Medicaid or CHIP programs. If you or your children aren't eligible for Medicaid or CHIP, you won't be eligible for these premium assistance programs but you may be able to buy individual insurance coverage through the Health Insurance Marketplace. For more information, visit **www.healthcare.gov**.

If you or your dependents are already enrolled in Medicaid or CHIP and you live in a State listed below, contact your State Medicaid or CHIP office to find out if premium assistance is available.

If you or your dependents are NOT currently enrolled in Medicaid or CHIP, and you think you or any of your dependents might be eligible for either of these programs, contact your State Medicaid or CHIP office or dial **1-877-KIDS NOW** or **www.insurekidsnow.gov** to find out how to apply. If you qualify, ask your state if it has a program that might help you pay the premiums for an employer-sponsored plan.

If you or your dependents are eligible for premium assistance under Medicaid or CHIP, as well as eligible under your employer plan, your employer must allow you to enroll in your employer plan if you aren't already enrolled. This is called a "special enrollment" opportunity, and **you must request coverage within 60 days of being determined eligible for premium assistance**. If you have questions about enrolling in your employer plan, contact the Department of Labor at **www.askebsa.dol.gov** or call **1-866-444-EBSA (3272)**.

You may be eligible for assistance paying your employer health plan premiums. See below for more information on eligibility –

GEORGIA – Medicaid
Website: http://dch.georgia.gov/ - Click on Programs, then Medicaid, then Health Insurance Premium Payment (HIPP) Phone: 404-656-4507

To see if any other states have added a premium assistance program since July 31, 2015, or for more information on special enrollment rights, contact either:

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

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

OMB Control Number 1210-0137 (expires 10/31/2016)

NOTICE OF SPECIAL ENROLLMENT RIGHTS

If you are an active employee declining enrollment for yourself or your dependents (including your spouse) because of other health insurance coverage, you may in the future be able to enroll yourself or your dependents in this plan, provided that you request enrollment within 30 days after your other coverage ends and you fulfill other special enrollment requirements. (These requirements are set out in your Certificate of Coverage)

In addition, if active employees 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, provided that you request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption.

There is an additional enrollment period if an active employee or dependent loses eligibility for Children's Health Insurance Program (CHIP), Medicaid or becomes eligible for CHIP for Medicaid premium assistance. The special enrollment allows children or their parents to have 60 days, rather than 30, to request enrollment.

Also, your health plan may not establish rules for eligibility (including continued eligibility) of an individual to enroll under the terms of the plan based on a health status-related factor.

Complete If You Are Declining Coverage For Yourself Or Any Dependent:

If you are an active employee declining coverage for yourself or for any of your eligible dependents, you must complete the following information if you want to preserve your rights of Special Enrollment as explained above. If you decline coverage for yourself, the reason is:

□ **I have other coverage** □ **Another reason**

If you decline coverage for one or more eligible dependents, please give the dependent's name below and indicate the reason coverage is declined.

Name ____________________________ ☐ Dependent has other coverage ☐ Another reason

Name ____________________________ ☐ Dependent has other coverage ☐ Another reason

Name ____________________________ ☐ Dependent has other coverage ☐ Another reason

Name ____________________________ ☐ Dependent has other coverage ☐ Another reason

____
Employee Name – Please Print

____
Employee Social Security Number

____
Employee Signature

_________/__________/_________
Date

Introduction

You're getting this notice because you recently gained coverage under a group health plan (the Plan). This notice has important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan. This notice explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect your right to get it. When you become eligible for COBRA, you may also become eligible for other coverage options that may cost less than COBRA continuation coverage.

The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage can become available to you and other members of your family when group health coverage would otherwise end. For more information about your rights and obligations under the Plan and under federal law, you should review the Plan's Summary Plan Description or contact the Plan Administrator.

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

What is COBRA continuation coverage?

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

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

Your hours of employment are reduced, or
Your employment ends for any reason other than your gross misconduct.

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

Your spouse dies;
Your spouse's hours of employment are reduced;
Your spouse's employment ends for any reason other than his or her gross misconduct;
Your spouse becomes entitled to Medicare benefits (under Part A, Part B, or both); or
You become divorced or legally separated from your spouse.

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

The parent-employee dies;
The parent-employee's hours of employment are reduced;
The parent-employee's employment ends for any reason other than his or her gross misconduct;
The parent-employee becomes entitled to Medicare benefits (Part A, Part B, or both);
The parents become divorced or legally separated; or
The child stops being eligible for coverage under the Plan as a "dependent child."

When is COBRA continuation coverage available?

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

The end of employment or reduction of hours of employment;
Death of the employee; or
The employee's becoming entitled to Medicare benefits (under Part A, Part B, or both).

For all other qualifying events (divorce or legal separation of the employee and spouse or a dependent child's losing eligibility for coverage as a dependent child), you must notify the Plan Administrator within 60 days after the qualifying event occurs. You must provide this notice to: Sandy Butler, Human Resources Director, (404) 364-8325.

How is COBRA continuation coverage provided?

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

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

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

Disability extension of 18-month period of COBRA continuation coverage

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

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

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

Are there other coverage options besides COBRA Continuation Coverage?

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

If you have questions

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

Keep your Plan informed of address changes

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

Plan contact information

Sandy Butler, Human Resources Director, (404) 364-8325, 4484 Peachtree Road, NE, Atlanta, GA 30319, sbutler1@oglethorpe.edu

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Disclaimer: This Benefit Guide provides a brief summary of the benefits available under the Oglethorpe University Benefit Program. In the event of any discrepancy(ies) between this summary and any Document, Insurance Contract or Certificate, the Insurance Document(s) will prevail. Oglethorpe University retains the right to modify or eliminate these benefits at any time and for any reason.