A guide to your Oberlin College Faculty & Staff benefit plan options.

Plan year: 01/01/2018 - 12/31/2018
Deductible: An annual amount you’ll pay out-of-pocket before your health plan begins to pay for covered health care costs.

Copay: A pre-set amount you pay for your covered health care services. The health plan pays the rest.

Coinsurance: Your share of the cost of your covered health care services. The health plan pays the rest.

Out-of-pocket maximum: The most you pay before the health plan begins to pay 100% of covered charges. You’ll still need to pay for any expenses the health plan doesn’t count towards the limit.

In-network: Health care providers and facilities that have contracts with Cigna to deliver services at a negotiated rate (discount). You pay a lower amount for those services.

Out-of-network: A health care provider or facility that doesn’t participate in your plan’s network and doesn’t provide services at a discounted rate. Using an out-of-network health care provider or facility will cost you more.

Generics: Generic medications have the same active ingredients, dosage, and strength as their brand-name counterparts. You’ll usually pay less for generic medications.

Preferred brand: Preferred brand medications will usually cost more than generics. But may cost less than a non-preferred brand on your plan.

Non-preferred brands: Non-preferred brand medications generally have generic alternatives and/or one or more preferred brand options within the same drug class. You'll usually pay more for non-preferred brand medications.
Ways to get better health

Cigna wants to help you choose benefits that fit your needs and help keep you healthy.

This year, Oberlin College Faculty & Staff offers you the following health plans:

- CDHP Cigna Choice Fund Health Savings Account
- Plan A (OAPA)

As well as:
- Cigna Dental Care® (DHMO)
- Cigna Vision

Cigna-administered health plans offer the coverage, tools and resources you need to help you better manage your health – and health spending.

- Ways to compare costs, look at claims, search for health care providers, and more using myCigna - online or through the mobile app.
- Take steps to maintain good health with annual wellness check-ups and screenings.
- Cost savings when using in-network providers.
- Find quick, convenient care for a number of routine medical conditions.
- 24/7/365 live customer service support.

At Cigna, we want to partner with you and support you in your health journey. We'll be there for you, every step of the way, so you don’t have to go it alone.

Health care reform: Meeting the requirements

Coverage under your employer-sponsored health plan satisfies the health care reform requirement to maintain “minimum essential coverage” under the “individual mandate” provision of the Affordable Care Act. While there may be changes in this requirement, it is likely that Americans will still need to report health coverage during the IRS tax season.*

Each year, Cigna, or your employer, will mail you an IRS Form 1095 confirming the coverage you were offered and any coverage you and any dependents may have had during the prior calendar year. The form should be kept with your tax records for audit purposes, and not filed with your income tax return.

Please read all of the information in this brochure. Health plans may work differently, so it’s important to use this along with your other enrollment materials as a guide to how your health plans work. If you need help, please contact Human Resources.

* Health care reform information last updated in May 2017. With possible "repeal and replace" legislation pending, please check InformedOnReform.com for any updates about individual and/or employer requirements under the law.

Call the preenrollment hotline at 800.401.4041 if you have questions.
Understand your plan options

Option 1

CDHP Cigna Choice Fund Health Savings Account: A health plan plus a health savings account that puts you in charge

A Cigna Choice Fund HSA plan combines a health plan with a compatible tax advantaged health savings account (HSA). You can use your HSA to help pay for some of your covered health care costs. You can also use your HSA to pay for qualified covered health care costs not covered through your health plan such as dental and vision expenses. You decide how and when you spend your health plan dollars.

Here’s how your HSA works. Once your HSA account is open, both you and your employer may contribute to your account, up to the current federal limit.

With your health plan, you’ll pay an annual amount (deductible) before your health plan begins to pay for covered health care costs. Only services covered by your health plan count toward your deductible.

Once you meet your deductible, you pay a percentage of the cost (coinsurance) for your covered health care costs and your plan pays the rest.

You can choose to pay for your share of the health care costs up to the health plan’s out-of-pocket maximum by using your HSA, other personal funds or both.

Once you reach an annual limit on your payments (out-of-pocket maximum), the health plan pays your covered health care costs at 100%.

You can take the HSA with you when you leave the health plan, change jobs or retire.

Key benefits of choosing an HSA:

• You and your employer may contribute to your account, up to the current federal limit.
• You decide how and when to use the money in your HSA. Pay for qualified expenses during the year, save it for future health care needs or open an investment account.
• Your savings account earns interest, tax-free.
• You can take your HSA with you when you leave the plan, change jobs or retire.

Important features:

• Choose the in-network health care providers you want to see – no referral is needed to see a specialist.
• Certain in-network preventive care services are covered at no added cost to you.
• 24-hour emergency care, in- or out-of-network.
• The amount you pay out-of-pocket is limited by your plan’s out-of-pocket maximum. Once you spend the annual maximum amount, the health plan pays your covered health care costs at 100%.

You can view highlights of these plans on pages 6-7. Remember, this brochure is a guide only. Make sure to read all your enrollment information. Plan details may vary.

1. If you go out-of-network your expenses may exceed the coinsurance amount because the doctor may bill you for the charges not covered under the plan.
2. HSA contributions and earnings are not subject to federal taxes and not subject to state taxes in most states. A few states do not allow pretax treatment of contributions or earnings. Contact your tax professional or accountant for information about your state.

How your HSA works

How your HSA is funded: Your contribution and money from your employer.

What’s covered: Your medical care and prescription drugs. Certain in-network preventive care services are covered at no added cost to you.

Cigna Choice Fund plans are insured and/or administered by Cigna Health and Life Insurance Company or Connecticut General Life Insurance Company.
Understand your plan options

Option 2

Plan A (OAPA): A health plan that lets you choose which doctors to see and when

The Open Access Plus (OAP) plan provides coverage for medical care, including visits to your doctor’s office, hospital stays, mental health and substance use services, chiropractic treatment, physical therapy and other services.

You’re encouraged to select a primary care provider to help guide your care, and can see a specialist without a referral. You have the option to see any licensed health care provider; however, your costs will be lowest when you use the OAP network.

With the OAP and OAP In-network plans, you pay a predetermined fee (copay) for certain covered health care expenses and the plan pays the rest. For other services, you pay a deductible then a percentage of the cost (coinsurance).*

Once you reach an annual limit on your payments (out-of-pocket maximum), the health plan pays your covered health care costs at 100%.

Important features:

- Option to choose a primary care provider to help guide your care. It’s recommended, but not required.
- No referral is needed to see a specialist, although precertification may be required.
- Certain in-network preventive care services are covered at no added cost to you.
- 24-hour emergency care, in- or out-of-network.
- The amount you pay out-of-pocket is limited by your plan’s out-of-pocket maximum. Once you spend the annual maximum amount, the health plan pays your covered health care costs at 100%.
- No claim paperwork necessary when you receive care in-network.

You can view highlights of this plan on pages 6-7. Remember, this brochure is a guide only. Make sure to read all your enrollment information. Plan details may vary.

* If you go out-of-network for care, your expenses may exceed the coinsurance amount because the doctor may bill you for charges not covered under the plan.

Open Access Plus plans are insured and/or administered by Cigna Health and Life Insurance Company or Connecticut General Life Insurance Company.

How your OAP plan works

What’s covered: Your medical care and prescription drugs. Certain in-network preventive care services are covered at no added cost to you.
Review your plan options

### Option 1

**CDHP Cigna Choice Fund Health Savings Account**

<table>
<thead>
<tr>
<th>Medical deductible</th>
<th>Employee</th>
<th>Employee + 1</th>
<th>Family</th>
</tr>
</thead>
<tbody>
<tr>
<td>In-network</td>
<td>$2,000</td>
<td>$3,000</td>
<td>$4,000</td>
</tr>
<tr>
<td>Out-of-network</td>
<td>$4,000</td>
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</table>

<table>
<thead>
<tr>
<th>Minimum Contribution from employer</th>
<th>$750(^1)</th>
<th>$1,000(^1)</th>
<th>$1,500(^1)</th>
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<table>
<thead>
<tr>
<th>Out-of-pocket maximum</th>
<th>In-network</th>
<th>Out-of-network</th>
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<tr>
<td>$4,000</td>
<td>$8,000</td>
<td>$12,000</td>
</tr>
<tr>
<td>$8,000</td>
<td>$16,000</td>
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### Option 2

**Plan A (OAPA)**

<table>
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<th>Medical deductible</th>
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<th>Employee + 1</th>
<th>Family</th>
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</thead>
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<tr>
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<td>$1,100</td>
<td>$1,100</td>
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<tr>
<td>Out-of-network</td>
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<table>
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<tr>
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<th>$0</th>
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<table>
<thead>
<tr>
<th>Out-of-pocket maximum</th>
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<th>Out-of-network</th>
</tr>
</thead>
<tbody>
<tr>
<td>$4,200</td>
<td>$8,400</td>
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<td>$8,400</td>
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### Prescription Medication Highlights

<table>
<thead>
<tr>
<th>Pharmacy deductible</th>
<th>Retail (30-day supply)</th>
<th>Retail (90-day supply)</th>
<th>Home Delivery (90-day supply)</th>
<th>Retail (30-day supply)</th>
<th>Retail (90-day supply)</th>
<th>Home Delivery (90-day supply)</th>
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</thead>
<tbody>
<tr>
<td>Generic</td>
<td>&quot;included in medical above&quot;</td>
<td>&quot;included in medical above&quot;</td>
<td>&quot;included in medical above&quot;</td>
<td>Not applicable</td>
<td>Not applicable</td>
<td>Not applicable</td>
</tr>
<tr>
<td>Preferred brand</td>
<td>20% after plan deductible</td>
<td>20% after plan deductible</td>
<td>20% after plan deductible</td>
<td>$10</td>
<td>$20</td>
<td>$20</td>
</tr>
<tr>
<td>Non-preferred brand</td>
<td>20% after plan deductible</td>
<td>20% after plan deductible</td>
<td>20% after plan deductible</td>
<td>$75</td>
<td>$150</td>
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</tbody>
</table>

### Words to know:

**Deductible:** An annual amount you will pay out-of-pocket before your health plan begins to pay for covered health care costs.

**Copay:** A preset amount you pay for your covered health care services. The health plan pays the rest.

**Coinsurance:** Your share of the cost of your covered health care services. The health plan pays the rest.

**Out-of-pocket maximum:** The most you pay before the health plan begins to pay 100% of covered charges. You will still need to pay for any expenses the health plan doesn’t count towards the limit.

**In-network:** Many health care providers and facilities that have a contract with Cigna to deliver services at a negotiated rate (discount). You pay a lower amount for those services.

**Out-of-network:** A health care provider or facility that doesn’t participate in your plan’s network and doesn’t provide services at a discounted rate. Using an out-of-network health care provider or facility may cost you more.

**Generics:** Generic medications have the same active ingredients, dosage, and strength as their brand-name counterparts. You’ll usually pay less for generic medications under your plan.

**Preferred brands:** Preferred brand medications will usually cost more than generics. But may cost less than non-preferred brands.

**Non-preferred brands:** Non-preferred brand medications generally have generic alternatives and/or one or more preferred brand options within the same drug class. You’ll usually pay more for non-preferred brand medications.

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Please read all of the information in this brochure. Health plans may work differently, so it’s important to use this along with your other enrollment materials as a guide to how your health plans work. If you need help, please contact Human Resources.
## Option 1

### CDHP Cigna Choice Fund Health Savings Account

<table>
<thead>
<tr>
<th>Service</th>
<th>In-Network</th>
<th>Out-of-Network</th>
<th>In-Network</th>
<th>Out-of-Network</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adult preventive care¹</td>
<td>No Charge</td>
<td>Not Covered</td>
<td>No Charge</td>
<td>Not Covered</td>
</tr>
<tr>
<td>Office visit</td>
<td>20% after plan deductible</td>
<td>40% after plan deductible</td>
<td>$30 Copay</td>
<td>35% after plan deductible</td>
</tr>
<tr>
<td>Specialist visit</td>
<td>20% after plan deductible</td>
<td>40% after plan deductible</td>
<td>$40 Copay</td>
<td>35% after plan deductible</td>
</tr>
<tr>
<td>Prenatal care</td>
<td>20% after plan deductible</td>
<td>40% after plan deductible</td>
<td>10% after plan deductible</td>
<td>35% after plan deductible</td>
</tr>
<tr>
<td>Chiropractic</td>
<td>20% after plan deductible</td>
<td>40% after plan deductible</td>
<td>$40 Copay</td>
<td>35% after plan deductible</td>
</tr>
<tr>
<td>Physical, occupational and speech therapy</td>
<td>20% after plan deductible</td>
<td>40% after plan deductible</td>
<td>$40 Copay</td>
<td>35% after plan deductible</td>
</tr>
<tr>
<td>Well-child care⁴</td>
<td>No Charge</td>
<td>Not Covered</td>
<td>No Charge</td>
<td>35% after plan deductible</td>
</tr>
<tr>
<td>Lab, X-ray, diagnostic tests</td>
<td>20% after plan deductible</td>
<td>40% after plan deductible</td>
<td>10% after plan deductible</td>
<td>35% after plan deductible</td>
</tr>
<tr>
<td>Durable medical equipment</td>
<td>20% after plan deductible</td>
<td>40% after plan deductible</td>
<td>10% after plan deductible</td>
<td>35% after plan deductible</td>
</tr>
</tbody>
</table>

### Option 2

### Plan A (OAPA)

<table>
<thead>
<tr>
<th>Service</th>
<th>In-Network</th>
<th>Out-of-Network</th>
<th>In-Network</th>
<th>Out-of-Network</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adult preventive care¹</td>
<td>No Charge</td>
<td>Not Covered</td>
<td>No Charge</td>
<td>Not Covered</td>
</tr>
<tr>
<td>Office visit</td>
<td>20% after plan deductible</td>
<td>40% after plan deductible</td>
<td>$30 Copay</td>
<td>35% after plan deductible</td>
</tr>
<tr>
<td>Specialist visit</td>
<td>20% after plan deductible</td>
<td>40% after plan deductible</td>
<td>$40 Copay</td>
<td>35% after plan deductible</td>
</tr>
<tr>
<td>Prenatal care</td>
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<td>40% after plan deductible</td>
<td>10% after plan deductible</td>
<td>35% after plan deductible</td>
</tr>
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<td>Chiropractic</td>
<td>20% after plan deductible</td>
<td>40% after plan deductible</td>
<td>$40 Copay</td>
<td>35% after plan deductible</td>
</tr>
<tr>
<td>Physical, occupational and speech therapy</td>
<td>20% after plan deductible</td>
<td>40% after plan deductible</td>
<td>$40 Copay</td>
<td>35% after plan deductible</td>
</tr>
<tr>
<td>Well-child care⁴</td>
<td>No Charge</td>
<td>Not Covered</td>
<td>No Charge</td>
<td>35% after plan deductible</td>
</tr>
<tr>
<td>Lab, X-ray, diagnostic tests</td>
<td>20% after plan deductible</td>
<td>40% after plan deductible</td>
<td>10% after plan deductible</td>
<td>35% after plan deductible</td>
</tr>
<tr>
<td>Durable medical equipment</td>
<td>20% after plan deductible</td>
<td>40% after plan deductible</td>
<td>10% after plan deductible</td>
<td>35% after plan deductible</td>
</tr>
</tbody>
</table>

### Hospital Care – What you’ll pay once you meet your deductible

<table>
<thead>
<tr>
<th>Service</th>
<th>In-Network</th>
<th>Out-of-Network</th>
<th>In-Network</th>
<th>Out-of-Network</th>
</tr>
</thead>
<tbody>
<tr>
<td>Inpatient hospitalization</td>
<td>20% after plan deductible</td>
<td>40% after plan deductible</td>
<td>10% after plan deductible</td>
<td>35% after plan deductible</td>
</tr>
<tr>
<td>Outpatient surgery</td>
<td>20% after plan deductible</td>
<td>40% after plan deductible</td>
<td>10% after plan deductible</td>
<td>35% after plan deductible</td>
</tr>
<tr>
<td>Emergency room</td>
<td>20% after plan deductible</td>
<td>40% after plan deductible</td>
<td>$105 Copay</td>
<td>35% after plan deductible</td>
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<tr>
<td>Urgent care center</td>
<td>20% after plan deductible</td>
<td>40% after plan deductible</td>
<td>$30 Copay</td>
<td>35% after plan deductible</td>
</tr>
<tr>
<td>Ambulance</td>
<td>20% after plan deductible</td>
<td>40% after plan deductible</td>
<td>10% after plan deductible</td>
<td>35% after plan deductible</td>
</tr>
</tbody>
</table>

### Mental Health and Substance Abuse – What you’ll pay once you meet your deductible

<table>
<thead>
<tr>
<th>Service</th>
<th>In-Network</th>
<th>Out-of-Network</th>
<th>In-Network</th>
<th>Out-of-Network</th>
</tr>
</thead>
<tbody>
<tr>
<td>Inpatient (Unlimited day maximum)</td>
<td>20% after plan deductible</td>
<td>40% after plan deductible</td>
<td>10% after plan deductible</td>
<td>35% after plan deductible</td>
</tr>
<tr>
<td>Outpatient</td>
<td>20% after plan deductible</td>
<td>40% after plan deductible</td>
<td>$40 Copay</td>
<td>35% after plan deductible</td>
</tr>
</tbody>
</table>

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1. You can make contributions to build your balance, up to a calendar year maximum of $3,400 for an individual and $6,750 for a family in 2017. For 2018, the calendar year maximum is $3,450 for an individual and $6,900 for a family. Limits are set by the IRS. Employees who reach age 55 may make an additional catch-up contribution of $1,000. The maximum contribution allowed is determined by the number of months you are allowed in the plan during the year. Employer or incentive contributions reduce the maximum an employee can contribute by an amount equal to the contribution.

2. This is the most a family (employees plus covered family members) will pay for in-network out-of-pocket expenses. It's important to note that each individual family member's out-of-pocket costs are capped by the ACA at $7,350 for 2018 health plans, overall family in-network costs are capped at $14,700. The out-of-pocket costs for people with individual coverage are capped at $7,350. To see examples of how this works, please visit www.InformedOnReform.com > Reform Topics Overview > Cost Sharing Limits, or Cigna.com/health-care-reform/embedded-oop-customer-impacts.

3. What you’ll pay after you meet your deductible. You’ll pay 100% of the cost until you meet your deductible.

4. Certain in-network preventive care services and well-childcare services are covered at no added cost to you. You have no deductible to meet for these services.

* Additional incentive funding available - Single $250, EE+SP/DP, EE+CH, Family $500

Health plans provide coverage for most medically necessary services. However, there are certain services and supplies that may not be covered. See the "What’s Not Covered" section of this guide for examples of plan exclusions.
Understand your plan options

Cigna Dental Care (DHMO)
A plan that helps you save money.

The Cigna Dental Care® (DHMO®) plan provides coverage for dental care, including visits to your dentist for regular oral exams, cleanings, fluoride treatments, X-rays and other covered services.²

When you visit your in-network dentist, you pay the charge listed on your Patient Charge Schedule. As part of your plan, most preventive services are covered at low cost or no cost to you. In most states, to receive coverage under your plan, you must use a dentist in the DHMO network, except for emergencies.³

You’ll receive your Patient Charge Schedule in the mail after you enroll. In addition to listing all of the covered services and the amount you’ll pay for those services when you use an in-network dentist, it also outlines any frequency limitations.

With the Cigna Dental Care plan, you don’t have to pay an annual amount (deductible) before your dental plan begins paying for covered dental care costs. In addition, there are no annual or lifetime dollar maximums.

Important features:

• You must select a primary care dentist in the DHMO network who will coordinate all of your dental care needs. You may select a different primary dentist for each member of your family and you may select a pediatric dentist for children under seven years old.

• Your dentist will give you a referral if you need to see a dental specialist.

• You do not need an ID card to receive care. But you can print one from myCigna.com.

• Your plan has no deductible or annual/lifetime dollar maximums. You pay the copay listed on your Patient Charge Schedule.

Remember, this brochure is a guide only. The details of your plan may vary. Make sure to read your enrollment materials for details of your specific dental plan, including plan exclusions and limitations.

1. The term “DHMO” is used to refer to product designs that may differ by state of residence of enrollee, including but not limited to, prepaid plans, managed care plans, and plans with open access features. The Cigna Dental Care (DHMO) plan is not available in the following states: AK, HI, ME, NH, NM, ND, PR, RI, SD, VI, VT, WV, and WY.

2. In general, the following frequency limitations apply: two (2) exams, cleanings and fluoride treatments per calendar year; two (2) bitewing x-rays per calendar year; one (1) full mouth x-ray every three (3) calendar years; one (1) panoramic x-ray every three (3) calendar years. Plans may vary, so review your plan documents for a complete list of covered and non-covered services.

3. If you reside in OK or MN, see inside back cover page for information about out-of-network coverage in your state.

Vision: A plan that helps you find quality vision and eye care

Vision plans provide access to one of the largest specialty networks of quality eye care* – from private practice eye doctors to nationally recognized retail optical stores.

When you choose one of the eye doctors in the Cigna Vision network, you’ll get the most savings for covered services. You can also choose to see an eye doctor who is out of the network; however, you’ll have to pay the full cost of the service at the time of the appointment. Then you’ll need to submit a claim form to get reimbursed**. Whether you choose a doctor in or out of our network, you’ll also be responsible for paying any charges that aren’t covered by your plan.

In addition to your vision plan coverage, check with your eye doctor to see if he or she participates in the Healthy Rewards® Vision Network Savings Program. This program is available to all Cigna Vision customers, and you can save 20% or more on additional eyeglass frames and/or lenses with a valid prescription***.

Important features:

- The Cigna Vision network is different from the networks supporting our health plans. You can choose your own eye doctor, but you’ll save money when you stay in the Cigna Vision network.
- You pay your plan stated copay(s), any amount over the plan stated allowances and cost for non-covered services.
- No claim paperwork necessary when you receive care in-network.
- You may find additional savings if your eye doctor participates in the Healthy Rewards Vision Network Savings Program.

Remember, this brochure is a guide only. Make sure to read your benefit summary for details of your specific vision plans. Plan details may vary.

*Cigna Vision plans are insured and/or administered by Cigna Health and Life Insurance Company or Connecticut General Life Insurance Company.

**Your plan coverage is based on the plan chosen by your employer. Be sure to review your plan benefit summary for details on covered and non-covered services. Plan deductibles, coinsurance, copays and materials allowances may apply.

***Discount is based on retail prices. Healthy Rewards is a discount program and is NOT insurance. You are required to pay the entire discounted charge.

How your Cigna Vision PPO Comprehensive (C1) plan works

<table>
<thead>
<tr>
<th>Plan details for In-Network Coverage</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Exam Copay</td>
<td>$10</td>
</tr>
<tr>
<td>Materials Copay</td>
<td>$20</td>
</tr>
<tr>
<td>Frame Retail Allowance</td>
<td>Up to $120</td>
</tr>
<tr>
<td>Elective Contact Lenses and Professional Services</td>
<td>Up to $110</td>
</tr>
</tbody>
</table>

Please review your Benefit Summary for details, including plan exclusions and limitations.
Get smarter about ways to stay healthy

With Cigna, we’ll help you have more control over your health care. And we’ll be here to help you understand your options and choose the care that best fits you and your family’s needs – and budget.

Here are a few easy ways you can save on out-of-pocket health care expenses if you enroll in a health plan.

**Stay in-network**
Save big when you use a doctor, hospital or facility that’s part of your plan’s network. Chances are, there’s a network doctor or facility right in your neighborhood. It’s easy to find quality, cost-effective care right where you need it.

**Consider using an urgent care center**
If you need medical attention, but it’s not serious or life-threatening, you may not have to go to an emergency room (ER). An urgent care center provides quality care like an ER, but can save you hundreds of dollars. Visit an urgent care center for things like minor cuts, burns and sprains, fever and flu symptoms, joint or lower back pain and urinary tract infections.

**Consider using a convenience care or retail clinic**
Need to see your doctor immediately but can’t get an appointment? Try going to a convenience care clinic. You’ll get quick access to quality and cost-effective medical care. A convenience care clinician can treat you for sinus infections, rashes, earaches, minor burns and other routine medical conditions. You can find convenience care clinics in pharmacies, grocery stores and other retail stores.

**Stick with lower-cost labs**
If you go to a national lab, such as Quest Diagnostics® or Laboratory Corporation of America (LabCorp), you can get the same quality service and save up to 75%. Even though other labs may be part of the Cigna network, you’ll often get even bigger savings when you go to a national lab. And with hundreds of locations nationwide, they make it easy to get lab services at a lower cost. *(Savings estimate is based on national 2016 averages of participating facilities. Savings will vary.)*

**Visit independent radiology centers**
If you need a CT scan or MRI, you could save hundreds of dollars by using an independent radiology center. These centers can provide you with quality service like you’d get at a hospital, but usually at a lower price.

**Choose the right place for your colonoscopy, endoscopy or arthroscopy**
When you choose to have one of these procedures at an in-network freestanding outpatient surgery center, you could save hundreds of dollars. These facilities specialize in certain types of outpatient procedures, and offer quality care, just like a hospital, but at a lower cost to you.
Get smarter about ways to stay healthy

Prescription drug coverage

Your plan's drug list

Your prescription drug list is a complete listing of covered generic and brand name medications. You can search for a specific medication or view your plan’s drug list on myCigna.com.

Cigna 90 Now

Your plan includes a maintenance medication program called Cigna 90 Now™. These are the medications you take every day to treat an ongoing health condition such as diabetes, high blood pressure, high cholesterol or asthma. Cigna 90 Now offers you more choice in how, and where, you can fill your prescriptions for maintenance medications. Choose what works best for you.

If you choose to fill your prescription in a 90-day supply, you have to use a 90-day retail pharmacy in your plan’s network, or Cigna Home Delivery Pharmacy™. If you choose to fill your prescription in a 30-day supply, you can use any retail pharmacy in your plan’s network.

Most plans require that prescriptions be filled at an in-network pharmacy to receive coverage under the plan. If you fill a prescription at a pharmacy that’s not in your plan’s network, it may not be covered or you may pay more out-of-pocket. See your plan materials for details.

The money you spend on your prescription medications goes toward your plan’s annual deductible. This includes prescriptions filled at your local in-network retail pharmacy and/or through Cigna Home Delivery Pharmacy, as well as pharmacies that are not in our network.

Use the pharmacy tools on myCigna.com to better understand your coverage

To help you stay healthy and manage your family's prescription medication needs, you have access to many online resources and tools on myCigna™. Here you can:

• Review your specific pharmacy coverage details
• Search for a medication or view your plan’s prescription drug list
• Track your pharmacy expenses, claims and account balances
• Use the Drug Cost tool to estimate medication costs, search for lower cost alternatives (if available) and find pharmacies
• Learn more about Cigna Home Delivery Pharmacy! We do the work – we’ll call your doctor’s office to transfer your prescription to Cigna. You can order refills, track your shipments, and talk to your pharmacist at anytime, day or night.
• You can also use the myCigna App to access these features when you’re on the go.

24-hour Health Information Line

Call the 24-hour Health Information Line (24 hours a day, seven days a week) to speak with a nurse who is ready to provide information and help answer your health questions. This toll-free number is printed on the back of your Cigna ID card.

• Get information to help you decide where and when you should get treatment.
• If you need general health information or have a specific health concern.
• You can also listen to hundreds of podcasts to help you stay informed about your health.

Select a topic and download podcasts to your mobile device* or listen via live-stream on your computer via myCigna.com. 24-hour Health Information Line does not apply to voluntary products or DPO plans.

* Standard mobile phone carrier and data usage charges apply
Living with your chronic health condition

If you are living with a chronic health condition such as diabetes, back pain, depression, arthritis, asthma or cardiac issues, programs are available where, in addition to seeing your physician, you will have the opportunity to work with a health coach who will work with you to establish and reach goals to improve your overall health and well-being.

With a one-on-one relationship you can get help managing your health condition and making more informed decisions, and create a plan to improve your health based on your personal goals. You can also focus on coping with stress, becoming tobacco-free, maintaining good eating habits and managing or losing weight.

The combination of knowledge and support can make a healthy difference. Programs that help manage a chronic condition can be an effective way to help you better manage your health and have more time and energy for life.

Cigna Health Advisor®
Your health advocate

Health advocates are professionals trained as coaches, nutritionists and clinicians. They are here to listen to you, understand your needs and help you find solutions. Even when you’re not sure where to start, you can get confidential support from reliable health care professionals. Partner with a health advocate to take an active role in your health.

- Discuss your health assessment results.
- Learn how to reduce your health risks.
- Maintain better eating and exercise habits.
- Receive support and encouragement as you set and reach health improvement goals.
- Get helpful information about treatment options so you and your doctor can make decisions that meet your health needs and work best for you.
- Access support 24 hours a day when you need medical information, like how to treat a twisted ankle or your child’s high fever.
- Better understand your preventive screenings, annual exams and steps you can take to stay healthy.
- Better manage conditions, including high blood pressure, high cholesterol and more.

Start saving today with Cigna Healthy Rewards**
Health and wellness discounts

Get discounts on the health products and programs you use every day for:
- Weight management and nutrition
- Fitness clubs and equipment
- Mind/body programs and equipment
- Vision and hearing care
- Alternative medicine
- Vitamins, health and wellness products

Just use your cigna ID card when you pay and let the savings begin.

*Some Healthy Reward programs are not available in all states and programs may be discontinued at any time. If your plan includes coverage for any of these services, this program is in addition to, not instead of your plan benefits. A discount program is NOT insurance, and you must pay the entire discounted charge.
What’s not covered*

Your benefit plan pays for health services that may help you stay well, treat illness or manage medical conditions, but all plans have exclusions and limitations. Following are examples of some services not covered by your employer’s medical plan, unless required by law:

- Services provided through government programs
- Services that aren’t medically necessary
- Experimental, investigational or unproven services
- Services for an injury or illness that occurs while working for pay or profit, including services covered by Worker’s Compensation benefits
- Cosmetic services
- Dental care, unless due to accidental injury to sound natural teeth
- Reversal of sterilization procedures
- Genetic screenings
- Custodial and other non-skilled services
- Weight-loss programs
- Hearing aids
- Treatment of sexual dysfunction
- Travel immunizations
- Telephone, email and Internet consultations in the absence of a specific benefit
- Acupuncture
- Obesity surgery and services
- Eyeglass lenses and frames, contact lenses and surgical vision correction

These services may not be covered under your medical plan. However, you may be able to pay for them using your health account (for example HRA, HSA or FSA) if you have one, if permitted under applicable federal tax regulations.

• Not all drugs are covered. For example, nonprescription and antiobesity drugs are generally not covered. Plans may vary, but in general to be eligible for coverage a drug must be approved by the Food and Drug Administration (FDA), prescribed by a health care provider, purchased from a licensed pharmacy and medically necessary. If your plan provides coverage for certain prescription drugs with no cost-share, you may be required to use an in-network pharmacy to fill the prescription. If you use a pharmacy that does not participate in your plan’s network, your prescription may not be covered, or reimbursement may be limited by your plan’s copayment, coinsurance or deductible requirements.

These services may not be covered under your medical plan. However, you may be able to pay for them using your health account (for example HRA, HSA or FSA) if you have one, if permitted under applicable federal tax regulations.

* This is a summary only and your plan’s actual terms may vary. For a complete list of both covered and not-covered services, including benefits required by your state, please see your employer’s insurance certificate or summary plan description — the official plan document. If there are any differences between the information in this brochure and the plan document, the information in the plan document takes precedence.
Discrimination is against the law

Medical coverage

Cigna complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Cigna does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

Cigna:
• Provides free aids and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats)
• Provides free language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, contact customer service at the toll-free number shown on your ID card, and ask a Customer Service Associate for assistance.

If you believe that Cigna has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance by sending an email to ACAGrievance@Cigna.com or by writing to the following address:

Cigna
Nondiscrimination Complaint Coordinator
PO Box 188016
Chattanooga, TN 37422

If you need assistance filing a written grievance, please call the number on the back of your ID card or send an email to ACAGrievance@Cigna.com. You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, DC 20201
800.368.1019, 800.537.7697 (TDD)
Complaint forms are available at
Proficiency of Language Assistance Services

English – ATTENTION: Language assistance services, free of charge, are available to you. For current Cigna customers, call the number on the back of your ID card. Otherwise, call 1.800.244.6224 (TTY: Dial 711).

Spanish – ATENCIÓN: Hay servicios de asistencia de idiomas, sin cargo, a su disposición. Si es un cliente actual de Cigna, llame al número que figura en el reverso de su tarjeta de identificación. Si no lo es, llame al 1.800.244.6224 (los usuarios de TTY deben llamar al 711).

Chinese – 注意：我們可為您免費提供語言協助服務。對於Cigna的現有客戶，請致電您的ID卡背面的號碼。其他客戶請致電1.800.244.6224（聽障專線：請撥711）。

Vietnamese – XIN LƯU Ý: Quý vị được cấp dịch vụ trợ giúp về ngôn ngữ miễn phí. Dành cho khách hàng hiện tại của Cigna, vui lòng gọi số ở mặt sau thẻ Hội viên. Các trường hợp khác xin gọi số 1.800.244.6224 (TTY: 側面對6711)。

Korean – 주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 현재 Cigna 가입자들이는 ID 카드 뒷면에 있는 전화번호로 연락해주시오. 기타 다른 경우에는 1.800.244.6224 (TTY: 다이얼 711)번으로 전화해주십시오。


Russian – ВНИМАНИЕ: вам могут предоставить бесплатные услуги перевода. Если вы уже участвуете в плане Cigna, позвоните по номеру, указанному на обратной стороне вашей идентификационной карточки участника плана. Если вы не являетесь участником одного из наших планов, позвоните по номеру 1.800.244.6224 (TTY: 1.800.244.6224 (TTY: اتصل ب 711)。

Arabic – أو اتصل ب 1.800.244.6224  （TTY: اتصل ب 711）。


Portuguese – ATENÇÃO: Tem ao seu dispor serviços de assistência linguística, totalmente gratuitos. Para clientes Cigna atuais, ligue para o número que se encontra no verso do seu cartão de identificação. Caso contrário, ligue para 1.800.244.6224 (Dispositivos TTY: marque 711).

Polish – UWAGA: w celu skorzystania z dostosowanej, bezpłatnej pomocy językowej, obecni klienci firmy Cigna mogą dzwonić pod numer podany na odwrocie karty identyfikacyjnej. Wszystkie inne osoby prosimy o skorzystanie z numeru 1 800 244 6224 (TTY: wybierz 711).

Japanese – 注意事項: 日本語を話される場合、無料の言語支援サービスをご利用いただけます。現在のCignaのお客様は、IDカード裏面の電話番号まで、お電話にてご連絡ください。その他の方は、1.800.244.6224（TTY: 711）まで、お電話にてご連絡ください。

Italian – ATTENZIONE: Sono disponibili servizi di assistenza linguistica gratuiti. Per i clienti Cigna attuali, chiamate il numero sul retro della tessera di identificazione. In caso contrario, chiamate il numero 1.800.244.6224 (utenti TTY: chiamate il numero 711).


Persian (Farsi) – توجه: خدمات کمک زبانی، به صورت رایگان به شما ارائه می‌شود. برای مشتریان فعلی Cigna، لطفاً با شماره‌ای که در شما وارد شده، تماس بگیرید. در غیر اینصورت با شماره 1.800.244.6224 تماس بگیرید (شناسه آگاهی ویژه ناشنوایان: شماره 711 را شماره گهری کنید)。

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Important notice: special enrollment requirements

Here is important information you should read before you enroll. If you have any questions about this information, please contact Human Resources.

If you are declining enrollment

If you are declining enrollment for yourself or your dependents (including your spouse) because you have other health insurance or group health plan coverage, you may be able to enroll yourself and your dependents in this plan if:

• You or your dependents lose eligibility for that other coverage (or if the employer stops contributing toward you or your dependents’ other coverage). However, you must request enrollment within 30 days after you or your dependents’ other coverage ends (or after the employer stops contributing toward the other coverage). If the other coverage is COBRA continuation coverage, you and your dependents must complete your entire COBRA coverage period before you can enroll in this plan, even if your former employer ceases contributions toward the COBRA coverage.

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.

Effective April 1, 2009 or later, if you or your dependents lose eligibility for state Medicaid or Children’s Health Insurance Program (CHIP) coverage or become eligible for assistance with group health plan premium payment under a state Medicaid or CHIP plan, you may be able to enroll yourself and your dependents. However, you must request enrollment within 60 days after the state Medicaid or CHIP coverage ends or you are determined eligible for premium assistance.

To request special enrollment or obtain more information, call our Customer Service Team at 800.Cigna24 (800.244.6224).

Women’s Health and Cancer Rights Act (WHCRA)

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

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

These benefits will be provided subject to the same deductibles and coinsurance or copays applicable to other medical and surgical benefits provided under this plan as shown in the Summary of Benefits. If you would like more information on WHCRA benefits, call Customer Service at 800.Cigna24 (800.244.6224).

Other late entrants

If you decide not to enroll in this plan now, then want to enroll later, you must qualify for special enrollment. If you do not qualify for special enrollment, you may have to wait until an open enrollment period, or you may not be able to enroll, depending on the terms and conditions of your benefit plan. Please contact your plan administrator for more information.
Enrollment checklist and choice deadline.

This is one of the most important decisions you’ll make this year. These steps will help you choose wisely.

☐ Think about your health history and health care needs.
   How much do you spend, on average, for health care?
   How might that change in the upcoming year?

☐ Check the online directory on Cigna.com to see if your doctor participates in our network.

☐ Visit www.myCIGNAplans.com to review benefit details and choose the best plan for you.
   User ID: OberlinOBERLIN2018
   Password: cigna

☐ Visit myCigna.com to compare prescription drug prices or to see if your medicine is covered.

If you need help, please contact Human Resources.

Call the preenrollment hotline at 800.401.4041 if you have questions.
Important Notice: DHMO Coverage for Residents of Minnesota and Oklahoma

Minnesota Residents: If you are considering enrollment or are enrolled in a Cigna Dental Care (DHMO) plan through your employer, you must visit your selected network dentist in order for the charges on the Patient Charge Schedule to apply. You may also visit other dentists that participate in our network or you may visit dentists outside the Cigna Dental Care network. If you do, the fees listed on the Patient Charge Schedule will not apply. You will be responsible for the dentist’s usual fee. We will pay 50% of the value of your network benefit for those services. Of course, you’ll pay less if you visit your selected Cigna Dental Care network dentist. Call Customer Service for more information.

Oklahoma Residents: DHMO for Oklahoma is an Employer Group Pre-Paid Dental Plan. You may also visit dentists outside the Cigna Dental Care network. If you do, the fees listed on the Patient Charge Schedule will not apply. You will be responsible for the dentist’s usual fee. We pay non-network dentists the same amount we’d pay network dentists for covered services. You’ll pay less if you visit a network dentist in the Cigna Dental Care network. Call Customer Service for more information.

The information in this brochure is provided as a guide only. Make sure to read all your enrollment information thoroughly as plan details may vary. If you need more assistance, talk to your Human Resources representative.

The health care provider information we include in this guide and through Cigna websites is for educational purposes only. It is not a guarantee of the quality of care that will be provided to individual patients. You are encouraged to consider all relevant factors and consult with your physician when selecting a health care provider. Providers are independent practitioners solely responsible for the treatment provided to their patients. They are not agents of Cigna.

Product availability may vary by location and plan type and is subject to change. All group insurance policies and group benefit plans may contain exclusions, limitations, reduction of benefits, and terms under which the policies or plans may be continued in force or discontinued. For costs and complete details of coverage, see your plan documents.

All Cigna products and services are provided exclusively by or through operating subsidiaries of Cigna Corporation. “Cigna Home Delivery Pharmacy” refers to Tel-Drug, Inc. and Tel-Drug of Pennsylvania, L.L.C. In Texas, Open Access Plus and LocalPlus plans are considered Preferred Provider Plans with certain managed care features, and Open Access Plus In-Network and LocalPlus IN plans are considered Exclusive Provider plans with certain managed care features. The Cigna name, logo, and other Cigna marks are owned by Cigna Intellectual Property, Inc.
A HEALTHIER PARTNERSHIP STARTS HERE.

Preparing for a doctor’s visit is an important step in taking control of your own health. Spend time thinking about what questions you want to ask. Your doctor will welcome your active participation. Here are some simple steps you can take to make the most of your visit.

MAKE A LIST.
Prepare for your visit by writing down your most important questions and concerns. Put them in order of importance. This will help make sure you don’t spend too much time talking about less important things – or run out of time before you get to what really matters to you.

PREPARE TO SHARE.
The best way for your doctor to get a full picture of your health is by examining you and then talking with you. Be prepared to share your basic health history. If you have a complex health history, bring the contact information of your other doctors.

DEAL WITH PAPERWORK EARLY.
If you need any paperwork completed – school physicals, disability forms, etc. – let your doctor know early in the visit. Lengthy paperwork often requires your input too, so plan for enough time during the visit to fill in the information.

UNDERSTAND YOUR COVERAGE.
Knowing how your health plan works can help your doctor get through the necessary paperwork quickly and efficiently. Also, don’t forget to bring your Cigna ID card. It has the information your doctor will need to process any claims.

FIND THE RIGHT FIT.
You should leave your doctor’s office feeling like your concerns were heard and addressed. Together, you and your doctor should come up with a health care plan that fits your needs.

Develop a good relationship with your doctor. It can help you live a healthier life.

Together, all the way.