SUMMARY OF BENEFITS

Cigna Health and Life Insurance Co.
For - Oberlin College
Indemnity Plan - Comp Plan

Direct Access to Obstetricians and Gynecologists - You do not need prior authorization from the plan 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 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 health care professionals who specialize in obstetrics or gynecology, visit www.mycigna.com or contact customer service at the phone number listed on the back of your ID card.

Plan Highlights	Benefit Amount
Lifetime Maximum	$2,000,000
Coinsurance	Your plan pays 90%
Maximum Reimbursable Charge	80th Percentile
Calendar Year Deductible	Individual: $500 Family: $1,000

- After each eligible family member meets his or her individual deductible, covered expenses for that family member will be paid based on the coinsurance level specified by the plan. Or, after the family deductible has been met, covered expenses for each eligible family member will be paid based on the coinsurance level specified by the plan.

Note: Services where plan deductible applies are noted with a caret (^)

Calendar Year Out-of-Pocket Maximum	Individual: $3,000 Family: $6,000

- Plan deductible contributes towards your out-of-pocket maximum.
- Benefit deductibles contribute towards the out-of-pocket maximum.
- Mental Health and Substance Use Disorder covered expenses contribute towards your out-of-pocket maximum.
- After each eligible family member meets his or her individual out-of-pocket maximum, the plan will pay 100% of their covered expenses. Or, after the family out-of-pocket maximum has been met, the plan will pay 100% of each eligible family member's covered expenses.

Benefit	Benefit Amount
Note: Services where plan deductible applies are noted with a caret (^)	
Physician Services	
Physician Office Visit • All services including Lab & X-ray	Your plan pays 90%
Surgery Performed in Physician's Office	Your plan pays 90% ^
Allergy Treatment/Injections	Your plan pays 90%
Allergy Serum Dispensed by the physician in the office	Your plan pays 90%

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Benefit	Benefit Amount
Note: Services where plan deductible applies are noted with a caret (^)	
Preventive Care	
Routine Preventive Care for Children through age 2 • Includes coverage of additional service such as urinalysis, EKG, and other laboratory tests, supplementing the standard preventive Care benefit • $500 maximum per Calendar Year	Your plan pays 90%
Immunizations for Children through age 2	Your plan pays 90%
Preventive Care from age 3 and above • $500 maximum per Calendar Year	Your plan pays 90%
Immunizations from age 3 and above • $500 maximum per Calendar Year	Your plan pays 90%
Early Cancer Detection Colon/Rectal Preventive as well as Diagnostic are to be paid at 90%. Deductible is waived and no maximum.	Your plan pays 90%
Mammogram, PAP, and PSA Tests	Your plan pays 90%
• Coverage includes the associated Preventive Outpatient Professional Services. • Diagnostic-related services are covered at the same level of benefits as other x-ray and lab services, based on place of service.	
Inpatient	
Inpatient Hospital Facility	Your plan pays 90% ^
Semi-Private Room: Limited to semi-private rate **Private Room:** Limited to semi-private rate **Special Care Units (Intensive Care Unit (ICU), Critical Care Unit (CCU)):** Limited to ICU/CCU daily room rate	
Inpatient Hospital Physician's Visit/Consultation	Your plan pays 90% ^
Inpatient Professional Services • For services performed by Surgeons, Radiologists, Pathologists and Anesthesiologists	Your plan pays 90% ^
Outpatient	
Outpatient Facility Services	Your plan pays 90%
Outpatient Professional Services • For services performed by Surgeons, Radiologists, Pathologists and Anesthesiologists	Your plan pays 90% ^

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Benefit	Benefit Amount
Note: Services where plan deductible applies are noted with a caret (^)	
Short-Term Rehabilitation	Your plan pays 90%

Calendar Year Maximums:

- Pulmonary Rehabilitation, Cognitive Therapy, Physical Therapy, Speech Therapy, Occupational Therapy, Cardiac Rehabilitation and Chiropractic Care – Unlimited days
- Speech Therapy is covered for functional speech disorder without an underlying medical condition includes coverage for autism spectrum disorders and developmental delays.

Note: Therapy days, provided as part of an approved Home Health Care plan, accumulate to the applicable outpatient short term rehab therapy maximum.

Other Health Care Facilities/Services

Benefit	Benefit Amount
Home Health Care (includes outpatient private duty nursing subject to medical necessity) • Unlimited days maximum per Calendar Year • 16 hour maximum per day	Your plan pays 90% ^
Skilled Nursing Facility, Rehabilitation Hospital, Sub-Acute Facility • Unlimited days maximum per Calendar Year	Your plan pays 90% ^
Durable Medical Equipment • Unlimited maximum per Calendar Year	Your plan pays 90% ^
External Prosthetic Appliances (EPA) • Unlimited maximum per Calendar Year	Your plan pays 90% ^
Bone Density Testing • Bone density testing is covered when Medically Necessary and once every five years as a preventative test for ages 35 and older in network and out of network.	Your plan pays 90%
Routine Foot Disorders $700 maximum per Calendar Year • Note: Services associated with foot care for diabetes and peripheral vascular disease are covered when medically necessary.	Your plan pays 90% ^

Place of Service - your plan pays based on where you receive services

Note: Services where plan deductible applies are noted with a caret (^)

Benefit	Physician's Office	Independent Lab	Emergency Room/ Urgent Care Facility	Outpatient Facility
	Benefit Amount	Benefit Amount	Benefit Amount	Benefit Amount
Lab and X-ray	Plan pays 90%	Plan pays 90%	Plan pays 100%	Plan pays 90%

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Place of Service - your plan pays based on where you receive services

Note: Services where plan deductible applies are noted with a caret (^)

Benefit	Physician's Office	Independent Lab	Emergency Room/ Urgent Care Facility	Outpatient Facility
	Benefit Amount	Benefit Amount	Benefit Amount	Benefit Amount
Advanced Radiology Imaging	Plan pays 90%	Not Applicable	Plan pays 100%	Plan pays 90% ^

Advanced Radiology Imaging (ARI) includes MRI, MRA, CAT Scan, PET Scan, etc...
Note: All lab and x-ray services, including ARI, provided at Inpatient Hospital are covered under Inpatient Hospital benefit

Benefit	Emergency Room / Urgent Care Facility	Outpatient Professional Services	*Ambulance
	Benefit Amount	Benefit Amount	Benefit Amount
Emergency Care	$150 per visit (deductible waived if admitted)	Plan pays 100%	Plan pays 90% ^
Urgent Care	$30 per visit (deductible waived if admitted)	Plan pays 100%	Not Applicable

*Ambulance services used as non-emergency transportation (e.g., transportation from hospital back home) generally are not covered.

Benefit	Inpatient Hospital and Other Health Care Facilities	Outpatient Services
	Benefit Amount	Benefit Amount
Hospice	Plan pays 90% ^	Plan pays 90% ^
Bereavement Counseling	Plan pays 90% ^	Plan pays 90% ^

Note: Services provided as part of Hospice Care Program
Note: Services where plan deductible applies are noted with a caret (^)

Benefit	Initial Visit to Confirm Pregnancy	Global Maternity Fee (All Subsequent Prenatal Visits, Postnatal Visits and Physician's Delivery Charges)	Office Visits in Addition to Global Maternity Fee (Performed by OB/GYN or Specialist)	Delivery - Facility (Inpatient Hospital, Birthing Center)
	Benefit Amount	Benefit Amount	Benefit Amount	Benefit Amount
Maternity	Plan pays 90%	Plan pays 90% ^	Plan pays 90%	Covered same as plan's Inpatient Hospital benefit

Note: Services where plan deductible applies are noted with a caret (^)

Benefit	Physician's Office	Inpatient Facility	Outpatient Facility	Inpatient Professional Services	Outpatient Professional Services
	Benefit Amount	Benefit Amount	Benefit Amount	Benefit Amount	Benefit Amount
Abortion (Elective and non-elective procedures)	Plan pays 90%	Plan pays 90% ^	Plan pays 90%	Plan pays 90% ^	Plan pays 90%
Family Planning	Plan pays 90% ^	Plan pays 90% ^	Plan pays 90% ^	Plan pays 90% ^	Plan pays 90% ^

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Benefit	Physician's Office	Inpatient Facility	Outpatient Facility	Inpatient Professional Services	Outpatient Professional Services
	Benefit Amount	Benefit Amount	Benefit Amount	Benefit Amount	Benefit Amount
Includes surgical services, such as tubal ligation or vasectomy (excludes reversals) Contraceptive devices as ordered or prescribed by a physician .					
Infertility **Note:** Coverage will be provided for the treatment of an underlying medical condition up to the point an infertility condition is diagnosed. Services will be covered as any other illness.					
TMJ, Surgical and Non-Surgical	Plan pays 90%	Plan pays 90% ^	Plan pays 90%	Plan pays 90% ^	Plan pays 90%
Services provided on a case-by-case basis. Always excludes appliances & orthodontic treatment. Subject to medical necessity.					
Unlimited maximum per lifetime					
Note: Services where plan deductible applies are noted with a caret (^)					

Benefit	Inpatient Hospital Facility	Inpatient Professional Services
	Benefit Amount	Benefit Amount
Organ Transplants	Plan pays 90% ^	Plan pays 90% ^
• Travel Lifetime Maximum - Lifesource Facility: In-Network: $10,000 maximum per Transplant per Lifetime		
Note: Services where plan deductible applies are noted with a caret (^)		

Benefit	Inpatient	Outpatient - Physician's Office	Outpatient – All Other Services
	Benefit Amount	Benefit Amount	Benefit Amount
Mental Health	Plan pays 90% ^	Plan pays 90%	Plan pays 90%
Substance Use Disorder	Plan pays 90% ^	Plan pays 90%	Plan pays 90%
Note: Services where plan deductible applies are noted with a caret (^)			

Note: Detox is covered under medical

- Unlimited maximum per Calendar Year
- Services are paid at 100% after you reach your out-of-pocket maximum.
- Inpatient includes Residential Treatment.
- Outpatient includes partial hospitalization and individual, intensive outpatient and group therapy.

Mental Health and Substance Use Disorder Services

Mental Health/Substance Use Disorder Utilization Review, Case Management and Programs

Inpatient Management Only

- Inpatient utilization review and case management

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Pharmacy	In-Network	Out-of-Network
Cigna Pharmacy three-tier copay plan • Retail drugs may be obtained In-Network at a wide range of pharmacies across the nation. • Patient is responsible for the applicable copay based upon the tier of the dispensed medication. • Self Administered injectable drugs - excludes infertility drugs • Oral contraceptives included • Prescription smoking cessation drugs included - covered at retail only • Insulin, glucose test strips, lancets, insulin needles & syringes, insulin pens and cartridges included - covered at $0 copay • Preventive generic medications covered at $0 copay	**Retail** - 30 day supply Generic: You pay $10 Preferred Brand: You pay $50 Non-Preferred Brand: You pay $75 **Retail and Home delivery** - 90 day supply Generic: You pay $20 Preferred Brand: You pay $100 Non-Preferred Brand: You pay $150	**Retail** You pay 40% Your plan pays 60% **Home Delivery** Not Covered

Pharmacy Program Information

Pharmacy Clinical Management and Prior Authorization

- Your plan is subject to refill-too-soon and other clinical edits as well as prior authorization requirements.
- Plan exclusion edits are always included.
- Additional clinical management - Basic package - provides a limited set of clinical edits such as prior authorization, age edits and quantity limits for a specific list of prescription medications.

Prescription Drug List:

- Your Cigna Standard Prescription Drug List includes a full range of drugs including all those required under applicable health care laws. To check which drugs are included in your plan, please log on to myCigna.com.

Specialty Pharmacy Management:

- Clinical Programs
  - Prior authorization is required on specialty medications but quantity limits may apply.
  - Theracare® Program
- Medication Access Option
  - Retail and/or Home Delivery

Additional Information

Case Management

Coordinated by Cigna HealthCare. This is a service designated to provide assistance to a patient who is at risk of developing medical complexities or for whom a health incident has precipitated a need for rehabilitation or additional health care support. The program strives to attain a balance between quality and cost effective care while maximizing the patient's quality of life.

Maximum Reimbursable Charge

Services are subject to a Calendar Year deductible and maximum reimbursable charge limitations. Payments made to health care professionals are determined based on the lesser of: the health care professional's normal charge for a similar service or supply, or a percentile (80%) of charges made by health care professionals of such service or supply in the geographic area where it is received. These charges are compiled in a database selected by Cigna. The health care professional may bill the customer the difference between the health care professional's normal charge and the Maximum Reimbursable Charge as determined by the benefit plan, in addition to applicable deductibles, co-payments and coinsurance.

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Additional Information

Multiple Surgical Reduction
Multiple surgeries performed during one operating session result in payment reduction of 50% to the surgery of lesser charge. The most expensive procedure is paid as any other surgery.

Pre-Certification - Continued Stay Review - PHS Inpatient - required for all inpatient admissions
Customer is responsible for contacting Cigna Healthcare. Subject to penalty/reduction or denial for non-compliance.

- 50% penalty applied to hospital inpatient charges for failure to contact Cigna Healthcare to precertify admission.
- Benefits are denied for any admission reviewed by Cigna Healthcare and not certified.
- Benefits are denied for any additional days not certified by Cigna Healthcare.

Pre-Existing Condition Limitation (PCL) does not apply.

Definitions

Coinsurance - After you've reached your deductible, you and your plan share some of your medical costs. The portion of covered expenses you are responsible for is called Coinsurance.
Copay - A flat fee you pay for certain covered services such as prescriptions.
Deductible - A flat dollar amount you must pay out of your own pocket before your plan begins to pay for covered services.
Out-of-Pocket Maximum - Specific limits for the total amount you will pay out of your own pocket before your plan coinsurance percentage no longer applies. Once you meet these maximums, your plan then pays 100 percent of the "Maximum Reimbursable Charges" or negotiated fees for covered services.
Prescription Drug List - The list of prescription brand and generic drugs covered by your pharmacy plan.

Exclusions

What's Not Covered (not all-inclusive):
Your plan provides for most medically necessary services. The complete list of exclusions is provided in your Certificate or Summary Plan Description. To the extent there may be differences, the terms of the Certificate or Summary Plan Description control. Examples of things your plan does not cover, unless required by law or covered under the pharmacy benefit, include (but aren't limited to):

- Care for health conditions that are required by state or local law to be treated in a public facility.
- Care required by state or federal law to be supplied by a public school system or school district.
- Care for military service disabilities treatable through governmental services if you are legally entitled to such treatment and facilities are reasonably available.
- Treatment of an Injury or Sickness which is due to war, declared, or undeclared, riot or insurrection.
- Charges which you are not obligated to pay or for which you are not billed or for which you would not have been billed except that they were covered under this plan. For example, if Cigna determines that a provider is or has waived, reduced, or forgiven any portion of its charges and/or any portion of copayment, deductible, and/or coinsurance amount(s) you are required to pay for a Covered Service (as shown on the Schedule) without Cigna's express consent, then Cigna in its sole discretion shall have the right to deny the payment of benefits in connection with the Covered Service, or reduce the benefits in proportion to the amount of the copayment, deductible, and/or coinsurance amounts waived, forgiven or reduced, regardless of whether the provider represents that you remain responsible for any amounts that your plan does not cover. In the exercise of that discretion, Cigna shall have the right to require you to provide proof sufficient to Cigna that you have made your required cost share payment(s) prior to the payment of any benefits by Cigna. This exclusion includes, but is not limited to, charges of a Non-Participating Provider who has agreed to charge you or charged you at an in-network benefits level or some other benefits level not otherwise applicable to the services received.
- Charges arising out of or related to any violation of a healthcare-related state or federal law or which themselves are a violation of a healthcare-related state or federal law.

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Exclusions

- Assistance in the activities of daily living, including but not limited to eating, bathing, dressing or other Custodial Services or self-care activities, homemaker services and services primarily for rest, domiciliary or convalescent care.
- For or in connection with experimental, investigational or unproven services.
- Experimental, investigational and unproven services are medical, surgical, diagnostic, psychiatric, substance use disorder or other health care technologies, supplies, treatments, procedures, drug therapies or devices that are determined by the utilization review Physician to be:
  - Not demonstrated, through existing peer-reviewed, evidence-based, scientific literature to be safe and effective for treating or diagnosing the condition or sickness for which its use is proposed;
  - Not approved by the U.S. Food and Drug Administration (FDA) or other appropriate regulatory agency to be lawfully marketed for the proposed use;
  - The subject of review or approval by an Institutional Review Board for the proposed use except as provided in the "Clinical Trials" section of this plan; or
  - The subject of an ongoing phase I, II or III clinical trial, except for routine patient care costs related to qualified clinical trials as provided in the "Clinical Trials" section(s) of this plan.
- Cosmetic surgery and therapies. Cosmetic surgery or therapy is defined as surgery or therapy performed to improve or alter appearance.
- The following services are excluded from coverage regardless of clinical indications: Gynecomastia Surgeries; Surgical treatment of varicose veins; Abdominoplasty; Panniculectomy; Rhinoplasty; Blepharoplasty; Acupressure; Craniosacral/cranial therapy; Dance therapy, Movement therapy; Applied kinesiology; Rolfing; Prolotherapy; and Extracorporeal shock wave lithotripsy (ESWL) for musculoskeletal and orthopedic conditions.
- Dental treatment of the teeth, gums or structures directly supporting the teeth, including dental X-rays, examinations, repairs, orthodontics, periodontics, casts, splints and services for dental malocclusion, for any condition. Charges made for services or supplies provided for or in connection with an accidental injury to sound natural teeth are covered provided a continuous course of dental treatment is started within twelve months of an accident. Sound natural teeth are defined as natural teeth that are free of active clinical decay, have at least 50% bony support and are functional in the arch.
- For medical and surgical services, initial and repeat, intended for the treatment or control of obesity including clinically severe (morbid) obesity, including: medical and surgical services to alter appearances or physical changes that are the result of any surgery performed for the management of obesity or clinically severe (morbid) obesity; and weight loss programs or treatments, whether prescribed or recommended by a Physician or under medical supervision.
- Unless otherwise covered in this plan, for reports, evaluations, physical examinations, or hospitalization not required for health reasons including, but not limited to, employment, insurance or government licenses, and court-ordered, forensic or custodial evaluations.
- Court-ordered treatment or hospitalization, unless such treatment is prescribed by a Physician and listed as covered in this plan.
- Reversal of male or female voluntary sterilization procedures.
- Any services or supplies for the treatment of male or female sexual dysfunction such as, but not limited to, treatment of erectile dysfunction (including penile implants), anorgasmy, and premature ejaculation.
- Medical and Hospital care and costs for the infant child of a Dependent, unless this infant child is otherwise eligible under this plan.
- Nonmedical counseling or ancillary services, including but not limited to Custodial Services, education, training, vocational rehabilitation, behavioral training, biofeedback, neurofeedback, hypnosis, sleep therapy, employment counseling, back school, return to work services, work hardening programs, driving safety, and services, training, educational therapy or other nonmedical ancillary services for learning disabilities, developmental delays, autism or intellectual disabilities.
- Therapy or treatment intended primarily to improve or maintain general physical condition or for the purpose of enhancing job, school, athletic or recreational performance, including but not limited to routine, long term, or maintenance care which is provided after the resolution of the acute medical problem and when significant therapeutic improvement is not expected.
- Consumable medical supplies other than ostomy supplies and urinary catheters. Excluded supplies include, but are not limited to bandages and other disposable medical supplies, skin preparations and test strips, except as specified in the "Home Health Services" or "Breast Reconstruction and Breast Prostheses" sections of this plan.

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Exclusions

- Private Hospital rooms and/or private duty nursing except as provided under the Home Health Services provision.
- Personal or comfort items such as personal care kits provided on admission to a Hospital, television, telephone, newborn infant photographs, complimentary meals, birth announcements, and other articles which are not for the specific treatment of an Injury or Sickness.
- Artificial aids including, but not limited to, corrective orthopedic shoes, arch supports, elastic stockings, garter belts, corsets, dentures and wigs.
- Hearing aids, including but not limited to semi-implantable hearing devices, audiant bone conductors and Bone Anchored Hearing Aids (BAHAs). A hearing aid is any device that amplifies sound.
- Aids or devices that assist with nonverbal communications, including but not limited to communication boards, prerecorded speech devices, laptop computers, desktop computers, Personal Digital Assistants (PDAs), Braille typewriters, visual alert systems for the deaf and memory books.
- Eyeglass lenses and frames and contact lenses (except for the first pair of contact lenses for treatment of keratoconus or post cataract surgery).
- Routine refractions, eye exercises and surgical treatment for the correction of a refractive error, including radial keratotomy.
- Treatment by acupuncture.
- All non-injectable prescription drugs, injectable prescription drugs that do not require Physician supervision and are typically considered self-administered drugs, nonprescription drugs, and investigational and experimental drugs, except as provided in this plan.
- Membership costs or fees associated with health clubs, weight loss programs and smoking cessation programs.
- Dental implants for any condition.
- Fees associated with the collection or donation of blood or blood products, except for autologous donation in anticipation of scheduled services where in the utilization review Physician's opinion the likelihood of excess blood loss is such that transfusion is an expected adjunct to surgery.
- Blood administration for the purpose of general improvement in physical condition.
- Cost of biologicals that are immunizations or medications for the purpose of travel, or to protect against occupational hazards and risks.
- Cosmetics, dietary supplements and health and beauty aids.
- All nutritional supplements and formulae except for infant formula needed for the treatment of inborn errors of metabolism.
- Medical treatment for a person age 65 or older, who is covered under this plan as a retiree, or their Dependent, when payment is denied by the Medicare plan because treatment was received from a nonparticipating provider.
- Medical treatment when payment is denied by a Primary Plan because treatment was received from a nonparticipating provider.
- For or in connection with an Injury or Sickness arising out of, or in the course of, any employment for wage or profit.
- Charges for the delivery of medical and health-related services via telecommunications technologies, including telephone and internet, unless provided as specifically described under the benefit section.
- Massage therapy.
- Genetic screening or pre-implantations genetic screening. General population-based genetic screening is a testing method performed in the absence of any symptoms or any significant, proven risk factors for genetically linked inheritable disease.
- Infertility services including infertility drugs, surgical or medical treatment programs for infertility, including in vitro fertilization, gamete intrafallopian transfer (GIFT), zygote intrafallopian transfer (ZIFT), variations of these procedures, and any costs associated with the collection, washing, preparation or storage of sperm for artificial insemination (including donor fees). Cryopreservation of donor sperm and eggs are also excluded from coverage.

These are only the highlights
This summary outlines the highlights of your plan. For a complete list of both covered and not covered services, including benefits required by your state, see your employer's insurance certificate or summary plan description -- the official plan documents. If there are any differences between this summary and the plan documents, the information in the plan documents takes precedence. This summary provides additional information not provided in the Summary of Benefits and Coverage document required by the Federal Government.

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