Home Office: Bloomfield, Connecticut
Mailing Address: Hartford, Connecticut 06152

CIGNA HEALTH AND LIFE INSURANCE COMPANY
a Cigna company (hereinafter called Cigna)

CERTIFICATE RIDER

No. CR7SI057a-1

Policyholder: Pace University

Rider Eligibility: Each Employee as reported to the insurance company by your Employer.

Policy No. or Nos. 3331784-CN6

EFFECTIVE DATE: January 1, 2019

You will become insured on the date you become eligible if you are in Active Service on that date or if you are not in Active Service on that date due to your health status. If you are not insured for the benefits described in your certificate on that date, the effective date of this certificate rider will be the date you become insured.

This certificate rider forms a part of the certificate issued to you by Cigna describing the benefits provided under the policy(ies) specified above.

Anna Krishtul

Anna Krishtul, Corporate Secretary

HC-RDR1 04-10
V1

THE SCHEDULE — Open Access Plus Medical Benefits — section in your certificate is changed to read as attached.
THE SCHEDULE — Prescription Drug Benefits — section in your certificate is changed to read as attached.

Open Access Plus Medical Benefits

The Schedule

For You and Your Dependents

Open Access Plus Medical Benefits provide coverage for care In-Network and Out-of-Network. To receive Open Access Plus Medical Benefits, you and your Dependents may be required to pay a portion of the Covered Expenses for services and supplies. That portion is the Copayment, Deductible or Coinsurance.

If you are unable to locate an In-Network Provider in your area who can provide you with a service or supply that is covered under this plan, you must call the number on the back of your I.D. card to obtain authorization for Out-of-Network Provider coverage. If you obtain authorization for services provided by an Out-of-Network Provider, benefits for those services will be covered at the In-Network benefit level.

Coinsurance

The term Coinsurance means the percentage of charges for Covered Expenses that an insured person is required to pay under the plan.

Copayments/Deductibles

Copayments are expenses to be paid by you or your Dependent for covered services. Note: if the costs of a covered service is less than the copayment for that service, you or your Dependent are responsible for the lesser amount. Deductibles are also expenses to be paid by you or your Dependent. Deductible amounts are separate from and not reduced by Copayments. Copayments and Deductibles are in addition to any Coinsurance. Once the Deductible maximum in The Schedule has been reached, you and your family need not satisfy any further medical deductible for the rest of that year.

Out-of-Pocket Expenses - For In-Network Charges Only

Out-of-Pocket Expenses are Covered Expenses incurred for charges that are not paid by the benefit plan because of any Deductibles, Copayments or Coinsurance. Such Covered Expenses accumulate to the Out-of-Pocket Maximum shown in the Schedule. When the Out-of-Pocket Maximum is reached, all Covered Expenses, except charges for non-compliance penalties, are payable by the benefit plan at 100%.

Out-of-Pocket Expenses - For Out-of-Network Charges Only

Out-of-Pocket Expenses are Covered Expenses incurred for charges that are not paid by the benefit plan. The following Expenses contribute to the Out-of-Pocket Maximum, and when the Out-of-Pocket Maximum shown in The Schedule is reached, they are payable by the benefit plan at 100%:

- Coinsurance.
- Plan Deductible.

The following Out-of-Pocket Expenses and charges do not contribute to the Out-of-Pocket Maximum, and they are not payable by the benefit plan at 100% when the Out-of-Pocket Maximum shown in The Schedule is reached:

- Non-compliance penalties.
- Any copayments and/or benefit deductibles.
- Provider charges in excess of the Maximum Reimbursable Charge.

Accumulation of Plan Deductibles and Out-of-Pocket Maximums

Deductibles and Out-of-Pocket Maximums will accumulate in one direction (that is, Out-of-Network will accumulate to In-Network). All other plan maximums and service-specific maximums (dollar and occurrence) cross-accumulate between In- and Out-of-Network unless otherwise noted.

Open Access Plus Medical Benefits

The Schedule

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.

Assistant Surgeon and Co-Surgeon Charges

Assistant Surgeon

The maximum amount payable will be limited to charges made by an assistant surgeon that do not exceed a percentage of the surgeon's allowable charge as specified in Cigna Reimbursement Policies. (For purposes of this limitation, allowable charge means the amount payable to the surgeon prior to any reductions due to coinsurance or deductible amounts.)

Co-Surgeon

The maximum amount payable for charges made by co-surgeons will be limited to the amount specified in Cigna Reimbursement Policies.

BENEFIT HIGHLIGHTS	IN-NETWORK	OUT-OF-NETWORK
Lifetime Maximum for non-Essential and Essential Health Benefits * *(Essential Health benefits are noted throughout the Schedule as EHB)	Unlimited	
The Percentage of Covered Expenses the Plan Pays **Note:** "No charge" means an insured person is not required to pay Coinsurance.	85%	65% of the Maximum Reimbursable Charge

BENEFIT HIGHLIGHTS	IN-NETWORK	OUT-OF-NETWORK
Maximum Reimbursable Charge Maximum Reimbursable Charge is determined based on the lesser of the provider's normal charge for a similar service or supply; or A percentage of a schedule that Cigna has developed that is based upon a methodology similar to a methodology utilized by Medicare to determine the allowable fee for similar services within the geographic market. In some cases, a Medicare based schedule will not be used and the Maximum Reimbursable Charge for covered services is determined based on the lesser of: • the provider's normal charge for a similar service or supply; or • the 80th percentile of charges made by providers of such service or supply in the geographic area where it is received as compiled in a database selected by Cigna. **Note:** The provider may bill you for the difference between the provider's normal charge and the Maximum Reimbursable Charge, in addition to applicable deductibles, copayments and coinsurance.	Not Applicable	300%
Calendar Year Deductible		
Individual	$750 per person	$2,000 per person
Family Maximum	$1,500 per family	$4,000 per family
Family Maximum Calculation **Individual Calculation:** Family members meet only their individual deductible and then their claims will be covered under the plan coinsurance; if the family deductible has been met prior to their individual deductible being met, their claims will be paid at the plan coinsurance.		

BENEFIT HIGHLIGHTS	IN-NETWORK	OUT-OF-NETWORK
Out-of-Pocket Maximum		
Individual	$2,000 per person	$5,000 per person
Family Maximum	$4,000 per family	$10,000 per family
Family Maximum Calculation **Individual Calculation:** Family members meet only their individual Out-of-Pocket and then their claims will be covered at 100%; if the family Out-of-Pocket has been met prior to their individual Out-of-Pocket being met, their claims will be paid at 100%.		
Physician's Services ***EHB**		
Primary Care Physician's Office Visit	No charge after $30 per office visit copay	65% after plan deductible
Specialty Care Physician's Office Visits	No charge after $50 Specialist per office visit copay	65% after plan deductible
Consultant and Referral Physician's Services		
Note: OB/GYN providers will be considered either as a PCP or Specialist, depending on how the provider contracts with the Insurance Company.		
Surgery Performed in the Physician's Office	No charge after the $30 PCP or $50 Specialist per office visit copay	65% after plan deductible
Second Opinion Consultations (provided on a voluntary basis)	No charge after the $30 PCP or $50 Specialist per office visit copay	65% after plan deductible
Allergy Treatment/Injections	No charge after either the $30 PCP or $50 Specialist per office visit copay or the actual charge, whichever is less	65% after plan deductible
Allergy Serum (dispensed by the Physician in the office)	No charge	65% after plan deductible
Preventive Care ***EHB**		
Routine Preventive Care - all ages	No charge	70% after plan deductible
Immunizations - all ages	No charge	70% after plan deductible

BENEFIT HIGHLIGHTS	IN-NETWORK	OUT-OF-NETWORK
Mammograms, PSA, PAP Smear ***EHB**		
Preventive Care Related Services (i.e. "routine" services)	No charge	65% after plan deductible
Diagnostic Related Services (i.e. "non-routine" services)	Subject to the plan's x-ray & lab benefit; based on place of service	Subject to the plan's x-ray & lab benefit; based on place of service
Inpatient Hospital - Facility Services ***EHB**	85% after plan deductible	65% after plan deductible
Semi-Private Room and Board	Limited to the semi-private room negotiated rate	Limited to the semi-private room rate
Private Room	Limited to the semi-private room negotiated rate	Limited to the semi-private room rate
Special Care Units (ICU/CCU)	Limited to the negotiated rate	Limited to the ICU/CCU daily room rate
Outpatient Facility Services ***EHB** Operating Room, Recovery Room, Procedures Room, Treatment Room and Observation Room	85% after plan deductible	65% after plan deductible
Inpatient Hospital Physician's Visits/Consultations ***EHB**	85% after plan deductible	65% after plan deductible
Inpatient Hospital Professional Services ***EHB** Surgeon Radiologist Pathologist Anesthesiologist	85% after plan deductible	65% after plan deductible
Outpatient Professional Services ***EHB** Surgeon Radiologist Pathologist Anesthesiologist	85% after plan deductible	65% after plan deductible

BENEFIT HIGHLIGHTS	IN-NETWORK	OUT-OF-NETWORK
Emergency and Urgent Care Services ***EHB**		
Physician's Office Visit	No charge after the $30 PCP or $50 Specialist per office visit copay	No charge after the $30 PCP or $50 Specialist per office visit copay
Hospital Emergency Room	No charge after $85 per visit copay* *waived if admitted	No charge after $85 per visit copay* *waived if admitted
Outpatient Professional Services (radiology, pathology and ER physician)	No charge	No charge after plan deductible
Urgent Care Facility or Outpatient Facility	No charge after $30 per visit copay* *waived if admitted	No charge after $30 per visit copay* *waived if admitted
X-ray and/or Lab performed at the Emergency Room/Urgent Care Facility (billed by the facility as part of the ER/UC visit)	No charge	No charge
Independent x-ray and/or Lab Facility in conjunction with an ER visit	No charge	No charge
Advanced Radiological Imaging (i.e. MRIs, MRAs, CAT Scans, PET Scans etc.)	No charge	No charge
Ambulance	85% after plan deductible	85% after plan deductible
Inpatient Services at Other Health Care Facilities ***EHB** Includes Skilled Nursing Facility, Rehabilitation Hospital and Sub-Acute Facilities Calendar Year Maximum: 60 days combined	85% after plan deductible	65% after plan deductible
Laboratory and Radiology Services (includes pre-admission testing) ***EHB**		
Physician's Office Visit	No charge	65% after plan deductible
Outpatient Hospital Facility	No charge	65% after plan deductible
Independent X-ray and/or Lab Facility	No charge	65% after plan deductible

BENEFIT HIGHLIGHTS	IN-NETWORK	OUT-OF-NETWORK
Advanced Radiological Imaging (i.e. MRIs, MRAs, CAT Scans and PET Scans) ***EHB**		
Physician's Office Visit	No charge	65% after plan deductible
Inpatient Facility	85% after plan deductible	65% after plan deductible
Outpatient Facility	85% after plan deductible	65% after plan deductible
Outpatient Short-Term Rehabilitative Therapy ***EHB** Calendar Year Maximum: 90 days for all therapies combined **Note:** The Short-Term Rehabilitative Therapy maximum does not apply to the treatment of autism. Includes: Cardiac Rehab Physical Therapy Speech Therapy Occupational Therapy Pulmonary Rehab Cognitive Therapy	No charge after the $30 PCP or $50 Specialist per office visit copay **Note:** Outpatient Short Term Rehab copay applies, regardless of place of service, including the home.	65% after plan deductible
Chiropractic Care ***EHB** Calendar Year Maximum: Unlimited		
Physician's Office Visit	No charge after the $30 PCP or $50 Specialist per office visit copay	70% after plan deductible
Home Health Care ***EHB** Regardless of the Individual Plan Deductible, the Home Health Care Deductible will not exceed $50.		
Calendar Year Maximum: Unlimited (includes outpatient private nursing when approved as Medically Necessary)	85% after the Home Health Care Deductible	75% after the Home Health Care Deductible

BENEFIT HIGHLIGHTS	IN-NETWORK	OUT-OF-NETWORK
Hospice ***EHB**		
Inpatient Services	85% after plan deductible	65% after plan deductible
Outpatient Services	85% after plan deductible	65% after plan deductible
Bereavement Counseling ***EHB**		
Services provided as part of Hospice Care		
Inpatient	85% after plan deductible	65% after plan deductible
Outpatient	85% after plan deductible	65% after plan deductible
Services provided by Mental Health Professional	Covered under Mental Health benefit	Covered under Mental Health benefit
Maternity Care Services ***EHB**		
Initial Visit to Confirm Pregnancy	No charge after the $30 PCP or $50 Specialist per office visit copay	65% after plan deductible
Note: OB/GYN providers will be considered either as a PCP or Specialist, depending on how the provider contracts with the Insurance Company.		
All subsequent Prenatal Visits, Postnatal Visits and Physician's Delivery Charges (i.e. global maternity fee)	85% after plan deductible	65% after plan deductible
Physician's Office Visits in addition to the global maternity fee when performed by an OB/GYN or Specialist	No charge after the $30 PCP or $50 Specialist per office visit copay	65% after plan deductible
Delivery - Facility (Inpatient Hospital, Birthing Center)	85% after plan deductible	65% after plan deductible
Abortion ***EHB**		
Includes elective and non-elective procedures		
Physician's Office Visit	No charge after the $30 PCP or $50 Specialist per office visit copay	65% after plan deductible
Inpatient Facility	85% after plan deductible	65% after plan deductible
Outpatient Facility	85% after plan deductible	65% after plan deductible
Physician's Services	85% after plan deductible	65% after plan deductible

BENEFIT HIGHLIGHTS	IN-NETWORK	OUT-OF-NETWORK
Women's Family Planning Services ***EHB**		
Office Visits, Lab and Radiology Tests and Counseling	No charge	70% after plan deductible
Surgical Sterilization Procedures for Tubal Ligation (excludes reversals)		
Physician's Office Visit	No charge	70% after plan deductible
Inpatient Facility	No charge	70% after plan deductible
Outpatient Facility	No charge	70% after plan deductible
Physician's Services	No charge	70% after plan deductible
Men's Family Planning Services ***EHB**		
Office Visits, Lab and Radiology Tests and Counseling	No charge after the $30 PCP or $50 Specialist per office visit copay	65% after plan deductible
Surgical Sterilization Procedures for Vasectomy (excludes reversals)		
Physician's Office Visit	No charge after the $30 PCP or $50 Specialist per office visit copay	65% after plan deductible
Inpatient Facility	85% after plan deductible	65% after plan deductible
Outpatient Facility	85% after plan deductible	65% after plan deductible
Physician's Services	85% after plan deductible	65% after plan deductible
Infertility Treatment ***EHB (except for In-vitro, GIFT and ZIFT)** Coverage will be provided for the following services: • Testing and treatment services performed in connection with an underlying medical condition. • Testing performed specifically to determine the cause of infertility. • Treatment and/or procedures performed specifically to restore fertility (e.g. procedures to correct an infertility condition). • Artificial Insemination, In-vitro, GIFT, ZIFT, etc. Calendar Year Maximum: $10,000 Note: Artificial Insemination is unlimited.		
Physician's Office Visit (Lab and Radiology Tests, Counseling)	No charge after the $30 PCP or $50 Specialist per office visit copay	65% after plan deductible
Inpatient Facility	85% after plan deductible	65% after plan deductible
Outpatient Facility	85% after plan deductible	65% after plan deductible
Physician's Services	85% after plan deductible	65% after plan deductible

BENEFIT HIGHLIGHTS	IN-NETWORK	OUT-OF-NETWORK
Organ Transplants ***EHB (Applicable to In-Network Benefits only. Does not include travel).** Includes all medically appropriate, non-experimental transplants		
Physician's Office Visit	No charge after the $30 PCP or $50 Specialist per office visit copay	65% after plan deductible
Inpatient Facility	100% at Lifesource center, otherwise 85% after plan deductible	70% after plan deductible
Physician's Services	100% at Lifesource center, otherwise 85% after plan deductible	70% after plan deductible
Lifetime Travel Maximum: $10,000 per transplant	No charge (only available when using Lifesource facility)	In-Network coverage only
Durable Medical Equipment ***EHB**		
Calendar Year Maximum: Unlimited	85% after plan deductible	65% after plan deductible
External Prosthetic Appliances ***EHB**		
Calendar Year Maximum: Unlimited	85% after plan deductible	65% after plan deductible
Diabetic Equipment ***EHB** Calendar Year Maximum: Unlimited	85% after plan deductible	65% after plan deductible
Nutritional Evaluation ***EHB (applicable to treatment of diabetes; treatment of eating disorders; and in connection with enteral formulas as a result of an underlying medical condition)** Calendar Year Maximum: 3 visits per person however, the 3 visit limit will not apply to treatment of diabetes or treatment prescribed in connection with mental health diagnosis.		
Physician's Office Visit	No charge after the $30 PCP or $50 Specialist per office visit copay	65% after plan deductible
Inpatient Facility	85% after plan deductible	65% after plan deductible
Outpatient Facility	85% after plan deductible	65% after plan deductible
Physician's Services	85% after plan deductible	65% after plan deductible

BENEFIT HIGHLIGHTS	IN-NETWORK	OUT-OF-NETWORK
Dental Care ***EHB (for oral surgery only)** Limited to charges made for a continuous course of dental treatment started within twelve months of an injury to sound, natural teeth and charges made for dental care and treatment due to congenital disease or anomaly.		
Physician's Office Visit	No charge after the $30 PCP or $50 Specialist per office visit copay	65% after plan deductible
Inpatient Facility	85% after plan deductible	65% after plan deductible
Outpatient Facility	85% after plan deductible	65% after plan deductible
Physician's Services	85% after plan deductible	65% after plan deductible
TMJ Surgical and Non-Surgical ***EHB** Always excludes appliances and orthodontic treatment. Subject to medical necessity.		
Physician's Office Visit	No charge after the $30 PCP or $50 Specialist per office visit copay	65% after plan deductible
Inpatient Facility	85% after plan deductible	65% after plan deductible
Outpatient Facility	85% after plan deductible	65% after plan deductible
Physician's Services	85% after plan deductible	65% after plan deductible
Routine Foot Disorders ***EHB (when provided in connection with treatment of diabetes)**	Not covered except for services associated with foot care for diabetes and peripheral vascular disease when Medically Necessary.	Not covered except for services associated with foot care for diabetes and peripheral vascular disease when Medically Necessary.
Treatment Resulting From Life Threatening Emergencies ***EHB** Medical treatment required as a result of an emergency, such as a suicide attempt, will be considered a medical expense until the medical condition is stabilized. Once the medical condition is stabilized, whether the treatment will be characterized as either a medical expense or a mental health/substance abuse expense will be determined by the utilization review Physician in accordance with the applicable mixed services claim guidelines.		
Mental Health ***EHB**		
Inpatient	85% after plan deductible	65% after plan deductible
Outpatient (Includes Individual, Group and Intensive Outpatient)		
Physician's Office Visit	$50 per visit copay	70% after plan deductible
Outpatient Facility	100%	70% after plan deductible

BENEFIT HIGHLIGHTS	IN-NETWORK	OUT-OF-NETWORK
Substance Abuse ***EHB**		
Inpatient	85% after plan deductible	65% after plan deductible
Outpatient (Includes Individual and Intensive Outpatient)		
Physician's Office Visit	$50 per visit copay	70% after plan deductible
Outpatient Facility	100%	70% after plan deductible

Prescription Drug Benefits
The Schedule

For You and Your Dependents

This plan provides Prescription Drug benefits for Prescription Drugs and Related Supplies provided by Pharmacies as shown in this Schedule. To receive Prescription Drug Benefits, you and your Dependents may be required to pay a portion of the Covered Expenses for Prescription Drugs and Related Supplies. That portion includes any applicable Copayment, Deductible and/or Coinsurance.

Coinsurance

The term Coinsurance means the percentage of Charges for covered Prescription Drugs and Related Supplies that you or your Dependent are required to pay under this plan.

Charges

The term Charges means the amount charged by the Insurance Company to the plan when the Pharmacy is a Participating Pharmacy, and it means the actual billed charges when the Pharmacy is a non-Participating Pharmacy.

Copayments

Copayments are expenses to be paid by you or your Dependent for Covered Prescription Drugs and Related Supplies.

Note:
If the cost of a covered Prescription Drug or Related Supply is less than the copayment for that Prescription Drug or Related Supply, you or your Dependent are responsible for the lesser amount.

Calendar Year Deductible

Deductibles are expenses to be paid by you or your Dependent for Covered Prescription Drugs and Related Supplies. These Deductibles are in addition to any copayments or coinsurance. Once the Deductible maximum shown in The Schedule has been reached you and your family need not satisfy any further Prescription Drug Deductible for the rest of that year.

Out-of-Pocket Expenses

Out-of-Pocket Expenses are Covered Expenses incurred at a Pharmacy for Prescription Drugs and Related Supplies for which no payment is provided because of the Coinsurance factor and any Copayments or Deductibles. When the Out-of-Pocket maximum shown in The Schedule is reached, benefits are payable at 100%.

BENEFIT HIGHLIGHTS	PARTICIPATING PHARMACY	Non-PARTICIPATING PHARMACY
Calendar Year Deductible		
Individual	$125 per person	$125 per person
Family	$375 per family	$375 per family
Note: Generic Drugs are not subject to the Deductible		
Out-of-Pocket Maximum		
Individual	$4,000 per person	$4,000 per person
Family	$8,000 per family	$8,000 per family

BENEFIT HIGHLIGHTS	PARTICIPATING PHARMACY	Non-PARTICIPATING PHARMACY
Retail Prescription Drugs	**The amount you pay for each 30-day supply**	**The amount you pay for each 30-day supply**
Certain medications covered under this plan and required as part of preventive care services (detailed information is available at www.healthcare.gov) are payable at 100% with no copayment or deductible, when purchased from a Participating Pharmacy. A written prescription is required.		
Tier 1		
Preventive Generic* drugs on the Prescription Drug List	No charge	No charge
Non-Preventive Generic* drugs on the Prescription Drug List	No charge after $20 copay	35%
Tier 2		
Brand-Name* drugs designated as preferred on the Prescription Drug List with no Generic equivalent	No charge after $45 copay after pharmacy deductible	35% after pharmacy deductible
Tier 3		
Brand-Name* drugs with a Generic equivalent and drugs designated as non-preferred on the Prescription Drug List	No charge after $70 copay after pharmacy deductible	35% after pharmacy deductible
* Designated as per generally-accepted industry sources and adopted by the Insurance Company		
Home Delivery Prescription Drugs	**The amount you pay for each 90-day supply**	**The amount you pay for each 90-day supply**
Certain medications covered under this plan and required as part of preventive care services (detailed information is available at www.healthcare.gov) are payable at 100% with no copayment or deductible, when purchased from a Participating Pharmacy. A written prescription is required.		
Tier 1		
Preventive Generic* drugs on the Prescription Drug List	No charge	In-network coverage only
Non-Preventive Generic* drugs on the Prescription Drug List	No charge after $20 copay	In-network coverage only
Tier 2		
Brand-Name* drugs designated as preferred on the Prescription Drug List with no Generic equivalent	No charge after $45 copay after pharmacy deductible	In-network coverage only
Tier 3		
Brand-Name* drugs with a Generic equivalent and drugs designated as non-preferred on the Prescription Drug List	No charge after $70 copay after pharmacy deductible	In-network coverage only

BENEFIT HIGHLIGHTS	PARTICIPATING PHARMACY	Non-PARTICIPATING PHARMACY
* Designated as per generally-accepted industry sources and adopted by the Insurance Company		