

Pace University
CIGNA Medical Detailed Benefit Summaries
January 1, 2020 - December 31, 2020

| Plan Name | Consumer Core HDHP | Network Core Plan |
|---|--|---|
| Carrier | <u>CIGNA</u> | <u>CIGNA</u> |
| Network | Choice Fund Open Access Plus | Open Access Plus |
| | In Network | In Network |
| Deductible | \$1,400/\$2,800 (Cumulative) | N/A |
| Coinsurance | 90% | N/A |
| Out of Pocket Maximum | \$2,500/\$5,000 (Cumulative) | \$2,000/\$4,000 |
| Annual Maximum , Unless noted otherwise | Unlimited | Unlimited |
| Lifetime Maximum, Unless noted otherwise | Unlimited | Unlimited |
| Prescription Drugs | Deductible and then 80%/70%/60% Coinsurance up to the Out of Pocket Maximum (Generic Preventive Medication - \$0 copay & not subject to deductible) | \$20/\$45/\$70 (\$125/\$375 Deductible - waived for generic) (Generic Preventive Medication - \$0 copay & not subject to deductible) |
| Mail Order Prescription Drugs (Three (3) month Supply) | Same as retail | Same copay as retail |
| Pharmacy Maximum Out of Pocket | Combined with medical | \$4,000/\$8,000 |
| Oral Contraceptive Coverage | Included | Included |
| PCP Office Visits | Deductible and Coinsurance | \$30 copay |
| Specialist Visits | Deductible and Coinsurance | \$50 copay |
| Telehealth Connection Services | Deductible and Coinsurance | \$30 copay |
| OB/GYN Visits | Deductible and Coinsurance Preventive care - Covered 100% | Office Visit - \$30/\$50 copay Preventive care - Covered 100% |
| Routine Preventive Care (adult) | 100%; Unlimited Maximum | 100%; Unlimited Maximum |
| Well Child Exams (through age 18) | 100%; Unlimited Maximum | 100%; Unlimited Maximum |
| Vision Coverage- Active Employees Only | Separate vision plan through CIGNA Vision | Separate vision plan through CIGNA Vision |
| Gym Reimbursement | Discounts available through Healthy Rewards | Discounts available through Healthy Rewards |
| Lab and X-ray | Deductible & Coinsurance | Participating lab - 100% Office Visit - \$30/\$50 copay (No charge if only lab/x-ray services performed and billed) Outpatient - 100% |
| Advanced Radiology | Deductible & Coinsurance | Office Visit - \$30/\$50 copay (no charge if only radiology services performed and billed) Outpatient - 100% |
| Chiropractic | Deductible & Coinsurance Unlimited visits per calendar yr | \$50 Unlimited visits per calendar yr |
| Ambulance Service | Deductible & Coinsurance | 100% (when Medically necessary) |
| Emergency Room | Deductible & Coinsurance | \$85 per visit; Waived if admitted |
| Urgent Care | Deductible & Coinsurance | \$30 per visit; Waived if admitted |
| Hospitalization | Deductible & Coinsurance | 100% |
| Outpatient Surgery | Deductible & Coinsurance | 100% |

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| Network | Choice Fund Open Access Plus | Open Access Plus |
| | In Network | In Network |
| Inpatient Mental Health | Deductible & Coinsurance Unlimited day maximum per calendar year | 100% Unlimited day maximum per calendar year |
| Outpatient Mental Health | Deductible & Coinsurance Unlimited maximum per calendar year | Office Visit - \$50 copay Outpatient Facility - 100% Unlimited maximum per calendar year |
| Substance Abuse | Deductible & Coinsurance Unlimited maximum per calendar year | Inpatient - 100%; Office Visit - \$50 Copay Outpatient Facility - 100% Unlimited maximum per calendar year |
| Inpatient Physical Therapy | Deductible & Coinsurance 60 days maximum per calendar year includes Skilled Nursing Facility, Rehabilitation Hospital, Sub Acute Facilities | 100%; 60 days per calendar year includes Skilled Nursing, Rehabilitation Hospital and Sub Acute Facilities |
| Outpatient Physical Therapy | Deductible & Coinsurance 90 days combined maximum per calendar year Includes: Cardiac Rehab, Physical Therapy, Speech Therapy, Occupational Therapy, Pulmonary Rehab, Cognitive Therapy | \$50 Copay; 90 days combined maximum per calendar year. Includes: Cardiac Rehab, Physical Therapy, Speech Therapy, Occupational Therapy, Pulmonary Rehab, Cognitive Therapy |
| Hospice Care | Deductible & Coinsurance; Unlimited Maximum | 100%; Unlimited Maximum |
| Home Health Care (includes Outpatient Private Duty Nursing) | Deductible & Coinsurance Unlimited days maximum per calendar yr; 16 hour maximum per day; Subject to medical necessity | 100% Unlimited days maximum per calendar yr; 16 hour maximum per day; Subject to medical necessity |
| Skilled Nursing Facility | Deductible & Coinsurance; 60 day maximum per calendar yr Includes Rehabilitation Hospital and Sub-Acute Facilities | 100% 60 day maximum per calendar yr Includes Rehabilitation Hospital and Sub-Acute Facilities |

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| Network | Choice Fund Open Access Plus | Open Access Plus |
| | In Network | In Network |
| TMJ- Surgical and Non Surgical - Always excludes appliances & orthodontic treatment. Subject to medical necessity. | Deductible & Coinsurance | Office Visit - \$30/\$50 copay Inpatient and Outpatient facility - 100%. |
| Infertility | Deductible & Coinsurance Basic (includes artificial insemination) - No Max. Advanced Infertility (IV, ZIFT, GIFT) - No Max. | Office Visit - \$30/\$50 copay Inpatient & Outpatient Facility - 100% Basic (includes artificial insemination) - No Max. Advanced Infertility (IV, ZIFT, GIFT)- No Max. |
| Abortion | Deductible & Coinsurance | Office Visit - \$30/\$50 copay Inpatient & Outpatient Facility - 100% |
| Dependent Age | 26, End of calendar yr | 26, End of calendar yr |
| Durable Medical Equip. | Deductible & Coinsurance; Unlimited maximum | 100%; Unlimited maximum |
| Out of Network Reasonable & Customary | N/A | N/A |
| Pre-certification required | Yes, coordinated by provider/PCP | Yes, coordinated by provider/ PCP |
| Penalty for Failure to Pre-certify | N/A | N/A |

*Many of the above services may require precertification through CIGNA.

**The benefit summaries shown above do not replace the official plan documents or contracts that govern your eligibility to participate in these plans or the amount of benefits you may receive. If there is a discrepancy between the official plan documents and this summary, your actual benefits will always be governed by the plan documents.

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| Plan Name | Choice PPO | |
|---|---|--|
| Carrier | CIGNA | |
| Network | Open Access Plus | |
| | In Network | Out of Network |
| Deductible | \$750/\$1,500 | \$2,000/\$4,000 |
| Coinsurance | 85% | 65% |
| Out of Pocket Maximum | \$2,000/\$4,000 | \$5,000/\$10,000 |
| Annual Maximum , Unless noted otherwise | Unlimited | Unlimited |
| Lifetime Maximum, Unless noted otherwise | Unlimited | Unlimited |
| Prescription Drugs | \$20/\$45/\$70 (\$125/\$375 Deductible - waived for generic) (Generic Preventive Medication - \$0 copay & not subject to deductible) | 35% Coinsurance (\$125/\$375 Deductible - waived for generic) |
| Mail Order Prescription Drugs (Three (3) month Supply) | Same copay as retail | In-Network Benefit Only |
| Pharmacy Maximum Out of Pocket | \$4,000/\$8,000 | \$4,000/\$8,000 |
| Oral Contraceptive Coverage | Included | Included |
| PCP Office Visits | \$30 copay | Deductible & 70% Coinsurance |
| Specialist Visits | \$50 copay | Deductible & 70% Coinsurance |
| Telehealth Connection Services | \$30 copay | Not Covered |
| OB/GYN Visits | Office Visit - \$30/\$50 copay Preventive care - Covered 100% | Deductible & 70% Coinsurance |
| Routine Preventive Care (adult) | 100%; Unlimited Maximum | Deductible & 70% Coinsurance; Unlimited Maximum |
| Well Child Exams (through age 18) | 100%; Unlimited Maximum | Deductible & 70% Coinsurance; Unlimited Maximum |
| Vision Coverage- Active Employees Only | Separate vision plan through CIGNA Vision | |
| Gym Reimbursement | Discounts available through CIGNA Healthy Rewards Program | |
| Lab and X-ray | Participating lab - 100% Office Visit - \$30/\$50 copay (No charge if only lab/x-ray services performed and billed) Outpatient - 100% | Deductible & 70% Coinsurance |
| Advanced Radiology | Office Visit - \$30/\$50 copay (no charge if only radiology services performed and billed) Outpatient - Deductible & Coinsurance | Deductible & Coinsurance |
| Chiropractic | \$50 Unlimited visits per calendar yr | Deductible & 70% Coinsurance Unlimited visits per calendar yr |
| Ambulance Service | Deductible & Coinsurance | Deductible & 15% Coinsurance |
| Emergency Room | \$85 per visit; Waived if admitted | \$85 per visit; Waived if admitted |
| Urgent Care | \$30 per visit; Waived if admitted | \$30 per visit; Waived if admitted |
| Hospitalization | Deductible & Coinsurance | Deductible & Coinsurance |
| Outpatient Surgery | Deductible & Coinsurance | Deductible & Coinsurance |

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| | In Network | Out of Network |
| Inpatient Mental Health | Deductible & Coinsurance Unlimited day maximum per calendar year | Deductible & Coinsurance Unlimited day maximum per calendar year |
| Outpatient Mental Health | Office Visit - \$50 copay Outpatient Facility - Deductible & Coinsurance Unlimited maximum per calendar year | Office Visit - Deductible & Coinsurance Outpatient Facility - Deductible & 70% Coinsurance Unlimited maximum per calendar year |
| Substance Abuse | Inpatient - Deductible & Coinsurance; Office Visit - \$50 copay Outpatient Facility - Deductible & Coinsurance Unlimited maximum per calendar year | Inpatient - Deductible & Coinsurance; Office Visit - Deductible & 70% Coinsurance Outpatient Facility - Deductible & 70% Coinsurance Unlimited maximum per calendar year |
| Inpatient Physical Therapy | Deductible & Coinsurance; 60 days per calendar year includes Skilled Nursing, Rehabilitation Hospital and Sub Acute Facilities | Deductible & Coinsurance; 60 days per calendar year includes Skilled Nursing, Rehabilitation Hospital and Sub Acute Facilities |
| Outpatient Physical Therapy | \$50 Copay; 90 days combined maximum per calendar year. Includes: Cardiac Rehab, Physical Therapy, Speech Therapy, Occupational Therapy, Pulmonary Rehab, Cognitive Therapy | Deductible & 70% Coinsurance; 90 days combined maximum per calendar year. Includes: Cardiac Rehab, Physical Therapy, Speech Therapy, Occupational Therapy, Pulmonary Rehab, Cognitive Therapy |
| Hospice Care | Deductible & Coinsurance; Unlimited Maximum | Deductible & Coinsurance; Unlimited Maximum |
| Home Health Care (includes Outpatient Private Duty Nursing) | \$50 Deductible & Coinsurance, plan deductible does not apply. Unlimited days maximum per calendar yr; 16 hour maximum per day; Subject to medical necessity | 25% after \$50 Deductible, plan deductible does not apply Unlimited maximum per calendar yr; 16 hour maximum per day; Subject to medical necessity |
| Skilled Nursing Facility | Deductible & Coinsurance 60 day maximum per calendar yr Includes Rehabilitation Hospital and Sub-Acute Facilities | Deductible & Coinsurance 60 day maximum per calendar yr Includes Rehabilitation Hospital and Sub-Acute Facilities |

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| TMJ- Surgical and Non Surgical - Always excludes appliances & orthodontic treatment. Subject to medical necessity. | Office Visit - \$30/\$50 copay Inpatient and Outpatient facility - Deductible & Coinsurance | Office Visit - Deductible & 70% Coinsurance Inpatient and Outpatient facility - Deductible & Coinsurance |
| Infertility | Office Visit - \$30/\$50 copay Inpatient & Outpatient Facility - 100% Basic (includes artificial insemination) - No Max. Advanced Infertility (IV, ZIFT, GIFT)- No Max. | Office Visit - Deductible & 70% Coinsurance Inpatient & Outpatient Facility - Deductible & Coinsurance; Basic (includes artificial insemination) - No Max. Advanced Infertility (IV, ZIFT, GIFT)- No Max. |
| Abortion | Office Visit - \$30/\$50 copay Inpatient & Outpatient Facility - Deductible & Coinsurance | Office Visit - Deductible & 70% Coinsurance Inpatient & Outpatient Facility - Deductible & Coinsurance |
| Dependent Age | 26, End of calendar yr | 26, End of calendar yr |
| Durable Medical Equip. | Deductible & Coinsurance; Unlimited maximum | Deductible & Coinsurance; Unlimited maximum |
| Out of Network Reasonable & Customary | N/A | 300% of Medicare |
| Pre-certification required | Yes, coordinated by provider/ PCP | Yes, EE responsible |
| Penalty for Failure to Pre-certify | N/A | Lesser of 50% or \$500 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. |

*Many of the above services may require precertification through CIGNA. Day & Visit limits are combined both in and out of network. Please confirm with CIGNA

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