

BENEFIT SUMMARY

Cigna Health and Life Insurance Co.
For - University of New England
Open Access Plus Plan
Enhanced
Effective - 01/01/2024

Selection of a Primary Care Provider - your plan may require or allow the designation of a primary care provider. You have the right to designate any primary care provider who participates in the network and who is available to accept you or your family members. If your plan requires designation of a primary care provider, Cigna may designate one for you until you make this designation. For information on how to select a primary care provider, and for a list of the participating primary care providers, visit www.mycigna.com or contact customer service at the phone number listed on the back of your ID card. For children, you may designate a pediatrician as the primary care provider.

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 in our network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals. For a list of participating health care professionals who specialize in obstetrics or gynecology, visit www.mycigna.com or contact customer service at the phone number listed on the back of your ID card.

Plan Highlights	In-Network	Out-of-Network
Plan Out-of-Pocket Maximum	Individual: \$3,000 Family: \$6,000	Individual: \$3,000 Family: \$6,000
<p>The amount you pay for all covered expenses counts towards both your in-network and out-of-network out-of-pocket maximums.</p> <p>Plan deductible contributes towards your out-of-pocket maximum.</p> <p>All benefit copays/deductibles contribute towards your out-of-pocket maximum.</p> <p>Covered expenses that count towards your out-of-pocket maximum include customer paid coinsurance and charges for Mental Health and Substance Use Disorder. Out-of-network non-compliance penalties or charges in excess of Maximum Reimbursable Charge do not contribute towards the out-of-pocket maximum.</p> <p>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.</p> <p>This plan includes a combined Medical/Pharmacy out-of-pocket maximum.</p>		
Benefit	In-Network	Out-of-Network
Note: Services where plan deductible applies are noted with a caret (^). Benefit copays/deductibles always apply before plan deductible.		
Physician Services - Office Visits		
Primary Care Physician (PCP) Services/Office Visit Plan pays 100% for the initial visit per Calendar Year. Plans First PCP Office Visit per year paid at no charge.	\$20 copay, and plan pays 100%	Plan pays 80% ^
Specialty Care Physician Services/Office Visit	\$20 copay, and plan pays 100%	Plan pays 80% ^
NOTE: Obstetrician and Gynecologist (OB/GYN) visits are subject to either the PCP or Specialist cost share depending on how the provider contracts with Cigna (i.e. as PCP or as Specialist).		
Surgery Performed in Physician's Office	Covered same as Physician Services - Office Visit	Covered same as Physician Services - Office Visit
Allergy Treatment/Injections and Allergy Serum Allergy serum dispensed by the physician in the office	Covered same as Physician Services - Office Visit	Covered same as Physician Services - Office Visit
Note: Office copay does not apply if only the allergy serum is provided.		
Virtual Care		
Dedicated Virtual Providers - MDLIVE		
MDLIVE Urgent Virtual Care Services	\$20 copay, and plan pays 100%	Not Covered
<p>Dedicated Virtual Providers may deliver services that are payable under other benefits (e.g., Preventive Care, Primary Care Physician, Behavioral; Dermatology/Specialty Care Physician).</p> <p>Lab services supporting a virtual visit must be obtained through dedicated labs.</p> <p>Includes charges for the delivery of medical and health-related services and consultations by dedicated virtual providers as medically appropriate through audio, video, and secure internet-based technologies.</p>		

Benefit	In-Network	Out-of-Network
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Note: Services where plan deductible applies are noted with a caret (^). Benefit copays/deductibles always apply before plan deductible.

Virtual Physician Services - Office Visits

Primary Care Physician (PCP) Services/Office Visit

\$20 copay, and plan pays 100%

Plan pays 80% ^

Specialty Care Physician Services/Office Visit

\$20 copay, and plan pays 100%

Plan pays 80% ^

Physicians may deliver services virtually that are payable under other benefits (e.g., Preventive Care, Outpatient Therapy Services).

Includes charges for the delivery of medical and health-related services and consultations as medically appropriate through audio, video, and secure internet-based technologies that are similar to office visit services provided in a face-to-face setting.

NOTE: Obstetrician and Gynecologist (OB/GYN) visits are subject to either the PCP or Specialist cost share depending on how the provider contracts with Cigna (i.e. as PCP or as Specialist).

Preventive Care

Preventive Care

Plan pays 100%

PCP: Plan pays 80% ^

Specialist: Plan pays 80% ^

Includes coverage of additional services, such as urinalysis, EKG, and other laboratory tests, supplementing the standard Preventive Care benefit when billed as part of office visit.

Annual Limit: Unlimited

Immunizations

Plan pays 100%

PCP: Plan pays 80% ^

Specialist: Plan pays 80% ^

Mammogram, PAP, and PSA Tests

Plan pays 100%

Covered same as other x-ray and lab services, based on Place of Service

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 Services

Plan pays 100% ^

Plan pays 80% ^

Note: Includes all Lab and Radiology services, including Advanced Radiological Imaging as well as Medical Specialty Drugs

Inpatient Hospital Physician's Visit/Consultation

Plan pays 100% ^

Plan pays 80% ^

Inpatient Professional Services

Plan pays 100% ^

Plan pays 80% ^

For services performed by Surgeons, Radiologists, Pathologists and Anesthesiologists

Outpatient

Outpatient Facility Services

Plan pays 100% ^

Plan pays 80% ^

Outpatient Professional Services

Plan pays 100% ^

Plan pays 80% ^

For services performed by Surgeons, Radiologists, Pathologists and Anesthesiologists

Emergency Services

Emergency Room

Includes Professional, X-ray and/or Lab services performed at the Emergency Room and billed by the facility as part of the ER visit.

Per visit copay is waived if admitted.

Benefit	In-Network	Out-of-Network
Note: Services where plan deductible applies are noted with a caret (^). Benefit copays/deductibles always apply before plan deductible.		
Urgent Care Facility		
Includes Professional, X-ray and/or Lab services performed at the Urgent Care Facility and billed by the facility as part of the urgent care visit.	\$20 copay, and plan pays 100%	\$20 copay, and plan pays 100%
Ambulance		
Ambulance services used as non-emergency transportation (e.g., transportation from hospital back home) generally are not covered.		
Inpatient Services at Other Health Care Facilities		
Skilled Nursing Facility, Rehabilitation Hospital, Sub-Acute Facilities		
Annual Limit: 150 days	Plan pays 100% ^	Plan pays 80% ^
Laboratory Services		
Physician's Services/Office Visit		
	Plan pays 100% ^	Plan pays 80% ^

Benefit

In-Network

Out-of-Network

01/01/2024

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Benefit	In-Network	Out-of-Network
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Note: Services where plan deductible applies are noted with a caret (^). Benefit copays/deductibles always apply before plan deductible.

Infertility

Infertility Treatment

Coverage varies based on Place of Service

Coverage varies based on Place of Service

Infertility covered services: lab and radiology test, counseling, surgical treatment, includes artificial insemination, in-vitro fertilization, GIFT, ZIFT, etc.

Lifetime Maximum: Unlimited

Other Health Care Facilities/Services

Home Health Care

Plan pays 100% ^

Plan pays 80% ^

Annual Limit: Unlimited

16 hour maximum per day

Note: Includes outpatient private duty nursing when approved as medically necessary

Organ Transplants

Inpatient Hospital Facility Services

LifeSOURCE Facility

Plan pays 100%

Plan pays 80% ^

Non-LifeSOURCE Facility

Plan pays 80%

Plan pays 80% ^

Inpatient Professional Services

LifeSOURCE Facility

Plan pays 100%

Plan pays 80% ^

Covered same as plan's Inpatient Professional benefit up to the following transplant maximums:

Non-LifeSOURCE Facility

Covered same as plan's Inpatient Professional benefit

- Bone Marrow - \$130,000
- Heart - \$150,000
- Heart/Lung - \$185,000
- Kidney - \$80,000
- Kidney/Pancreas - \$80,000
- Liver - \$230,000
- Lung - \$185,000
- Pancreas - \$50,000

Travel Maximum - Cigna LifeSOURCE Transplant Network® Facility Only: \$10,000 maximum per Transplant per Lifetime

Durable Medical Equipment

Annual Limit: Unlimited

Plan pays 100%

Plan pays 80% ^

Diabetic Pumps and Supplies

Annual Limit: Unlimited

Plan pays 100%

Plan pays 80% ^

Benefit

In-Network

Out-of-Network

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Pharmacy

In-Network

Out-of-Network

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Pharmacy Program Information

Pharmacy Clinical Management: Essential

Your plan features drug management programs and edits to ensure safe prescribing, and access to medications proven to be the most reliable and cost effective for the medical condition, including:

- Prior authorization requirements

- Step Therapy on select classes of medications and drugs new to the market

- Quantity limits, including maximum daily dose edits, quantity over time edits, duration of therapy edits, and dose optimization edits

- Age edits, and refill-too-soon edits

- Plan exclusion edits

Current users of Step Therapy medications will be allowed one 30-day fill during the first three months of coverage before Step Therapy program applies.

Your plan includes Specialty Drug Management features, such as prior authorization and quantity limits, to ensure the safe prescribing and access to specialty medications.

For customers with complex conditions taking a specialty medication, we will offer Accredo Therapeutic Resource Centers (TRCs) to provide specialty medication and condition counseling. For customers taking a specialty medication not dispensed by Accredo, Cigna experts will offer this important specialty medication and condition counseling.

Patient Assurance Program

Your plan includes the Patient Assurance Program, which waives the deductible and reduces the amount you owe for certain of the provide specialty

medication and condition counseliion coutr and a chron0019962 35.49700165 cm BT /FAAABF 10 .59997559 60.8429985s(d reduci)66d Prior authorization requ

Additional Information

Maximum Reimbursable Charge

The allowable covered expense for non-network services is based on the lesser of the health care professional's normal charge for a similar service or a percentage of a fee schedule (200%) developed by Cigna that is based on a methodology similar to one used by Medicare to determine the allowable fee for the same or similar service in a geographic area. In some cases, the Medicare based fee schedule will not be used and the maximum reimbursable charge for covered services is based on the lesser of the health care professional's normal charge for a similar service or a percentile (80th) of charges made by health care professionals of such service or supply in the geographic area where it is received. If sufficient charge data is unavailable in the database for that geographic area to determine the Maximum Reimbursable Charge, then data in the database for similar services may be used. Out-of-network services are subject to a Calendar Year deductible and maximum reimbursable charge limitations.

Out-of-Network Emergency Services Charges

1. Emergency Services are covered at the In-Network cost-sharing level as required by applicable state or federal law if services are received from a non-participating (Out-of-Network) provider.
2. The allowable amount used to determine the maximum reimbursable charge for Out-of-Network Emergency Services is based on the lesser of the health care professional's normal charge for a similar service or a percentile (80th) of charges made by health care professionals of such service or supply in the geographic area where it is received. If sufficient charge data is unavailable in the database for that geographic area to determine the Maximum Reimbursable Charge, then data in the database for similar services may be used. Out-of-network services are subject to a Calendar Year deductible and maximum reimbursable charge limitations.

Additional Information

Pre-Certification - Continued Stay Review - Preferred Care Management Inpatient - required for all inpatient admissions

In-Network: Coordinated by your physician

Out-of-Network: Customer is responsible for contacting Cigna Healthcare. Subject to penalty/reduction or denial for non-compliance.

The 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.

Pre-Certification - Preferred Care Management Outpatient Prior Authorization - required for selected outpatient procedures and diagnostic testing

In-Network: Coordinated by your physician

Out-of-Network: Customer is responsible for contacting Cigna Healthcare. Subject to penalty/reduction or denial for non-compliance.

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 doctor's visits or 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.

Place of Service - Your plan pays based on where you receive services. For example, for hospital stays, your coverage is paid at the inpatient level.

Prescription Drug List - The list of prescription brand and generic drugs covered by your pharmacy plan.

Professional Services - Services performed by Surgeons, Assistant Surgeons, Hospital Based Physicians, Radiologists, Pathologists and Anesthesiologists

Transition of Care - Provides in-network health coverage to new customers when the customer's doctor is not part of the Cigna network and there are approved clinical reasons why the customer should continue to see the same doctor.

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):

Exclusions

- supplies, treatments, procedures, drug or Biologic therapies or devices that are determined by the utilization review Physician to be:
- o Not approved by the U.S. Food and Drug Administration (FDA) or other appropriate regulatory agency to be lawfully marketed;
 - o 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;
 - o The subject of review or approval by an Institutional Review Board for the proposed use except as provided in the "Clinical Trials" sections of this plan.
 - o In determining whether any such technologies, supplies, treatments, drug or Biologic therapies, or devices are experimental, investigational, and/or unproven, the utilization review Physician may rely on the clinical coverage policies maintained by Cigna or the Review Organization. Clinical coverage policies may incorporate, without limitation and as applicable, criteria relating to U.S. Food and Drug Administration-approved labeling, the standard medical reference compendia and peer-reviewed, evidence-based scientific literature or guidelines.

Cosmetic surgery and therapies. Cosmetic surgery or therapy is defined as surgery or therapy performed to improve or alter appearance or self-esteem. The following services are excluded from coverage regardless of clinical indications: macromastia or gynecomastia surgeries (except as specifically provided for in Covered Expenses); surgical treatment of varicose veins (except as specifically provided for in Covered Expenses); abdominoplasty; panniculectomy; rhinoplasty; blepharoplasty; redundant skin surgery; removal of skin tags; acupressure; craniosacral/cranial therapy; dance therapy, movement therapy; applied kinesiology; rolfing; prolotherapy; and extracorporeal shock wave lithotripsy (ESWL) for musculoskeletal and orthopedic conditions.

Surgical and non-surgical treatment of Temporomandibular Joint Dysfunction (TMJ).

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. However, charges made for services or supplies provided for or in connection with an accidental Injury to teeth are covered.

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 appearance 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.

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, unless otherwise covered in this plan.

Court-ordered treatment or hospitalization, unless treatment is prescribed by a Physician and is a covered service or supply under this plan.

Reversal of male and female voluntary sterilization procedures.

Medical and Hospital care and costs for the child of your Dependent child, unless the child is otherwise eligible under this plan.

Non-medical counseling and/or ancillary services including, but not limited to, Custodial Services, educational services, vocational counseling training and rehabilitation services, behavioral training, biofeedback, neurofeedback, hypnosis, sleep therapy, return to work services, work hardening programs, and driver safety courses.

Consumable medical supplies other than ostomy supplies and urinary catheters. Excluded supplies include, but are not limited to bandages and other

Exclusions

cataract surgery.

Eye exercises and surgical treatment for the correction of a refractive error, including radial keratotomy.

Acupuncture.

All non-injectable prescription drugs unless Physician administration or oversight is required, injectable prescription drugs to the extent they do not require Physician supervision and are typically considered self-administered drugs, non-prescription drugs, and investigational and experimental drugs, except as provided in this plan.

Products and supplies associated with the administration of medications that are available to be covered under the Prescription Drug Benefit. Such products and supplies include but are not limited to therapeutic Continuous Glucose Monitor (CGM) sensors and transmitters and insulin pods.

Routine foot care, including the paring and removing of corns and calluses and toenail maintenance. However, foot care services for diabetes, peripheral neuropathies and peripheral

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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. (TTY: dial 711)

Spanish – ATENCION: Los servicios de asistencia lingüística, 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：我們為您免費提供語言協助服務。如果您目前的現有客戶，請致電您ID卡背面的號碼。其他客戶請致電1.800.244.6224 (TTY: 711)。

Vietnamese – CHÚ Ý: Quý khách có thể nhận được dịch vụ hỗ trợ 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: Quay số 711).

Korean – 주의: 하중을 사용하시는 경우, Cigna 지원 서비스를 무료로 이용하실 수 있습니다. 현재 Cigna 가입자 분들께는 ID 카드 뒷면에 있는 번호를 호출하십시오. 기타 다른 경우 1.800.244.6224 (TTY: 다이얼 711번으로 전화해 주십시오).

Tagalog – PAUNANG: Makakakuha ka ng mga libre sa wika nang tulong sa wika nang libre. Para sa mga kasalukuyang ang mga ng Cigna, tawagan ang numero sa likuran ng iyong ID card. O kaya, tumawag sa 1.800.244.6224 (TTY: I-dial ang 711).

Russian – Внимание: Услуги перевода доступны бесплатно. Если вы не являетесь участником одного из наших планов, 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: 711).

Arabic – Cigna حارة الانتباه خدمات الله حمة المجانية، مجاناً. الحاليين برجاء الاتصال بالرقم المدون علي ظهر بطاقتكم الشخصية. او اتصل ب (1.800.244.6224 (TTY: اتصل ب 711).

French – ATTENTION: Des services d'aide linguistique vous sont disponibles gratuitement. Si vous êtes un client actuel de Cigna, veuillez appeler le numéro indiqué au verso de votre carte d'identité. Sinon, veuillez appeler le numéro 1.800.244.6224 (ATS : composez le numéro 711).

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

Polish – UWAGA: Aby skorzystać z darmowej pomocy językowej, obecni klienci firmy Cigna mogą dzwonić pod numer podany na odwrocie karty identyfikacyjnej. Wszystkie inne osoby korzystanie 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Cignaのお客さまは、IDカード裏面の電話番号よりご連絡ください。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 gratuita. Per i clienti Cigna attuali, chiamare il numero sul retro della tessera di identificazione. In caso contrario, chiamare il numero 1.800.244.6224 (utente TTY: chiamare il numero 711).

Cigna-Kunde sind, rufen Sie bitte 1.800.244.6224 (TTY: wählen Sie 711).

خدمات لغوی رایجی، به صورت رایجی، به شما ارائه می شود. برای Cigna، لطفاً به هر کس کارت شناسایی شماست تماس بگیرد. اگر غیر اینصورت یا شماره 1.800.244.6224 تماس بگیرد (شماره تلفن ویژه ناشنوايان: شماره 711 را شمار دیگری کنید).