

SUMMARY OF BENEFITS Connecticut General Life Insurance Co.



Mount St. Mary's University Health Reimbursement Arrangement Open Access Plus Coinsurance Plan

Notice of Grandfathered Plan Status

This plan is being treated as a "grandfathered health plan" under the Patient Protection and Affordable Care Act (the Affordable Care Act). As permitted by the Affordable Care Act, a grandfathered health plan can preserve certain basic health coverage that was already in effect when that law was enacted. Being a grandfathered health plan means that your coverage may not include certain consumer protections of the Affordable Care Act that apply to other plans, for example, the requirement for the provision of preventive health services without any cost sharing. However, grandfathered health plans must comply with certain other consumer protections in the Affordable Care Act, for example, the elimination of lifetime limits on benefits.

Questions regarding which protections apply and which protections do not apply to a grandfathered health plan and what might cause a plan to change from grandfathered health plan status can be directed to the plan administrator at the phone number or address provided in your plan documents, to your employer or plan sponsor or an explanation can be found on Cigna's website at http://www.cigna.com/sites/healthcare_reform/customer.html.

If your plan is subject to ERISA, you may also contact the Employee Benefits Security Administration, U.S. Department of Labor at 1-866-444-3272 or www.dol.gov/ebsa/healthreform. This website has a table summarizing which protections do and do not apply to grandfathered health plans.

If your plan is a nonfederal government plan or a church plan, you may also contact the U.S. Department of Health and Human Services at www.healthreform.gov.

Health Reimbursement Account

Your employer has established a health reimbursement account that you can use to pay for eligible out-of-pocket expenses during the calendar year.

Employer Contribution	Employee	Employee + 1	Family
	\$750	\$1,500	\$2,250

Annual deductibles and maximums	In-network	Out-of-network
Lifetime maximum	Unlimited	
Pre-Existing Condition Limitation (PCL)	Not Applicable	
Coinsurance	You pay 20% Plan pays 80% after the plan deductible is met	You pay 40% Plan pays 60% after the plan deductible is met
Maximum Reimbursable Charge <ul style="list-style-type: none"> Determined based on the lesser of: <ul style="list-style-type: none"> the health care professional's normal charge for a similar service; or a percentile of the amount charged by health care professionals in the geographic area where the service is received. Out-of-network services are subject to a calendar year plan deductible and maximum reimbursable charge limitations. 	N/A	80 th Percentile

Annual deductibles and maximums	In-network	Out-of-network
<p>Calendar year plan deductible</p> <ul style="list-style-type: none"> The amount you pay for out-of-network services counts towards both your in-network and out-of-network plan deductibles. (One way accumulation). All family members contribute towards the family plan deductible. The plan cannot pay an individual's claims until the total family plan deductible has been met, even if he or she has met the individual plan deductible. This plan includes a combined Medical/Rx plan deductible. Out-of-network pharmacy plan deductible accumulates to the in-network pharmacy plan deductible. Home delivery pharmacy costs contribute to the plan deductible. 	<p>Employee \$1,000</p> <p>Employee + 1 \$2,000</p> <p>Employee and Family \$3,000</p>	<p>Employee \$1,000</p> <p>Employee + 1 \$2,000</p> <p>Employee and Family \$3,000</p>
<p>Calendar year out-of-pocket maximum</p> <ul style="list-style-type: none"> The amount you pay for out-of-network services counts towards both your in-network and out-of-network out-of-pocket maximums. (One way accumulation) Plan deductibles contribute towards your out-of-pocket maximum. Mental health and substance abuse services contribute towards your out-of-pocket maximum. All family members contribute towards the family out-of-pocket maximum. The plan cannot pay an individual's covered expenses at 100% until the total family out-of-pocket maximum has been reached. This plan includes a combined Medical/Rx out-of-pocket maximum. Out-of-network pharmacy out-of-pocket expenses accumulates to the in-network pharmacy out-of-pocket maximum. Home delivery pharmacy costs contribute to the out-of-pocket maximum. 	<p>Employee \$2,000</p> <p>Employee + 1 \$4,000</p> <p>Employee and Family \$6,000</p>	<p>Employee \$2,000</p> <p>Employee + 1 \$4,000</p> <p>Employee and Family \$6,000</p>

Benefits	In-network	Out-of-network
Physician services		
<p>Office visit</p> <ul style="list-style-type: none"> Primary care physician and specialist office visits 	<p>You pay 20% Plan pays 80% after the plan deductible is met</p>	<p>You pay 40% Plan pays 60% after the plan deductible is met</p>
<p>Physician services (hospital)</p> <ul style="list-style-type: none"> In hospital visits and consultations Inpatient services Outpatient services 	<p>You pay 20% Plan pays 80% after the plan deductible is met</p>	<p>You pay 40% Plan pays 60% after the plan deductible is met</p>

Benefits	In-network	Out-of-network
Surgery (in a physician's office)	You pay 20% Plan pays 80% after the plan deductible is met	You pay 40% Plan pays 60% after the plan deductible is met
Preventive care		
Preventive care <ul style="list-style-type: none"> Includes well-baby, well-child, well-woman and adult preventive care In-network immunizations are included at no charge. Unlimited calendar year maximum 	No charge, no plan deductible	No charge, no plan deductible
Mammogram, PSA, Pap Smear and Maternity Screening <ul style="list-style-type: none"> 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. 	No charge, no plan deductible	No charge, no plan deductible
Inpatient hospital facility services		
Semi-private room and board and other non-physician services <ul style="list-style-type: none"> Inpatient room and board, pharmacy, x-ray, lab, operating room, surgery, etc. 	You pay 20% Plan pays 80% after the plan deductible is met	You pay 40% Plan pays 60% after the plan deductible is met
Inpatient Professional Services <ul style="list-style-type: none"> For services performed by surgeons, radiologists, pathologists and anesthesiologists 	You pay 20% Plan pays 80% after the plan deductible is met	You pay 40% Plan pays 60% after the plan deductible is met
Multiple surgical reduction <ul style="list-style-type: none"> 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. 	Included	Included
Outpatient services		
Outpatient surgery (facility charges)	You pay 20% Plan pays 80% after the plan deductible is met	You pay 40% Plan pays 60% after the plan deductible is met
Outpatient Professional Services <ul style="list-style-type: none"> For services performed by surgeons, radiologists, pathologists and anesthesiologists 	You pay 20% Plan pays 80% after the plan deductible is met	You pay 40% Plan pays 60% after the plan deductible is met

Benefits	In-network	Out-of-network
<p>Physical, occupational, cognitive and speech therapy</p> <ul style="list-style-type: none"> Limited to 60 days per calendar year for all therapies combined Includes physical therapy, speech therapy, occupational therapy, pulmonary rehabilitation and cognitive therapy Includes chiropractic therapy (includes chiropractors) Includes cardiac rehabilitation Therapy days, provided as part of an approved Home Health Care plan, accumulate to the outpatient short term rehab therapy maximum. 	<p>You pay 20% Plan pays 80% after the plan deductible is met</p>	<p>You pay 40% Plan pays 60% after the plan deductible is met</p>
Lab and X-ray		
<p>Lab and X-ray</p> <ul style="list-style-type: none"> Physician's office Outpatient hospital facility Independent lab & x-ray facility 	<p>You pay 20% Plan pays 80% after the plan deductible is met</p>	<p>You pay 40% Plan pays 60% after the plan deductible is met</p>
<p>Lab and X-ray, emergency room and urgent care</p> <ul style="list-style-type: none"> Emergency room when billed by the facility as part of the emergency room visit Urgent care when billed by the facility as part of the urgent care visit. Independent x-ray and/or lab facility in conjunction with a emergency room visit 	<p>You pay 20% Plan pays 80% after the in-network plan deductible is met</p>	
<p>Advanced radiological imaging (MRI, MRA, CAT Scan, PET Scan, etc.)</p> <ul style="list-style-type: none"> Physician's office Inpatient hospital facility Outpatient facility 	<p>You pay 20% Plan pays 80% after the plan deductible is met Prior Authorization Required</p>	<p>You pay 40% Plan pays 60% after the plan deductible is met Prior Authorization Required</p>
<p>Advanced radiological imaging (MRI, MRA, CAT Scan, PET Scan, etc.)</p> <ul style="list-style-type: none"> Emergency room Urgent care facility 	<p>You pay 20% Plan pays 80% after the in-network plan deductible is met</p>	
Emergency and urgent care services		
<p>Hospital emergency room</p> <ul style="list-style-type: none"> Includes radiology, pathology and physician charges Out-of-network services are covered at the in-network rate. 	<p>You pay 20% Plan pays 80% after the in-network plan deductible is met</p>	
<p>Ambulance</p> <ul style="list-style-type: none"> Out-of-network services are covered the same as in-network services. Note: Non-emergency transportation (e.g. from hospital back home) is generally not covered. 	<p>You pay 20% Plan pays 80% after the in-network plan deductible is met</p>	

Benefits	In-network	Out-of-network
Urgent care services <ul style="list-style-type: none"> Out-of-network services are covered at the in-network rate. 	<p>You pay 20% Plan pays 80% after the in-network plan deductible is met</p>	
Other health care facilities		
Skilled nursing facility, rehabilitation hospital and other facilities <ul style="list-style-type: none"> 60 days per calendar year 	<p>You pay 20% Plan pays 80% after the plan deductible is met</p>	<p>You pay 40% Plan pays 60% after the plan deductible is met</p>
Home health care <ul style="list-style-type: none"> Unlimited days per calendar year 	<p>You pay 20% Plan pays 80% after the plan deductible is met</p>	<p>You pay 40% Plan pays 60% after the plan deductible is met</p>
Hospice <ul style="list-style-type: none"> Inpatient services Outpatient services 	<p>You pay 20% Plan pays 80% after the plan deductible is met</p>	<p>You pay 40% Plan pays 60% after the plan deductible is met</p>
Other health care services		
Durable medical equipment <ul style="list-style-type: none"> Unlimited calendar year maximum 	<p>You pay 20% Plan pays 80% after the plan deductible is met</p>	<p>You pay 40% Plan pays 60% after the plan deductible is met</p>
External prosthetic appliances (EPA) <ul style="list-style-type: none"> An additional \$200 calendar year EPA annual deductible is applied in addition to the regular calendar year plan deductible to both in-network and out-of-network services. Unlimited calendar year maximum 	<p>You pay 20% Plan pays 80% after the EPA annual deductible and the plan deductible are met</p>	<p>You pay 40% Plan pays 60% after the EPA annual deductible and the plan deductible are met</p>
TMJ <ul style="list-style-type: none"> Doctor's Office Inpatient Facility Outpatient Facility Physician's Services 	<p>You pay 20% Plan pays 80% after the plan deductible is met</p>	<p>You pay 40% Plan pays 60% after the plan deductible is met</p>
Maternity Care Services <ul style="list-style-type: none"> Covers maternity for employee or dependent spouse. 	<p>You pay 20% Plan pays 80% after the plan deductible is met</p>	<p>You pay 40% Plan pays 60% after the plan deductible is met</p>

Benefits	In-network	Out-of-network
<p>Infertility</p> <ul style="list-style-type: none"> Office visit for testing, treatment and artificial insemination Inpatient hospital facility Outpatient hospital facility Physician services <p>Benefit Description: <i>Services related to diagnosis of infertility and treatment of infertility (both male and female) once a condition of infertility has been diagnosed. Services include, but are not limited to: infertility drugs which are administered or provided by a participating Provider; approved surgeries and other therapeutic procedures that have been demonstrated in existing peer-reviewed, evidence-based, scientific literature to have a reasonable likelihood of resulting in pregnancy; laboratory tests; sperm washing or preparation; diagnostic evaluations; gamete intrafallopian transfer (GIFT); in vitro fertilization (IVF); zygote intrafallopian transfer (ZIFT); and the services of an embryologist. Excludes infertility services when the infertility is caused by or related to voluntary sterilization; donor charges and services; cryopreservation of donor sperm and eggs; and any experimental, investigational or unproven infertility procedures or therapies.</i></p> <p><i>Limited to 3 attempts per live birth, and \$100,000 lifetime maximum benefit.</i></p> <p><i>All other infertility treatment limited to a lifetime maximum of \$20,000</i></p> <p><i>Must have 2 year History of Infertility. Two year requirement may be waived if infertility is caused by: (a) endometriosis; (b) exposure in utero to diethylstilbestrol; (c) blockage of one or both fallopian tubes; or (d) abnormal male factors, including oligospermia. Sperm Must Be Provided by Employee's or Dependent Wife's Husband and Embryo Must Be Carried by Employee or Dependent Wife.</i></p>	<p>You pay 20% Plan pays 80% after the plan deductible is met</p>	<p>You pay 40% Plan pays 60% after the plan deductible is met</p>
<p>Family planning</p> <ul style="list-style-type: none"> Inpatient hospital facility Outpatient facility Physician services <p>Benefit Description: <i>Includes: Medical history, physical examination, related laboratory tests (billed by the physician), medical supervision in accordance with generally accepted medical practice. Services will be covered as any other illness.</i></p>	<p>You pay 20% Plan pays 80% after the plan deductible is met</p>	<p>You pay 40% Plan pays 60% after the plan deductible is met</p>

Benefits	In-network	Out-of-network
Mental health and substance abuse services		
<p>Please note the following regarding Mental Health (MH) and Substance Abuse (SA) benefit administration:</p> <ul style="list-style-type: none"> Substance Abuse includes Alcohol and Drug Abuse services. Transition of Care benefits are provided for a 90-day time period. 		
<p>Inpatient mental health services</p> <ul style="list-style-type: none"> Unlimited days per calendar year Mental health services are paid at 100% after you reach your out-of-pocket maximum. 	<p>You pay 20% Plan pays 80% after the plan deductible is met</p>	<p>You pay 40% Plan pays 60% after the plan deductible is met</p>
<p>Outpatient mental health physician's office services</p> <ul style="list-style-type: none"> Unlimited visits per calendar year Mental health services are paid at 100% after you reach your out-of-pocket maximum. This includes individual, group therapy mental health and intensive outpatient mental health 	<p>You pay 20% Plan pays 80% after the medical plan deductible is met</p>	<p>You pay 40% Plan pays 60% after the medical plan deductible is met</p>
<p>Outpatient mental health facility services</p> <ul style="list-style-type: none"> Unlimited visits per calendar year Mental health services are paid at 100% after you reach your out-of-pocket maximum. This includes individual, group therapy mental health, and intensive outpatient mental health 	<p>You pay 20% Plan pays 80% after the plan deductible is met</p>	<p>You pay 40% Plan pays 60% after the plan deductible is met</p>
<p>Inpatient substance abuse services</p> <ul style="list-style-type: none"> Unlimited days per calendar year Substance abuse services are paid at 100% after you reach your out-of-pocket maximum. 	<p>You pay 20% Plan pays 80% after the plan deductible is met</p>	<p>You pay 40% Plan pays 60% after the plan deductible is met</p>
<p>Outpatient substance abuse physician's office services</p> <ul style="list-style-type: none"> Unlimited visits per calendar year Substance abuse services are paid at 100% after you reach your out-of-pocket maximum. This includes individual and intensive outpatient substance abuse 	<p>You pay 20% Plan pays 80% after the medical plan deductible is met</p>	<p>You pay 40% Plan pays 60% after the medical plan deductible is met</p>
<p>Outpatient substance abuse facility services</p> <ul style="list-style-type: none"> Unlimited visits per calendar year Substance abuse services are paid at 100% after you reach your out-of-pocket maximum. This includes individual and intensive outpatient substance abuse 	<p>You pay 20% Plan pays 80% after the plan deductible is met</p>	<p>You pay 40% Plan pays 60% after the plan deductible is met</p>

Benefits	In-network	Out-of-network
Prescription Drugs		
<p>Cigna Pharmacy four-tier coinsurance plan</p> <ul style="list-style-type: none"> No mandatory generics Self administered injectables (e.g. injectable drugs used to treat rheumatoid arthritis, hepatitis C, multiple sclerosis, asthma) Self administered injectable and optional injectable drugs –includes infertility drugs Prescription smoking cessation drugs included Prescription vitamins included Oral fertility drugs included 	<p>Retail (30 or 90 day supply) You pay: Generic 30% Preferred brand 40% Non-preferred brand 50% Specialty Drugs 20% (\$100 maximum)</p> <p>Home Delivery (90 day supply) You pay: Generic 20% Preferred brand 30% Non-preferred brand 40% Specialty Drugs 20% (\$200 maximum)</p>	<p>You pay 50% Plan pays 50%</p> <p>Out of Network Home Delivery Drugs Not Covered</p>
<p>Pharmacy Clinical Management and Prior Authorization</p> <ul style="list-style-type: none"> Your plan is subject to certain clinical edits and prior authorization requirements. 		
<p>Specialty Pharmacy</p> <ul style="list-style-type: none"> Clinical Programs <ul style="list-style-type: none"> Prior authorization required on specialty medications and quantity limits may apply. TheraCare® Program Medication Access Option: Retail and/or Home Delivery 		
Vision care	Not covered	

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.

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.

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.

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.

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.

Maximizing your health care dollars

Log on to myCigna.com for resources to help you choose a health care professional or compare the cost and quality of medical services, medications and hospital care.

When you need a medical service or procedure, Cigna offers you opportunities to save on prescription medicine, routine medical care, laboratory services, radiology scans, and outpatient surgery. Details are below:

Cigna Home Delivery Pharmacy – You can save money and enjoy convenient home delivery by using Cigna Home Delivery Pharmacy for your prescription medications. You can get up to a 90-day supply of your medication.

Lab – Save on lab services by using a free-standing laboratory instead of a hospital- or clinic-based lab.

Urgent Care – For non-emergency conditions that need attention before you can see your doctor, you can save money by going to an urgent care center instead of an Emergency Room (ER).

Convenience Care – For minor or routine conditions, go to a Convenience Care Clinic when your doctor is unavailable. Convenience Care Clinics are retail-based and often found in pharmacies or grocery stores.

Radiology – Costs for MRIs, PET, and CT scans can vary greatly. Non-hospital based outpatient radiology centers often cost much less than a hospital. Cigna's network includes both hospitals and outpatient centers, so you can find a radiology center that's right for you.

Outpatient Surgery – Costs for colonoscopies, arthroscopies, and other outpatient procedures can vary greatly. Using a free-standing outpatient surgery center can save hundreds of dollars.

Exclusions

What's Not Covered (*not all-inclusive*):

Your plan provides coverage for most medically necessary services. Examples of things your plan does not cover, unless required by law or covered under the pharmacy benefit, include (but aren't limited to):

- 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
- Non-prescription and anti-obesity drugs
- Custodial and other non-skilled services
- Weight loss programs
- Hearing aids
- Acupuncture
- Travel immunizations
- Telephone, email and internet consultations in the absence of a specific benefit
- Eyeglass lenses and frames, contact lenses and surgical vision correction

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.

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