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

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

CERTIFICATE RIDER

No. CR7BI025-3

Policyholder: University of New England

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

Policy No. or Nos. 3332272-OPINB

EFFECTIVE DATE: January 1, 2017

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 page in your certificate coded HC-TRM1 V1 M is replaced by the page coded HC-TRM1 V1 M attached to this certificate rider. THE SCHEDULE — Open Access Plus In-Network 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 In-Network Medical Benefits

The Schedule

For You and Your Dependents

Open Access Plus In-Network Medical Benefits provide coverage for care In-Network. To receive Open Access Plus In-Network 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 the services received. 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

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%.

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
Lifetime Maximum	Unlimited
The Percentage of Covered Expenses the Plan Pays **Note:** "No charge" means an insured person is not required to pay Coinsurance.	80%
Calendar Year Deductible Individual Family Maximum 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.	 $350 per person $700 per family
Out-of-Pocket Maximum Individual Family Maximum 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%.	 $3,000 per person $6,000 per family

BENEFIT HIGHLIGHTS	IN-NETWORK
Combined Medical/Pharmacy Out-of-Pocket Maximum	
Combined Medical/Pharmacy Out-of-Pocket: includes retail and home delivery prescription drugs	Yes
Home Delivery Pharmacy Costs Contribute to the Combined Medical/Pharmacy Out-of-Pocket Maximum	Yes
Physician's Services	
Primary Care Physician's Office Visit	No charge after $25 per office visit copay
Specialty Care Physician's Office Visits	No charge after $50 per office visit copay
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 $25 PCP or $50 Specialist per office visit copay
Second Opinion Consultations (provided on a voluntary basis)	No charge after the $25 PCP or $50 Specialist per office visit copay
Allergy Treatment/Injections	No charge after either the $25 PCP or $50 Specialist per office visit copay or the actual charge, whichever is less
Allergy Serum (dispensed by the Physician in the office)	No charge
Preventive Care	
Routine Preventive Care - all ages	No charge
Immunizations - all ages	No charge
Mammograms, PSA, PAP Smear	
Preventive Care Related Services (i.e. "routine" services)	No charge
Diagnostic Related Services (i.e. "non-routine" services)	Subject to the plan's x-ray & lab benefit; based on place of service
Inpatient Hospital - Facility Services	80% after plan deductible
Semi-Private Room and Board	Limited to the semi-private negotiated rate
Private Room	Limited to the semi-private negotiated rate
Special Care Units (ICU/CCU)	Limited to the negotiated rate
Outpatient Facility Services Operating Room, Recovery Room, Procedures Room, Treatment Room and Observation Room	80% after plan deductible
Inpatient Hospital Physician's Visits/Consultations	80% after plan deductible

BENEFIT HIGHLIGHTS	IN-NETWORK
Inpatient Hospital Professional Services Surgeon Radiologist Pathologist Anesthesiologist	80% after plan deductible
Outpatient Professional Services Surgeon Radiologist Pathologist Anesthesiologist	80% after plan deductible
Emergency and Urgent Care Services	
Physician's Office Visit	No charge after the $25 PCP or $50 Specialist per office visit copay
Hospital Emergency Room	No charge after $100 per visit copay* and plan deductible *waived if admitted
Outpatient Professional services (radiology, pathology and ER Physician)	No charge after plan deductible
Urgent Care Facility or Outpatient Facility	No charge after $50 per visit copay* *waived if admitted
X-ray and/or Lab performed at the Emergency Room (billed by the facility as part of the ER visit)	No charge after plan deductible
X-ray and/or Lab performed at the Urgent Care Facility (billed by the facility as part of the UC visit)	No charge
Independent x-ray and/or Lab Facility in conjunction with an ER visit	No charge after plan deductible
Advanced Radiological Imaging (i.e. MRIs, MRAs, CAT Scans, PET Scans etc.) for ER	No charge after plan deductible
Advanced Radiological Imaging (i.e. MRIs, MRAs, CAT Scans, PET Scans etc.) for UC	No charge
Ambulance	No charge after plan deductible
Inpatient Services at Other Health Care Facilities Includes Skilled Nursing Facility, Rehabilitation Hospital and Sub-Acute Facilities Calendar Year Maximum: Unlimited	80% after plan deductible

BENEFIT HIGHLIGHTS	IN-NETWORK
Laboratory and Radiology Services (includes pre-admission testing)	
Physician's Office Visit	No charge after the $25 PCP or $50 Specialist per office visit copay
Outpatient Hospital Facility	80% after plan deductible
Independent X-ray and/or Lab Facility	80% after plan deductible
Advanced Radiological Imaging (i.e. MRIs, MRAs, CAT Scans and PET Scans)	
Physician's Office Visit	No charge
Inpatient Facility	80% after plan deductible
Outpatient Facility	80% after plan deductible
Outpatient Short-Term Rehabilitative Therapy and Chiropractic Services 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 Chiropractic Therapy (includes Chiropractors)	No charge after the $25 PCP or $50 Specialist per office visit copay **Note:** Outpatient Short Term Rehab copay applies, regardless of place of service, including the home.
Home Health Care Calendar Year Maximum: Unlimited (includes outpatient private nursing when approved as Medically Necessary)	No charge after plan deductible
Hospice	
Inpatient Services	No charge
Outpatient Services	No charge
Bereavement Counseling Services Provided as part of Hospice Care	
Inpatient	No charge
Outpatient	No charge
Services Provided by Mental Health Professional	Covered under Mental Health benefit

BENEFIT HIGHLIGHTS	IN-NETWORK
Maternity Care Services	
Initial Visit to Confirm Pregnancy **Note:** OB/GYN providers will be considered either as a PCP or Specialist, depending on how the provider contracts with the Insurance Company.	No charge after the $25 PCP or $50 Specialist per office visit copay
All subsequent Prenatal Visits, Postnatal Visits and Physician's Delivery Charges (i.e. global maternity fee)	80% 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 $25 PCP or $50 Specialist per office visit copay
Delivery - Facility (Inpatient Hospital, Birthing Center)	80% after plan deductible
Abortion Includes elective and non-elective procedures	
Physician's Office Visit	No charge after the $25 PCP or $50 Specialist per office visit copay
Inpatient Facility	80% after plan deductible
Outpatient Facility	80% after plan deductible
Physician's Services	80% after plan deductible
Women's Family Planning Services	
Office Visits, Lab and Radiology Tests and Counseling **Note:** Includes coverage for contraceptive devices (e.g., Depo-Provera and Intrauterine Devices (IUDs)) as ordered or prescribed by a physician. Diaphragms also are covered when services are provided in the physician's office.	No charge
Surgical Sterilization Procedures for Tubal Ligation (excludes reversals)	
Physician's Office Visit	No charge
Inpatient Facility	No charge
Outpatient Facility	No charge
Physician's Services	No charge

BENEFIT HIGHLIGHTS	IN-NETWORK
Men's Family Planning Services	
Office Visits, Lab and Radiology Tests and Counseling	No charge after the $25 PCP or $50 Specialist per office visit copay
Surgical Sterilization Procedures for Vasectomy (excludes reversals)	
Physician's Office Visit	No charge after the $25 PCP or $50 Specialist per office visit copay
Inpatient Facility	80% after plan deductible
Outpatient Facility	80% after plan deductible
Physician's Services	80% after plan deductible
Infertility Treatment 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. Surgical Treatment: Limited to procedures for the correction of infertility (excludes In-vitro, GIFT, ZIFT, etc.)	
Physician's Office Visit (Lab and Radiology Tests, Counseling)	No charge after the $25 PCP or $50 Specialist per office visit copay
Inpatient Facility	80% after plan deductible
Outpatient Facility	80% after plan deductible
Physician's Services	80% after plan deductible
Organ Transplants Includes all medically appropriate, non-experimental transplants	
Physician's Office Visit	No charge after the $25 PCP or $50 Specialist per office visit copay
Inpatient Facility	100% at Lifesource center, otherwise 80% after plan deductible
Physician's Services	100% at Lifesource center, otherwise 80% after plan deductible
Lifetime Travel Maximum: $10,000 per transplant	No charge (only available when using Lifesource facility)
Durable Medical Equipment Calendar Year Maximum: Unlimited	No charge
Consumable Medical Supplies Calendar Year Maximum: Unlimited	No charge

BENEFIT HIGHLIGHTS	IN-NETWORK
External Prosthetic Appliances Calendar Year Maximum: Unlimited	No charge
Diabetic Equipment Calendar Year Maximum: Unlimited	No charge
Hearing Aids Maximum: 2 devices (one per ear) per 36 months. Note: Includes testing and fitting of hearing aid devices covered at PCP or Specialist Office visit level. Coverage up to age 19	No charge
Nutritional Evaluation Calendar Year Maximum: 3 visits per person however, the 3 visit limit will not apply to treatment of diabetes.	
Physician's Office Visit	No charge after the $25 PCP or $50 Specialist per office visit copay
Inpatient Facility	80% after plan deductible
Outpatient Facility	80% after plan deductible
Physician's Services	80% after plan deductible
Dental Care Limited to charges made for a continuous course of dental treatment started within six months of an injury to sound, natural teeth.	
Physician's Office Visit	No charge after the $25 PCP or $50 Specialist per office visit copay
Inpatient Facility	80% after plan deductible
Outpatient Facility	80% after plan deductible
Physician's Services	80% after plan deductible

BENEFIT HIGHLIGHTS	IN-NETWORK
Obesity/Bariatric Surgery **Note:** Coverage is provided subject to medical necessity and clinical guidelines subject to any limitations shown in the "Exclusions, Expenses Not Covered and General Limitations" section of this certificate.	
Physician's Office Visit	No charge after the $25 PCP or $50 Specialist per office visit copay
Inpatient Facility	80% after plan deductible
Outpatient Facility	80% after plan deductible
Physician's Services	80% after plan deductible
Surgical Professional Services Lifetime Maximum: Unlimited **Notes:** • Includes charges for surgeon only; does not include radiologist, anesthesiologist, etc.	
Routine Foot Disorders	Not covered except for services associated with foot care for diabetes and peripheral vascular disease when Medically Necessary.
Treatment Resulting From Life Threatening Emergencies 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	
Inpatient	80% after plan deductible
Outpatient (Includes Individual, Group and Intensive Outpatient)	
Physician's Office Visit	$25 per visit copay
Outpatient Facility	80% after plan deductible
Substance Abuse	
Inpatient	80% after plan deductible
Outpatient (Includes Individual and Intensive Outpatient)	
Physician's Office Visit	$25 per visit copay
Outpatient Facility	80% 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.

Copayments

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

BENEFIT HIGHLIGHTS	PARTICIPATING PHARMACY	Non-PARTICIPATING PHARMACY
Lifetime Maximum	Refer to the Medical Benefits Schedule	Refer to the Medical Benefits Schedule
Out-of-Pocket Maximum		
Individual	Refer to the Medical Benefits Schedule	Refer to the Medical Benefits Schedule
Family	Refer to the Medical Benefits Schedule	Refer to the Medical Benefits Schedule
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 Generic* drugs on the Prescription Drug List	No charge after $15 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 $30 copay	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 $50 copay	In-network coverage only
* Designated as per generally-accepted industry sources and adopted by the Insurance Company		

BENEFIT HIGHLIGHTS	PARTICIPATING PHARMACY	Non-PARTICIPATING PHARMACY
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 Generic* drugs on the Prescription Drug List	No charge after $30 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 $60 copay	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 $100 copay	In-network coverage only
* Designated as per generally-accepted industry sources and adopted by the Insurance Company		

Termination of Insurance

Employees

Your insurance will cease on the earliest date below:

- the date you cease to be in a Class of Eligible Employees or cease to qualify for the insurance.
- the last day for which you have made any required contribution for the insurance.
- the date the policy is canceled.
- the last day of the calendar month in which your Active Service ends except as described below.

Any continuation of insurance must be based on a plan which precludes individual selection.

Temporary Layoff or Leave of Absence

If your Active Service ends due to temporary layoff or leave of absence, your insurance will be continued until the date your Employer: stops paying premium for you; or otherwise cancels your insurance. However, your insurance will not be continued past the end of month in which your Active Service ends.

Injury or Sickness

If your Active Service ends due to an Injury or Sickness, your insurance will be continued while you remain totally and continuously disabled as a result of the Injury or Sickness. However, your insurance will not continue past the date your Employer stops paying premium for you or otherwise cancels your insurance.

Retirement

If your Active Service ends because you retire, and you are 60 years of age or older up to the age of 65 and you have been in Active Service for your Employer for 20 years or longer, your insurance will be continued until the earlier of a) the date on which your Employer stops paying premium for you or otherwise cancels the insurance; or b) your 65th birthday.

Dependents

Your insurance for all of your Dependents will cease on the earliest date below:

- the date your insurance ceases.
- the date you cease to be eligible for Dependent Insurance.
- the last day for which you have made any required contribution for the insurance.
- the date Dependent Insurance is canceled.

The insurance for any one of your Dependents will cease on the date that Dependent no longer qualifies as a Dependent.

HC-TRM1 04-10
V1 M