



Insured by Cigna Health and Life Insurance Company

GROUP ACCIDENTAL INJURY COVERAGE PLAN HIGHLIGHT SHEET

Accident-only insurance coverage is designed to provide, to person insured, coverage for certain losses resulting from a covered accident **ONLY**, subject to any limitations contained in the policy/certificate. Coverage is not provided for basic hospital, basic medical-surgical, or major medical expenses.

BENEFITS:

The benefit amounts shown below will be paid regardless of the actual expenses incurred. Be aware the Certificate may contain specific conditions, definitions, maximums, limitations, and exclusions for the benefits described below.

Note: There may be some variations by state.

Benefit Percentage Amount (unless otherwise indicated)	Employee 100% of benefits shown	Spouse* 100% of benefits shown	Children 100% of benefits shown
Initial & Emergency Care	Plan 1	Plan 2	
Emergency Care Treatment	\$100	\$200	
Physician Office Visit (includes urgent care)	\$50	\$100	
Diagnostic Exam (x-ray or lab)	\$50	\$75	
Ground or Water Ambulance/Air Ambulance	\$300/\$1,200	\$400/\$1,600	
Hospitalization Benefits	Plan 1	Plan 2	
Hospital Admission	\$500	\$1,000	
Hospital Stay	\$100 per day	\$200 per day	
Intensive Care Unit Stay	\$200 per day	\$400 per day	
Fractures and Dislocations	Plan 1	Plan 2	
Per covered surgically-repaired fracture	\$100-\$4,000	\$200-\$8,000	
Per covered non-surgically-repaired fracture	\$50-\$2,000	\$100-\$4,000	
Chip Fracture (percent of fracture benefit)	25%	25%	
Per covered surgically-repaired dislocation	\$100-\$4,000	\$200-\$6,000	
Per covered non-surgically-repaired dislocation	\$50-\$2,000	\$100-\$3,000	

** Wherever the term Spouse appears, it may also include Domestic Partner registered under any state which legally recognizes Domestic Partnerships or Civil Unions.*

Follow-Up Care	Plan 1	Plan 2
Follow-up Physician (or medical professional) Office Visit (limited to 10 per accident)	\$50	\$75
Follow-up Physical Therapy Visit (limited to 10 per accident)	\$25	\$50
Enhanced Accident Benefits	Plan 1	Plan 2
Examples:		
Small Lacerations (Less than or equal to 6 inches long and requires 2 or more sutures)	\$50	\$100
Large Lacerations (more than 6 inches long and requires 2 or more sutures)	\$400	\$600
Concussion	\$100	\$150
Coma (lasting 7 days with no response)	\$5,000	\$10,000

Additional Accidental Injury benefits included - See certificate for details. Virtual Care accepted for Initial Physician Office Visit and Follow-Up Care.

Accidental Death and Dismemberment Benefit	Plan 1	Plan 2
Examples of benefits include (but are not limited to) payment for death from Automobile accident; total and permanent loss of speech or hearing in both ears. Actual benefit amount paid depends on the type of Covered Loss. The Spouse and Child benefit is 50% of the benefit shown.	Loss of Life: \$25,000 - \$75,000 Dismemberment: \$1,000 - \$20,000	Loss of Life: \$50,000 - \$100,000 Dismemberment: \$2,000 - \$30,000
Wellness Treatment, Health Screening Test & Preventive Care Benefit	Plan 1	Plan 2
Wellness Treatment, Health Screening Test and Preventive Care Benefit: Benefit paid for all covered persons is 100% of the benefit shown. <i>Also includes COVID-19 Immunization. Virtual Care accepted.</i>	\$50 1 per year	\$75 1 per year

EMPLOYEE'S MONTHLY COST OF COVERAGE*:

	Plan 1	Plan 2
Employee	\$5.18	\$9.13
Employee + Spouse	\$9.48	\$16.75
Employee + Child(ren)	\$11.78	\$21.02
Employee + Family	\$16.08	\$28.64

**Costs are subject to change. Costs vary based on payroll frequency.*

EXCLUSIONS AND LIMITATIONS: This document provides only the highlights. All claims for a covered loss must meet Benefit Specific Conditions and Limitations and are otherwise subject to all other terms set forth in the group policy and certificate. Please be aware that state specific exclusions and limitations may apply. Please see Your certificate for complete details.

COMMON EXCLUSIONS: In addition to any benefit specific exclusions, no payments will be made for losses which directly or indirectly, is caused by or results from: intentionally self-inflicted injury, including suicide or any attempted suicide; committing or attempt to commit an assault or felony; bungee jumping; parachuting; skydiving; parasailing; hang-gliding; declared or undeclared war or act of war; aircraft or air travel, except as a commercial passenger or Aircraft used by the Air Mobility Command (unless owned, leased or controlled by client); sickness, disease, bodily or mental infirmity, bacterial or viral infection or medical or surgical treatment, except bacterial infection from an accidental external cut or wound or accidental ingestion of contaminated food; activities of active military duty, except Reserve or National Guard active duty training lasting 31 days or less; operating any vehicle under the influence of alcohol or any drug, narcotic or other intoxicant; voluntary use of drugs, unless taken as prescribed and under direction of a physician; services or treatment rendered by a physician, nurse or any other person who is: employed by the client, living with or immediate family of the Covered Person, or providing alternative medical treatments. Actual exclusions may vary depending on your plan design and location.

BENEFIT SPECIFIC EXCLUSIONS AND LIMITATIONS: **Emergency Care Treatment:** Treatment must occur within 30 days of the Covered Accident. Limits: payable once per Covered Accident, per Covered Person; Excludes: treatment provided by an immediate family member, clinic, or doctor's office. **Physician Office Visit:** Must be diagnosed and treated by a physician within 90 days of the Covered Accident. Limits: payable once per Covered Accident, per Covered Person; not payable if a Covered Person is eligible to receive a benefit under Emergency Treatment. Excludes: and visits by a surgeon while confined to a Hospital. **Diagnostic Exam:** payable once per Covered Accident, per Covered Person; Treatment must occur within 90 days of the Covered Accident. **Ground or Water Ambulance/Air Ambulance:** Services must be provided from the scene of the Covered Accident or within 90 days of Covered Accident. Limits: payable once per Covered Accident, per Covered Person; only one benefit will be paid ground or water/air, whichever is greater. **Hospital Admission:** Inpatient admission must occur within 90 days of the Covered Accident due to such accident. Limits: payable once per Covered Accident; Excludes: treatment in an emergency room, provided on an outpatient basis, or for re-admission for the same Covered Accident. **Hospital Stay per day:** Must be admitted for at least 23 hours or admitted inpatient and confined within 90 days of the Covered Accident. Limits: 365 days per Covered Accident; 1 stay per accident; not payable for hospital re-admission for same Covered Accident; if eligible for Hospital Stay Benefit and Initial Intensive Care Unit Benefit, only 1 benefit will be paid for the same Covered Accident, whichever is greater; Stays within 90 days for the same or a related Covered Accident are considered one Stay. **Intensive Care Unit Stay per day:** Must be admitted for at least 23 hours or admitted inpatient and confined within 90 days of the Covered Accident. Limits: 365 days per Covered Accident; not payable for hospital re-admission for same Covered Accident; if eligible for Hospital Stay Benefit and Initial Intensive Care Unit Benefit, only 1 benefit will be paid for the same Covered Accident, whichever is greater; Stays within 90 days for the same or a related Covered Accident are considered one Stay. **Fracture/Dislocation:** If more than one fracture, only one benefit will be paid, whichever is the greater amount. Chip fracture not paid in addition to closed fracture. Limits: Both fractures and dislocations are limited to 1 per accident. Must be diagnosed and treated by a physician within 90 days of the Covered Accident. **Follow-up Physician Office Visit:** Limits: 10 follow up visit(s) for each Covered Person per Covered Accident for follow up physician office visits; Must be examined, treated or prescribed by physician. First examination or treatment must be provided within 90 days of the Covered Accident. Subsequent follow up treatment must be completed within 365 days of the Covered Accident. Follow Up Office Visit can include treatment by providers that are appropriately licensed professionals practicing chiropractic care, speech therapy, occupational therapy, vocational therapy, respiratory therapy, and mental health treatment associated with traumatic Covered Accidents. **Follow-up Physical Therapy Visit:** Limits: 10 follow up visit(s) for each Covered Person per Covered Accident for follow up physical therapy visits. Must be examined, treated or prescribed by physician. First examination or treatment must be provided within 120 days of the Covered Accident. Subsequent follow up treatment must be completed within 365 days of the Covered Accident. **Wellness Treatment, Health Screening Test and Preventive Care Benefit:** Limit: 1 per year per Covered Person. **Large Lacerations:** Treatment by Physician must be received within 90 days of the Covered Accident. Limits: payable 1 time per Covered Person, Per Covered Accident; Multiple lacerations pay a maximum of 2 times the benefit. **Concussion:** Must be diagnosed by a physician within 90 days of the Covered Accident. Limits: payable 1 time per Covered Accident. **Coma:** Limits: payable 1 time per Covered Accident. Must be unconscious for 7 days or more with no response to external stimuli and requiring artificial respiratory or life support. Excludes: medically induced coma. **Accidental Death and Dismemberment Rider:** To receive benefits, the death or loss must occur within 365 days of the covered accident. The exclusions that apply to this benefit are in the Common Exclusions Section. If a Covered Person dies as a result of an automobile accident other loss of life benefits will not be paid. If the driver, he/she must hold a current and valid driver's license. If total and permanent loss of speech or hearing in both ears is payable, no benefits will be paid under the dismemberment benefit and total benefits will not exceed the loss of life death benefit. This is not a complete list. See certificate for complete details, including limitations and exclusions that apply to this benefit.

WHEN YOUR COVERAGE BEGINS: Coverage begins on the later of the program's effective date, the date you become eligible, or the first of the month following the date your completed enrollment form is received unless otherwise agreed upon by Cigna Healthcare. Your coverage will not begin unless you are actively at work on the effective date. Coverage for all Covered Persons will not begin on the effective date if hospital, facility or home confined.

WHEN YOUR COVERAGE ENDS: Coverage ends on the earliest of the date you and your dependents are no longer eligible, the date the group policy is no longer in force, or the date for the last period for which required premiums are paid. For your dependent, coverage also ends when your coverage ends, when their premiums are not paid or when they are no longer eligible. (Under certain circumstances, your coverage may be continued. Be sure to read the provisions in your Certificate.)

PORTABILITY/CONTINUATION PROVISION: You can continue 100% of coverage for all Covered Persons at the time Your coverage ends. You must be covered under the policy and may be required to be under the age of 100 in order to continue your coverage. Rates may change and all coverage may end at age 100. May only be available to United States Citizens, Permanent Resident Aliens and non-United States Citizens working in the United States lawfully (Inpats) while residing in the United States.

STATE VARIATIONS: Please be aware that state specific exclusions and limitations may apply. Please see the certificate for complete details.

The term **Hospital** does not include a clinic, facility, or unit of a Hospital for: rehabilitation, convalescent, custodial, educational, or nursing care; the aged, treatment of drug or alcohol addiction.

GROUP ACCIDENTAL INJURY INSURANCE POLICIES PAY LIMITED BENEFITS ONLY. THEY DO NOT CONSTITUTE COMPREHENSIVE HEALTH INSURANCE COVERAGE AND ARE NOT INTENDED TO COVER ALL MEDICAL EXPENSES. THIS COVERAGE DOES NOT SATISFY THE "MINIMUM ESSENTIAL COVERAGE" OR INDIVIDUAL MANDATE REQUIREMENTS OF THE AFFORDABLE CARE ACT (ACA). LACK OF MAJOR MEDICAL COVERAGE (OR OTHER MINIMUM ESSENTIAL COVERAGE) MAY RESULT IN AN ADDITIONAL PAYMENT WITH YOUR TAXES. THIS COVERAGE IS NOT MEDICAID OR MEDICARE SUPPLEMENT INSURANCE.

Product availability may vary by location and plan type and is subject to change. All group accidental injury insurance policies may contain exclusions, limitations, reductions of benefits, and terms under which the policy may be cancelled or continued in force. For complete details of coverage, contact your Cigna Healthcare sales representative/see your plan documents. Accidental Injury insurance policies are distributed exclusively by or through operating subsidiaries of The Cigna Group, are administered by Cigna Health and Life Insurance Company, and are insured by Cigna Health and Life Insurance Company (Bloomfield, CT). The Cigna names, logos, and marks, including THE CIGNA GROUP and CIGNA HEALTHCARE are owned by Cigna Intellectual Property, Inc. Policy form series: GAI-00-1000.00, GAI-00-0000a. OR CHC R0322 et al.

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GROUP CRITICAL ILLNESS COVERAGE PLAN HIGHLIGHT SHEET

Critical Illness insurance coverage is designed to provide, to persons insured, restricted coverage paying benefits ONLY when certain losses occur as a result of covered critical illness. Coverage is not provided for basic hospital, basic medical surgical, or major medical expenses.

Benefits:

The benefit amounts shown will be paid regardless of the actual expenses incurred. Be aware the Certificate may contain specific conditions, definitions, maximums, limitations, and exclusions for the benefits described below.

Note: There may be some variations by state. All Covered Critical Illness Conditions must be due to disease or sickness.

	Benefit Amount	Guaranteed Issue Amount
Employee	\$10,000, \$20,000	Up to \$20,000
Spouse*	50% of employee amount	Up to \$10,000
Children	25% of employee amount, including Childhood Conditions.	All guaranteed issue

Covered Conditions	Initial Benefit Amount %	Recurrence % of Initial Benefit Amount
<u>Cancer Conditions</u>		
Invasive Cancer	100%	100%
Carcinoma in Situ	25%	25%
	<u>Benefit Amount</u>	
Skin Cancer	\$250 1x per lifetime	Not Available
<u>Vascular Conditions</u>		
Heart Attack	100%	100%
Stroke	100%	100%
Coronary Artery Disease	25%	25%
Aortic & Cerebral Aneurysm	25%	25%
Advanced Heart Failure	25%	Not Available
<u>Nervous System Conditions</u>		
Advanced Stage Alzheimer's Disease	25%	Not Available
Amyotrophic Lateral Sclerosis (ALS)	25%	Not Available
Parkinson's Disease	25%	Not Available
Multiple Sclerosis	25%	Not Available

* Wherever the term Spouse appears, it may also include Domestic Partner registered under any state which legally recognizes Domestic Partnerships or Civil Unions.

Infectious Conditions

Severe Sepsis	25%	25%
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Childhood Conditions*

Cerebral Palsy	100%	Not Available
Cystic Fibrosis	100%	Not Available
Muscular Dystrophy	100%	Not Available
Poliomyelitis	100%	Not Available
Sickle Cell Anemia	100%	Not Available
Heart Wall Malformation	100%	Not Available

Other Specified Conditions

Benign Brain Tumor	100%	100%
Blindness	100%	Not Available
Coma	25%	25%
End-Stage Renal (Kidney) Disease	100%	100%
Major Organ Failure	100%	100%
Paralysis	100%	100%
Advanced Obesity	25%	25%
Crohn's Disease	25%	Not Available
Pulmonary Embolism	25%	25%

**For Childhood Conditions please refer to the beginning of the Benefit Amount section above for details on how much coverage is available for covered children.*

Wellness Treatment, Health Screening Test and Preventive Care Benefit

The benefit amount shown will be paid regardless of the actual expenses incurred and is paid on a per day basis. *Also includes COVID-19 Immunization. Virtual Care accepted.*

Benefit Amount

\$50
1 per year

Hospital Indemnity Benefit

Pays when a newborn child of the Employee is confined to a hospital in the Neonatal Intensive Care Unit (NICU), payable even if the coverage for child is not elected. No benefits are available for any other Covered Person.

Benefit Amount

Newborn NICU Stay:
25% of the issued Employee
Benefit Amount
Limited to 1 benefit per
newborn child

Benefits

Initial Critical Illness Benefit

Benefit for a diagnosis made after the effective date of coverage for each Covered Condition shown above. The amount payable per Covered Condition is the Initial Benefit Amount multiplied by the applicable percentage shown. Each Covered Condition will be payable one time per Covered Person, subject to the Maximum Lifetime Limit. A 180-day separation period between the dates of diagnosis may be required.

Recurrence Benefit

Benefit for the diagnosis of a subsequent and same Covered Condition for which an Initial Critical Illness Benefit has been paid. May require a 12-month separation period from diagnosis of a previous Covered Condition.

Skin Cancer Benefit

Pays benefit stated above.

EMPLOYEE'S MONTHLY COST OF COVERAGE*:**Guaranteed Issue Benefit Amount: \$10,000**

	Employee	Employee + Spouse	Employee + Child(ren)	Employee + Family
Age	Uni-Tobacco			
0-24	\$3.95	\$6.34	\$5.48	\$7.88
25-29	\$4.44	\$7.12	\$5.97	\$8.65
30-34	\$5.28	\$8.45	\$6.81	\$9.98
35-39	\$7.31	\$11.65	\$8.85	\$13.19
40-44	\$9.62	\$15.30	\$11.15	\$16.84
45-49	\$13.52	\$21.48	\$15.06	\$23.02
50-54	\$18.19	\$28.84	\$19.72	\$30.37
55-59	\$25.75	\$40.77	\$27.28	\$42.30
60-64	\$32.68	\$51.74	\$34.22	\$53.28
65-69	\$42.79	\$67.78	\$44.33	\$69.32
70-74	\$55.92	\$88.51	\$57.45	\$90.04
75-79	\$72.90	\$115.31	\$74.43	\$116.85
80-84	\$86.37	\$136.55	\$87.91	\$138.08
85+	\$113.83	\$179.78	\$115.36	\$181.32

Guaranteed Issue Benefit Amount: \$20,000

	Employee	Employee + Spouse	Employee + Child(ren)	Employee + Family
Age	Uni-Tobacco			
0-24	\$7.90	\$12.69	\$10.97	\$15.75
25-29	\$8.88	\$14.24	\$11.95	\$17.31
30-34	\$10.56	\$16.90	\$13.63	\$19.97
35-39	\$14.63	\$23.30	\$17.70	\$26.37
40-44	\$19.23	\$30.61	\$22.30	\$33.68
45-49	\$27.05	\$42.97	\$30.12	\$46.04
50-54	\$36.38	\$57.68	\$39.45	\$60.75
55-59	\$51.50	\$81.53	\$54.57	\$84.60
60-64	\$65.37	\$103.49	\$68.44	\$106.56
65-69	\$85.58	\$135.57	\$88.65	\$138.64
70-74	\$111.83	\$177.02	\$114.90	\$180.09
75-79	\$145.80	\$230.63	\$148.87	\$233.69
80-84	\$172.74	\$273.10	\$175.81	\$276.17
85+	\$227.66	\$359.56	\$230.73	\$362.63

**Costs are subject to change. Costs vary based on payroll frequency. The policy's rate structure is based on attained age, which means the premium can increase due to the increase in your age.*

EXCLUSIONS AND LIMITATIONS: This document provides only the highlights. All claims for a covered loss must meet specific Benefit Conditions and Limitations and are otherwise subject to all other terms set forth in the group policy and certificate. Please be aware that state specific exclusions and limitations may apply. Please see Your certificate for complete details.

COMMON EXCLUSIONS AND LIMITATIONS:

Exclusions: In addition to any benefit-specific exclusions, benefits will not be paid for any Covered Loss that is caused directly or indirectly, in whole or in part by any of the following: intentionally self-inflicted injury, suicide or any attempt thereof while sane or insane; • commission or attempt to commit a felony or an assault; declared or undeclared war or act of war; a Covered Loss that results from active duty service in the military, naval or air force of any country or international organization (upon our receipt of proof of service, we will refund any premium paid for this time; Reserve or National Guard active duty training is not excluded unless it extends beyond 31 days); voluntary ingestion of any narcotic, drug, poison, gas or fumes, unless prescribed or taken under the direction of a Physician and taken in accordance with the prescribed dosage; operating any type of vehicle while under the influence of alcohol or any drug, narcotic or other intoxicant ("Under the influence of alcohol", for purposes of this exclusion, means intoxicated, as defined by the law of the state in which the Covered Loss occurred); a diagnosis not in accordance with generally accepted medical principles prevailing in the United States at the time of the diagnosis.

BENEFIT SPECIFIC EXCLUSIONS AND LIMITATIONS:

Invasive Cancer: Excludes pre-malignant conditions or conditions with malignant potential, carcinoma in situ, basal cell carcinoma, squamous cell carcinoma of the skin, unless metastatic disease develops, melanoma that is diagnosed as Clark's Level I or II or Breslow less than 0.75mm, or melanoma in situ, or prostate tumor that is classified as T-1a, b, or c, N-0, and M-0 on a TNM classification scale. Also excludes the recurrence or metastasis of an original Cancer that was diagnosed prior to the coverage effective date if the Insured has undergone treatment for such cancer within 12 months of being diagnosed with cancer while under this coverage. **Carcinoma in Situ:** Excludes premalignant conditions or conditions with malignant potential, skin cancers, invasive cancer (basal/squamous cell carcinoma or melanoma/melanoma in situ). **Stroke:** Excludes transient ischemic attack (TIAs), brain injury related to trauma or infection, brain injury associated with hypoxia or anoxia, vascular disease affecting eye or optic nerve or ischemic disorders of the vestibular system. **Coronary Artery Disease:** Excludes angioplasty (percutaneous coronary intervention) and stent implantation. **Aortic and Cerebral Aneurysm:** Excludes surgical repair of complications resulting from prior repair for an aneurysm. **Advanced Heart Failure:** Excludes heart attack, coronary artery disease, pulmonary embolism, and arrhythmias. **Severe Sepsis:** Excludes relapse of the underlying bacterial infection causing the Severe Sepsis. Must be treatment free for Invasive Cancer and Carcinoma in Situ and have an inpatient admission. **Poliomyelitis:** Excludes non-paralytic polio or post-polio syndrome. **Sickle Cell Anemia:** Excludes the sickle cell trait. **Blindness:** May require loss be due to specific illness. **Coma:** May require loss be due to specific illness. **End-Stage Renal (Kidney) Failure:** Requires hemo or peritoneal dialysis. **Major Organ Failure:** If the Covered Person has a combination transplant (i.e., heart and lung), a single benefit amount will be payable. Recurrence Benefit not payable for same organ for which a benefit was previously paid. **Paralysis:** Excludes loss due to Stroke and Multiple Sclerosis. May require loss be due to specific illness. **Crohn's Disease:** Excludes irritable bowel syndrome or ulcerative colitis. **Pulmonary Embolism:** Excludes blood clot confined to the lower extremities or pelvis. **Wellness Treatment, Health Screening Test and Preventive Care Benefit:** Limit: 1 per year per Covered Person. **Hospital Indemnity Newborn Neonatal Intensive Care (NICU) Stay:** Must be admitted as an inpatient and confined in an NICU of a Hospital at the direction and under the care of a physician. Cannot be discharged from Hospital prior to be admitted to NICU.

WHEN YOUR COVERAGE BEGINS: Coverage begins on the later of the program's effective date, the date you become eligible, or the first of the month following the date your completed enrollment form is received unless otherwise agreed upon by Cigna Healthcare. Your coverage will not begin unless you are actively at work on the effective date. Coverage for all other Covered Persons will not begin on the effective date if the covered person is confined to a hospital, facility or at home.

WHEN YOUR COVERAGE ENDS: Coverage ends on the earliest of the date you and your dependents are no longer eligible, the date the group policy is no longer in force, or the date for the last period for which required premiums are paid. For your dependent, coverage also ends when your coverage ends, when their premiums are not paid or when they are no longer eligible. (Under certain circumstances, your coverage may be continued. Be sure to read the provisions in your Certificate about when coverage may continue).

PORTABILITY/CONTINUATION PROVISION: You can continue 100% of coverage for all Covered Persons at the time Your coverage ends. You must be covered under the policy and may be required to be under the age of 100 in order to continue your coverage. Rates may change and all coverage may end at age 100. May only be available to United States Citizens, Permanent Resident Aliens and non-United States Citizens working in the United States lawfully (Inpats) while residing in the United States.

STATE VARIATIONS: Please be aware that state specific exclusions and limitations may apply. Please see the certificate for complete details.

GROUP CRITICAL ILLNESS INSURANCE POLICIES PAY LIMITED BENEFITS ONLY. THEY DO NOT CONSTITUTE COMPREHENSIVE HEALTH INSURANCE COVERAGE AND ARE NOT INTENDED TO COVER ALL MEDICAL EXPENSES. THIS COVERAGE DOES NOT SATISFY THE "MINIMUM ESSENTIAL COVERAGE" OR INDIVIDUAL MANDATE REQUIREMENTS OF THE AFFORDABLE CARE ACT (ACA). LACK OF MAJOR MEDICAL COVERAGE (OR OTHER MINIMUM ESSENTIAL COVERAGE) MAY RESULT IN AN ADDITIONAL PAYMENT WITH YOUR TAXES. THIS COVERAGE IS NOT MEDICAID OR MEDICARE SUPPLEMENT INSURANCE.

Product availability may vary by location and plan type and is subject to change. All group critical illness insurance policies may contain exclusions, limitations, reductions of benefits, and terms under which the policy may be cancelled or continued in force. For costs and complete details of coverage, contact your Cigna Healthcare sales representative/see your plan documents. Critical Illness plans or insurance policies are distributed exclusively by or through operating subsidiaries of The Cigna Group, are administered by Cigna Health and Life Insurance Company, and are insured by Cigna Health and Life Insurance Company (Bloomfield, CT). The Cigna names, logos, and marks, including THE CIGNA GROUP and CIGNA HEALTHCARE are owned by Cigna Intellectual Property, Inc. Policy form series: GCI-02-1000.00, GCI-02-1000.OR CHC et al.

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THE FOLLOWING NOTICE IS REQUIRED BY THE FEDERAL GOVERNMENT

IMPORTANT: This is a fixed indemnity policy, NOT health insurance

This fixed indemnity policy may pay you a limited dollar amount if you're sick or hospitalized. You're still responsible for paying the cost of your care.

- The payment you get isn't based on the size of your medical bill.
- There might be a limit on how much this policy will pay each year.
- This policy isn't a substitute for comprehensive health insurance.
- Since this policy isn't health insurance, it doesn't have to include most Federal consumer protections that apply to health insurance.

Looking for comprehensive health insurance?

- Visit [HealthCare.gov](https://www.healthcare.gov) or call 1-800-318-2596 (TTY: 1-855-889-4325) to find health coverage options.
- To find out if you can get health insurance through your job, or a family member's job, contact the employer.

Questions about this policy?

- For questions or complaints about this policy, contact your State Department of Insurance. Find their number on the National Association of Insurance Commissioners' website ([naic.org](https://www.naic.org)) under "Insurance Departments."
- If you have this policy through your job, or a family member's job, contact the employer.



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GROUP HOSPITAL CARE (INDEMNITY) COVERAGE PLAN HIGHLIGHT SHEET

Hospital confinement indemnity insurance coverage is designed to provide, to persons insured, coverage in the form of a fixed daily benefit during periods of hospitalization resulting from a covered accident or sickness, subject to any limitations set forth in the policy. Coverage is not provided for any benefits other than the fixed daily indemnity for hospital confinement and any additional benefit described below.

BENEFITS:

The benefit amounts shown below will be paid regardless of the actual expenses incurred. Be aware the Certificate may contain specific conditions, definitions, maximums, limitations, and exclusions for the benefits described below.

Note: There may be some variations by state.

Benefit Percentage Amount (unless otherwise indicated)	Employee 100% of benefits shown	Spouse* 100% of benefits shown	Children 100% of benefits shown
Hospitalization Benefits			Plan 1
Hospital Admission No Elimination Period. Limited to 1 day, 1 benefit(s) every 365 days.			\$1,000
Hospital Chronic Condition Admission No Elimination Period. Limited to 1 day, 1 benefit(s) every 90 days.			\$50
Hospital Stay No Elimination Period. Limited to 30 days, 1 benefit(s) every 90 days.			\$100 per day
Hospital Intensive Care Unit (ICU) Stay No Elimination Period. Limited to 30 days, 1 benefit(s) every 90 days.			\$200 per day
Hospital Observation Stay 24-Hour Elimination Period. Limited to 72 hours.			\$100 per day
Newborn Nursery Care Stay Limited to 30 days, 1 benefit per newborn child. This benefit is payable to the employee even if child coverage is not elected.			\$200 per day

* Wherever the term Spouse appears, it may also include Domestic Partner registered under any state which legally recognizes Domestic Partnerships or Civil Unions.

EMPLOYEE'S MONTHLY COST OF COVERAGE*:

	Employee	Employee + Spouse	Employee + Child(ren)	Employee + Family
Age	Uni-Tobacco			
0-49	\$11.68	\$29.54	\$19.71	\$37.57
50-59	\$10.94	\$27.02	\$18.98	\$35.06
60-69	\$15.45	\$41.90	\$23.49	\$49.94
70+	\$102.18	\$213.35	\$110.22	\$221.38

**Costs are subject to change. Costs vary based on [Employer's] payroll frequency. The policy's rate structure is based on attained age, which means the premium can increase due to the increase in your age.*

EXCLUSIONS AND LIMITATIONS: This document provides only the highlights. All claims for a covered loss must meet specific Benefit Conditions and Limitations and are otherwise subject to all other terms set forth in the group policy and certificate. Please be aware that state specific exclusions and limitations may apply. Please see Your certificate for complete details.

COMMON EXCLUSIONS: In addition to any benefit-specific exclusion, benefits will not be paid for any Covered Injury or Covered Illness which is caused by or results from any of the following (unless otherwise provided for in the policy): Intentionally self-inflicted injury, suicide or any attempted threat while sane or insane; Commission or attempt to commit a felony or an assault; Declared or undeclared war or act of war; A Covered Injury or Covered Illness that occurs while on active duty service in the military, naval or air force of any country or international organization. Upon our receipt of proof of service, we will refund any premium paid for this time. Reserve or National Guard active duty training is not excluded unless it extends beyond 31 days; Voluntary ingestion of any narcotic, drug, poison, gas or fumes, unless prescribed or taken under the direction of a Physician and taken in accordance with the prescribed dosage; Operating any type of vehicle while under the influence of alcohol or any drug, narcotic or other intoxicant including any prescribed drug for which the Covered Person has been provided a written warning against operating a vehicle while taking it. "Under the influence of alcohol", for purposes of this exclusion, means intoxicated, as defined by the law of the state in which the Covered Injury or Covered Illness occurred; Elective or cosmetic surgery. This does not include reconstructive, cosmetic surgery: a) incidental to or following surgery for trauma, infection, or other disease of the involved part; or b) due to congenital disease or anomaly of a Covered Dependent child which has resulted in a functional defect; Dental surgery, unless the surgery is the result of an accidental injury. In addition, benefits will not be paid for services or treatment rendered by a Physician, Nurse or any other person who is: employed or retained by the client or providing homeopathic, aroma-therapeutic, or herbal therapeutic services or living in the Covered Person's household or a parent, sibling, spouse, or child of the Covered Person.

BENEFIT SPECIFIC CONDITIONS, EXCLUSIONS AND LIMITATIONS: **Hospital Admission:** Must be admitted as an Inpatient due to a Covered Injury or Covered Illness. Excludes: treatment in an emergency room, provided on an outpatient basis, or for re-admission for the same Covered Injury or Covered Illness (including chronic conditions). **Hospital Chronic Condition Admission:** Must be admitted as an Inpatient due to a covered chronic condition and treatment for a covered chronic condition must be provided by a specialist in that field of medicine. Excludes: treatment in an emergency room, provided on an outpatient basis, or for re-admission for the same Covered Injury or Covered Illness (including chronic conditions). **Hospital Stay:** Must be admitted as an Inpatient and confined to the Hospital, due to a Covered Injury or Covered Illness, at the direction and under the care of a physician. If also eligible for the ICU Stay Benefit, only 1 benefit will be paid for the same Covered Injury or Covered Illness, whichever is greater. Hospital stays within 90 days for the same or a related Covered Injury or Covered Illness is considered one Hospital Stay. **Intensive Care Unit (ICU) Stay:** Must be admitted as an Inpatient and confined in an ICU of a Hospital, due to a Covered Injury or Covered Illness, at the direction and under the care of a physician. If also eligible for the Hospital Stay Benefit, only 1 benefit will be paid for the same Covered Injury or Covered Illness, whichever is greater. ICU stays within 90 days for the same or a related Covered Injury or Covered Illness is considered one ICU stay. **Hospital Observation Stay:** Must be receiving treatment for a Covered Injury or Covered Illness in a Hospital, including an observation room, or ambulatory surgical center, for more than 24 hours on a non-inpatient basis and a charge must be incurred. This benefit is not payable if a benefit is payable under the Hospital Stay Benefit or Hospital Intensive Care Unit Stay Benefit. **Newborn Nursery Care Stay:** Must be admitted as an Inpatient and confined in a Hospital immediately following birth at the

direction and under the care of a physician.

WHEN YOUR COVERAGE BEGINS: Coverage begins on the later of the program's effective date, the date you become eligible, the first of the month following the date your completed enrollment form is received unless otherwise agreed upon by Cigna Healthcare. Your coverage will not begin unless you are actively at work on the effective date. Coverage for Covered Persons will not begin on the effective date if the covered person is confined to a hospital, facility or at home. Deferral of the effective date will not apply to the Newborn Nursery Care Stay Benefit.

WHEN YOUR COVERAGE ENDS: Coverage for any Covered Person ends on the earliest of the date they are no longer eligible, the date the group policy is no longer in force, or the date for the last period for which required premiums are paid. For your Spouse and Dependent Child(ren), if applicable, coverage also ends when your coverage ends, when their premiums are not paid or when they are no longer eligible. (Under certain circumstances, your coverage may be continued if you stop working. Be sure to read the *Continuation of Insurance* provisions in your Certificate.)

PORTABILITY/CONTINUATION PROVISION: You, your spouse, and child(ren) can continue 100% of your coverage at the time your coverage ends. You must be covered under the policy and may be required to be under the age of 100 in order to continue your coverage. Rates may change and all coverage may end at age 100. May only be available to United States Citizens, Permanent Resident Aliens and non-United States Citizens working in the United States lawfully (Inpats) while residing in the United States.

STATE VARIATIONS: Please be aware that state specific exclusions and limitations may apply. Please see the certificate for complete details.

The term **Hospital** does not include a clinic, facility, for: (1) rehabilitation, convalescent, custodial, educational, hospice, or skilled nursing care; (2) the aged, treatment of drug addiction or alcoholism; or (3) a facility primarily or solely providing psychiatric services to mentally ill patients. The term Hospital also does not include a unit of a Hospital for rehabilitation, convalescent, custodial, educational, hospice, or skilled nursing care.

GROUP HOSPITAL CARE (INDEMNITY) INSURANCE POLICIES PAY LIMITED BENEFITS ONLY. THEY DO NOT CONSTITUTE COMPREHENSIVE HEALTH INSURANCE COVERAGE AND ARE NOT INTENDED TO COVER ALL MEDICAL EXPENSES. THIS COVERAGE DOES NOT SATISFY THE "MINIMUM ESSENTIAL COVERAGE" OR INDIVIDUAL MANDATE REQUIREMENTS OF THE AFFORDABLE CARE ACT (ACA). LACK OF MAJOR MEDICAL COVERAGE (OR OTHER MINIMUM ESSENTIAL COVERAGE) MAY RESULT IN AN ADDITIONAL PAYMENT WITH YOUR TAXES. THIS COVERAGE IS NOT MEDICAID OR MEDICARE SUPPLEMENT INSURANCE.

Product availability may vary by location and plan type and is subject to change. All group hospital indemnity insurance policies may contain exclusions, limitations, reductions of benefits, and terms under which the policy may be cancelled or continued in force. For costs and complete details of coverage, contact your Cigna Healthcare sales representative/see your plan documents. Hospital Care plans or insurance policies are distributed exclusively by or through operating subsidiaries of The Cigna Group, are administered by Cigna Health and Life Insurance Company, and are insured by Cigna Health and Life Insurance Company (Bloomfield, CT). The Cigna names, logos, and marks, including THE CIGNA GROUP and CIGNA HEALTHCARE are owned by Cigna Intellectual Property, Inc. Policy form series: GHIP1.2-1000.00, GHIP1.21-1000.00 OR CHC et al.

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