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

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

CERTIFICATE RIDER

No. CR7SIASO9-1
CR7SIASO10-1

Policyholder: Adelphi University

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

Policy No. or Nos. 3336505-HDHF/HDHI, HSAF/HSAI

EFFECTIVE DATE: January 1, 2025

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.

Geneva Cambell Brown, Corporate Secretary

HC-RDR1 04-10
V1

The sections entitled **Calendar Year Deductible**, **Combined Out-of-Pocket Maximum for Medical and Pharmacy expenses** and **Hearing Aids** in THE SCHEDULE — **Open Access Plus Medical Benefits** — in your certificate are changed to read as attached.

THE SCHEDULE — **Prescription Drug Benefits** For You and Your Dependents — section in your certificate is changed to read as attached.

Open Access Plus Medical Benefits The Schedule		
BENEFIT HIGHLIGHTS	IN-NETWORK	OUT-OF-NETWORK
Calendar Year Deductible Individual Family Maximum Family Maximum Calculation **Collective Deductible:** All family members contribute towards the family deductible. An individual cannot have claims covered under the plan coinsurance until the total family deductible has been satisfied.	 $1,650 per person $3,300 per family	 $3,000 per person $6,000 per family
Combined Out-of-Pocket Maximum for Medical and Pharmacy expenses Individual – Employee Only Individual – within a Family 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 $3,300 per person $6,000 per family	 $6,000 per person $6,000 per person $12,000 per family
Hearing Aids Calendar Year Maximum: $5,000	Plan deductible, then 80%	In-Network coverage only

Prescription Drug Benefits
The Schedule

For You and Your Dependents

This plan provides Prescription Drug benefits for Prescription Drug Products provided by Pharmacies as shown in this Schedule. To receive Prescription Drug Benefits, you and your Dependents may be required to pay a Deductible, Copayment or Coinsurance requirement for Covered Expenses for Prescription Drug Products.

You and your Dependents will pay 100% of the cost of any Prescription Drug Product excluded from coverage under this plan. The amount you and your Dependent pays for any excluded Prescription Drug Product to the dispensing Pharmacy, will not count towards your Deductible, if any, or Out-of-Pocket Maximum.

Coinsurance

The term Coinsurance means the percentage of the Prescription Drug Charge for a covered Prescription Drug Product dispensed by a Network Pharmacy that you or your Dependent are required to pay under this plan in addition to the Deductible, if any.

BENEFIT HIGHLIGHTS	NETWORK PHARMACY	NON-NETWORK PHARMACY
Lifetime Maximum	Refer to the Medical Benefits Schedule	Refer to the Medical Benefits Schedule
Calendar Year Deductible		
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
Pre-Deductible Preventive Medications Certain Generic Pre-Deductible Preventive Medications identified by Cigna and that are dispensed by a retail or home delivery Network Pharmacy are not subject to the Deductible. Certain Brand Pre-Deductible Preventive Medications identified by Cigna and that are dispensed by a retail or home delivery Network Pharmacy are not subject to the Deductible. You may determine whether a drug is a Pre-Deductible Preventive Care Medication through the website shown on your ID card or by calling member services at the telephone number on your ID card.		
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

BENEFIT HIGHLIGHTS	NETWORK PHARMACY	NON-NETWORK PHARMACY
Maintenance Drug Products Maintenance Drug Products must be filled in an amount equal to a consecutive 90 day supply per Prescription Order or Refill at a retail Designated Pharmacy or home delivery Pharmacy, after 2 30-day supply fills at a retail Pharmacy or home delivery Pharmacy. If you do not fill your Maintenance Drug Products in a 90-day supply at a retail Designated Pharmacy or home delivery Pharmacy after the specified 30-day supply fill limit, the Plan will not cover the Maintenance Drug Product.		
Certain Preventive 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 Network Pharmacy. A written prescription is required.		
Prescription Drug Products at Retail Pharmacies	**The amount you pay for up to a consecutive 30-day supply at a Network Pharmacy**	**The amount you pay for up to a consecutive 30-day supply at a non-Network Pharmacy**
Certain Specialty Prescription Drug Products are only covered when dispensed by a home delivery Pharmacy, after 1 fill of the Specialty Prescription Drug Product at a retail Pharmacy.		
Tier 1 Generic Drugs on the Prescription Drug List	Non-Maintenance Drug Products: 20% after plan Deductible Maintenance Drug Products: 20% after plan Deductible for the first 2 fills, then no coverage for a 30-day supply	In-network coverage only In-network coverage only
Tier 2 Brand Drugs designated as preferred on the Prescription Drug List	Non-Maintenance Drug Products: 20% after plan Deductible Maintenance Drug Products: 20% after plan Deductible for the first 2 fills, then no coverage for a 30-day supply	In-network coverage only In-network coverage only
Tier 3 Brand Drugs designated as non-preferred on the Prescription Drug List	Non-Maintenance Drug Products: 20% after plan Deductible Maintenance Drug Products: 20% after plan Deductible for the first 2 fills, then no coverage for a 30-day supply	In-network coverage only In-network coverage only

BENEFIT HIGHLIGHTS	NETWORK PHARMACY	NON-NETWORK PHARMACY
Prescription Drug Products at Retail Designated Pharmacies	**The amount you pay for up to a consecutive 90-day supply at a Designated Pharmacy**	**The amount you pay for up to a consecutive 90-day supply at a non-Designated Pharmacy**
Certain Specialty Prescription Drug Products are only covered when dispensed by a home delivery Pharmacy, after 1 fill of the Specialty Prescription Drug Product at a retail Pharmacy.		
Specialty Prescription Drug Products are limited to up to a consecutive 30-day supply per Prescription Order or Refill.		
Note: In this context, a retail Designated Pharmacy is a retail Network Pharmacy that has contracted with Cigna for dispensing of covered Prescription Drug Products, including Maintenance Drug Products, in 90-day supplies per Prescription Order or Refill.		
Tier 1 Generic Drugs on the Prescription Drug List	20% after plan Deductible	In-network coverage only
Tier 2 Brand Drugs designated as preferred on the Prescription Drug List	20% after plan Deductible	In-network coverage only
Tier 3 Brand Drugs designated as non-preferred on the Prescription Drug List	20% after plan Deductible	In-network coverage only
Prescription Drug Products at Home Delivery Pharmacies	**The amount you pay for up to a consecutive 90-day supply at a Network Pharmacy**	**The amount you pay for up to a consecutive 90-day supply at a non-Network Pharmacy**
Tier 1 Generic Drugs on the Prescription Drug List	20% after plan Deductible	In-network coverage only
Tier 2 Brand Drugs designated as preferred on the Prescription Drug List	20% after plan Deductible	In-network coverage only
Tier 3 Brand Drugs designated as non-preferred on the Prescription Drug List	20% after plan Deductible	In-network coverage only