

# TECH INSURANCE AGENCY INC

<b>NIKTOR LLC</b> <b>Dental Rates</b> <b>EFFECTIVE DATE:05/01/2021</b>	
<b>Insurance Carrier</b>	<b>Cigna</b>
<b>Plan Codes</b>	<b>Cigna DPPO</b>
<b>Network</b>	<b>PPO</b>
<b>Benefit Overview</b>	
<b>Deductible: SingleIn/Out</b>	<b>\$50/\$150</b>
<b>Family In/Out</b>	<b>\$50/\$150</b>
<b>Coinsurance:</b>	
<b>Preventive&amp;Diagnostic</b>	<b>100%/100%</b>
<b>Minor Restorative(I/O)</b>	<b>80%/80%</b>
<b>Endodontic/Periodic/ Oral Surgery(I/O)</b>	<b>50%/50%</b>
<b>Major (I/O)</b>	<b>50%/50%</b>
<b>Waiting Period</b>	
<b>Major</b>	<b>None</b>
<b>Annual Maximum(I/O)</b>	<b>\$1,250</b>
<b>Rates</b>	
<b>Employee Only</b>	<b>25.32</b>
<b>Employee + Spouse</b>	<b>50.64</b>
<b>Employee + Child</b>	<b>67.09</b>
<b>Employee + Family</b>	<b>86.65</b>



28 Main St, Farmington, CT 06032

[www.niktor.com](http://www.niktor.com)

# TECH INSURANCE AGENCY INC

<b>NIKTOR LLC</b>	
<b>Vision Rates</b>	
<b>EFFECTIVE DATE:05/01/2021</b>	
<b>Insurance Carrier</b>	<b>Cigna</b>
<b>Plan Codes</b>	<b>Voluntary</b>
<b>Network</b>	<b>PPO</b>
<b>Benefit Overview/Frequency</b>	
<b>Exam</b>	<b>12 MONTHS</b>
<b>Lenses</b>	<b>12 MONTHS</b>
<b>Frames</b>	<b>12 MONTHS</b>
<b>In network Copays</b>	
<b>Exam</b>	<b>\$10</b>
<b>Materials</b>	<b>\$25</b>
<b>Out of network allowance</b>	
<b>Exam</b>	<b>\$45 allowance</b>
<b>Single vision Lenses</b>	<b>\$32 allowance</b>
<b>Frames</b>	<b>\$71 allowance</b>
<b>Contact Lenses</b>	<b>\$80 allowance</b>
<b>Rates</b>	
<b>Employee Only</b>	<b>\$5.19</b>
<b>Employee + Spouse</b>	<b>\$9.84</b>
<b>Employee + Child</b>	<b>\$11.54</b>
<b>Employee + Family</b>	<b>\$16.24</b>



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## **CIGNA GLOBAL HEALTH ADVANTAGE 10+**

### **Hallmark Global Technologies Inc. Summary of Benefits**

Policy No.: 08892A

Cigna Global Health Benefits®







Insured and/or administered by:

Cigna Health and Life Insurance Company

## Hallmark Global Technologies Inc.

Benefits at a Glance

Global Plan for all covered Employees.

Policy # 08892A

Plan Start Date April 1, 2021

### This plan provides minimum essential coverage.

Please Note: This is a high level summary of your benefits. Please see your certificate booklet for detailed benefits and exclusions.

#### Cigna Global Customer Service

<b>Toll Free Telephone Number:</b>	1.800.441.2668	
<b>Direct Telephone:</b>	1.302.797.3100 (collect calls accepted)	
<b>Toll Free Fax Number:</b>	1.800.243.6998	
<b>Direct Fax Number:</b>	001.302.797.3150	
<b>Secure Website:</b>	<a href="http://www.CignaEnvoy.com">www.CignaEnvoy.com</a> . Registration is Required (See member kit for registration information.) Secure email available at this site.	
<b>Mail Delivery:</b>	Cigna Global Health Benefits P.O. Box 15050 Wilmington DE 19850-5050 U.S.A.	Cigna Global Health Benefits 300 Bellevue Parkway Wilmington DE 19809 U.S.A.

#### General Plan Provisions - All Amounts in U.S. Dollars

##### Global Medical Plan

	International (Outside of the U.S.)	U.S. In-Network	U.S. Out-of-Network
<b>Area of Cover</b>	Worldwide		
<b>U.S. Medical Network</b>	OAP		
<b>Eligibility</b>	Refer to eligibility definition in the certificate		
<b>Lifetime Maximum</b>	Unlimited		
<b>Calendar Year Deductible</b>			
· Per Individual	\$1,000	\$1,000	\$6,500
· Per Family	\$2,000	\$2,000	\$13,000
<b>Coinsurance</b> (The percentage of covered expenses the plan pays)	100%	100%	50%
<b>Out-of-Pocket Maximum (Includes Deductible)</b>			
· Per Individual	\$4,500	\$4,500	\$10,000
· Per Family	\$9,000	\$9,000	\$20,000



## Global Medical Plan

<b>Deductible Calculation</b>	<p>Claims for a family member are covered at plan coinsurance:</p> <ul style="list-style-type: none"> <li>• When that family member satisfies the Individual Deductible</li> <li>-OR-</li> <li>• When the Family Deductible is satisfied regardless of whether or not the Individual Deductible is satisfied.</li> </ul>
<b>Out-of-Pocket Calculation</b>	<p>Claims for a family member are covered at 100% coinsurance:</p> <ul style="list-style-type: none"> <li>• When that family member satisfies the Individual Out-of-Pocket Maximum</li> <li>-OR-</li> <li>• When the Family Out-of-Pocket Maximum is satisfied regardless of whether or not the Individual Out-of-Pocket Maximum is satisfied.</li> </ul> <p>Out-of-Pocket will: Include deductible payments; Include copay payments; Include pharmacy copays; Include pharmacy coinsurance payments; Exclude Pre-Admission Certification/Continued Stay Review penalties.</p>
<b>Network Accumulation</b>	Plan Deductible, Out-of-Pocket, maximums and service specific maximums (dollar and occurrence) will cross-accumulate across international and domestic networks.

## Certification Requirements - For services rendered inside the United States

Precertification for inpatient and outpatient services received in the U.S. may be required.

- Providers must call our toll-free number, 1.800.441.2668 to pre-certify services.
- You or your dependents are responsible for ensuring that Out-of-Network providers pre-certify services.
- Failure to obtain precertification may affect Out-of-Pocket costs.
- This is a summary only and further details can be found in the certificate booklet.

	International (Outside of the U.S.)	U.S. In-Network	U.S. Out-of-Network
<b>Physician's Services</b>			
· Physician's Office Visit	100% after deductible	\$20 copay not subject to deductible	50% after deductible
· Surgery Performed In the Physician's Office	100% after deductible	\$20 copay not subject to deductible	50% after deductible
<b>Preventive Care</b>			
· Routine Preventive Care - all ages	100% not subject to deductible	100% not subject to deductible	50% after deductible
· Immunizations - all ages			
<b>Travel Immunizations</b> (Immunizations as required for travel)	100% not subject to deductible	100% not subject to deductible	50% after deductible
<b>Mammograms, PSA, PAP Smear and Colorectal Cancer Screenings</b>	100% not subject to deductible	100% not subject to deductible	50% after deductible
<b>Inpatient Hospital Facility Services</b>	100% after deductible	100% after deductible	50% after deductible
<b>Inpatient Hospital Physician Visits/Consultations</b>	100% after deductible	100% after deductible	50% after deductible
<b>Outpatient Facility Services</b>	100% after deductible	100% after deductible	50% after deductible
<b>Emergency Room</b>	100% subject to deductible	\$200 per visit copay, then 100% not subject to deductible	\$200 per visit copay, then 100% not subject to deductible
<b>Urgent Care Services</b>	100% after deductible	\$20 copay not subject to deductible	50% after deductible
<b>Ambulance</b>	100% after deductible	100% after deductible	100% after deductible



Global Medical Plan			
	International (Outside of the U.S.)	U.S. In-Network	U.S. Out-of-Network
Laboratory and Radiology Services (including pre-admission testing)	100% after deductible	100% not subject to deductible	50% after deductible
Advanced Radiology (i.e., MRIs, MRAs, CAT Scans, PET Scans)	100% after deductible	100% after deductible	50% after deductible
Short-Term Rehabilitation Calendar Year Maximum: 60 Days for all Therapies Combined  Includes: Cardiac and Pulmonary Rehab, Speech, Occupational and Cognitive Therapy  Note: The Short-Term Rehabilitation Therapy maximum does not apply to the treatment of Autism and/or Mental Health conditions	100% after deductible	\$40 copay not subject to deductible	50% after deductible
Short-Term Rehabilitation Physical Therapy / Physiotherapy Calendar Year Maximum: Unlimited	100% after deductible	100% after deductible	50% after deductible
Chiropractic Care Calendar Year Maximum: Unlimited	100% after deductible	100% after deductible	50% after deductible
Maternity Care Services · Initial Visit to Confirm Pregnancy  · All subsequent Prenatal Visits, Postnatal Visits and Physician's Delivery Charges (i.e. global maternity fee)  · Physician's Office Visits in addition to the global maternity fee when performed by an OB/GYN or Specialist  · Delivery – Facility (Inpatient Hospital, Birthing Center)	100% after deductible	\$20 copay, then 100% not subject to deductible	50% after deductible
	100% after deductible	100% after deductible	50% after deductible
	100% after deductible	\$20 copay, then 100% not subject to deductible	50% after deductible
	100% after deductible	100% after deductible	50% after deductible
Infertility Treatments  · Gift, Zift  · Invitro  · Artificial Insemination	Diagnosis of Infertility is covered under general Physician Office Visits.		
	100% after deductible	\$40 copay, then 100% not subject to deductible	50% after deductible
	100% after deductible	\$40 copay, then 100% not subject to deductible	50% after deductible
	100% after deductible	\$40 copay, then 100% not subject to deductible	50% after deductible



## Global Medical Plan

	International (Outside of the U.S.)	U.S. In-Network	U.S. Out-of-Network
<b>Hearing Benefit</b> · 1 Exam Every 24 Months	100% after deductible	100% after deductible	50% after deductible
<b>Hearing Device / Aids</b> · Limited to Dependent Children Under 24 Years · 1 Per Ear Every 36 Months up to \$1,000	100% after deductible	100% after deductible	50% after deductible
<b>Mental Health</b> · Inpatient Facility	100% after deductible	100% after deductible	50% after deductible
· Outpatient Office Visit	100% after deductible	\$20 copay not subject to deductible	50% after deductible
<b>Substance Use Disorder</b> · Inpatient Facility	100% after deductible	100% after deductible	50% after deductible
· Outpatient Office Visit	100% after deductible	100% not subject to deductible	50% after deductible

## Prescription Drug Benefits

International (Outside of the U.S.)		
<b>Purchased outside the United States</b>	No Charge	
Certain preventive care medications covered under this plan and required as part of preventive care services (detailed information is available at <a href="http://www.healthcare.gov">www.healthcare.gov</a> ) are payable at 100% with no copayment or deductible, when purchased from a Network Pharmacy. A written prescription is required.		
Purchased Inside the United States Only		
Benefit Highlights	Network Pharmacy (U.S. In-Network)	Non-Network Pharmacy (U.S. Out-of-Network)
<b>Prescription Drug Products at Retail Pharmacies</b>	The amount you pay for up to a consecutive 30-day supply	
<b>Tier 1 - Generic Drugs on the Prescription Drug List</b>	No Charge	You pay 50% after plan deductible
<b>Tier 2 – Brand Drugs designated as preferred on the Prescription Drug List</b>	No charge after you pay the \$10 copay	You pay 50% after plan deductible
<b>Tier 3 – Brand Drugs designated as non-preferred on the Prescription Drug List</b>	No charge after you pay the \$30 copay	You pay 50% after plan deductible
<b>Prescription Drug Products at Home Delivery Pharmacies</b>	The amount you pay for up to a consecutive 90-day supply	
<b>Tier 1 - Generic Drugs on the Prescription Drug List</b>	No Charge	In-Network coverage only
<b>Tier 2 – Brand Drugs designated as preferred on the Prescription Drug List</b>	No charge after you pay the \$30 copay	In-Network coverage only
<b>Tier 3 – Brand Drugs designated as non-preferred on the Prescription Drug List</b>	No charge after you pay the \$90 copay	In-Network coverage only





Pharmacy Plan Features for Prescriptions Drugs Purchased Inside the United States Only	
<b>Dispense As Written</b>	If you request to fill a brand name drug that has a generic equivalent available, you will be financially responsible for the difference in cost between the brand name and the generic drug, plus any required brand name drug copayment and/or coinsurance, if applicable. However, if your doctor has determined a generic drug is not an acceptable alternative for you, you will only be responsible for payment of the appropriate brand name drug copayment and/or coinsurance, if applicable
<b>Prescription Drug List</b>	Performance 3-Tier
<b>Step Therapy</b>	Certain drugs are subject to step therapy requirements. To identify whether a particular drug is subject to step therapy, please refer to your prescription drug list.
<b>Prior Authorization</b>	Coverage for certain drugs require your Physician to obtain prior authorization from Cigna. To identify whether a particular drug requires prior authorization, please refer to your prescription drug list.
To see if your medication is covered, you can view Cigna's Prescription Drug List by going to <a href="http://www.Cigna.com/druglist">www.Cigna.com/druglist</a> and select "Performance 3-Tier"	

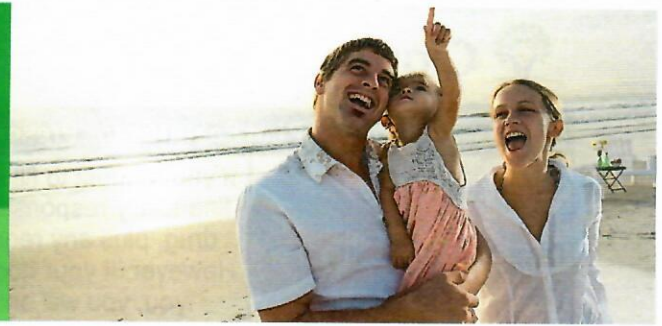
Global Evacuation Plan	
<b>Toll Free telephone number</b>	1.800.441.2668
<b>Repatriation Only</b>	Covered with a per occurrence limit of USD 20,000.00

Global Telehealth	
<b>Teladoc Health International</b>	<p>Available 24/7 via the Cigna Wellbeing App, Global Telehealth gives you access to licensed doctors around the world.</p> <ul style="list-style-type: none"><li>• Video or phone consultations with licensed doctors when medically necessary</li><li>• Prescriptions for common health concerns when medically necessary and permitted</li><li>• Treating medical conditions like fever, rash, pain and more</li><li>• Assistance with preparations for an upcoming consultation</li><li>• Discussing medication plan and potential side effects</li><li>• Diagnosing non-emergency health issues ranging from acute conditions to complex chronic conditions</li></ul>



# CIGNA GLOBAL HEALTH ADVANTAGE 10+

## How to reach us



### How we make a difference

Cigna is committed to providing superior service to our clients and customers. It doesn't matter where you are working or what time zone you are in. Our clients and customers can reach us 24 hours a day, 7 days a week by calling our global service center or via email through Cigna Envoy®.

PHONE	
Toll-free phone (U.S. & Canada)	1.800.441.2668
Toll-free TDD telephone number for the hearing impaired	1.800.558.3604
Direct phone (collect calls accepted)	001.302.797.3100
FAX	
Toll-Free facsimile	1.800.243.6998
Direct fax (inside the U.S.)	001.302.797.3150
WEBSITE	
Cigna Envoy	<a href="http://www.CignaEnvoy.com">www.CignaEnvoy.com</a>

## Cigna Global Health Benefits\*



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