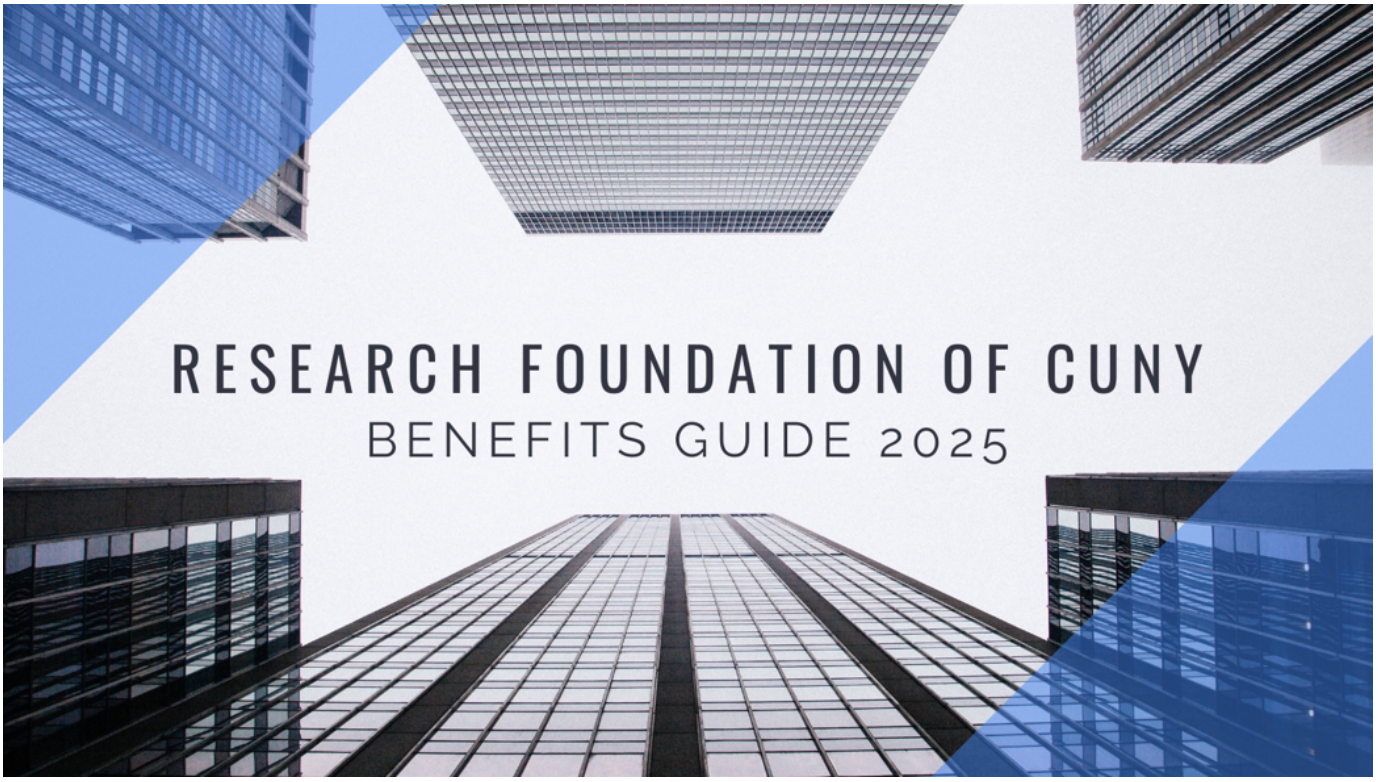

RESEARCH FOUNDATION OF CUNY
BENEFITS GUIDE 2025

SECTION **PAGE**

DISCLAIMER:

This guide contains highlights of only the major provisions of the benefit programs of the Research Foundation of CUNY. Legal documents describe the plan in complete detail and govern its operation. If there is a disagreement between this guide and any legal document, the terms of the legal document always govern. The Research Foundation of CUNY, at its discretion, may change any benefits, term or conditions contained therein without notice.

None of the Benefits or Policies stated herein are intended to be contractual in nature. They do not confer any right or privilege but are informational only. The Research Foundation retains the absolute right to amend or terminate any Benefit or Policy at any time.

WELCOME

Welcome to the Research Foundation of the City University of New York (RFCUNY). We are pleased that you have accepted a position with us. This guide will outline the many group insurance benefits offered. RFCUNY's goal is to provide you with well-balanced coverage that allows you to create a package of health benefits suited to your needs and your budget. Some of the benefits available to you require contributions on your part and some are provided by RFCUNY at no cost to you. The amount you will need to contribute for your benefits will vary, based on your selection of coverage.

All employees must log-on to **www.rfcuny.org > Electronic Tools > My Payroll and Benefits** portal in order to view eligibility, enroll, or waive coverage. Newly hired employees have until their benefits eligibility date to elect their benefits online.

IMPORTANT CONTACTS

Research Foundation Benefits: 212-417-8600, option 4; benefits@rfcuny.org

Baruch, City, CUNY Law, John Jay, Queens

Cecilia Patxot	Benefits Manager	212-417-8632

Brooklyn, CUNY SPH, Graduate, Hunter, Journalism, Medgar Evers, NYCCT, CUNY ASRC

Lisa Mayo	Sr. Campus Benefits Coordinator	212-417-8631

Bronx CC, College of Staten Is, BMCC, Hostos, KBCC, LaGuardia, Lehman, Queensborough, York

Cristian Valdovinos	Campus Benefits Coordinator	212-417-8638

CUNY Central, CUNY ISLG, CUNY SPS, Macaulay Honors, S&C Guttman

Sara Tahir	Campus Benefits Coordinator	212-417-8634

Unemployment information: 212-417-8630 Ratna_Karki@rfcuny.org
Employment Verifications: www.QuickConfirm.com; 1-631-651-8730 or 888-505-6745 option 3
Cigna Healthcare Customer Service: 800-244-6224; www.cigna.com
Advanced Benefits Strategies: 877-732-8125; www.abs125.com
Aflac: Denise Perez 201-739-6897; denise_perez@us.aflac.com
Health Advocate: 866-799-2728; www.healthadvocate.com/rfcuny
TIAA: 800-842-2252: https://www.tiaa.org/public/tcm/rfcuny
RFCUNY 403(b) Enrollments: Julian_Osorio@rfcuny.org
RFCUNY Healthcare Claims Assistance: Quynn_Brock@rfcuny.org

ABOUT THE RESEARCH FOUNDATION of CUNY (RFCUNY)

The Research Foundation of CUNY(RFCUNY) is a private, not-for-profit educational corporation chartered by the State of New York in 1963. The RFCUNY supports City University of New York (CUNY) faculty and staff in identifying and obtaining external support (pre-award) from government and private sponsors and is responsible for the administration of all such funded programs (post-award). CUNY is the nation's largest urban public university. RFCUNY was established to manage the distinctive environment of sponsored programs and to respond quickly to a wide variety of conditions and changing sponsor requirements. Approximately 6,000 full- and part-time staff are employed by the RF annually and can be found in the laboratories, theaters, studios, libraries, and offices of CUNY's 25 colleges and professional schools, as well as at numerous off-campus sites.

Although the RFCUNY serves CUNY, it is governed by its own Board of Directors, issues its own independently audited financial statements, operates its own payroll system and benefits plan, and purchases a wide variety of goods and services in accordance with its own rules and regulations.

BENEFITS AT A GLANCE

FULL TIME PROJECT EMPLOYEES

PAID TIME-OFF (PTO)

- 15 Vacation Days
- 20 Sick Days
- 18 Scheduled and Unscheduled Holidays

Vacation (Annual Leave)

- Maximum annual accrual is 15 days (105 hours) per fiscal year
- Accrued at a rate of .057692 hours per 1 hour worked

Sick

- Maximum annual accrual is 20 days (140 hours) per fiscal year
- Accrued at a rate of .078571 hours per 1 hour worked
- 56 hours of Sick time is also available under the NYC & NYS Earned Sick Time Act

Personal Days (Unscheduled Holiday)

- 4 days per year, earned on the 1st day of the quarter
- Eligible after 90 days of employment

Holiday

- 14 days per year
    - Independence Day
    - Labor Day
    - Columbus Day
    - Thanksgiving Holiday (Thursday)
    - Day After Thanksgiving (Friday)
    - Christmas Holiday
    - Day After Christmas
    - New Year's Holiday
    - Day After New Year's
    - Martin Luther King Jr.
    - Lincoln's Birthday
    - President's Day
    - Memorial Day
    - Juneteenth

MEDICAL INSURANCE

- Medical insurance package is bundled with dental and vision insurance
- Eligible on the 1st day of the month following 30 days of employment
- Cigna Point of Service (POS) with participating providers in NY and counties bordering NY, NJ and CT
- Cigna Open Access Plus Plan (OAP) has a national and international network of participating providers
- Cigna Open Access Plus Plan In (OAPIN)shares a national network of OAP providers
- Employees who waive medical insurance and show proof of coverage elsewhere will be credited $38.47/paycheck (individual plan) or $57.70/paycheck (family plan)

  Coverage Levels:

  Employee Coverage
  Employee + Spouse Coverage
  Employee + Child (ren) Coverage
  Family Coverage

- Prescription drug coverage offered on all three plans. Co-pays vary by plan and drug tier. See Summary Plan Descriptions for more information

Prescription Drug Deductible	Applies to OAP plan only; Annual deductible is per person for Brand and Non-Formulary prescription drugs

DENTAL INSURANCE

- Cigna Dental PPO, national network of providers
- In-network and out-of-network coverage
- Eligible on the 1st day of the month following 30 days of employment
- Dental insurance is bundled with medical insurance. Costs per paycheck above include dental insurance.

DENTAL INSURANCE - PPO

	In-Network	Out-Of-Network
Diagnostic & Preventative exams, X-rays, sealant, fluoride treatment, prophylaxis	100%	80%
Basic Restorative filling, endodontics, routine extractions	100%	60%
Major Restorative periodontics, oral surgery, prosthetics	60%	50%
Orthodontia (coverage for dependent children up to age 26)	50%	50%
Deductible	$0	$50 Individual $100 Family

VISION INSURANCE

- Eligible on the 1st day of the month following 30 days of employment
- Benefit is covered every 24 months
- Vision insurance is bundled with medical insurance. Costs per paycheck above include vision insurance.
- Cigna EyeMeD , national network of providers
- In-network and out-of-network coverage

VISION BENEFITS

Eye Exam Co-Payment (every 24 months)	$5
Frames Co-Payment (every 24 months)	$130 allowance
Lenses Co-Payment	$0
Non-Network Frames	$45 allowance
Non-Network Lenses	$25 -$55 allowance

PRE-TAX FLEXIBLE SPENDING ACCOUNTS

Healthcare Flexible Spending Account

- Eligible after 90 days of employment
- Maximum annual deferral is $3,300

Dependent Care Flexible Spending Account

- Available upon benefits eligibility date
- Maximum annual deferral is $5,000

Transit Flexible Spending Account

- Available upon benefits eligibility date
- Maximum monthly election is $325

Parking Flexible Spending Account

- Available upon benefits eligibility date
- Maximum monthly election is $325

DISABILITY INSURANCE

Short-Term Disability Insurance

- Eligible after 30 days of employment
- Maximum weekly benefit is 50% of weekly salary, up to $170 per week
- 7-day waiting period
- 26-week maximum

Paid Family Medical Leave Disability Insurance

- Eligible scheduled to work 20 hours or more per week for 26 consecutive weeks
- To bond with a new child during first 12 months
- To provide care for an eligible family member with a serious illness
- To participate in qualifying exigencies as defined by FMLA due to spouse, domestic partner, child, or parent's active military service
- The amount of coverage may not be based on their specific salary.
- Coverage is capped at the amount an average New York worker would receive
- The maximum payout in 2025, will be $1,177.32

Long-Term Disability Insurance

- Eligible after 1 year of employment
- Maximum weekly benefit is 60% of monthly wage, up to $15,000 per month
- 26-week waiting period
- Maximum benefit determined by plan rules

LIFE AND AD&D INSURANCE

- Covered by RFCUNY at 100%
- Project employees earning over $30,000 annually have $30,000 coverage
- Project employees earning less than $30,000 annually have $15,000 coverage
- Eligible on the 1st day of the month following 30 days of employment

RESEARCH EDUCATIONAL ASSISTANCE PROGRAM (REAP) – Tuition Reimbursement

- Eligible after 1 year of employment
- Eligible for Full Time and Part Time A employees only for matriculated and job–related at CUNY colleges
- Contact Ratna Karki 212-417-8630 for more information

RFCUNY 403(b) RETIREMENT SAVINGS PLAN

Mandatory Participation

- Only applies to Full Time and Part Time A employees (see Plan Summary for details)
- Eligible after 1 year of employment
- Employees are 100% vested after completing 3 years of employment
- Employee contributions are not available
- Employer contributions are 8% of earnings for first 7 years of service, 10% thereafter

Elective (Voluntary) Contributions

- Annual maximums are set by IRS
- 2025 employee contributions are capped at $23,500 (under age 50) and $31,000 (over age 50)
- No employer contributions
- No waiting period
- All employees, regardless of status, are eligible

AFLAC VOLUNTARY SUPPLEMENTAL INDEMNITY PLANS

- Disability Income Protection Plan
- Accident Advantage Plan
- Hospital Advantage Plan – Essential
- Cancer Care Plan
- Contact Denise Perez at 201-739-6897 or via email at Denise_Perez@us.aflac.com

EMPLOYEE ASSISTANCE PROGRAM & HEALTH ADVOCACY PLAN

- By Health Advocate, 100% employer paid
- Available for use by employee, spouse, dependents, grandparents and/or in-laws
- Call 866-799-2728 or visit www.healthadvocate.com/rfcuny

RFCUNYPERKS

RFCUNYPerks gives employees access to premium discounts and access to shows, travel, car rentals, restaurants, shopping, special events, subscription services and more. Enjoy limited time and exclusive offers for holidays savings, savings for amusement parks such as Disney, Universal Orlando Resorts, Legoland, Sesame Place, and more. Registration is free.

RFCUNYPerks are available to all RFCUNY employees through partnership with:

- Working Advantage (formerly Plum Benefits) https://rfcuny.savings.workingadvantage.com/home
- FunEx **https://rfcuny.funex.com/**

UNION DUES

Employees at LaGuardia Community College, the Graduate Center and New York City Technical College may be covered under PSC-CUNY collective bargaining agreement. Under the CBA, as a condition of continued employment, within 30 calendar days of employment, the employee covered under the agreement must become a member of PSC-CUNY and pay dues or PSC-CUNY agency fees. Failure to pay union dues or agency fees will result in termination of employment as per the PSC-CUNY agreement. PSC-CUNY will contact eligible employees.

ELIGIBILITY

New appointments (or rehire after a 30-day break in service) as a Full-time or Part-time A employee will become eligible to participate in RFCUNY's health insurance program on the first day of the second complete calendar month of employment.

If the first day of the calendar month is a non-business day (Saturday, Sunday, or Holiday), the first business day of the month will count as the first day of the waiting period and benefits will begin on the first day of the following month.

The following employees are eligible for coverage:

1. All employees regardless of status or length of appointment are eligible for statutory benefits and RFCUNY Employee Perks. New York State Short Term Disability coverage, Unemployment Insurance, and Worker's Compensation coverage are government required benefits. RFCUNY Perks are available through Working Advantage and FunEx.

2. Full-time employees (those who work 70 or more hours biweekly and have a 90 day or more appointment) are eligible for Individual, Employee & Spouse, Parent and Child (ren), or Family coverage of Health, Prescription, Vision, Dental, Group Life and Accidental Death & Dismemberment (AD&D) Insurance, Long Term Disability Insurance (LTD), the Employee Assistance Program (EAP), Retirement Plan, Flexible Spending Accounts, Tuition Assistance Program, and Statutory benefits.

3. Part-time A employees (those who work more than 38 hours but fewer than 70 hours biweekly and have a 90 Day or more appointment) are eligible for coverage of Individual Health, Prescription, Vision, Dental, Employee Assistance Program (EAP), Retirement Plan, Flexible Spending Accounts, Tuition Assistance Program, and Statutory Benefits.

   Part-time A employees have the option to directly purchase additional Health, Prescription, Vision, and Dental coverage for their eligible dependents through our Direct Pay Program (see Direct Pay for more information).

4. Part-time B employees who work no more than 38 hours biweekly are eligible for Parking and Transit Pre-tax Flexible Spending Plans and voluntary Tax Deferred Annuity plan.

5. J1 Visa scholars with new appointment (or rehire after a 30-day break in service) as Full-time or Part-time A who is eligible to participate in RFCUNY's health insurance program must enroll as of the first day of employment. For example, the J1 Visa scholar with a start date of March 1, will begin participation on March 1.

Benefits Eligible Dependents:

1. Spouse
2. Domestic Partner
3. Dependent children are covered to the end of the month following the month in which they turn age 26.

The New York State Insurance Law permits young adults who have exceeded the age for dependent coverage under their parent's group health insurance plan to purchase coverage through their parent's policy or contract through the age of 29.

The eligibility date for health insurance is effective on the first day of the second complete calendar month of employment. For example, John Doe was hired on June 15, therefore, he is eligible for benefits on August 1.

Benefit	Full-Time Eligible?	Part-time A Eligible?	Part-time B Eligible?	Effective Date
Health and Prescription	Yes	Yes (Direct Pay for dependents)	No	Eligibility Date
Vision	Yes	Yes	No	Eligibility Date
Dental	Yes	Yes	No	Eligibility Date
Life and AD&D	Yes	No	No	Eligibility Date
Short-Term Disability	Yes	Yes	Yes	FT- after 30 calendar days. PT - after 20 workdays
Long-Term Disability	Yes	No	No	After 1 year of employment
Workers' Compensation	Yes	Yes	Yes	Eligibility Date
REAP Tuition Assistance Program	Yes	Yes	No	After 1 year of employment
Group Retirement Annuity (GRA)	Yes	Yes	No	After 1 year of employment
Group Supplemental Retirement Annuity (GSRA) *Optional	Yes	Yes	Yes	Eligibility Date
Health Care FSA	Yes	Yes	No	After 90 Days of employment
Dependent Care FSA	Yes	Yes	No	Eligibility Date
Parking/Transit	Yes	Yes	Yes	Eligibility Date
Voluntary/ Supplemental Plans (Aflac)	Yes	Yes	No	Eligibility Date

MEDICAL BENEFITS

Research Foundation offers health insurance coverage through Cigna Healthcare. Benefits eligible employees may enroll in the following plans: Cigna OAP, Cigna POS, Cigna OAPIN, or the Health Insurance Waiver (see page 9 & 18). The chart below highlights the major provisions of the plans. Please note, for a detailed list of the plans, see the summary plan descriptions on www.rfcuny.org **> Employees > Explore & Enroll in Employee Benefits**.

Cigna Plan Comparison-Project Employees January 1 to December 31, 2025			
	OAP w/Dental	**POS w/Dental**	**OAPIN w/Dental**
Primary Care Co-pay	**$30**	**$20**	**$20**
Specialist Co-pay	**$40**	**$25**	**$25**
Emergency Rm. Co-pay	**$75**	**$75**	**$75**
In Network Co-Insurance	**n/a**	**n/a**	**n/a**
In-Patient Hospital Co-pay	**$300 per episode**	**$250 per episode**	**$300 per episode**
	$750 Annual Max	**$625 Annual Max**	**$750 Annual Max**
Out of Network Deductibles	**$750**	**$500**	**No Out of Network Coverage**
	$1875 max. per family	**$1250 max. per family**	
Network	**National**	**NY Metro area**	**National**
Drug Co-pay	**$50 Annual Deductible for Brand and Non-Formulary Drugs**	**No deductible**	**No deductible**
	Deductible waived for generic drugs		
	$5 Generic	**$5 Generic**	**$5 Generic**
	$25 Brand	**$25 Brand**	**$25 Brand**
	$50 Non-Formulary	**$50 Non-Formulary**	**$50 Non-Formulary**

For additional information and a complete list of providers, contact Cigna Healthcare on Cigna App, 1-800-Cigna24 (800-244-6224) or www.myCigna.com.

DENTAL BENEFITS

Dental benefits are provided by Cigna. The plan summary is listed below.

Cigna Dental PPO				
Network Options	**In-Network Total Cigna DPPO Network**		**Out-of-Network Non-Network Reimbursement**	
Reimbursement Levels	**Based on Contracted Fee**		**Maximum Allowable Charge**	
Calendar Year Deductible Individual Family	 $0 $0		 $50 $150	
Benefit Highlights	**Plan Pays**	**You Pay**	**Plan Pays**	**You Pay**
Class I: Diagnostic & Preventive Oral Evaluations Prophylaxis: routine cleanings X-rays: routine X-rays: non-routine Fluoride Application Sealants: per tooth Space Maintainers: non-orthodontic Emergency Care to Relieve Pain	100% No Deductible	No Charge No Deductible	80% No Deductible	20% No Deductible
Class II: Basic Restorative Restorative: fillings Endodontics: minor and major Oral Surgery: minor Brush biopsy	100% No Deductible	No Charge No Deductible	80% After Deductible	20% After Deductible
Class III: Major Restorative Inlays and Onlays Oral Surgery: major Periodontics: minor and major Prosthesis Over Implant Crowns: prefabricated stainless steel /resin Crowns: permanent cast and porcelain Bridges and Dentures Anesthesia: general and IV sedation Endodontics: minor and major Repairs: Bridges, Crowns and Inlays Repairs: Dentures Denture Relines, Rebases and Adjustments	60% No Deductible	40% No Deductible	50% No Deductible	50% No Deductible
Class IV: Orthodontia Coverage for Dependent Children to age 26 Lifetime Benefits Maximum: $1,750	50% No Deductible	50% No Deductible	50% No Deductible	50% No Deductible

CIGNA customer service number 1-800-Cigna24 (800-244-6224) or visit myCigna.com

VISION BENEFITS

Vision benefits are bundled with medical and dental coverage through Cigna. See summary below.

BENEFIT	IN-NETWORK	OUT-OF-NETWORK
Routine Eye Exam (once exam every 24 months)	$5 co-pay	$40 allowance
Eyeglass Frames (once every 24 months)	$130 allowance, then 20% off any remaining balance	$45 allowance
Eyeglass Lenses (single vision, bifocal, or trifocal) One pair once every 24 months	$0 co-pay	$25 - $55 allowance
Elective Conventional Lenses (Hard)	$130 allowance, then 15% off any remaining balance	$105 allowance
Elective Disposable Contact Lenses (Soft)	$130.00 allowance (must be used in full). Only applies to first purchase.	$105 allowance
Non-Elective Contact Lenses	Covered in Full	$210 allowance
Eyeglass Lens Upgrades	$15 - $110 member cost depending on upgrade	

For information on Cigna EyeMed participating eye care providers, locations, and vision services, contact CIGNA customer service number 1-800-Cigna24 (800-244-6224) or visit myCigna.com

WAIVING HEALTH COVERAGE

This benefit is for Full-time and Part-time A employees.

Eligible employees have the option to waive their right to participate in RFCUNY's Health Insurance programs and receive a monetary incentive in lieu of health, dental, and vision insurance. Employees who apply for the waiver must provide proof (supporting documentation) that they are covered through another health insurance carrier. Medicare, Medicaid, and ACA Health Exchange (Obamacare) are ineligible for opt-out incentives. This means that anyone who is enrolled in a government issued health insurance subsidy plan such as **Medicare, Medicaid and other government sponsored health insurance exchange does NOT qualify as alternative coverage**.

Depending on the tier level of their alternate coverage, employees can receive an annual incentive of $1,000 for waiving an individual plan or $1,500 for waiving a family plan and it is paid in prorated bi-weekly installments. You would receive the annualized amounts if you are on the payroll for 26 pay periods in a year.

Waiver Type	Biweekly	Annual
Individual	$38.47	$1,000
Parent and Child(ren)	$57.70	$1,500
Couple	$57.70	$1,500
Family	$57.70	$1,500

Under no circumstances will waivers be paid retroactively. Enrollment for the waiver program is for one calendar year only. Re-enrollment in the Benefits Waiver Program is not automatic.

Employees who choose to waive their health insurance benefits may not re-enroll in coverage until the next open enrollment period unless they experience a qualifying life event.

Examples of supporting documentation include a letter from the other health insurance carrier, a print-out of the profile page with employee's name and effective date of coverage, or a letter on official letterhead from the spouse or domestic partner's employer indicating that the RFCUNY employee is covered. RFCUNY will not accept copies of insurance cards or any supporting documentation without the RFCUNY employee's name on it.

COVERAGE LEVEL OPTIONS

The RFCUNY insurance program consists of the following insurance types and coverage level options: Individual, Parent & Child(ren), Employee & Spouse/Couple, and Family.

January 1, 2025 through December 31, 2025

FULL-TIME:

Program	Option	Monthly Premium Due
Cigna OAPIN(Medical) + Cigna PPO (Dental)	Individual	$185.44
	Parent & Child(ren)	$336.67
	Employee & Spouse/Couple	$381.18
	Family	$567.30
Cigna POS (Medical) + Cigna PPO (Dental)	Individual	$246.17
	Parent & Child(ren)	$454.97
	Employee & Spouse/Couple	$516.55
	Family	$773.98
Cigna OAP (Medical) + Cigna PPO (Dental)	Individual	$254.53
	Parent & Child(ren)	$463.35
	Employee & Spouse/Couple	$525.14
	Family	$784.21

PART-TIME A are only eligible for individual coverage (Direct Pay option available)

Program	Option	Monthly Premium Due
Cigna OAPIN(Medical) + Cigna PPO (Dental)	Individual	$185.44
Cigna POS (Medical) + Cigna PPO (Dental)	Individual	$246.17
Cigna OAP (Medical) + Cigna PPO (Dental)	Individual	$254.53

Medical, prescription, vision and dental coverage are bundled. When enrolling in medical coverage there is automatic enrollment in prescription and vision. Dental coverage is included for Full-time and Part-Time A employees.

The monthly premium is deducted from the first paycheck of every month. Please note that new hires and newly eligible employees will have a double deduction when they first enroll in benefits. The first deduction covers the current month of enrollment while the additional deduction provides for an extra month of coverage after separation from RFCUNY employment or otherwise loss of coverage.

Direct Pay Program (for Part Time A Employees)

Individual health insurance coverage is available to all Part-time A employees along with the option to directly purchase additional coverage for their spouse/ domestic partner and /or children at 100% of the cost for the dependent(s)' coverage. A deduction will be taken from the employee's paycheck each month for the employee's individual coverage. In addition, the employee will need to submit payment directly to RFCUNY each month to cover any additional dependents. RFCUNY's Department of Human Resources must receive payment no later than the fifth calendar day of the month for which coverage applies. (Example - a check must be received by July 5th for coverage during the month of July). Failure to provide full payment will result in the cancellation of the dependent's coverage. Payment may be furnished through a direct debit to a bank account, or by check or money order.

In order to participate in the Direct Pay program, the employee must enroll in Health Insurance online in the **My Payroll and Benefits** system and elect an option other than Individual coverage.

DIRECT PAY PROGRAM (This chart includes rates for insuring Dependents up to the age of 29)

Program	Option	Monthly Premium Due
Cigna OAPIN(Medical) + Cigna PPO (Dental)	Individual (Dep. up to age 29) Parent w/Child(ren) Employee & Spouse/Couple Family	$883.05 $720.14 $932.11 $1,818.37
Cigna POS(Medical) + Cigna PPO (Dental)	Individual (Dep. up to age 29) Parent w/Child(ren) Employee & Spouse/Couple Family	$1,172.25 $994.27 $1,287.51 $2,513.37
Cigna OAP(Medical) + Cigna PPO (Dental)	Individual (Dep. up to age 29) Parent w/Child(ren) Employee & Spouse/Couple Family	$1,212.07 $994.36 $1,288.62 $2,522.26

BENEFIT SUMMARY

Administered by - Cigna Health and Life Insurance Co.
For - Research Foundation of the City University of New York
Open Access Plus IN Plan
OAPIN
Effective - 01/01/2025

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.

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.

Plan Highlights	In-Network
Lifetime Maximum	Unlimited
Plan Year Accumulation	Your Plan's Deductibles, Out-of-Pockets and benefit level limits accumulate on a calendar year basis unless otherwise stated.
Plan Coinsurance	Plan pays 100%
Maximum Reimbursable Charge	Not Applicable
Plan Deductible	Individual: None Family: None
Plan Out-of-Pocket Maximum	Individual: $5,080 Family: $12,700

- All benefit copays/deductibles contribute towards your out-of-pocket maximum.
- Covered expenses that count towards your out-of-pocket maximum include customer paid coinsurance and charges for Mental Health and Substance Use Disorder.
- After each eligible family member meets his or her individual out-of-pocket maximum, the plan will pay 100% of their covered expenses. Or, after the family out-of-pocket maximum has been met, the plan will pay 100% of each eligible family member's covered expenses.
- This plan includes a combined Medical/Pharmacy out-of-pocket maximum.

Benefit	In-Network
Physician Services - Office Visits	
Primary Care Physician (PCP) Services/Office Visit	$20 copay, and plan pays 100%
Specialty Care Physician Services/Office Visit	$25 copay, and plan pays 100%
NOTE: Obstetrician and Gynecologist (OB/GYN) visits are subject to either the PCP or Specialist cost share depending on how the provider contracts with Cigna (i.e. as PCP or as Specialist).	
Surgery Performed in Physician's Office	Covered same as Physician Services - Office Visit
Allergy Treatment/Injections and Allergy Serum Allergy serum dispensed by the physician in the office **Note:** Office copay does not apply if only the allergy serum is provided.	Covered same as Physician Services - Office Visit
Virtual Care	
Dedicated Virtual Providers - MDLIVE	
MDLIVE Urgent Virtual Care Services	Plan pays 100%
MDLIVE Primary Care Services	Plan pays 100%
MDLIVE Specialty Care Services	Plan pays 100%
• Primary Care cost share applies to routine care. Virtual wellness screenings are payable under Preventive Care. • For MDLIVE Behavioral Services, please refer to the Mental Health and Substance Use Disorder section (below). • Lab services supporting a virtual visit must be obtained through dedicated labs. • Includes charges for the delivery of medical and health-related services and consultations by dedicated virtual providers as medically appropriate through audio, video, and secure internet-based technologies.	
Virtual Physician Services - Office Visits	
Primary Care Physician (PCP) Services/Office Visit	$20 copay, and plan pays 100%
Specialty Care Physician Services/Office Visit	$25 copay, and plan pays 100%
• Physicians may deliver services virtually that are payable under other benefits (e.g., Preventive Care, Outpatient Therapy Services). • Includes charges for the delivery of medical and health-related services and consultations as medically appropriate through audio, video, and secure internet-based technologies that are similar to office visit services provided in a face-to-face setting.	
NOTE: Obstetrician and Gynecologist (OB/GYN) visits are subject to either the PCP or Specialist cost share depending on how the provider contracts with Cigna (i.e. as PCP or as Specialist).	
Convenience Care Clinic	
Convenience Care Clinic	$20 copay, and plan pays 100%

Benefit	In-Network
Preventive Care	
Preventive Care • Includes coverage of additional services, such as urinalysis, EKG, and other laboratory tests, supplementing the standard Preventive Care benefit when billed as part of office visit. • Annual Limit: Unlimited	Plan pays 100%
Immunizations	Plan pays 100%
Mammogram, PAP, and PSA Tests • 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.	Plan pays 100%
Inpatient	
Inpatient Hospital Facility Services	$300 per admission copay up to a $750 maximum per calendar year
Note: Includes all Lab and Radiology services, including Advanced Radiological Imaging as well as Medical Specialty Drugs	
Inpatient Hospital Physician's Visit/Consultation	Plan pays 100%
Inpatient Professional Services • For services performed by Surgeons, Radiologists, Pathologists and Anesthesiologists	Plan pays 100%
Outpatient	
Outpatient Facility Services	Plan pays 100%
Outpatient Professional Services • For services performed by Surgeons, Radiologists, Pathologists and Anesthesiologists	Plan pays 100%
Emergency Services	
Emergency Room • Includes Professional, X-ray and/or Lab services performed at the Emergency Room and billed by the facility as part of the ER visit. • Per visit copay is waived if admitted.	$75 copay, and plan pays 100%
Urgent Care Facility • Includes Professional, X-ray and/or Lab services performed at the Urgent Care Facility and billed by the facility as part of the urgent care visit.	$25 copay, and plan pays 100%
Ambulance	Plan pays 100%
Ambulance services used as non-emergency transportation (e.g., transportation from hospital back home) generally are not covered.	
Ambulance - Mental Health and Substance Use Disorder	Plan pays 100%
Ambulance services used as non-emergency transportation (e.g., transportation from hospital back home) generally are not covered.	
Inpatient Services at Other Health Care Facilities	
Skilled Nursing Facility, Rehabilitation Hospital, Sub-Acute Facilities • Annual Limit: 60 days	Plan pays 100%

Benefit	In-Network
Laboratory Services	
Physician's Services/Office Visit	Plan pays 100%
Independent Lab	Plan pays 100%
Outpatient Facility	Plan pays 100%
Radiology Services	
Physician's Services/Office Visit	Plan pays 100%
Outpatient Facility	Plan pays 100%
Advanced Radiological Imaging (ARI)	Includes MRI, MRA, CAT Scan, PET Scan, etc.
Outpatient Facility	Plan pays 100%
Physician's Services/Office Visit	Covered same as Physician Services - Office Visit
Outpatient Therapy Services	
Outpatient Therapy Services	Covered same as Physician Services - Office Visit
Annual Limits: • Speech Therapy - 30 days • Occupational Therapy and Physical Therapy - 30 days • All other therapies - Includes Cognitive Therapy and Pulmonary Rehabilitation - 20 days • Limits are not applicable to mental health conditions for Physical, Speech and Occupational Therapies. **Note:** Therapy days, provided as part of an approved Home Health Care plan, accumulate to the applicable outpatient therapy services maximum.	
Chiropractic Services	Covered same as Physician Services - Office Visit
Annual Limit: • Chiropractic Care - Unlimited days	
Cardiac Rehabilitation Services	Covered same as Physician Services - Office Visit
Annual Limit: • Cardiac Rehabilitation - 36 days	
Hospice	
Inpatient Facilities	Plan pays 100%
Outpatient Services	Plan pays 100%
Note: Includes Bereavement counseling provided as part of a hospice program.	
Bereavement Counseling (for services not provided as part of a hospice program)	
Services Provided by a Mental Health Professional	Covered under Mental Health benefit

Benefit	In-Network
Medical Pharmaceutical Drugs	
Outpatient Facility	Plan pays 100%
Physician's Office	Plan pays 100%
Home	Plan pays 100%
Note: This benefit only applies to the cost of the Infusion Therapy drugs administered. This benefit does not cover the related Facility, Office Visit or Professional charges.	
Maternity	
Initial Visit to Confirm Pregnancy	Covered same as Physician Services - Office Visit
All Subsequent Prenatal Visits, Postnatal Visits and Physician's Delivery Charges (Global Maternity Fee)	Plan pays 100%
Office Visits in Addition to Global Maternity Fee (Performed by OB/GYN or Specialist)	Covered same as Physician Services - Office Visit
Delivery - Facility (Inpatient Hospital, Birthing Center)	Covered same as plan's Inpatient Hospital benefit
Abortion	
Abortion Services	Coverage varies based on Place of Service
Note: Elective and non-elective procedures	
Family Planning	
Women's Services	Plan pays 100%
Includes contraceptive devices as ordered or prescribed by a physician and surgical sterilization services, such as tubal ligation (excludes reversals)	
Men's Services	Coverage varies based on Place of Service
Includes surgical sterilization services, such as vasectomy (excludes reversals)	
Infertility	
Infertility Treatment	Coverage varies based on Place of Service
Infertility covered services: lab and radiology test, counseling, surgical treatment, includes artificial insemination, in-vitro fertilization, GIFT, ZIFT, etc. • Lifetime Maximum: Unlimited	

Benefit	In-Network
Outpatient Dialysis Services	
Physician's Services/Office Visit	Covered same as Physician Services - Office Visit
Home Dialysis **Note:** Dialysis visits will not accumulate to Home Health Care maximum	Covered same as plan's Home Health Care benefit
Outpatient Facility Services	Covered same as plan's Outpatient Facility Services benefit
Outpatient Professional Services	Covered same as plan's Outpatient Professional Services benefit
Other Health Care Facilities/Services	
Home Health Care	Plan pays 100%
• Annual Limit: 200 days (The limit is not applicable to mental health and substance use disorder conditions.) • 16 hour maximum per day **Note:** Includes outpatient private duty nursing when approved as medically necessary	
Organ Transplants	
Inpatient Hospital Facility Services	
LifeSOURCE Facility	$300 per admission copay up to $750 maximum per calendar year
Non-LifeSOURCE Facility	Covered same as plan's Inpatient Hospital benefit
Inpatient Professional Services	
LifeSOURCE Facility	Plan pays 100%
Non-LifeSOURCE Facility	Covered same as plan's Inpatient Professional benefit
• Travel Maximum - Cigna LifeSOURCE Transplant Network® Facility Only: $10,000 maximum per Transplant per Lifetime	
Durable Medical Equipment • Annual Limit: Unlimited	Plan pays 100%
Breast Feeding Equipment and Supplies • Limited to the rental of one breast pump per birth as ordered or prescribed by a physician • Includes related supplies	Plan pays 100%
External Prosthetic Appliances (EPA) • Annual Limit: Unlimited	Plan pays 100%
Temporomandibular Joint Disorder (TMJ) • Unlimited Non-Surgical lifetime maximum	Coverage varies based on Place of Service
Note: Provided on a limited, case-by-case basis. Excludes appliances and orthodontic treatment.	
Bariatric Surgery • Unlimited lifetime limit	Coverage varies based on Place of Service
Treatment of Clinically severe obesity, as defined by the body mass index (BMI) is covered. The following are excluded: • medical and surgical services to alter appearances or physical changes that are the result of any surgery performed for the management of obesity or clinically severe (morbid) obesity • weight loss programs or treatments, whether prescribed or recommended by a physician or under medical supervision	

Benefit	In-Network
Routine Foot Care	Not Covered
Note: Services associated with foot care for diabetes and peripheral vascular disease are covered when approved as medically necessary.	
Hearing Aids • Maximum of 2 devices per 24 months • Includes testing and fitting of hearing aid devices at Physician Office Visit cost share	Plan pays 100%
Acupuncture • Annual Limit: Unlimited	Covered same as Physician Services - Office Visit
Mental Health and Substance Use Disorder	
Inpatient Mental Health	$300 per admission copay up to $750 maximum per year
Outpatient Mental Health – Physician's Office	$20 copay, and plan pays 100%
Outpatient Mental Health - MDLIVE Behavioral Services	Plan pays 100%
Outpatient Mental Health – All Other Services	Plan pays 100%
Inpatient Substance Use Disorder	$300 per admission copay up to $750 maximum per year
Outpatient Substance Use Disorder – Physician's Office	$20 copay, and plan pays 100%
Outpatient Substance Use Disorder - MDLIVE Behavioral Services	Plan pays 100%
Outpatient Substance Use Disorder – All Other Services	Plan pays 100%
Annual Limits: • Unlimited maximum <u>Notes:</u> • Inpatient includes Acute Inpatient and Residential Treatment. • Outpatient - Physician's Office and MDLIVE Behavioral Services - may include Individual, family and group therapy, psychotherapy, medication management, etc. • Outpatient - All Other Services - may include Partial Hospitalization, Intensive Outpatient Services, Applied Behavior Analysis (ABA Therapy), etc. • Services are paid at 100% after you reach your out-of-pocket maximum. **Important Note on Mental Health and Substance Use Disorder Coverage:** Covered medical services listed above, which are received to diagnose or treat a Mental Health or Substance Use Disorder condition will be payable according to this section titled "Mental Health and Substance Use Disorder."	

Benefit	In-Network
Mental Health/Substance Use Disorder Utilization Review, Case Management and Programs **Cigna Total Behavioral Health - Inpatient and Outpatient Management** • Inpatient utilization review and case management • Outpatient utilization review and case management • Partial Hospitalization • Intensive outpatient programs • Changing Lives by Integrating Mind and Body Program • Lifestyle Management Programs: Stress Management, Tobacco Cessation and Weight Management. • Narcotic Therapy Management • inMynd℠ program - a comprehensive, holistic solution to help recognize and find resources to treat behavioral health conditions.	

Pharmacy	In-Network
Cost Share and Supply	
Cigna Pharmacy Cost Share • Retail – up to 90-day supply (except Specialty up to 30-day supply) • Home Delivery – up to 90-day supply	**Retail (per 30-day supply):** Generic: You pay $5 Preferred Brand: You pay $25 Non-Preferred Brand: You pay $50 **Retail (per 90-day supply):** Generic: You pay $15 Preferred Brand: You pay $75 Non-Preferred Brand: You pay $150 **Home Delivery (per 90-day supply):** Generic: You pay $10 Preferred Brand: You pay $50 Non-Preferred Brand: You pay $100

- **Cigna 90 Now Walgreens:** Retail drugs for a 30 day supply may be obtained In-Network at a wide range of pharmacies across the nation although prescriptions for a 90 day supply (such as maintenance drugs) will be available at select network pharmacies. CVS will be considered Out-of-Network for a 90 day supply.
- Cigna 90 Now Program: You can choose to fill your medications in a 30- or 90-day supply. If you choose to fill a 30-day prescription, it can be filled at any network retail pharmacy or network home delivery pharmacy. If you choose to fill a 90-day prescription, it must be filled at a 90-day network retail pharmacy or network home delivery pharmacy to be covered by the plan.
- This plan will not cover out-of-network pharmacy benefits.
- Specialty medications are used to treat an underlying disease which is considered to be rare and chronic including, but not limited to, multiple sclerosis, hepatitis C or rheumatoid arthritis. Specialty Drugs may include high cost medications as well as medications that may require special handling and close supervision when being administered.
- When patient requests brand drug, patient pays the brand cost share plus the cost difference between the brand and generic drugs up to the cost of the brand drug (unless the physician indicates "Dispense As Written" DAW).
- Exclusive specialty home delivery: Specialty medications must be filled through home delivery; otherwise you pay the entire cost of the prescription upon your first fill. Some exceptions may apply.
- If you use a manufacturer coupon to pay for some or all of the cost of a medication, the value of the coupon may not apply towards meeting your plan deductible or out-of-pocket maximum, if any.
- **SaveOn Specialty Program:** Certain specialty pharmacy drugs may be considered non-essential health benefits and may fall outside of the deductible and out-of-pocket limits. All drugs in this program are potentially subject to a higher cost share than amounts set forth above. If you participate in the program, cost share may be paid through a manufacturer copay assistance program and your out-of-pocket cost may be reduced to $0. If you do not participate in the program, then you will be responsible for the payment of the cost share for these medications and payment will not be applied towards your deductible and out-of-pocket maximums. See your plan documents for more specific information.
- Your pharmacy benefits share an out-of-pocket maximum with the medical/behavioral benefits.
- If you receive a supply of 34 days or less at home delivery (including a Specialty Prescription Drug), the home delivery pharmacy cost share will be adjusted to reflect a 30-day supply.

Drugs Covered

Prescription Drug List:
Your Cigna Legacy Prescription Drug List includes a full range of drugs including all those required under applicable health care laws. To check which drugs are included in your plan, please log on to myCigna.com.
Some highlights:

- Self Administered injectables are covered.
- Contraceptive devices and drugs are covered with federally required products covered at 100%.
- Insulin, glucose test strips, lancets, insulin needles & syringes, insulin pens and cartridges are covered.
- Lifestyle drugs are covered - limited to sexual dysfunction.
- Oral Fertility drugs are covered.
- Prescription weight loss drugs are covered.
- Prescription smoking cessation drugs are covered.

Pharmacy Program Information

Pharmacy Clinical Management: Essential
Your plan features drug management programs and edits to ensure safe prescribing, and access to medications proven to be the most reliable and cost effective for the medical condition, including:

- Prior authorization requirements
- Step Therapy on select classes of medications and drugs new to the market
- Quantity limits, including maximum daily dose edits, quantity over time edits, duration of therapy edits, and dose optimization edits
- Age edits, and refill-too-soon edits
- Plan exclusion edits
- Current users of Step Therapy medications will be allowed one 30-day fill during the first three months of coverage before Step Therapy program applies.
- Your plan includes Specialty Drug Management features, such as prior authorization and quantity limits, to ensure the safe prescribing and access to specialty medications.
- For customers with complex conditions taking a specialty medication, we will offer Accredo Therapeutic Resource Centers (TRCs) to provide specialty medication and condition counseling. For customers taking a specialty medication not dispensed by Accredo, Cigna experts will offer this important specialty medication and condition counseling.

Clinical Day Supply Program
Your plan includes the Clinical Day Supply Program for specialty drugs which provides a balance between specialty drug waste control and improved therapy adherence. During a stabilization period, certain specialty drugs, dispensed by a Cigna designated specialty pharmacy, may be limited to less than a consecutive 90 day supply. Further, for some drugs with a very high risk for early discontinuation, a split-fill (either 14 or 15 days), may be dispensed. Your cost share will be prorated to reflect the actual days' supply dispensed.

Patient Assurance Program
Your plan includes the Patient Assurance Program, which waives the deductible and reduces the amount you owe for certain medications used to treat chronic conditions included in the program. Additionally:

- Any amount you pay for these medications only count toward meeting your out-of-pocket maximum.
- Any discount provided by a pharmaceutical manufacturer for these medications only count toward meeting your out-of-pocket maximum.

Additional Information

Case Management
Coordinated by Cigna HealthCare. This is a service designated to provide assistance to a patient who is at risk of developing medical complexities or for whom a health incident has precipitated a need for rehabilitation or additional health care support. The program strives to attain a balance between quality and cost effective care while maximizing the patient's quality of life.

Cigna Diabetes Prevention Program in collaboration with Omada
Cigna Diabetes Prevention Program in collaboration with Omada is a program to help you avoid the onset of diabetes, as well as health risks that might lead to heart disease or a stroke. The program is covered by your health plan at the preventive level, just like for your wellness visit. Program participants have access to a professional virtual health coach, an online support group, interactive lessons, and a smart-technology scale. The program will help you make small changes in your eating, activity, sleep, and stress to achieve healthy weight loss through a series of 16 weekly lessons and tools to help you maintain weight loss over time. You will also be offered the opportunity to join a gym for a low monthly fee and no enrollment fee.

Comprehensive Oncology Program • Care Management outreach • Case Management	Included
Healthy Pregnancies/Healthy Babies • Care Management outreach • Maternity Case Management • Neo-natal Case Management	$150 (1st trimester) / $75 (2nd trimester) - Option 3

Out-of-Network Emergency Services Charges
1. Emergency Services are covered at the In-Network cost-sharing level as required by applicable state or federal law if services are received from a non-participating (Out-of-Network) provider.
2. The allowable amount used to determine the Plan's benefit payment for covered Emergency Services rendered in an Out-of-Network Hospital, or by an Out-of-Network provider in an In-Network Hospital, is the amount agreed to by the Out-of-Network provider and Cigna, or as required by applicable state or federal law.

The member is responsible for applicable In-Network cost-sharing amounts (any deductible, copay or coinsurance). The member is not responsible for any charges that may be made in excess of the allowable amount. If the Out-of-Network provider bills you for an amount higher than the amount you owe as indicated on the Explanation of Benefits (EOB), contact Cigna Customer Service at the phone number on your ID card.

Medicare Coordination
In accordance with the Social Security Act of 1965, this plan will pay Secondary to Medicare Part A and B as follows:
(a) a former Employee such as a retiree, a former Disabled Employee, a former Employee's Dependent Spouse and/or Dependent Child(ren), including a former Employee's Domestic Partner, or a COBRA continuant (whose insurance is continued for any reason), and who is also eligible for Medicare due to age or disability;
(b) an Employee's Domestic Partner who is also eligible for Medicare due to age;
(c) an Employee, a former Employee, an Employee's or former Employee's Dependent Spouse and/or Dependent Child(ren), an Employee's Dependent, including a Domestic Partner, who is eligible for Medicare due to End Stage Renal Disease after that person has been eligible for Medicare for 30 months.

When a person is eligible for Medicare A and B as described above, this plan will pay as the Secondary Plan to Medicare Part A and B **regardless if the person is actually enrolled in Medicare Part A and/or Part B and regardless if the person seeks care at a Medicare Provider or not for Medicare covered services.**

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.

Additional Information

One Guide
Available by phone or through myCigna mobile application. One Guide helps you navigate the health care system and make the most of your health benefits and programs.

Pre-Certification - Continued Stay Review - PHS+ Inpatient - required for all inpatient admissions
In-Network: Coordinated by your physician

Pre-Certification - PHS+ Outpatient Prior Authorization - required for selected outpatient procedures and diagnostic testing
In-Network: Coordinated by your physician

Pre-Existing Condition Limitation (PCL) does not apply.

Well-Being Solution: Core Plus

- Health assessment
- Device/app integration
- Personalized online content and data-driven actions
- Social connections/challenges
- Incentive administration

Your Health First - 200
Individuals with one or more of the chronic conditions, identified on the right, may be eligible to receive the following type of support:

- Condition Management
- Medication adherence
- Risk factor management
- Lifestyle issues
- Health & Wellness issues
- Pre/post-admission
- Treatment decision support
- Gaps in care

Holistic health support for the following chronic health conditions:

- Heart Disease
- Coronary Artery Disease
- Angina
- Congestive Heart Failure
- Acute Myocardial Infarction
- Peripheral Arterial Disease
- Asthma
- Chronic Obstructive Pulmonary Disease (Emphysema and Chronic Bronchitis)
- Diabetes Type 1
- Diabetes Type 2
- Metabolic Syndrome/Weight Complications
- Osteoarthritis
- Low Back Pain
- Anxiety
- Bipolar Disorder
- Depression

Definitions

Coinsurance - 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.
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.
Prescription Drug List - The list of prescription brand and generic drugs covered by your pharmacy plan.
Professional Services - Services performed by Surgeons, Assistant Surgeons, Hospital Based Physicians, Radiologists, Pathologists and Anesthesiologists
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.

Exclusions

What's Not Covered (not all-inclusive):
Your plan provides for most medically necessary services. The complete list of exclusions is provided in your Certificate or Summary Plan Description. To the extent there may be differences, the terms of the Certificate or Summary Plan Description control. Examples of things your plan does not cover, unless required by law or covered under the pharmacy benefit, include (but aren't limited to):

- Care for health conditions that are required by state or local law to be treated in a public facility.
- Care required by state or federal law to be supplied by a public school system or school district.
- Care for military service disabilities treatable through governmental services if you are legally entitled to such treatment and facilities are reasonably available.
- Treatment of an Injury or Sickness which is due to war, declared, or undeclared.
- Charges which you are not obligated to pay or for which you are not billed or for which you would not have been billed except that they were covered under this plan. For example, if Cigna determines that a provider or Pharmacy is or has waived, reduced, or forgiven any portion of its charges and/or any portion of Copayment, Deductible, and/or Coinsurance amount(s) you are required to pay for a Covered Expense (as shown on The Schedule) without Cigna's express consent, then Cigna in its sole discretion shall have the right to deny the payment of benefits in connection with the Covered Expense, or reduce the benefits in proportion to the amount of the Copayment, Deductible, and/or Coinsurance amounts waived, forgiven or reduced, regardless of whether the provider or Pharmacy represents that you remain responsible for any amounts that your plan does not cover. In the exercise of that discretion, Cigna shall have the right to require you to provide proof sufficient to Cigna that you have made your required cost share payment(s) prior to the payment of any benefits by Cigna. This exclusion includes, but is not limited to, charges of a non-Participating Provider who has agreed to charge you or charged you at an In-Network benefits level or some other benefits level not otherwise applicable to the services received.
- Provided further, if you use a coupon provided by a pharmaceutical manufacturer or other third party that discounts the cost of a prescription medication or other product, Cigna may, in its sole discretion, reduce the benefits provided under the plan in proportion to the amount of the Copayment, Deductible, and/or Coinsurance amounts to which the value of the coupon has been applied by the Pharmacy or other third party, and/or exclude from accumulation toward any plan Deductible or Out-of-Pocket Maximum the value of any coupon applied to any Copayment, Deductible and/or Coinsurance you are required to pay.
- Charges arising out of or relating to any violation of a healthcare-related state or federal law or which themselves are a violation of a healthcare-related state or federal law.
- Assistance in the activities of daily living, including but not limited to eating, bathing, dressing or other Custodial Services or self-care activities, homemaker services and services primarily for rest, domiciliary or convalescent care.
- For or in connection with experimental, investigational or unproven services.
- Experimental, investigational and unproven services are medical, surgical, diagnostic, psychiatric, substance use disorder or other health care technologies, supplies, treatments, procedures, drug or Biologic therapies or devices that are determined by the utilization review Physician to be:

Exclusions

- not approved by the U.S. Food and Drug Administration (FDA) or other appropriate regulatory agency to be lawfully marketed;
- not demonstrated, through existing peer-reviewed, evidence-based, scientific literature to be safe and effective for treating or diagnosing the condition or Sickness for which its use is proposed;
- the subject of review or approval by an Institutional Review Board for the proposed use except as provided in the "Clinical Trials" sections of this plan; or
- the subject of an ongoing phase I, II or III clinical trial, except for routine patient care costs related to qualified clinical trials as provided in the "Clinical Trials" sections of this plan.

In determining whether any such technologies, supplies, treatments, drug or Biologic therapies or devices are experimental, investigational and/or unproven, the utilization review Physician may rely on the clinical coverage policies maintained by Cigna or the Review Organization. Clinical coverage policies may incorporate, without limitation and as applicable, criteria relating to U.S. Food and Drug Administration-approved labeling, the standard medical reference compendia and peer-reviewed, evidence-based scientific literature or guidelines.

- Cosmetic surgery and therapies. Cosmetic surgery or therapy is defined as surgery or therapy performed to improve or alter appearance or self-esteem.
- The following services are excluded from coverage regardless of clinical indications: macromastia or gynecomastia surgeries; surgical treatment of varicose veins; abdominoplasty; panniculectomy; rhinoplasty; blepharoplasty; redundant skin surgery; removal of skin tags; acupressure; craniosacral/cranial therapy; dance therapy; movement therapy; applied kinesiology; rolfing; prolotherapy; and extracorporeal shock wave lithotripsy (ESWL) for musculoskeletal and orthopedic conditions.
- Dental treatment of the teeth, gums or structures directly supporting the teeth, including dental X-rays, examinations, repairs, orthodontics, periodontics, casts, splints and services for dental malocclusion, for any condition. Charges made for services or supplies provided for or in connection with an accidental Injury to teeth are covered provided a continuous course of dental treatment is started within six months of an accident.
- Medical and surgical services, initial and repeat, intended for the treatment or control of obesity, except for treatment of clinically severe (morbid) obesity as shown in Covered Expenses, including: medical and surgical services to alter appearance or physical changes that are the result of any surgery performed for the management of obesity or clinically severe (morbid) obesity; and weight loss programs or treatments, whether prescribed or recommended by a Physician or under medical supervision.
- Unless otherwise covered in this plan, for reports, evaluations, physical examinations, or hospitalization not required for health reasons including, but not limited to, employment, insurance or government licenses, and court-ordered, forensic or custodial evaluations.
- Court-ordered treatment or hospitalization, unless such treatment is prescribed by a Physician and listed as covered in this plan.
- Reversal of male or female voluntary sterilization procedures.
- Any medications, drugs, services or supplies for the treatment of male or female sexual dysfunction such as, but not limited to, treatment of erectile dysfunction (including penile implants), anorgasmy, and premature ejaculation.
- Medical and Hospital care and costs for the infant child of a Dependent, unless this infant child is otherwise eligible under this plan.
- Non-medical counseling and/or ancillary services including, but not limited to, Custodial Services, educational services, vocational counseling, training and rehabilitation services, behavioral training, biofeedback, neurofeedback, hypnosis, sleep therapy, return to work services, work hardening programs and driver safety courses.
- Therapy or treatment intended primarily to improve or maintain general physical condition or for the purpose of enhancing job, school, athletic or recreational performance, including but not limited to routine, long term, or maintenance care which is provided after the resolution of the acute medical problem and when significant therapeutic improvement is not expected.
- Consumable medical supplies other than ostomy supplies and urinary catheters. Excluded supplies include, but are not limited to bandages and other disposable medical supplies, skin preparations and test strips, except as specified in the "Home Health Services" or "Breast Reconstruction and Breast

Exclusions

Prostheses" sections of this plan.
- Private Hospital rooms and/or private duty nursing except as provided under the Home Health Services provision.
- Personal or comfort items such as personal care kits provided on admission to a Hospital, television, telephone, newborn infant photographs, complimentary meals, birth announcements, and other articles which are not for the specific treatment of an Injury or Sickness.
- Artificial aids including, but not limited to, corrective orthopedic shoes, arch supports, elastic stockings, garter belts, corsets, dentures and wigs.
- Aids or devices that assist with non-verbal communications, including but not limited to communication boards, pre-recorded speech devices, laptop computers, desktop computers, Personal Digital Assistants (PDAs), Braille typewriters, visual alert systems for the deaf and memory books.
- Eyeglass lenses and frames and contact lenses (except for the first pair of contact lenses for treatment of keratoconus or post cataract surgery).
- Routine refractions, eye exercises and surgical treatment for the correction of a refractive error, including radial keratotomy.
- All non-injectable prescription drugs, unless Physician administration or oversight is required, injectable prescription drugs to the extent they do not require Physician supervision and are typically considered self-administered drugs, non-prescription drugs, and investigational and experimental drugs, except as provided in this plan.
- Routine foot care, including the paring and removing of corns and calluses or trimming of nails. However, services associated with foot care for diabetes and peripheral vascular disease are covered when Medically Necessary.
- Membership costs or fees associated with health clubs, weight loss programs and smoking cessation programs.
- Genetic screening or pre-implantations genetic screening. General population-based genetic screening is a testing method performed in the absence of any symptoms or any significant, proven risk factors for genetically linked inheritable disease.
- Dental implants for any condition.
- Fees associated with the collection or donation of blood or blood products, except for autologous donation in anticipation of scheduled services where in the utilization review Physician's opinion the likelihood of excess blood loss is such that transfusion is an expected adjunct to surgery.
- Blood administration for the purpose of general improvement in physical condition.
- Cost of biologicals that are immunizations or medications for the purpose of travel, or to protect against occupational hazards and risks.
- Cosmetics, dietary supplements and health and beauty aids.
- All nutritional supplements and formulae except for infant formula needed for the treatment of inborn errors of metabolism.
- For or in connection with an Injury or Sickness arising out of, or in the course of, any employment for wage or profit.
- Charges for the delivery of medical and health-related services via telecommunications technologies, including telephone and internet, unless provided as specifically described under Covered Expenses.
- Massage therapy.

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, service agreement 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.

Cigna Healthcare products and services are provided exclusively by or through operating subsidiaries of The Cigna Group, including Cigna Health and Life Insurance Company, Connecticut General Life Insurance Company, Evernorth Behavioral Health, Inc., Evernorth Care Solutions, Inc. and HMO or service company subsidiaries of Cigna Health Corporation.

EHB State: NY

BENEFIT SUMMARY

Administered by - Cigna Health and Life Insurance Co.
For - Research Foundation of the City University of New York
Network POS Open Access Plan
POS
Effective - 01/01/2025

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.

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.

Plan Highlights	In-Network	Out-of-Network
Lifetime Maximum	Unlimited	Unlimited
Plan Year Accumulation	Your Plan's Deductibles, Out-of-Pockets and benefit level limits accumulate on a calendar year basis unless otherwise stated. In addition, all plan maximums and service-specific maximums (dollar and occurrence) cross-accumulate between In- and Out-of-Network unless otherwise noted.	
Plan Coinsurance	Plan pays 100%	Plan pays 70%
Maximum Reimbursable Charge	Not Applicable	80th Percentile
Plan Deductible	Individual: None Family: None	Individual: $500 Family: $1,250

- The amount you pay for out-of-network covered expenses counts towards your out-of-network deductibles.
- Benefit copays/deductibles always apply before plan deductible and coinsurance.
- 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.

Note: Services where plan deductible applies are noted with a caret (^).

Plan Highlights	In-Network	Out-of-Network
Plan Out-of-Pocket Maximum	Individual: $1,500 Family: $3,750	Individual: $1,500 Family: $3.750

- Only the amount you pay for in-network covered expenses counts toward your in-network out-of-pocket maximum. Only the amount you pay for out-of-network covered expenses counts toward your out-of-network out-of-pocket maximum.
- Plan deductible contributes towards your out-of-pocket maximum.
- All benefit copays/deductibles contribute towards your out-of-pocket maximum.
- Covered expenses that count towards your out-of-pocket maximum include customer paid coinsurance and charges for Mental Health and Substance Use Disorder. Out-of-network non-compliance penalties or charges in excess of Maximum Reimbursable Charge do not contribute towards the out-of-pocket maximum.
- After each eligible family member meets his or her individual out-of-pocket maximum, the plan will pay 100% of their covered expenses. Or, after the family out-of-pocket maximum has been met, the plan will pay 100% of each eligible family member's covered expenses.
- This plan includes a combined Medical/Pharmacy out-of-pocket maximum.

Benefit	In-Network	Out-of-Network
Note: Services where plan deductible applies are noted with a caret (^). Benefit copays/deductibles always apply before plan deductible.		
Physician Services - Office Visits		
Primary Care Physician (PCP) Services/Office Visit	$20 copay, and plan pays 100%	Plan pays 70% ^
Specialty Care Physician Services/Office Visit	$25 copay, and plan pays 100%	Plan pays 70% ^
Surgery Performed in Physician's Office	Covered same as Physician Services - Office Visit	Covered same as Physician Services - Office Visit
Allergy Treatment/Injections and Allergy Serum Allergy serum dispensed by the physician in the office **Note:** Office copay does not apply if only the allergy serum is provided.	Covered same as Physician Services - Office Visit	Covered same as Physician Services - Office Visit
Virtual Care		
Dedicated Virtual Providers - MDLIVE		
MDLIVE Urgent Virtual Care Services	Plan pays 100%	Not Covered

- Dedicated Virtual Providers may deliver services that are payable under other benefits (e.g., Preventive Care, Primary Care Physician, Behavioral; Dermatology/Specialty Care Physician).
- Lab services supporting a virtual visit must be obtained through dedicated labs.
- Includes charges for the delivery of medical and health-related services and consultations by dedicated virtual providers as medically appropriate through audio, video, and secure internet-based technologies.

Benefit	In-Network	Out-of-Network
Note: Services where plan deductible applies are noted with a caret (^). Benefit copays/deductibles always apply before plan deductible.		
Virtual Physician Services - Office Visits		
Primary Care Physician (PCP) Services/Office Visit	$20 copay, and plan pays 100%	Plan pays 70% ^
Specialty Care Physician Services/Office Visit	$25 copay, and plan pays 100%	Plan pays 70% ^
• Physicians may deliver services virtually that are payable under other benefits (e.g., Preventive Care, Outpatient Therapy Services). • Includes charges for the delivery of medical and health-related services and consultations as medically appropriate through audio, video, and secure internet-based technologies that are similar to office visit services provided in a face-to-face setting.		
Convenience Care Clinic		
Convenience Care Clinic	$20 copay, and plan pays 100%	Plan pays 70% ^
Preventive Care		
Preventive Care	Plan pays 100%	Plan pays 70% ^
• Includes Well-Baby, Well-Child, Well-Woman and Adult Preventive Care • Includes coverage of additional services, such as urinalysis, EKG, and other laboratory tests, supplementing the standard Preventive Care benefit when billed as part of office visit.		
Immunizations	Plan pays 100%	Plan pays 70% ^
Mammogram, PAP, and PSA Tests	Plan pays 100%	Covered same as other x-ray and lab services, based on Place of Service
• 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. • Associated wellness exam is covered in-network only.		
Inpatient		
Inpatient Hospital Facility Services	$250 per admission copay up to a $625 maximum per calendar year	Plan pays 70% ^
Note: Includes all Lab and Radiology services, including Advanced Radiological Imaging		
Inpatient Hospital Physician's Visit/Consultation	Plan pays 100%	Plan pays 70% ^
Inpatient Professional Services	Plan pays 100%	Plan pays 70% ^
• For services performed by Surgeons, Radiologists, Pathologists and Anesthesiologists		
Outpatient		
Outpatient Facility Services	Plan pays 100%	Plan pays 70% ^
Outpatient Professional Services	Plan pays 100%	Plan pays 70% ^
• For services performed by Surgeons, Radiologists, Pathologists and Anesthesiologists		

Benefit	In-Network	Out-of-Network
Note: Services where plan deductible applies are noted with a caret (^). Benefit copays/deductibles always apply before plan deductible.		
Emergency Services		
Emergency Room • Includes Professional, X-ray and/or Lab services performed at the Emergency Room and billed by the facility as part of the ER visit. • Per visit copay is waived if admitted.	$75 copay, and plan pays 100%	$75 copay, and plan pays 100%
Urgent Care Facility • Includes Professional, X-ray and/or Lab services performed at the Urgent Care Facility and billed by the facility as part of the urgent care visit.	$25 copay, and plan pays 100%	$25 copay, and plan pays 100%
Ambulance	Plan pays 100%	Plan pays 100%
Ambulance services used as non-emergency transportation (e.g., transportation from hospital back home) generally are not covered.		
Ambulance - Mental Health and Substance Use Disorder	Plan pays 100%	Plan pays 100%
Ambulance services used as non-emergency transportation (e.g., transportation from hospital back home) generally are not covered.		
Inpatient Services at Other Health Care Facilities		
Skilled Nursing Facility, Rehabilitation Hospital, Sub-Acute Facilities • Annual Limit: 60 days	Plan pays 100%	Plan pays 70% ^
Laboratory Services		
Physician's Services/Office Visit	Covered same as Physician Services - Office Visit	Covered same as Physician Services - Office Visit
Independent Lab	Plan pays 100%	Plan pays 70% ^
Outpatient Facility	Plan pays 100%	Plan pays 70% ^
Radiology Services		
Physician's Services/Office Visit	Covered same as Physician Services - Office Visit	Covered same as Physician Services - Office Visit
Outpatient Facility	Plan pays 100%	Plan pays 70% ^
Advanced Radiological Imaging (ARI)	Includes MRI, MRA, CAT Scan, PET Scan, etc.	
Outpatient Facility	Plan pays 100%	Plan pays 70% ^
Physician's Services/Office Visit	Covered same as Physician Services - Office Visit	Covered same as Physician Services - Office Visit

Benefit	In-Network	Out-of-Network
Note: Services where plan deductible applies are noted with a caret (^). Benefit copays/deductibles always apply before plan deductible.		
Outpatient Therapy Services		
Outpatient Therapy Services	Covered same as Physician Services - Office Visit	Covered same as Physician Services - Office Visit
Annual Limits: • All Therapies Combined - Includes Cognitive Therapy, Occupational Therapy, Physical Therapy, Pulmonary Rehabilitation, and Speech Therapy - 90 days • Limits are not applicable to mental health conditions for Physical, Speech and Occupational Therapies. **Note:** Therapy days, provided as part of an approved Home Health Care plan, accumulate to the applicable outpatient therapy services maximum.		
Chiropractic Services	Covered same as Physician Services - Office Visit	Covered same as Physician Services - Office Visit
Annual Limit: • Chiropractic Care - Unlimited days		
Cardiac Rehabilitation Services	Covered same as Physician Services - Office Visit	Covered same as Physician Services - Office Visit
Annual Limit: • Cardiac Rehabilitation - 36 days		
Hospice		
Inpatient Facilities	Plan pays 100%	Plan pays 70% ^
Outpatient Services	Plan pays 100%	Plan pays 70% ^
Note: Includes Bereavement counseling provided as part of a hospice program.		
Bereavement Counseling (for services not provided as part of a hospice program)		
Services Provided by a Mental Health Professional	Covered under Mental Health benefit	Covered under Mental Health benefit
Maternity		
Initial Visit to Confirm Pregnancy	Covered same as Physician Services - Office Visit	Covered same as Physician Services - Office Visit
All Subsequent Prenatal Visits, Postnatal Visits and Physician's Delivery Charges (Global Maternity Fee)	Plan pays 100%	Plan pays 70% ^
Office Visits in Addition to Global Maternity Fee (Performed by OB/GYN or Specialist)	Covered same as Physician Services - Office Visit	Covered same as Physician Services - Office Visit
Delivery - Facility (Inpatient Hospital, Birthing Center)	Covered same as plan's Inpatient Hospital benefit	Covered same as plan's Inpatient Hospital benefit
Abortion		
Abortion Services	Coverage varies based on Place of Service	Coverage varies based on Place of Service
Note: Elective and non-elective procedures		

Benefit	In-Network	Out-of-Network
Note: Services where plan deductible applies are noted with a caret (^). Benefit copays/deductibles always apply before plan deductible.		
Family Planning		
Women's Services	Plan pays 100%	Coverage varies based on Place of Service
Includes contraceptive devices as ordered or prescribed by a physician and surgical sterilization services, such as tubal ligation (excludes reversals)		
Men's Services	Coverage varies based on Place of Service	Coverage varies based on Place of Service
Includes surgical sterilization services, such as vasectomy (excludes reversals)		
Infertility		
Infertility Treatment	Coverage varies based on Place of Service	Coverage varies based on Place of Service
Infertility covered services: lab and radiology test, counseling, surgical treatment, includes artificial insemination, in-vitro fertilization, GIFT, ZIFT, etc. • Lifetime Maximum: Unlimited		
Outpatient Dialysis Services		
Physician's Services/Office Visit	Covered same as Physician Services - Office Visit	Covered same as Physician Services - Office Visit
Home Dialysis **Note:** Dialysis visits will not accumulate to Home Health Care maximum	Covered same as plan's Home Health Care benefit	Covered same as plan's Home Health Care benefit
Outpatient Facility Services	Covered same as plan's Outpatient Facility Services benefit	Covered same as plan's Outpatient Facility Services benefit
Outpatient Professional Services	Covered same as plan's Outpatient Professional Services benefit	Covered same as plan's Outpatient Professional Services benefit
Other Health Care Facilities/Services		
Home Health Care	Plan pays 100%	Plan pays 70% ^
• Annual Limit: 200 days (The limit is not applicable to mental health and substance use disorder conditions.) • 16 hour maximum per day **Note:** Includes outpatient private duty nursing when approved as medically necessary		
Organ Transplants	Coverage varies based on Place of Service at In-Network cost share	Not Covered
• Services paid at in-network level if performed at Cigna LifeSOURCE Transplant Network® Facilities. • Travel Maximum - Cigna LifeSOURCE Transplant Network® Facility Only: $10,000 maximum per Transplant per Lifetime		
Durable Medical Equipment • Annual Limit: Unlimited	Plan pays 100%	Plan pays 70% ^
Breast Feeding Equipment and Supplies • Limited to the rental of one breast pump per birth as ordered or prescribed by a physician • Includes related supplies	Plan pays 100%	Plan pays 70% ^

Benefit	In-Network	Out-of-Network
Note: Services where plan deductible applies are noted with a caret (^). Benefit copays/deductibles always apply before plan deductible.		
External Prosthetic Appliances (EPA) • Annual Limit: Unlimited	Plan pays 100%	Plan pays 70% ^
Temporomandibular Joint Disorder (TMJ)	Coverage varies based on Place of Service	Coverage varies based on Place of Service
Note: Provided on a limited, case-by-case basis. Excludes appliances and orthodontic treatment.		
Bariatric Surgery • Unlimited lifetime limit	Coverage varies based on Place of Service	Not Covered
Treatment of Clinically severe obesity, as defined by the body mass index (BMI) is covered. The following are excluded: • medical and surgical services to alter appearances or physical changes that are the result of any surgery performed for the management of obesity or clinically severe (morbid) obesity • weight loss programs or treatments, whether prescribed or recommended by a physician or under medical supervision		
Routine Foot Care	Not Covered	Not Covered
Note: Services associated with foot care for diabetes and peripheral vascular disease are covered when approved as medically necessary.		
Hearing Aids • Maximum of 2 devices per 24 months • Includes testing and fitting of hearing aid devices at Physician Office Visit cost share	Plan pays 100%	Not Covered
Acupuncture • Annual Limit: Unlimited days	Covered same as Physician Services - Office Visit	Covered same as Physician Services - Office Visit

Benefit	In-Network	Out-of-Network
Note: Services where plan deductible applies are noted with a caret (^). Benefit copays/deductibles always apply before plan deductible.		
Mental Health and Substance Use Disorder		
Inpatient Mental Health	$250 per admission copay up to a $625 maximum per calendar year.	Plan pays 70% ^
Outpatient Mental Health – Physician's Office	$20 copay, and plan pays 100%	Plan pays 70% ^
Outpatient Mental Health – All Other Services	Plan pays 100%	Plan pays 70% ^
Inpatient Substance Use Disorder	$250 per admission copay up to a $625 maximum per calendar year.	Plan pays 70% ^
Outpatient Substance Use Disorder – Physician's Office	$20 copay, and plan pays 100%	Plan pays 70% ^
Outpatient Substance Use Disorder – All Other Services	Plan pays 100%	Plan pays 70% ^

Annual Limits:

- Unlimited maximum

Notes:

- Inpatient includes Acute Inpatient and Residential Treatment.
- Outpatient - Physician's Office - may include Individual, family and group therapy, psychotherapy, medication management, etc.
- Outpatient - All Other Services - may include Partial Hospitalization, Intensive Outpatient Services, Applied Behavior Analysis (ABA Therapy), etc.
- Services are paid at 100% after you reach your out-of-pocket maximum.

Important Note on Mental Health and Substance Use Disorder Coverage: Covered medical services listed above, which are received to diagnose or treat a Mental Health or Substance Use Disorder condition will be payable according to this section titled "Mental Health and Substance Use Disorder."

Mental Health/Substance Use Disorder Utilization Review, Case Management and Programs

Cigna Total Behavioral Health - Inpatient and Outpatient Management

- Inpatient utilization review and case management
- Outpatient utilization review and case management
- Partial Hospitalization
- Intensive outpatient programs
- Changing Lives by Integrating Mind and Body Program
- Lifestyle Management Programs: Stress Management, Tobacco Cessation and Weight Management.
- Narcotic Therapy Management
- inMynd℠ program - a comprehensive, holistic solution to help recognize and find resources to treat behavioral health conditions.

Pharmacy	In-Network
Cost Share and Supply	
Cigna Pharmacy Cost Share • Retail – up to 90-day supply (except Specialty up to 30-day supply) • Home Delivery – up to 90-day supply	**Retail (per 30-day supply):** Generic: You pay $5 Preferred Brand: You pay $25 Non-Preferred Brand: You pay $50 **Retail (per 90-day supply):** Generic: You pay $15 Preferred Brand: You pay $75 Non-Preferred Brand: You pay $150 **Home Delivery (per 90-day supply):** Generic: You pay $10 Preferred Brand: You pay $50 Non-Preferred Brand: You pay $100

- **Cigna 90 Now Walgreens:** Retail drugs for a 30 day supply may be obtained In-Network at a wide range of pharmacies across the nation although prescriptions for a 90 day supply (such as maintenance drugs) will be available at select network pharmacies. CVS will be considered Out-of-Network for a 90 day supply.
- Cigna 90 Now Program: You can choose to fill your medications in a 30- or 90-day supply. If you choose to fill a 30-day prescription, it can be filled at any network retail pharmacy or network home delivery pharmacy. If you choose to fill a 90-day prescription, it must be filled at a 90-day network retail pharmacy or network home delivery pharmacy to be covered by the plan.
- This plan will not cover out-of-network pharmacy benefits.
- Specialty medications are used to treat an underlying disease which is considered to be rare and chronic including, but not limited to, multiple sclerosis, hepatitis C or rheumatoid arthritis. Specialty Drugs may include high cost medications as well as medications that may require special handling and close supervision when being administered.
- When patient requests brand drug, patient pays the brand cost share plus the cost difference between the brand and generic drugs up to the cost of the brand drug (unless the physician indicates "Dispense As Written" DAW).
- Exclusive specialty home delivery: Specialty medications must be filled through home delivery; otherwise you pay the entire cost of the prescription upon your first fill. Some exceptions may apply.
- If you use a manufacturer coupon to pay for some or all of the cost of a medication, the value of the coupon may not apply towards meeting your plan deductible or out-of-pocket maximum, if any.
- **SaveOn Specialty Program:** Certain specialty pharmacy drugs may be considered non-essential health benefits and may fall outside of the deductible and out-of-pocket limits. All drugs in this program are potentially subject to a higher cost share than amounts set forth above. If you participate in the program, cost share may be paid through a manufacturer copay assistance program and your out-of-pocket cost may be reduced to $0. If you do not participate in the program, then you will be responsible for the payment of the cost share for these medications and payment will not be applied towards your deductible and out-of-pocket maximums. See your plan documents for more specific information.
- Your pharmacy benefits share an out-of-pocket maximum with the medical/behavioral benefits.
- If you receive a supply of 34 days or less at home delivery (including a Specialty Prescription Drug), the home delivery pharmacy cost share will be adjusted to reflect a 30-day supply.

Drugs Covered

Prescription Drug List:
Your Cigna Legacy Prescription Drug List includes a full range of drugs including all those required under applicable health care laws. To check which drugs are included in your plan, please log on to myCigna.com.
Some highlights:

- Self Administered injectables are covered.
- Contraceptive devices and drugs are covered with federally required products covered at 100%.
- Insulin, glucose test strips, lancets, insulin needles & syringes, insulin pens and cartridges are covered.
- Lifestyle drugs are covered - limited to sexual dysfunction.
- Oral Fertility drugs are covered.
- Prescription weight loss drugs are covered.
- Prescription smoking cessation drugs are covered.

Pharmacy Program Information

Pharmacy Clinical Management: Essential
Your plan features drug management programs and edits to ensure safe prescribing, and access to medications proven to be the most reliable and cost effective for the medical condition, including:

- Prior authorization requirements
- Step Therapy on select classes of medications and drugs new to the market
- Quantity limits, including maximum daily dose edits, quantity over time edits, duration of therapy edits, and dose optimization edits
- Age edits, and refill-too-soon edits
- Plan exclusion edits
- Current users of Step Therapy medications will be allowed one 30-day fill during the first three months of coverage before Step Therapy program applies.
- Your plan includes Specialty Drug Management features, such as prior authorization and quantity limits, to ensure the safe prescribing and access to specialty medications.
- For customers with complex conditions taking a specialty medication, we will offer Accredo Therapeutic Resource Centers (TRCs) to provide specialty medication and condition counseling. For customers taking a specialty medication not dispensed by Accredo, Cigna experts will offer this important specialty medication and condition counseling.

Clinical Day Supply Program
Your plan includes the Clinical Day Supply Program for specialty drugs which provides a balance between specialty drug waste control and improved therapy adherence. During a stabilization period, certain specialty drugs, dispensed by a Cigna designated specialty pharmacy, may be limited to less than a consecutive 90 day supply. Further, for some drugs with a very high risk for early discontinuation, a split-fill (either 14 or 15 days), may be dispensed. Your cost share will be prorated to reflect the actual days' supply dispensed.

Patient Assurance Program
Your plan includes the Patient Assurance Program, which waives the deductible and reduces the amount you owe for certain medications used to treat chronic conditions included in the program. Additionally:

- Any amount you pay for these medications only count toward meeting your out-of-pocket maximum.
- Any discount provided by a pharmaceutical manufacturer for these medications only count toward meeting your out-of-pocket maximum.

Additional Information

Case Management
Coordinated by Cigna HealthCare. This is a service designated to provide assistance to a patient who is at risk of developing medical complexities or for whom a health incident has precipitated a need for rehabilitation or additional health care support. The program strives to attain a balance between quality and cost effective care while maximizing the patient's quality of life.

Cigna Diabetes Prevention Program in collaboration with Omada
Cigna Diabetes Prevention Program in collaboration with Omada is a program to help you avoid the onset of diabetes, as well as health risks that might lead to heart disease or a stroke. The program is covered by your health plan at the preventive level, just like for your wellness visit. Program participants have access to a professional virtual health coach, an online support group, interactive lessons, and a smart-technology scale. The program will help you make small changes in your eating, activity, sleep, and stress to achieve healthy weight loss through a series of 16 weekly lessons and tools to help you maintain weight loss over time. You will also be offered the opportunity to join a gym for a low monthly fee and no enrollment fee.

Comprehensive Oncology Program • Care Management outreach • Case Management	Included
Healthy Pregnancies/Healthy Babies • Care Management outreach • Maternity Case Management • Neo-natal Case Management	$150 (1st trimester) / $75 (2nd trimester) - Option 3

Maximum Reimbursable Charge
Payments made to health care professionals not participating in Cigna's network are determined based on the lesser of: the health care professional's normal charge for a similar service or supply, or a percentile (80th) of charges made by health care professionals of such service or supply in the geographic area where it is received. If sufficient charge data is unavailable in the database for that geographic area to determine the Maximum Reimbursable Charge, then state, regional or national charge data may be used. If sufficient charge data is unavailable in the database for that geographic area to determine the Maximum Reimbursable Charge, then data in the database for similar services may be used. These charges are compiled in a database selected by Cigna. The health care professional may bill the customer the difference between the health care professional's normal charge and the Maximum Reimbursable Charge as determined by the benefit plan, in addition to applicable deductibles, co-payments and coinsurance. Out-of-network services are subject to a Calendar Year deductible and maximum reimbursable charge limitations.

Out-of-Network Emergency Services Charges
1. Emergency Services are covered at the In-Network cost-sharing level as required by applicable state or federal law if services are received from a non-participating (Out-of-Network) provider.
2. The allowable amount used to determine the Plan's benefit payment for covered Emergency Services rendered in an Out-of-Network Hospital, or by an Out-of-Network provider in an In-Network Hospital, is the amount agreed to by the Out-of-Network provider and Cigna, or as required by applicable state or federal law.

The member is responsible for applicable In-Network cost-sharing amounts (any deductible, copay or coinsurance). The member is not responsible for any charges that may be made in excess of the allowable amount. If the Out-of-Network provider bills you for an amount higher than the amount you owe as indicated on the Explanation of Benefits (EOB), contact Cigna Customer Service at the phone number on your ID card.

Additional Information

Medicare Coordination
In accordance with the Social Security Act of 1965, this plan will pay Secondary to Medicare Part A and B as follows:
(a) a former Employee such as a retiree, a former Disabled Employee, a former Employee's Dependent Spouse and/or Dependent Child(ren), including a former Employee's Domestic Partner, or a COBRA continuant (whose insurance is continued for any reason), and who is also eligible for Medicare due to age or disability;
(b) an Employee's Domestic Partner who is also eligible for Medicare due to age;
(c) an Employee, a former Employee, an Employee's or former Employee's Dependent Spouse and/or Dependent Child(ren), an Employee's Dependent, including a Domestic Partner, who is eligible for Medicare due to End Stage Renal Disease after that person has been eligible for Medicare for 30 months.

When a person is eligible for Medicare A and B as described above, this plan will pay as the Secondary Plan to Medicare Part A and B **regardless if the person is actually enrolled in Medicare Part A and/or Part B and regardless if the person seeks care at a Medicare Provider or not for Medicare covered services.**

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.

One Guide
Available by phone or through myCigna mobile application. One Guide helps you navigate the health care system and make the most of your health benefits and programs.

Pre-Certification - Continued Stay Review - PHS+ Inpatient - required for all inpatient admissions
In-Network: Coordinated by your physician
Out-of-Network: Customer is responsible for contacting Cigna Healthcare. Subject to penalty/reduction or denial for non-compliance.

- $750 penalty applied to hospital inpatient charges for failure to contact Cigna Healthcare to precertify admission.
- Benefits are denied for any admission reviewed by Cigna Healthcare and not certified.
- Benefits are denied for any additional days not certified by Cigna Healthcare.

Pre-Certification - PHS+ Outpatient Prior Authorization - required for selected outpatient procedures and diagnostic testing
In-Network: Coordinated by your physician
Out-of-Network: Customer is responsible for contacting Cigna Healthcare. Subject to penalty/reduction or denial for non-compliance.

- $750 penalty applied to outpatient procedures/diagnostic testing charges for failure to contact Cigna Healthcare and to precertify admission.
- Benefits are denied for any outpatient procedures/diagnostic testing reviewed by Cigna Healthcare and not certified.

Pre-Existing Condition Limitation (PCL) does not apply.

Well-Being Solution: Core Plus

- Health assessment
- Device/app integration
- Personalized online content and data-driven actions
- Social connections/challenges
- Incentive administration

Additional Information

Your Health First - 200
Individuals with one or more of the chronic conditions, identified on the right, may be eligible to receive the following type of support:

- Condition Management
- Medication adherence
- Risk factor management
- Lifestyle issues
- Health & Wellness issues
- Pre/post-admission
- Treatment decision support
- Gaps in care

Holistic health support for the following chronic health conditions:

- Heart Disease
- Coronary Artery Disease
- Angina
- Congestive Heart Failure
- Acute Myocardial Infarction
- Peripheral Arterial Disease
- Asthma
- Chronic Obstructive Pulmonary Disease (Emphysema and Chronic Bronchitis)
- Diabetes Type 1
- Diabetes Type 2
- Metabolic Syndrome/Weight Complications
- Osteoarthritis
- Low Back Pain
- Anxiety
- Bipolar Disorder
- Depression

Definitions

Coinsurance - After you've reached your out-of-network 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.
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.
Prescription Drug List - The list of prescription brand and generic drugs covered by your pharmacy plan.
Professional Services - Services performed by Surgeons, Assistant Surgeons, Hospital Based Physicians, Radiologists, Pathologists and Anesthesiologists
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.

Exclusions

What's Not Covered (not all-inclusive):
Your plan provides for most medically necessary services. The complete list of exclusions is provided in your Certificate or Summary Plan Description. To the extent there may be differences, the terms of the Certificate or Summary Plan Description control. Examples of things your plan does not cover, unless required by law or covered under the pharmacy benefit, include (but aren't limited to):

- Care for health conditions that are required by state or local law to be treated in a public facility.
- Care required by state or federal law to be supplied by a public school system or school district.
- Care for military service disabilities treatable through governmental services if you are legally entitled to such treatment and facilities are reasonably available.

Exclusions

- Treatment of an Injury or Sickness which is due to war, declared, or undeclared.
- Charges which you are not obligated to pay or for which you are not billed or for which you would not have been billed except that they were covered under this plan. For example, if Cigna determines that a provider or Pharmacy is or has waived, reduced, or forgiven any portion of its charges and/or any portion of Copayment, Deductible, and/or Coinsurance amount(s) you are required to pay for a Covered Expense (as shown on The Schedule) without Cigna's express consent, then Cigna in its sole discretion shall have the right to deny the payment of benefits in connection with the Covered Expense, or reduce the benefits in proportion to the amount of the Copayment, Deductible, and/or Coinsurance amounts waived, forgiven or reduced, regardless of whether the provider or Pharmacy represents that you remain responsible for any amounts that your plan does not cover. In the exercise of that discretion, Cigna shall have the right to require you to provide proof sufficient to Cigna that you have made your required cost share payment(s) prior to the payment of any benefits by Cigna. This exclusion includes, but is not limited to, charges of a non-Participating Provider who has agreed to charge you or charged you at an In-Network benefits level or some other benefits level not otherwise applicable to the services received.
- Provided further, if you use a coupon provided by a pharmaceutical manufacturer or other third party that discounts the cost of a prescription medication or other product, Cigna may, in its sole discretion, reduce the benefits provided under the plan in proportion to the amount of the Copayment, Deductible, and/or Coinsurance amounts to which the value of the coupon has been applied by the Pharmacy or other third party, and/or exclude from accumulation toward any plan Deductible or Out-of-Pocket Maximum the value of any coupon applied to any Copayment, Deductible and/or Coinsurance you are required to pay.
- Charges arising out of or relating to any violation of a healthcare-related state or federal law or which themselves are a violation of a healthcare-related state or federal law.
- Assistance in the activities of daily living, including but not limited to eating, bathing, dressing or other Custodial Services or self-care activities, homemaker services and services primarily for rest, domiciliary or convalescent care.
- For or in connection with experimental, investigational or unproven services.
- Experimental, investigational and unproven services are medical, surgical, diagnostic, psychiatric, substance use disorder or other health care technologies, supplies, treatments, procedures, drug or Biologic therapies or devices that are determined by the utilization review Physician to be:
    - not approved by the U.S. Food and Drug Administration (FDA) or other appropriate regulatory agency to be lawfully marketed;
    - not demonstrated, through existing peer-reviewed, evidence-based, scientific literature to be safe and effective for treating or diagnosing the condition or Sickness for which its use is proposed;
    - the subject of review or approval by an Institutional Review Board for the proposed use except as provided in the "Clinical Trials" sections of this plan; or
    - the subject of an ongoing phase I, II or III clinical trial, except for routine patient care costs related to qualified clinical trials as provided in the "Clinical Trials" sections of this plan.

  In determining whether any such technologies, supplies, treatments, drug or Biologic therapies or devices are experimental, investigational and/or unproven, the utilization review Physician may rely on the clinical coverage policies maintained by Cigna or the Review Organization. Clinical coverage policies may incorporate, without limitation and as applicable, criteria relating to U.S. Food and Drug Administration-approved labeling, the standard medical reference compendia and peer-reviewed, evidence-based scientific literature or guidelines.

- Cosmetic surgery and therapies. Cosmetic surgery or therapy is defined as surgery or therapy performed to improve or alter appearance or self-esteem.
- The following services are excluded from coverage regardless of clinical indications: macromastia or gynecomastia surgeries; surgical treatment of varicose veins; abdominoplasty; panniculectomy; rhinoplasty; blepharoplasty; redundant skin surgery; removal of skin tags; acupressure; craniosacral/cranial therapy; dance therapy; movement therapy; applied kinesiology; rolfing; prolotherapy; and extracorporeal shock wave lithotripsy (ESWL) for musculoskeletal and orthopedic conditions.
- Dental treatment of the teeth, gums or structures directly supporting the teeth, including dental X-rays, examinations, repairs, orthodontics, periodontics,

Exclusions

casts, splints and services for dental malocclusion, for any condition. Charges made for services or supplies provided for or in connection with an accidental Injury to teeth are covered provided a continuous course of dental treatment is started within six months of an accident.

- Medical and surgical services, initial and repeat, intended for the treatment or control of obesity, except for treatment of clinically severe (morbid) obesity as shown in Covered Expenses, including: medical and surgical services to alter appearance or physical changes that are the result of any surgery performed for the management of obesity or clinically severe (morbid) obesity; and weight loss programs or treatments, whether prescribed or recommended by a Physician or under medical supervision.
- Unless otherwise covered in this plan, for reports, evaluations, physical examinations, or hospitalization not required for health reasons including, but not limited to, employment, insurance or government licenses, and court-ordered, forensic or custodial evaluations.
- Court-ordered treatment or hospitalization, unless such treatment is prescribed by a Physician and listed as covered in this plan.
- Reversal of male or female voluntary sterilization procedures.
- Any medications, drugs, services or supplies for the treatment of male or female sexual dysfunction such as, but not limited to, treatment of erectile dysfunction (including penile implants), anorgasmy, and premature ejaculation.
- Medical and Hospital care and costs for the infant child of a Dependent, unless this infant child is otherwise eligible under this plan.
- Non-medical counseling and/or ancillary services including, but not limited to, Custodial Services, educational services, vocational counseling, training and rehabilitation services, behavioral training, biofeedback, neurofeedback, hypnosis, sleep therapy, return to work services, work hardening programs and driver safety courses.
- Therapy or treatment intended primarily to improve or maintain general physical condition or for the purpose of enhancing job, school, athletic or recreational performance, including but not limited to routine, long term, or maintenance care which is provided after the resolution of the acute medical problem and when significant therapeutic improvement is not expected.
- Consumable medical supplies other than ostomy supplies and urinary catheters. Excluded supplies include, but are not limited to bandages and other disposable medical supplies, skin preparations and test strips, except as specified in the "Home Health Services" or "Breast Reconstruction and Breast Prostheses" sections of this plan.
- Private Hospital rooms and/or private duty nursing except as provided under the Home Health Services provision.
- Personal or comfort items such as personal care kits provided on admission to a Hospital, television, telephone, newborn infant photographs, complimentary meals, birth announcements, and other articles which are not for the specific treatment of an Injury or Sickness.
- Artificial aids including, but not limited to, corrective orthopedic shoes, arch supports, elastic stockings, garter belts, corsets, dentures and wigs.
- Aids or devices that assist with non-verbal communications, including but not limited to communication boards, pre-recorded speech devices, laptop computers, desktop computers, Personal Digital Assistants (PDAs), Braille typewriters, visual alert systems for the deaf and memory books.
- Eyeglass lenses and frames and contact lenses (except for the first pair of contact lenses for treatment of keratoconus or post cataract surgery).
- Routine refractions, eye exercises and surgical treatment for the correction of a refractive error, including radial keratotomy.
- All non-injectable prescription drugs, unless Physician administration or oversight is required, injectable prescription drugs to the extent they do not require Physician supervision and are typically considered self-administered drugs, non-prescription drugs, and investigational and experimental drugs, except as provided in this plan.
- Routine foot care, including the paring and removing of corns and calluses or trimming of nails. However, services associated with foot care for diabetes and peripheral vascular disease are covered when Medically Necessary.
- Membership costs or fees associated with health clubs, weight loss programs and smoking cessation programs.
- Genetic screening or pre-implantations genetic screening. General population-based genetic screening is a testing method performed in the absence of any symptoms or any significant, proven risk factors for genetically linked inheritable disease.
- Dental implants for any condition.
- Fees associated with the collection or donation of blood or blood products, except for autologous donation in anticipation of scheduled services where in the

Exclusions

utilization review Physician's opinion the likelihood of excess blood loss is such that transfusion is an expected adjunct to surgery.
- Blood administration for the purpose of general improvement in physical condition.
- Cost of biologicals that are immunizations or medications for the purpose of travel, or to protect against occupational hazards and risks.
- Cosmetics, dietary supplements and health and beauty aids.
- All nutritional supplements and formulae except for infant formula needed for the treatment of inborn errors of metabolism.
- For or in connection with an Injury or Sickness arising out of, or in the course of, any employment for wage or profit.
- Charges for the delivery of medical and health-related services via telecommunications technologies, including telephone and internet, unless provided as specifically described under Covered Expenses.
- Massage therapy.

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, service agreement 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.

Cigna Healthcare products and services are provided exclusively by or through operating subsidiaries of The Cigna Group, including Cigna Health and Life Insurance Company, Connecticut General Life Insurance Company, Evernorth Behavioral Health, Inc., Evernorth Care Solutions, Inc. and HMO or service company subsidiaries of Cigna Health Corporation.

EHB State: NY

BENEFIT SUMMARY

Administered by - Cigna Health and Life Insurance Co.
For - Research Foundation of the City University of New York
Open Access Plus Plan
OAP
Effective - 01/01/2025

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.

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.

Plan Highlights	In-Network	Out-of-Network
Lifetime Maximum	Unlimited	Unlimited
Plan Year Accumulation	Your Plan's Deductibles, Out-of-Pockets and benefit level limits accumulate on a calendar year basis unless otherwise stated. In addition, all plan maximums and service-specific maximums (dollar and occurrence) cross-accumulate between In- and Out-of-Network unless otherwise noted.	
Plan Coinsurance	Plan pays 100%	Plan pays 70%
Maximum Reimbursable Charge	Not Applicable	80th Percentile
Plan Deductible	Individual: None Family: None	Individual: $750 Family: $1,875

- The amount you pay for out-of-network covered expenses counts towards your out-of-network deductibles.
- Benefit copays/deductibles always apply before plan deductible and coinsurance.
- 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.

Note: Services where plan deductible applies are noted with a caret (^).

Plan Highlights	In-Network	Out-of-Network
Plan Out-of-Pocket Maximum	Individual: $3,000 Family: $7,500	Individual: $3,000 Family: $7,500

- Only the amount you pay for in-network covered expenses counts toward your in-network out-of-pocket maximum. Only the amount you pay for out-of-network covered expenses counts toward your out-of-network out-of-pocket maximum.
- Plan deductible contributes towards your out-of-pocket maximum.
- All benefit copays/deductibles contribute towards your out-of-pocket maximum.
- Covered expenses that count towards your out-of-pocket maximum include customer paid coinsurance and charges for Mental Health and Substance Use Disorder. Out-of-network non-compliance penalties or charges in excess of Maximum Reimbursable Charge do not contribute towards the out-of-pocket maximum.
- After each eligible family member meets his or her individual out-of-pocket maximum, the plan will pay 100% of their covered expenses. Or, after the family out-of-pocket maximum has been met, the plan will pay 100% of each eligible family member's covered expenses.
- This plan includes a combined Medical/Pharmacy out-of-pocket maximum.

Benefit	In-Network	Out-of-Network
Note: Services where plan deductible applies are noted with a caret (^). Benefit copays/deductibles always apply before plan deductible.		
Physician Services - Office Visits		
Primary Care Physician (PCP) Services/Office Visit	$30 copay, and plan pays 100%	Plan pays 70% ^
Specialty Care Physician Services/Office Visit	$40 copay, and plan pays 100%	Plan pays 70% ^
NOTE: Obstetrician and Gynecologist (OB/GYN) visits are subject to either the PCP or Specialist cost share depending on how the provider contracts with Cigna (i.e. as PCP or as Specialist).		
Surgery Performed in Physician's Office	Covered same as Physician Services - Office Visit	Covered same as Physician Services - Office Visit
Allergy Treatment/Injections and Allergy Serum Allergy serum dispensed by the physician in the office **Note:** Office copay does not apply if only the allergy serum is provided.	Covered same as Physician Services - Office Visit	Covered same as Physician Services - Office Visit
Virtual Care		
Dedicated Virtual Providers - MDLIVE		
MDLIVE Urgent Virtual Care Services	Plan pays 100%	Not Covered
MDLIVE Primary Care Services	Plan pays 100%	Not Covered
MDLIVE Specialty Care Services	Plan pays 100%	Not Covered

- Primary Care cost share applies to routine care. Virtual wellness screenings are payable under Preventive Care.
- For MDLIVE Behavioral Services, please refer to the Mental Health and Substance Use Disorder section (below).
- Lab services supporting a virtual visit must be obtained through dedicated labs.
- Includes charges for the delivery of medical and health-related services and consultations by dedicated virtual providers as medically appropriate through audio, video, and secure internet-based technologies.

Benefit	In-Network	Out-of-Network
Note: Services where plan deductible applies are noted with a caret (^). Benefit copays/deductibles always apply before plan deductible.		
Virtual Physician Services - Office Visits		
Primary Care Physician (PCP) Services/Office Visit	$30 copay, and plan pays 100%	Plan pays 70% ^
Specialty Care Physician Services/Office Visit	$40 copay, and plan pays 100%	Plan pays 70% ^
• Physicians may deliver services virtually that are payable under other benefits (e.g., Preventive Care, Outpatient Therapy Services). • Includes charges for the delivery of medical and health-related services and consultations as medically appropriate through audio, video, and secure internet-based technologies that are similar to office visit services provided in a face-to-face setting. **NOTE:** Obstetrician and Gynecologist (OB/GYN) visits are subject to either the PCP or Specialist cost share depending on how the provider contracts with Cigna (i.e. as PCP or as Specialist).		
Convenience Care Clinic		
Convenience Care Clinic	$30 copay, and plan pays 100%	Plan pays 70% ^
Preventive Care		
Preventive Care	Plan pays 100%	PCP: Plan pays 70% ^ Specialist: Plan pays 70% ^
• Includes coverage of additional services, such as urinalysis, EKG, and other laboratory tests, supplementing the standard Preventive Care benefit when billed as part of office visit. • Annual Limit: Unlimited		
Immunizations	Plan pays 100%	PCP: Plan pays 70% ^ Specialist: Plan pays 70% ^
Mammogram, PAP, and PSA Tests	Plan pays 100%	Covered same as other x-ray and lab services, based on Place of Service
• 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.		
Inpatient		
Inpatient Hospital Facility Services	$300 per admission copay up to a $750 maximum per calendar year	Plan pays 70% ^
Note: Includes all Lab and Radiology services, including Advanced Radiological Imaging as well as Medical Specialty Drugs		
Inpatient Hospital Physician's Visit/Consultation	Plan pays 100%	Plan pays 70% ^
Inpatient Professional Services	Plan pays 100%	Plan pays 70% ^
• For services performed by Surgeons, Radiologists, Pathologists and Anesthesiologists		
Outpatient		
Outpatient Facility Services	Plan pays 100%	Plan pays 70% ^
Outpatient Professional Services	Plan pays 100%	Plan pays 70% ^
• For services performed by Surgeons, Radiologists, Pathologists and Anesthesiologists		

Benefit	In-Network	Out-of-Network
Note: Services where plan deductible applies are noted with a caret (^). Benefit copays/deductibles always apply before plan deductible.		
Emergency Services		
Emergency Room • Includes Professional, X-ray and/or Lab services performed at the Emergency Room and billed by the facility as part of the ER visit. • Per visit copay is waived if admitted.	$75 copay, and plan pays 100%	$75 copay, and plan pays 100%
Urgent Care Facility • Includes Professional, X-ray and/or Lab services performed at the Urgent Care Facility and billed by the facility as part of the urgent care visit.	$30 copay, and plan pays 100%	$30 copay, and plan pays 100%
Ambulance	Plan pays 100%	Plan pays 100%
Ambulance services used as non-emergency transportation (e.g., transportation from hospital back home) generally are not covered.		
Ambulance - Mental Health and Substance Use Disorder	Plan pays 100%	Plan pays 100%
Ambulance services used as non-emergency transportation (e.g., transportation from hospital back home) generally are not covered.		
Inpatient Services at Other Health Care Facilities		
Skilled Nursing Facility, Rehabilitation Hospital, Sub-Acute Facilities • Annual Limit: 60 days	Plan pays 100%	Plan pays 70% ^
Laboratory Services		
Physician's Services/Office Visit	Plan pays 100%	Plan pays 70% ^
Independent Lab	Plan pays 100%	Plan pays 70% ^
Outpatient Facility	Plan pays 100%	Plan pays 70% ^
Radiology Services		
Physician's Services/Office Visit	Plan pays 100%	Plan pays 70% ^
Outpatient Facility	Plan pays 100%	Plan pays 70% ^
Advanced Radiological Imaging (ARI)	Includes MRI, MRA, CAT Scan, PET Scan, etc.	
Outpatient Facility	Plan pays 100%	Plan pays 70% ^
Physician's Services/Office Visit	Covered same as Physician Services - Office Visit	Covered same as Physician Services - Office Visit

Benefit	In-Network	Out-of-Network
Note: Services where plan deductible applies are noted with a caret (^). Benefit copays/deductibles always apply before plan deductible.		
Outpatient Therapy Services		
Outpatient Therapy Services	Covered same as Physician Services - Office Visit	Covered same as Physician Services - Office Visit
Annual Limits: • Speech Therapy - 30 days • Occupational Therapy and Physical Therapy - 30 days • All other therapies - Includes Cognitive Therapy and Pulmonary Rehabilitation - 20 days • Limits are not applicable to mental health conditions for Physical, Speech and Occupational Therapies. **Note:** Therapy days, provided as part of an approved Home Health Care plan, accumulate to the applicable outpatient therapy services maximum.		
Chiropractic Services	Covered same as Physician Services - Office Visit	Covered same as Physician Services - Office Visit
Annual Limit: • Chiropractic Care - Unlimited days		
Cardiac Rehabilitation Services	Covered same as Physician Services - Office Visit	Covered same as Physician Services - Office Visit
Annual Limit: • Cardiac Rehabilitation - 36 days		
Hospice		
Inpatient Facilities	Plan pays 100%	Not Covered
Outpatient Services	Plan pays 100%	Not Covered
Note: Includes Bereavement counseling provided as part of a hospice program.		
Bereavement Counseling (for services not provided as part of a hospice program)		
Services Provided by a Mental Health Professional	Covered under Mental Health benefit	Covered under Mental Health benefit
Medical Pharmaceutical Drugs		
Outpatient Facility	Plan pays 100%	Plan pays 70% ^
Physician's Office	Plan pays 100%	Plan pays 70% ^
Home	Plan pays 100%	Plan pays 70% ^
Note: This benefit only applies to the cost of the Infusion Therapy drugs administered. This benefit does not cover the related Facility, Office Visit or Professional charges.		

Benefit	In-Network	Out-of-Network
Note: Services where plan deductible applies are noted with a caret (^). Benefit copays/deductibles always apply before plan deductible.		
Maternity		
Initial Visit to Confirm Pregnancy	Covered same as Physician Services - Office Visit	Covered same as Physician Services - Office Visit
All Subsequent Prenatal Visits, Postnatal Visits and Physician's Delivery Charges (Global Maternity Fee)	Plan pays 100%	Plan pays 70% ^
Office Visits in Addition to Global Maternity Fee (Performed by OB/GYN or Specialist)	Covered same as Physician Services - Office Visit	Covered same as Physician Services - Office Visit
Delivery - Facility (Inpatient Hospital, Birthing Center)	Covered same as plan's Inpatient Hospital benefit	Covered same as plan's Inpatient Hospital benefit
Abortion		
Abortion Services **Note:** Elective and non-elective procedures	Coverage varies based on Place of Service	Coverage varies based on Place of Service
Family Planning		
Women's Services	Plan pays 100%	Coverage varies based on Place of Service
Includes contraceptive devices as ordered or prescribed by a physician and surgical sterilization services, such as tubal ligation (excludes reversals)		
Men's Services	Coverage varies based on Place of Service	Coverage varies based on Place of Service
Includes surgical sterilization services, such as vasectomy (excludes reversals)		
Infertility		
Infertility Treatment	Coverage varies based on Place of Service	Coverage varies based on Place of Service
Infertility covered services: lab and radiology test, counseling, surgical treatment, includes artificial insemination, in-vitro fertilization, GIFT, ZIFT, etc. • Lifetime Maximum: Unlimited		
Outpatient Dialysis Services		
Physician's Services/Office Visit	Covered same as Physician Services - Office Visit	Covered same as Physician Services - Office Visit
Home Dialysis **Note:** Dialysis visits will not accumulate to Home Health Care maximum	Covered same as plan's Home Health Care benefit	Covered same as plan's Home Health Care benefit
Outpatient Facility Services	Covered same as plan's Outpatient Facility Services benefit	Covered same as plan's Outpatient Facility Services benefit
Outpatient Professional Services	Covered same as plan's Outpatient Professional Services benefit	Covered same as plan's Outpatient Professional Services benefit

Benefit	In-Network	Out-of-Network
Note: Services where plan deductible applies are noted with a caret (^). Benefit copays/deductibles always apply before plan deductible.		
Other Health Care Facilities/Services		
Home Health Care • Annual Limit: 200 days (The limit is not applicable to mental health and substance use disorder conditions.) • 16 hour maximum per day **Note:** Includes outpatient private duty nursing when approved as medically necessary	Plan pays 100%	Plan pays 70% ^
Organ Transplants		
Inpatient Hospital Facility Services		
LifeSOURCE Facility	$300 per admission copay up to a $750 maximum per calendar year	Not Applicable
Non-LifeSOURCE Facility	Covered same as plan's Inpatient Hospital benefit	Not Covered
Inpatient Professional Services		
LifeSOURCE Facility	Plan pays 100%	Not Applicable
Non-LifeSOURCE Facility	Covered same as plan's Inpatient Professional benefit	Not Covered
• Travel Maximum - Cigna LifeSOURCE Transplant Network® Facility Only: $10,000 maximum per Transplant per Lifetime		
Durable Medical Equipment • Annual Limit: Unlimited	Plan pays 100%	Not Covered
Breast Feeding Equipment and Supplies • Limited to the rental of one breast pump per birth as ordered or prescribed by a physician • Includes related supplies	Plan pays 100%	Plan pays 70% ^
External Prosthetic Appliances (EPA) • Annual Limit: Unlimited	Plan pays 100%	Not Covered
Temporomandibular Joint Disorder (TMJ) • Unlimited Non-Surgical lifetime maximum **Note:** Provided on a limited, case-by-case basis. Excludes appliances and orthodontic treatment.	Coverage varies based on Place of Service	Coverage varies based on Place of Service
Bariatric Surgery • Unlimited lifetime limit Treatment of Clinically severe obesity, as defined by the body mass index (BMI) is covered. The following are excluded: • medical and surgical services to alter appearances or physical changes that are the result of any surgery performed for the management of obesity or clinically severe (morbid) obesity • weight loss programs or treatments, whether prescribed or recommended by a physician or under medical supervision	Coverage varies based on Place of Service	Not Covered
Routine Foot Care **Note:** Services associated with foot care for diabetes and peripheral vascular disease are covered when approved as medically necessary.	Not Covered	Not Covered

Benefit	In-Network	Out-of-Network
Note: Services where plan deductible applies are noted with a caret (^). Benefit copays/deductibles always apply before plan deductible.		
Hearing Aids • Maximum of 2 devices per 24 months • Includes testing and fitting of hearing aid devices at Physician Office Visit cost share	Plan pays 100%	Not Covered
Acupuncture • Annual Limit: Unlimited	Covered same as Physician Services - Office Visit	Covered same as Physician Services - Office Visit

Benefit	In-Network	Out-of-Network
Note: Services where plan deductible applies are noted with a caret (^). Benefit copays/deductibles always apply before plan deductible.		
Mental Health and Substance Use Disorder		
Inpatient Mental Health	$300 per admission copay up to a $750 maximum per calendar year	Plan pays 70% ^
Outpatient Mental Health – Physician's Office	$30 copay, and plan pays 100%	Plan pays 70% ^
Outpatient Mental Health - MDLIVE Behavioral Services	Plan pays 100%	Not Covered
Outpatient Mental Health – All Other Services	Plan pays 100%	Plan pays 70% ^
Inpatient Substance Use Disorder	$300 per admission copay up to a $750 maximum per calendar year	Plan pays 70% ^
Outpatient Substance Use Disorder – Physician's Office	$30 copay, and plan pays 100%	Plan pays 70% ^
Outpatient Substance Use Disorder - MDLIVE Behavioral Services	Plan pays 100%	Not Covered
Outpatient Substance Use Disorder – All Other Services	Plan pays 100%	Plan pays 70% ^

Annual Limits:

- Unlimited maximum

Notes:

- Inpatient includes Acute Inpatient and Residential Treatment.
- Outpatient - Physician's Office and MDLIVE Behavioral Services - may include Individual, family and group therapy, psychotherapy, medication management, etc.
- Outpatient - All Other Services - may include Partial Hospitalization, Intensive Outpatient Services, Applied Behavior Analysis (ABA Therapy), etc.
- Services are paid at 100% after you reach your out-of-pocket maximum.

Important Note on Mental Health and Substance Use Disorder Coverage: Covered medical services listed above, which are received to diagnose or treat a Mental Health or Substance Use Disorder condition will be payable according to this section titled "Mental Health and Substance Use Disorder."

Mental Health/Substance Use Disorder Utilization Review, Case Management and Programs

Cigna Total Behavioral Health - Inpatient and Outpatient Management

- Inpatient utilization review and case management
- Outpatient utilization review and case management
- Partial Hospitalization
- Intensive outpatient programs
- Changing Lives by Integrating Mind and Body Program
- Lifestyle Management Programs: Stress Management, Tobacco Cessation and Weight Management.
- Narcotic Therapy Management
- inMynd℠ program - a comprehensive, holistic solution to help recognize and find resources to treat behavioral health conditions.

Pharmacy	In-Network
Cost Share and Supply	
Cigna Pharmacy Cost Share • Retail – up to 90-day supply (except Specialty up to 30-day supply) • Home Delivery – up to 90-day supply	**Retail (per 30-day supply):** Generic: You pay $5 Preferred Brand: You pay $25 Non-Preferred Brand: You pay $50 **Retail (per 90-day supply):** Generic: You pay $15 Preferred Brand: You pay $75 Non-Preferred Brand: You pay $150 **Home Delivery (per 90-day supply):** Generic: You pay $5 Preferred Brand: You pay $25 Non-Preferred Brand: You pay $50

- **Cigna 90 Now Walgreens:** Retail drugs for a 30 day supply may be obtained In-Network at a wide range of pharmacies across the nation although prescriptions for a 90 day supply (such as maintenance drugs) will be available at select network pharmacies. CVS will be considered Out-of-Network for a 90 day supply.
- Cigna 90 Now Program: You can choose to fill your medications in a 30- or 90-day supply. If you choose to fill a 30-day prescription, it can be filled at any network retail pharmacy or network home delivery pharmacy. If you choose to fill a 90-day prescription, it must be filled at a 90-day network retail pharmacy or network home delivery pharmacy to be covered by the plan.
- This plan will not cover out-of-network pharmacy benefits.
- Specialty medications are used to treat an underlying disease which is considered to be rare and chronic including, but not limited to, multiple sclerosis, hepatitis C or rheumatoid arthritis. Specialty Drugs may include high cost medications as well as medications that may require special handling and close supervision when being administered.
- When patient requests brand drug, patient pays the brand cost share plus the cost difference between the brand and generic drugs up to the cost of the brand drug (unless the physician indicates "Dispense As Written" DAW).
- Exclusive specialty home delivery: Specialty medications must be filled through home delivery; otherwise you pay the entire cost of the prescription upon your first fill. Some exceptions may apply.
- If you use a manufacturer coupon to pay for some or all of the cost of a medication, the value of the coupon may not apply towards meeting your plan deductible or out-of-pocket maximum, if any.
- **SaveOn Specialty Program:** Certain specialty pharmacy drugs may be considered non-essential health benefits and may fall outside of the deductible and out-of-pocket limits. All drugs in this program are potentially subject to a higher cost share than amounts set forth above. If you participate in the program, cost share may be paid through a manufacturer copay assistance program and your out-of-pocket cost may be reduced to $0. If you do not participate in the program, then you will be responsible for the payment of the cost share for these medications and payment will not be applied towards your deductible and out-of-pocket maximums. See your plan documents for more specific information.
- Your pharmacy benefits share an out-of-pocket maximum with the medical/behavioral benefits.
- If you receive a supply of 34 days or less at home delivery (including a Specialty Prescription Drug), the home delivery pharmacy cost share will be adjusted to reflect a 30-day supply.

Pharmacy	In-Network
Pharmacy Deductible • The Pharmacy plan deductible does not apply to the following: Retail Generic, Home Delivery Generic	Individual: $50 Family: $100

Drugs Covered

Prescription Drug List:
Your Cigna Legacy Prescription Drug List includes a full range of drugs including all those required under applicable health care laws. To check which drugs are included in your plan, please log on to myCigna.com.
Some highlights:

- Self Administered injectables are covered.
- Contraceptive devices and drugs are covered with federally required products covered at 100%.
- Insulin, glucose test strips, lancets, insulin needles & syringes, insulin pens and cartridges are covered.
- Lifestyle drugs are covered - limited to sexual dysfunction.
- Oral Fertility drugs are covered.
- Prescription weight loss drugs are covered.
- Prescription smoking cessation drugs are covered.

Pharmacy Program Information

Pharmacy Clinical Management: Essential
Your plan features drug management programs and edits to ensure safe prescribing, and access to medications proven to be the most reliable and cost effective for the medical condition, including:

- Prior authorization requirements
- Step Therapy on select classes of medications and drugs new to the market
- Quantity limits, including maximum daily dose edits, quantity over time edits, duration of therapy edits, and dose optimization edits
- Age edits, and refill-too-soon edits
- Plan exclusion edits
- Current users of Step Therapy medications will be allowed one 30-day fill during the first three months of coverage before Step Therapy program applies.
- Your plan includes Specialty Drug Management features, such as prior authorization and quantity limits, to ensure the safe prescribing and access to specialty medications.
- For customers with complex conditions taking a specialty medication, we will offer Accredo Therapeutic Resource Centers (TRCs) to provide specialty medication and condition counseling. For customers taking a specialty medication not dispensed by Accredo, Cigna experts will offer this important specialty medication and condition counseling.

Clinical Day Supply Program
Your plan includes the Clinical Day Supply Program for specialty drugs which provides a balance between specialty drug waste control and improved therapy adherence. During a stabilization period, certain specialty drugs, dispensed by a Cigna designated specialty pharmacy, may be limited to less than a consecutive 90 day supply. Further, for some drugs with a very high risk for early discontinuation, a split-fill (either 14 or 15 days), may be dispensed. Your cost share will be prorated to reflect the actual days' supply dispensed.

Pharmacy Program Information

Patient Assurance Program
Your plan includes the Patient Assurance Program, which waives the deductible and reduces the amount you owe for certain medications used to treat chronic conditions included in the program. Additionally:

- Any amount you pay for these medications count toward meeting both your deductible and out-of-pocket maximum.
- Any discount provided by a pharmaceutical manufacturer for these medications count toward meeting both your deductible and out-of-pocket maximum.

Additional Information

Case Management
Coordinated by Cigna HealthCare. This is a service designated to provide assistance to a patient who is at risk of developing medical complexities or for whom a health incident has precipitated a need for rehabilitation or additional health care support. The program strives to attain a balance between quality and cost effective care while maximizing the patient's quality of life.

Cigna Diabetes Prevention Program in collaboration with Omada
Cigna Diabetes Prevention Program in collaboration with Omada is a program to help you avoid the onset of diabetes, as well as health risks that might lead to heart disease or a stroke. The program is covered by your health plan at the preventive level, just like for your wellness visit. Program participants have access to a professional virtual health coach, an online support group, interactive lessons, and a smart-technology scale. The program will help you make small changes in your eating, activity, sleep, and stress to achieve healthy weight loss through a series of 16 weekly lessons and tools to help you maintain weight loss over time. You will also be offered the opportunity to join a gym for a low monthly fee and no enrollment fee.

Comprehensive Oncology Program • Care Management outreach • Case Management	Included
Healthy Pregnancies/Healthy Babies • Care Management outreach • Maternity Case Management • Neo-natal Case Management	$150 (1st trimester) / $75 (2nd trimester) - Option 3

Additional Information

Maximum Reimbursable Charge
Payments made to health care professionals not participating in Cigna's network are determined based on the lesser of: the health care professional's normal charge for a similar service or supply, or a percentile (80th) of charges made by health care professionals of such service or supply in the geographic area where it is received. If sufficient charge data is unavailable in the database for that geographic area to determine the Maximum Reimbursable Charge, then state, regional or national charge data may be used. If sufficient charge data is unavailable in the database for that geographic area to determine the Maximum Reimbursable Charge, then data in the database for similar services may be used. These charges are compiled in a database selected by Cigna. The health care professional may bill the customer the difference between the health care professional's normal charge and the Maximum Reimbursable Charge as determined by the benefit plan, in addition to applicable deductibles, co-payments and coinsurance. Out-of-network services are subject to a Calendar Year deductible and maximum reimbursable charge limitations.

Out-of-Network Emergency Services Charges
1. Emergency Services are covered at the In-Network cost-sharing level as required by applicable state or federal law if services are received from a non-participating (Out-of-Network) provider.
2. The allowable amount used to determine the Plan's benefit payment for covered Emergency Services rendered in an Out-of-Network Hospital, or by an Out-of-Network provider in an In-Network Hospital, is the amount agreed to by the Out-of-Network provider and Cigna, or as required by applicable state or federal law.

The member is responsible for applicable In-Network cost-sharing amounts (any deductible, copay or coinsurance). The member is not responsible for any charges that may be made in excess of the allowable amount. If the Out-of-Network provider bills you for an amount higher than the amount you owe as indicated on the Explanation of Benefits (EOB), contact Cigna Customer Service at the phone number on your ID card.

Medicare Coordination
In accordance with the Social Security Act of 1965, this plan will pay Secondary to Medicare Part A and B as follows:
(a) a former Employee such as a retiree, a former Disabled Employee, a former Employee's Dependent Spouse and/or Dependent Child(ren), including a former Employee's Domestic Partner, or a COBRA continuant (whose insurance is continued for any reason), and who is also eligible for Medicare due to age or disability;
(b) an Employee's Domestic Partner who is also eligible for Medicare due to age;
(c) an Employee, a former Employee, an Employee's or former Employee's Dependent Spouse and/or Dependent Child(ren), an Employee's Dependent, including a Domestic Partner, who is eligible for Medicare due to End Stage Renal Disease after that person has been eligible for Medicare for 30 months.

When a person is eligible for Medicare A and B as described above, this plan will pay as the Secondary Plan to Medicare Part A and B **regardless if the person is actually enrolled in Medicare Part A and/or Part B and regardless if the person seeks care at a Medicare Provider or not for Medicare covered services.**

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.

One Guide
Available by phone or through myCigna mobile application. One Guide helps you navigate the health care system and make the most of your health benefits and programs.

Additional Information

Pre-Certification - Continued Stay Review - PHS+ Inpatient - required for all inpatient admissions
In-Network: Coordinated by your physician
Out-of-Network: Customer is responsible for contacting Cigna Healthcare. Subject to penalty/reduction or denial for non-compliance.

- $750 penalty applied to hospital inpatient charges for failure to contact Cigna Healthcare to precertify admission.
- Benefits are denied for any admission reviewed by Cigna Healthcare and not certified.
- Benefits are denied for any additional days not certified by Cigna Healthcare.

Pre-Certification - PHS+ Outpatient Prior Authorization - required for selected outpatient procedures and diagnostic testing
In-Network: Coordinated by your physician
Out-of-Network: Customer is responsible for contacting Cigna Healthcare. Subject to penalty/reduction or denial for non-compliance.

- $750 penalty applied to outpatient procedures/diagnostic testing charges for failure to contact Cigna Healthcare and to precertify admission.
- Benefits are denied for any outpatient procedures/diagnostic testing reviewed by Cigna Healthcare and not certified.

Pre-Existing Condition Limitation (PCL) does not apply.

Well-Being Solution: Core Plus

- Health assessment
- Device/app integration
- Personalized online content and data-driven actions
- Social connections/challenges
- Incentive administration

Your Health First - 200
Individuals with one or more of the chronic conditions, identified on the right, may be eligible to receive the following type of support:

- Condition Management
- Medication adherence
- Risk factor management
- Lifestyle issues
- Health & Wellness issues
- Pre/post-admission
- Treatment decision support
- Gaps in care

Holistic health support for the following chronic health conditions:

- Heart Disease
- Coronary Artery Disease
- Angina
- Congestive Heart Failure
- Acute Myocardial Infarction
- Peripheral Arterial Disease
- Asthma
- Chronic Obstructive Pulmonary Disease (Emphysema and Chronic Bronchitis)
- Diabetes Type 1
- Diabetes Type 2
- Metabolic Syndrome/Weight Complications
- Osteoarthritis
- Low Back Pain
- Anxiety
- Bipolar Disorder
- Depression

Definitions

Coinsurance - After you've reached your out-of-network 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.
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.
Prescription Drug List - The list of prescription brand and generic drugs covered by your pharmacy plan.
Professional Services - Services performed by Surgeons, Assistant Surgeons, Hospital Based Physicians, Radiologists, Pathologists and Anesthesiologists
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.

Exclusions

What's Not Covered (not all-inclusive):
Your plan provides for most medically necessary services. The complete list of exclusions is provided in your Certificate or Summary Plan Description. To the extent there may be differences, the terms of the Certificate or Summary Plan Description control. Examples of things your plan does not cover, unless required by law or covered under the pharmacy benefit, include (but aren't limited to):

- Care for health conditions that are required by state or local law to be treated in a public facility.
- Care required by state or federal law to be supplied by a public school system or school district.
- Care for military service disabilities treatable through governmental services if you are legally entitled to such treatment and facilities are reasonably available.
- Treatment of an Injury or Sickness which is due to war, declared, or undeclared.
- Charges which you are not obligated to pay or for which you are not billed or for which you would not have been billed except that they were covered under this plan. For example, if Cigna determines that a provider or Pharmacy is or has waived, reduced, or forgiven any portion of its charges and/or any portion of Copayment, Deductible, and/or Coinsurance amount(s) you are required to pay for a Covered Expense (as shown on The Schedule) without Cigna's express consent, then Cigna in its sole discretion shall have the right to deny the payment of benefits in connection with the Covered Expense, or reduce the benefits in proportion to the amount of the Copayment, Deductible, and/or Coinsurance amounts waived, forgiven or reduced, regardless of whether the provider or Pharmacy represents that you remain responsible for any amounts that your plan does not cover. In the exercise of that discretion, Cigna shall have the right to require you to provide proof sufficient to Cigna that you have made your required cost share payment(s) prior to the payment of any benefits by Cigna. This exclusion includes, but is not limited to, charges of a non-Participating Provider who has agreed to charge you or charged you at an In-Network benefits level or some other benefits level not otherwise applicable to the services received.
- Provided further, if you use a coupon provided by a pharmaceutical manufacturer or other third party that discounts the cost of a prescription medication or other product, Cigna may, in its sole discretion, reduce the benefits provided under the plan in proportion to the amount of the Copayment, Deductible, and/or Coinsurance amounts to which the value of the coupon has been applied by the Pharmacy or other third party, and/or exclude from accumulation toward any plan Deductible or Out-of-Pocket Maximum the value of any coupon applied to any Copayment, Deductible and/or Coinsurance you are required to pay.
- Charges arising out of or relating to any violation of a healthcare-related state or federal law or which themselves are a violation of a healthcare-related state or federal law.
- Assistance in the activities of daily living, including but not limited to eating, bathing, dressing or other Custodial Services or self-care activities, homemaker services and services primarily for rest, domiciliary or convalescent care.
- For or in connection with experimental, investigational or unproven services.
- Experimental, investigational and unproven services are medical, surgical, diagnostic, psychiatric, substance use disorder or other health care technologies,

Exclusions

supplies, treatments, procedures, drug or Biologic therapies or devices that are determined by the utilization review Physician to be:

- not approved by the U.S. Food and Drug Administration (FDA) or other appropriate regulatory agency to be lawfully marketed;
- not demonstrated, through existing peer-reviewed, evidence-based, scientific literature to be safe and effective for treating or diagnosing the condition or Sickness for which its use is proposed;
- the subject of review or approval by an Institutional Review Board for the proposed use except as provided in the "Clinical Trials" sections of this plan; or
- the subject of an ongoing phase I, II or III clinical trial, except for routine patient care costs related to qualified clinical trials as provided in the "Clinical Trials" sections of this plan.

In determining whether any such technologies, supplies, treatments, drug or Biologic therapies or devices are experimental, investigational and/or unproven, the utilization review Physician may rely on the clinical coverage policies maintained by Cigna or the Review Organization. Clinical coverage policies may incorporate, without limitation and as applicable, criteria relating to U.S. Food and Drug Administration-approved labeling, the standard medical reference compendia and peer-reviewed, evidence-based scientific literature or guidelines.

- Cosmetic surgery and therapies. Cosmetic surgery or therapy is defined as surgery or therapy performed to improve or alter appearance or self-esteem.
- The following services are excluded from coverage regardless of clinical indications: macromastia or gynecomastia surgeries; surgical treatment of varicose veins; abdominoplasty; panniculectomy; rhinoplasty; blepharoplasty; redundant skin surgery; removal of skin tags; acupressure; craniosacral/cranial therapy; dance therapy; movement therapy; applied kinesiology; rolfing; prolotherapy; and extracorporeal shock wave lithotripsy (ESWL) for musculoskeletal and orthopedic conditions.
- Dental treatment of the teeth, gums or structures directly supporting the teeth, including dental X-rays, examinations, repairs, orthodontics, periodontics, casts, splints and services for dental malocclusion, for any condition. Charges made for services or supplies provided for or in connection with an accidental Injury to teeth are covered provided a continuous course of dental treatment is started within six months of an accident.
- Medical and surgical services, initial and repeat, intended for the treatment or control of obesity, except for treatment of clinically severe (morbid) obesity as shown in Covered Expenses, including: medical and surgical services to alter appearance or physical changes that are the result of any surgery performed for the management of obesity or clinically severe (morbid) obesity; and weight loss programs or treatments, whether prescribed or recommended by a Physician or under medical supervision.
- Unless otherwise covered in this plan, for reports, evaluations, physical examinations, or hospitalization not required for health reasons including, but not limited to, employment, insurance or government licenses, and court-ordered, forensic or custodial evaluations.
- Court-ordered treatment or hospitalization, unless such treatment is prescribed by a Physician and listed as covered in this plan.
- Reversal of male or female voluntary sterilization procedures.
- Any medications, drugs, services or supplies for the treatment of male or female sexual dysfunction such as, but not limited to, treatment of erectile dysfunction (including penile implants), anorgasmy, and premature ejaculation.
- Medical and Hospital care and costs for the infant child of a Dependent, unless this infant child is otherwise eligible under this plan.
- Non-medical counseling and/or ancillary services including, but not limited to, Custodial Services, educational services, vocational counseling, training and rehabilitation services, behavioral training, biofeedback, neurofeedback, hypnosis, sleep therapy, return to work services, work hardening programs and driver safety courses.
- Therapy or treatment intended primarily to improve or maintain general physical condition or for the purpose of enhancing job, school, athletic or recreational performance, including but not limited to routine, long term, or maintenance care which is provided after the resolution of the acute medical problem and when significant therapeutic improvement is not expected.
- Consumable medical supplies other than ostomy supplies and urinary catheters. Excluded supplies include, but are not limited to bandages and other

Exclusions

disposable medical supplies, skin preparations and test strips, except as specified in the "Home Health Services" or "Breast Reconstruction and Breast Prostheses" sections of this plan.

- Private Hospital rooms and/or private duty nursing except as provided under the Home Health Services provision.
- Personal or comfort items such as personal care kits provided on admission to a Hospital, television, telephone, newborn infant photographs, complimentary meals, birth announcements, and other articles which are not for the specific treatment of an Injury or Sickness.
- Artificial aids including, but not limited to, corrective orthopedic shoes, arch supports, elastic stockings, garter belts, corsets, dentures and wigs.
- Aids or devices that assist with non-verbal communications, including but not limited to communication boards, pre-recorded speech devices, laptop computers, desktop computers, Personal Digital Assistants (PDAs), Braille typewriters, visual alert systems for the deaf and memory books.
- Eyeglass lenses and frames and contact lenses (except for the first pair of contact lenses for treatment of keratoconus or post cataract surgery).
- Routine refractions, eye exercises and surgical treatment for the correction of a refractive error, including radial keratotomy.
- All non-injectable prescription drugs, unless Physician administration or oversight is required, injectable prescription drugs to the extent they do not require Physician supervision and are typically considered self-administered drugs, non-prescription drugs, and investigational and experimental drugs, except as provided in this plan.
- Routine foot care, including the paring and removing of corns and calluses or trimming of nails. However, services associated with foot care for diabetes and peripheral vascular disease are covered when Medically Necessary.
- Membership costs or fees associated with health clubs, weight loss programs and smoking cessation programs.
- Genetic screening or pre-implantations genetic screening. General population-based genetic screening is a testing method performed in the absence of any symptoms or any significant, proven risk factors for genetically linked inheritable disease.
- Dental implants for any condition.
- Fees associated with the collection or donation of blood or blood products, except for autologous donation in anticipation of scheduled services where in the utilization review Physician's opinion the likelihood of excess blood loss is such that transfusion is an expected adjunct to surgery.
- Blood administration for the purpose of general improvement in physical condition.
- Cost of biologicals that are immunizations or medications for the purpose of travel, or to protect against occupational hazards and risks.
- Cosmetics, dietary supplements and health and beauty aids.
- All nutritional supplements and formulae except for infant formula needed for the treatment of inborn errors of metabolism.
- For or in connection with an Injury or Sickness arising out of, or in the course of, any employment for wage or profit.
- Charges for the delivery of medical and health-related services via telecommunications technologies, including telephone and internet, unless provided as specifically described under Covered Expenses.
- Massage therapy.

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, service agreement 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.

Cigna Healthcare products and services are provided exclusively by or through operating subsidiaries of The Cigna Group, including Cigna Health and Life Insurance Company, Connecticut General Life Insurance Company, Evernorth Behavioral Health, Inc., Evernorth Care Solutions, Inc. and HMO or service company subsidiaries of Cigna Health Corporation.

DOMESTIC PARTNERSHIP

RFCUNY offers benefits to employees' domestic partners (DP) and the domestic partner's eligible child(ren). Please be advised that the tax consequences of providing health benefits to your domestic partner are subject to the guidelines of the Internal Revenue Code and may result in additional taxable income to you. Similarly, there may be other legal consequences for you if you register a domestic partner.

DEFINITION OF A DOMESTIC PARTNERSHIP: Two people, both of whom are eighteen years of age or older, neither of whom is married to anyone or related by blood in a manner that would bar their marriage in New York State; who have a close and committed personal relationship; who have registered as domestic partners; and have not terminated the domestic partnership.

TAX DEPENDENCY: Covering your domestic partner is considered imputed income by the IRS. This means that the cost of covering your domestic partner is taxable to you for both the employee and the employer paid portion of your health insurance premium. If your domestic partner is your tax dependent, you will not be taxed on the premium. To claim tax dependency, you must complete the Domestic Partner Certificate of Tax Dependency (see website). Domestic Partner coverage may include Pre and Post tax premium deductions.

The following documentation is required to enroll in Health Insurance:

- You must provide a copy of your Domestic Partnership Registration Certificate from the jurisdiction in which you live, or
- A copy of the notarized Alternative Affidavit of Domestic Partnership (non-resident); together with
- A notarized, statement of financial interdependence, with corresponding documents; and
- A health insurance carrier enrollment form.

Policies are available under **Learning & Resources > Review Policies & Procedures.** The forms are available under **Learning & Resources > Find Documents & Forms**. For non-tax dependent rates, please contact your Campus Benefits Coordinator. For more information, please contact Human Resources (212) 417-8600 option 4.

PROJECT EMPLOYEE DOMESTIC PARTNER RATES FOR TAX DEPENDENTS

January 1, 2025 through December 31, 2025

Program	Option	Monthly Premium Due
Cigna OAPIN(Medical) + Cigna PPO (Dental)	Employee & DP Employee (Child) & DP Employee & DP (Child)	$381.18 $567.30 $567.30
Cigna POS(Medical) + Cigna PPO (Dental)	Employee & DP Employee (Child) & DP Employee & DP (Child)	$516.55 $773.98 $773.98
Cigna OAP(Medical) + Cigna PPO (Dental)	Employee & DP Employee (Child) & DP Employee & DP (Child)	$525.14 $784.21 $784.21

QUALIFYING LIFE EVENTS

Changes may be made to your benefit elections only during the annual open enrollment period, unless there is a qualifying life event as defined by the IRS. If a qualifying life event occurs, you are permitted to make changes consistent with the event.

Qualifying Life Events include:

- Loss of coverage
- Marriage
- Legal Separation
- Divorce
- Birth or Adoption of a child
- Loss of a dependent (through death or emancipation/reaching the maximum age)
- Start or termination of your spouse's employment or benefits.
- Change in work status (for you or your spouse) from PT B to PT A, PT A to FT, etc.
- Open enrollment of your spouse's employer

If any of these changes occur, it is **your responsibility** to make changes in the **My Payroll and Benefits** portal under "Qualifying Life Event" and provide the required document(s) to Human Resources within 30 days of the event. If you do not notify Human Resources within 30 days, changes to your coverage will not be permitted until the next open enrollment period.

Employees will then have the chance to change benefit elections (such as enrolling in or cancelling out of coverage and adding or removing dependents). The effective date of the change in benefits will be the date the major life event occurs. Employees will be required to supply supporting documentation (such as a marriage certificate, birth certificate, etc.).

COBRA

Federal legislation has made continuation of certain group health benefits available to employees and eligible dependents that have lost these benefits due to a "qualifying event." These rules are known as the **Consolidated Omnibus Budget Reconciliation Act of 1986** (COBRA). If employees experience one of the qualifying events listed below, they may become eligible to continue health coverage under COBRA. Employees should also be aware that under certain circumstances, they and/or their dependent might be covered under both COBRA and another insurance plan where a pre-existing condition is present.

Federal COBRA Qualifying Event	Maximum Length of COBRA
Termination of employment (other than gross misconduct)	36 months
Reduction of working hours (losing health benefits eligibility)	36 months
Retirement	36 months or until Medicare eligible
Death of an employee	36 months (for spouse and dependents)
Employee becomes Medicare eligible	36 months (for spouse and dependents)
End of FMLA	36 months
Divorce or legal separation	36 months (for spouse and dependents)
Dependent becomes ineligible due to age	36 months (for dependents)

Please be advised that upon the employee's termination from RFCUNY, they and their covered family members have the right to continue your present Group Health Plan in accordance with COBRA and HIPAA laws. The COBRA elections package will be mailed to employees by Human Resources.

The monthly cost for employees continuing current coverage will be provided on a COBRA benefit election form after they experience one of the qualified events. The cost represents 102% of the premium that RFCUNY pays for those benefits. In the case of extension of coverage due to a disability, the cost is 150% of the premium.

Coverage must be elected on the form within 60 days of the qualified event and their first payment is due within 45 days of your COBRA election date. Payments are due by the fifth (5^{th}) of each month. If payment is not received by that date, coverage will cease immediately, retroactive to the last date for which payment was made.

LIFE INSURANCE AND ACCIDENTAL DEATH AND DISMEMBERMENT (AD&D)

RFCUNY provides eligible Full-time employees with Life Insurance and Accidental Death and Dismemberment (AD&D) coverage through Guardian Life Insurance. We provide this benefit at no cost to employees and enrollment is automatic. Plan highlights are detailed below.

Eligibility	Full-time employees
Project employee earning over $30,000 annually	$30,000 Coverage
Project employee earning up to and including $30,000 annually	$15,000 Coverage

Life insurance coverage is terminated when employment ends or the employee retires. Employees may then be eligible to convert their group life insurance to an individual life insurance policy as outlined in the RFCUNY Certificate of Coverage.

To add or change beneficiary designation(s), employees must go to **My Payroll and Benefits** in the RFCUNY website. The link is called “Life Insurance Beneficiaries” located under the Employee Services tab.

RESEARCH FOUNDATION EDUCATIONAL ASSISTANCE PROGRAM (REAP)

RFCUNY supports its employees' ongoing professional development by providing tuition assistance benefits. RFCUNY recognizes that providing lifelong higher education opportunities to staff is in the best interest of the organization and its employees. The RF reimburses eligible employees for actual tuition paid, at the then current CUNY tuition rates, for any undergraduate or graduate level courses offered by or taken at any CUNY institution (senior or community college).

The REAP program includes reimbursement for job-related certificates, credit-bearing and non-credit bearing courses, regardless of matriculated status. The Foundation reserves the right, at its sole discretion, to reduce and/or eliminate this benefit at any time.

ELIGIBILITY:

RFCUNY project employees who have been continuously employed in Full-Time status for at least one year without a break in service and Part-Time A employees whose scheduled hours equal at least 19.5 hours of assigned work per week for at least one year without a break in service are eligible.

For the REAP policy, a "break in service" is defined as a lapse in employment for a period of time in excess of 30 days, from the end of one appointment and the beginning of the next appointment.

An eligible RFCUNY employee must be employed in an eligible status as described above, on the first day of classes and must continue in such eligible status without a break in service, through the last day of scheduled examinations.

WHAT WILL BE REIMBURSED?

1. For courses taken in pursuit of an undergraduate or graduate degree by eligible matriculated students:

Actual tuition paid, at then current CUNY tuition rates, for any undergraduate or graduate level courses offered by and taken at any CUNY institution (senior or community college) as a matriculated student, as follows:

- For eligible Full-Time (or its equivalent) employees the program shall pay the full tuition for a maximum of two courses per academic year, regardless of cost.
- For Part-Time A (or its equivalent) employees the program shall pay the full tuition for one course per academic year, regardless of cost.

2. For certificate, credit-bearing and non-credit bearing courses taken at any CUNY institution, that are job related, as attested to by the Principal Investigator/Project Director:

- For eligible Full-Time (or its equivalent) employees the program shall pay the tuition equivalent to that of a three (3) credit undergraduate or graduate level course, whichever is applicable, for a maximum of two courses per academic year.
- For Part-Time A (or its equivalent) employees the program shall pay the tuition equivalent to that of a three (3) credit undergraduate or graduate level course, whichever is applicable, for a maximum of one course per academic year.

Reimbursement for job-related courses is not dependent upon matriculated status

APPLICABLE LIMITATIONS:

Reimbursement is not available for remedial coursework.

Reimbursement is for tuition only; no fees, books, etc.

Reimbursement is for actual out of pocket expenses, not reimbursed from other sources, e.g., financial aid (other than student loans).

The academic year begins with the fall semester. There will be no rollover of unused funds from one academic year to another.

To be reimbursed, the employee/student must prove that he/she has achieved either a grade of C or better in the course(s) taken, a grade of Pass in a course taken Pass/Fail (limited to one Pass/Fail course per session), or a "P" or "SP" in a non-graded doctoral dissertation course, and that he/she has maintained an average of C or better for the applicable session.

Eligibility for tuition reimbursement for credit-bearing courses taken in pursuit of a degree extends for up to six (6) consecutive academic years, from and including the year of the first award of benefits.

REIMBURSEMENT PROCEDURE:

1. Employee must submit an application to RFCUNY's Office of Human Resources on or before the last day he/she is entitled to add or drop the class. Since reimbursement is available on a first come, first served basis, employees are encouraged to submit their applications upon course registration. The application process requires that the employee applicant's Principal Investigator/Project Director confirm that the course(s) for which tuition reimbursement is being sought will not interfere with the employee's work schedule.

2. All applications, whether approved or disallowed, will be returned to the employee as soon as practicable. If the application is disallowed, the reason for disallowance will be indicated.

3. Upon completion of the courses(s) approved for tuition reimbursement, and within 60 days of the last day of final exams, the employee must present the following to RFCUNY's Office of Human Resources in order to receive reimbursement:

- A copy of the original application, indicating that the course(s) was approved by RFCUNY's Office of Human Resources;
- Proof of matriculated status in a CUNY degree program (when applicable);
- The original bursar's receipt indicating the amount of tuition paid directly by the employee (employees will not be reimbursed for any part of their tuition which was covered by financial aid other than by student loans);
- A copy of the employee's grade report for the approved course(s), indicating the achievement of at least a grade of C, P, or SP if applicable;
- A copy of the employee's transcript indicating the maintenance of an average of a C or better for the applicable session.

The application is available under "Forms" in **My Payroll and Benefits**. For more information, please refer to the RFCUNY website or contact Ratna Karki at (212) 417-8630.

FLEXIBLE SPENDING ACCOUNT PLANS (FSA)

PARKING AND COMMUTER FLEXIBLE SPENDING ACCOUNTS

RFCUNY provides parking and commuter savings programs for all employees. These programs offer employees the opportunity to set aside money on a pre-tax basis to cover the cost of parking and public transit expenses. Deductions will automatically be taken from the employee's paycheck, which makes the program convenient to use.

Employees choose the amount to be deducted when they enroll in the program. They can contribute up to $325 a month ($3,900.00 per year) for transit and $325 a month ($3,900.00 per year) for parking towards the program on a pre-tax basis. Parking Expenses on or near place of employment and Parking Expenses at a commuting center such as a train or bus station.

Carrier	ABS
Eligibility	All employees
Maximum Monthly Amount	$325 for transit - $325 for parking
Year End Run-off Period	Reimbursements may be submitted up to 90 days following the end of the plan year.
Plan Year Payroll Deductions	24 payroll deductions (Twice a month)

1. The employee enrolls in the desired FSA plan through My Payroll and Benefits.
2. The employee may use the debit card to make purchase or purchase as an out-of-pocket expense to be submitted to reimbursement with claim form and receipts.
3. The employee submits receipt(s) along with Advanced Benefits Strategy's (ABS) Reimbursement Request form by email rfcunyclaims@abs125.com or fax to 860-673-2207
4. Reimbursements are made directly by ABS and will be made via check or direct deposit set up with ABS. There are no payroll reimbursements.

The total dollar amount you select is deducted from your paycheck over 24 pay periods in the plan year and deposited into your flexible benefit account.

The funds set aside in your Flexible Spending Account are reimbursed back to you, untaxed, for any healthcare expenses not covered by your insurance plan, certain dependent care costs, and commuting and parking expenses.

But there's more good news… because you've set aside money every paycheck on a pre-tax basis, you've now lowered your gross taxable paycheck by that amount. Your employer takes out less federal, state, local, Medicare and Social Security taxes. The savings may look small at first, but over the year it adds up. Think of this as a bonus in every paycheck, compliments of the IRS.

For more information, please contact ABS at www.abs125.com or call (877) 732-8125.

HEALTH CARE AND DEPENDENT CARE FLEXIBLE SPENDING ACCOUNTS

Flexible Spending Accounts (FSA) allow employees to set aside money on a pre-tax basis for certain expenses related to Health Care and Dependent Care. This provides an immediate tax break to cover out-of-pocket expenses.

Flexible Spending Account	Maximum Annual Contribution	Covered Expenses
Health Care FSA	**$3,300.00 ($250 minimum)**	Copays, deductibles, prescription, dental work, eyeglasses, contact lenses, etc.
Dependent Care FSA	**$5,000.00 ($250 minimum)**	After school programs, childcare and preschool (up to age 13). Elder care for tax dependents.

Employees will have to select a fixed annual amount. IRS regulations require that individuals forfeit any money left in an FSA account after the claim's submissions deadline. This is known as the "use it or lose it" rule. Conservative calculations should be made for the employee's own as well as dependent expenses when making FSA elections.

Carrier	ABS
Eligibility	Full-time and Part-time A Employees
Waiting Period	Employees are eligible to participate in the DC FSA on their eligibility date. HC FSA requires a 90 Day waiting period.
Year End Run-off Period and Grace Period	2 ½ Month after plan year ends.
Plan Year Payroll Deductions	24 payroll deductions (Twice a month)

For more information, please contact ABS at www.abs125.com or call (877) 732-8125.

HOW THIS PLAN WORKS

It is important that you fully understand how these plans work. Flexible Spending Plans allow you to set aside money on a pre-tax basis to cover public transit or parking expenses used to commute to and from your work place, out of pocket medical costs, or dependent care expenses (for children up to age 13 or eldercare). For the Transit and Parking plans are based on a monthly election amount. A minimum $1.00 election must be made in order to remain enrolled in these plans. For the Healthcare or Dependent care plans, a minimum $250 annual election ($10.42 per deduction) is required to enroll. Deductions are automatically taken from your paycheck twice a month. Reimbursement is on a post-tax basis allowing for tax savings.

Do not overestimate your eligible expenses when enrolling in these plans. Enrollment and reimbursement will follow IRS rule. Transit, Parking, and Dependent Care plans allow for enrollment, changes, and cancellations at any time. The Healthcare plan is an annual enrollment which cannot be increased, decreased, or changed outside of initial eligibility, within 31 days of a qualifying life event, or during annual open enrollment.

RFCUNY Plans have a 2 ½ month grace period following the end of the plan year. A grace period extends the period of time in which you can use your FSA funds on eligible expenses, such as going to the doctor or purchasing prescriptions and FSA eligible over-the-counter medications. The deadlines for Plan Year 2025 are as follows:

- Grace Period to Incur Claims: March 15, 2026
- Deadline to Submit Claims: March 31, 2026

FSA Plans follow IRS rule. Claims submitted after the deadline will not be approved. Use It or Lose It.

Healthcare and Dependent care funds do not roll over and remaining plan balances will not be refunded. Unclaimed Transit and Parking funds will automatically roll over to the next plan year **IF** you re-enroll. If you have the debit card, it will continue to work as normal, using the funds remaining in your prior plan year first.

DEBIT CARD REIMBURSMENTS

For the Transit, Parking, and Healthcare eligible expenses, you may use the FSA Debit Card provided by Advanced Benefit Strategies. See the attached Instructions for more information on How to Use the Debit Card. Dependent Care reimbursement is not available through Debit Card.

REIMBURSMENT USING CLAIM FORM AND RECEIPTS

Save your Receipts! The IRS views certain expenses as automatically eligible, while others will require an itemized receipt. *For example; vision centers and dental expenses (FSA)*. Duplicate expenses submitted via claim form for expenses already charged to the ABS Debit Card will not be reimbursed. ABS will review manual claims and reject claims submitted for the same dates of service which were previously charged to the ABS Debit Card.

There will be no payroll reimbursements. You can submit the reimbursement form by ABS Mobile App, through the ABS portal www.abs12.com, via email at rfcunyclaims@abs125.com, fax to 860-675-2260, or mail to ABS at 30 Mill Street, Unionville, CT 06085. The reimbursement claim form may be accessed on the RFCUNY site under Employees > Explore & Enroll in Benefits > Pre-Tax Flexible Spending Plans. Employees who submit claims will be reimbursed directly by ABS via direct deposit set up through ABS or via manual check. If you need assistance submitting your claims, please contact Support@abs125.com

ABS Consumer Portal and Mobile App

The ABS mobile App provides you with a centralized view of:

- Account balances, account activity, claim history and payment (reimbursement) history
- Submit claims online to reimburse yourself or pay a provider – snap a photo of a receipt and submit with a new or existing claim.
- Track your expenses, update personal profile information, and report a lost/stolen card to receive a new one
- Sign up for ***Direct Deposit –*** Mobile App, Consumer Portal or paper form
- Face enabled and contactless payments with Mobile Pay (mobile app)
- Built in eligibility scanner and EOB Smart Scan (mobile app)
- “Let's Chat" your AI-Virtual Account Manager is live on the ABS Consumer Portal to help with questions 24/7/365.

ABS DEBIT CARD

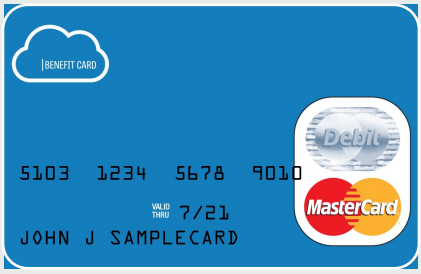
Our benefits debit card is the fastest and most convenient way to access your funds and pay for eligible expenses. Just one debit card is all you need for your card-eligible benefits with us.

While the IRS requires documentation for certain spending and reimbursement benefits, we automate some of that substantiation through:

IIAS approval: If a merchant uses the Inventory Information Approval System (IIAS), the debit card will automatically approve eligible expenses. You can view a list of IIAS merchants at www.sig-is.org/card-holders/store-locator.

Copayments: If your employer provides us copayment amounts for your insurance plans, we can auto-approve expenses that match these copayment amounts.

Recurring claims: If you use your debit card for a purchase that requires substantiation, once the claim has been approved and you make that same purchase for the same dollar amount at that merchant, the recurring claim will be automatically approved.



How do I get a card?

We'll automatically mail you two debit cards to the address listed in your account the first time you enroll. If you're already enrolled, continue using the debit card you have.

Additional cards

You can request additional debit cards for your spouse or dependents from your online account. Log in, under Accounts select Banking/Cards

Expiring debit card

We will automatically mail you a new debit card 30 or more days prior.

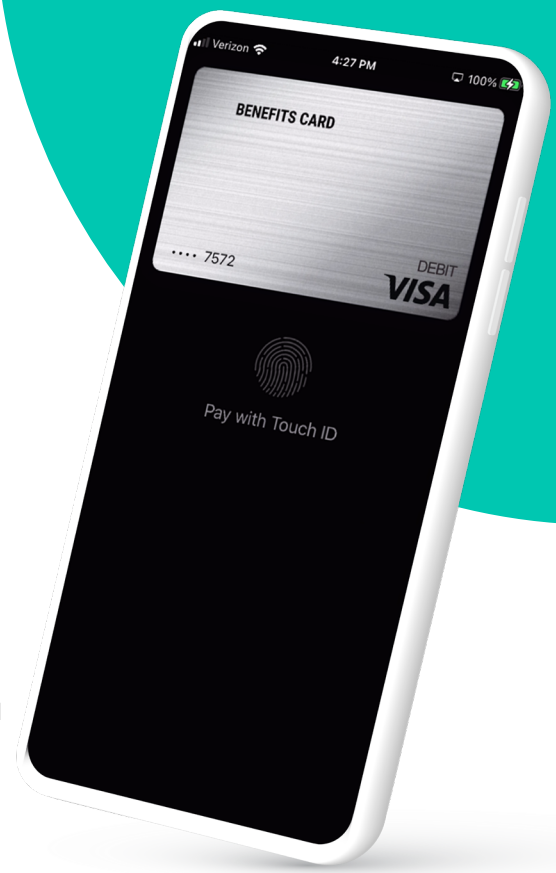
Lost or stolen cards

If your debit card is lost or stolen, you can report it in your online account or mobile app and request a new card.

ABS Advanced Benefit Strategies
Your Flexible Benefits Specialists

Mobile payments from ABS

Faster payments, more secure, and contactless = a better user experience for you as a participant



Contactless payments

Mobile payments = contactless! less germs, faster (and more secure) purchases, and a better user experience.

Add your benefits debit card to your mobile wallet

Whether you use Google Pay, Apple Pay, or Samsung Pay, quickly add the benefits debit card to your mobile wallet with just a few taps on your device.

Access the benefits debit card via mobile wallet to pay for eligible expenses

With mobile payments, you don't need to use (or even bring) your debit card when you want to pay for eligible expenses. The card will be accessible (alongside the rest of your credit or debit cards) in your mobile wallet.

With mobile payments, you have the option to add the debit card to the mobile wallet to pay for an eligible expense or take advantage of commuter or parking benefits are on-the-go.

ABS Advanced Benefit Strategies
Your Flexible Benefits Specialists

RESEARCH FOUNDATION RETIREMENT POLICY

This policy applies to all employees of the Research Foundation of the City University of New York unless otherwise provided for in a collective bargaining agreement or other governing document. Any deviations from this policy must be approved in writing by the President of the Research Foundation. Eligibility for retirement benefits is determined by employee status and length of service.

- A Research Foundation employee hired before July 1, 2012 is considered eligible for retirement with benefits when he/she:

has reached age 55, and
at the point of retirement has been employed full-time by the Research Foundation for a period of at least 10 years without a break in service, or was a part-time A employee on May 1, 1981 and has since been employed without a break in service, and
has a combination of age and years of service which equals 70 or more.

- A Research Foundation employee hired on or after July 1, 2012 is considered eligible for retirement with benefits when he/she:

has reached age 62, and
at the point of retirement has been employed full-time by the Research Foundation for a period of at least 10 years without a break in service, or was a part-time A employee on May 1, 1981 and has since been employed without a break in service.

In the case of instructional personnel on a 10-month academic year assignment, 12 months of employment in a 14-month period will be considered the equivalent of one year of service.

Break in Service

A lapse in employment by the Research Foundation lasting more than 30 days constitutes a break in service.

Retirement Benefit

The Research Foundation Retirement Benefit is a one-time cash payment. The employee may choose one of the following options:

OPTION A	A benefit period is derived using the formula of three calendar days of leave for each 12 full months of continuous service up to the last day actually worked, for a maximum of eighty calendar days. Actual payment is figured by determining the number of work days (i.e., Monday through Friday), in the benefit period.
OPTION B	One-half the temporary disability leave (sick leave) balance as of the last day actually worked. The maximum payment permitted is six days for each 12 full months of continuous service, not to exceed a maximum payment of 80 days.

Health Insurance

Upon application, health benefits will be continued by the Research Foundation for retired employees, their spouses or domestic partners, and dependents for the level of coverage for which they are eligible at the time of retirement. The retiree will contribute a share of the health insurance premium that equals the rate of contribution that active employees pay toward their health insurance premium, paid directly to the Research Foundation. The preferred method of payment is by direct debit. Eligible retirees and their spouses must enroll in Medicare to be eligible for this continued benefit. Upon request and with proof of payment, the Research Foundation will reimburse the retiree, and their spouse or domestic partner, a percentage of the standard monthly Medicare Part B premium (pursuant to the Research Foundation of the City University of New York Retiree HRA Plan), less an amount that equals the rate of contribution that the retiree pays toward their health insurance premium.

Eligible retirees must request each year to receive the Medicare Part B reimbursement benefit as either one lump sum annual reimbursement payment or two semi-annual reimbursement payments. If the eligible retiree chooses one annual lump sum payment, the required proof of payment must be submitted by March 31st of the following year. If the retiree chooses two semi-annual payments, proof of payment must be submitted by September 30th of the current year (for January through June Medicare Part B premiums) and March 31st of the following year (for July through December Medicare Part B premiums). The Medicare Part B reimbursement shall be payable in accordance with the terms of the Research Foundation of the City University of New York Retiree HRA Plan. The proper documentation for requesting reimbursement is a memo from the Social Security Administration (SSA) stating the amount of Medicare Part B premiums paid for each of the months for which you are requesting reimbursement, or a copy of the IRS 1099 issued by SSA.

Eligible retirees must also provide the Research Foundation with a copy of his/her Medicare enrollment card.

Waiver

Eligible retirees may waive their right to enroll and participate in health benefits. Eligible retirees who waive coverage and later choose to participate in the health insurance plan may do so only during the next scheduled open enrollment period, unless a "qualifying event" occurs.

Death of Retiree

Upon the death of the retiree, the spouse and/or qualified dependent(s) enrolled in a Research Foundation health insurance program may continue coverage in that same health insurance program by making payments pursuant to COBRA. Following the expiration of the COBRA period, the spouse and/or qualified dependent(s) may continue to participate in the health insurance program so long as they continue to satisfy the program's dependent eligibility criteria and make the requisite payments, which shall be equal to the applicable COBRA premium in effect at that time.

Annual Leave

The accumulation of time and leave benefits terminates on the last day worked. Retiring employees will receive payment for any unused annual leave balance if permitted by the sponsoring agency at the salary rate then in effect.

Reemploying Retirees

Research Foundation retirees may not be rehired by the Research Foundation unless there has been a break in service of at least 180 days. The appointment for which a retiree is being considered may not have been contemplated at the time of retirement. Further, there can be no agreement with a retiree before the end of a required break in service that the Research Foundation will use his or her services after such break.
In the event a retiree has commenced a distribution under the Research Foundation's retirement plans, the retiree may not be reemployed by the Research Foundation prior to the later of

(1) the end of the break in service period specified above, or
(2) the end of the calendar year in which the retiree received the distribution. If a retiree is reemployed, the retiree is subject to all applicable terms and limitations under the Research Foundation retirement plans relating to rehired employees.

A reemployed retiree may work no more than 19 hours per week (Part-time B).

The Research Foundation may recognize an exception to the 180-day restriction for a retiree who had a bona fide retirement, but unanticipated circumstances require the retiree to seek reemployment (e.g., death or disability of a working spouse). Any exception granted on this basis must be supported by credible evidence of an unanticipated change in circumstances and a legitimate change in plans to seek reemployment. Any exception must be approved by the Senior Director of Human Resources. Exceptions to the 180-day restriction should be rare.

Rehired Retiree Time and Leave Accrual

For purposes of time and leave accrual, a lapse in employment by the Research Foundation lasting more than four (4) months constitutes a break in service for purposes of leave accrual rates, which results in an employee re-starting at 0 years of service for the purpose of accrual rates.

Notification

The employee must notify the Research Foundation, in writing, of his/her intention to retire at least 90 days prior to the intended date of retirement.

PLAN RFCUNY 403(b) RETIREMENT SAVINGS PLAN

All employees look forward to retirement which is why it is important to plan financially.

Full-Time and Part-Time A employees, who are appointed for at least 90 days, are eligible to participate in the RFCUNY 403(b) Retirement Savings Plan ("Plan"). Participation in the Plan is mandatory for eligible employees. Some of the key conditions of the Plan are summarized below. Please see the Summary Plan Description for more details.

For employees in TIER IV (those first hired, or rehired after a break in service*, on or after January 1, 2009), there is a one-year waiting period to participate in the pension plan. After the employee enrolls in the plan, the Foundation contributes 8% of the employee's earnings during the first seven (7) years of service (as defined in the Plan), and 10% of the employee's earnings thereafter. The employer contribution for each year is allocated to the plan in a lump sum as soon as practicable after the final payroll for that year. Employees are vested in their employer contributions after three (3) years of service. (The one-year waiting period counts toward this vesting requirement.) No employee contributions are required.

For the purpose of determining an employee's Pension Tier level, a "break in service" is defined as a lapse in employment in excess of 120 days.

If employment ends before the vesting requirements are met, as per the plan rules, any employer contributions made to the plan which are not vested at the time of the end of employment will not be eligible for withdrawal, loan, or roll over. Should you be rehired in an eligible position under the Research Foundation of CUNY within a five-year period from the last day worked, you will be given the opportunity to complete the vesting requirement. Non-vested employer contributed funds will be forfeited after a five-year break in employment service.

ELECTIVE (VOLUNTARY) CONTRIBUTIONS

The RFCUNY 403(b) Retirement Savings Plan("Plan") is a tax-deferred annuity 403(b) individualized personal retirement savings account plan. This Plan allows for elective deferrals.

Employees may contribute to the program, which allows them to have a percentage of their pre-tax income withheld for retirement. Employee deductions usually commence on the payroll following RFCUNY's receipt of the employee's Salary Reduction Agreement agreement forms. Employees may make changes to their elective deferrals.

If an employee is currently participating in the Plan and does not wish to change the amount of contribution to the plan in subsequent years, no action is necessary. Otherwise to participate in the Plan or change the elective deferral amount, the employee must complete a Salary Reduction Agreement form and submit the form to the Human Resources Department Julian_Osorio@rfcuny.org.

The Plan permits rollover contributions from qualified retirement plans (e.g., a 401(k) plan or money purchase pension plan), other 403(b) plans, and certain IRAs provided that certain criteria are satisfied. For more information, please contact TIAA National Contact Center at 1 800 842-2252.

To schedule individual counseling session with a TIAA Financial Advisor, choose investment allocations, designate beneficiaries, or create online access, enroll online at www.tiaa.org/rfcuny.

Maximum Annual Contribution (2025)	$23,500 (Under age 50)
	$31,000 (Age 50 or older)
Withdrawal Permissions	Retirement
	Termination of employment
	Attainment of age 59 ½
	Financial hardship as defined in the plan
	Disability or death
Early Withdrawal Penalty	If you take a withdrawal prior to age 59 1/2, you will pay a 10% penalty in addition to taxes.

457(b) SALARY DEFERRAL PLAN

The 457(b) Salary Deferral plan is a tax-deferred compensation plan only available to employees who have satisfied the eligibility requirements as described in the plan document. This plan allows voluntary pre-tax contributions for your retirement savings. Plan contributions and subsequent earnings will not be subject to applicable tax until you receive a distribution or withdrawal after your end of RF employment. Eligible employees will be notified by the Office of Human Resources. Participation is voluntary. Annual re-enrollment for the 457(b) plan is not required. **Upon separation of employment, 457(b) participants must contact TIAA within 90 days. Failure to contact TIAA within the required time will result in lump sum distribution of 457(b) funds as taxable earnings.**

HEALTH ADVOCATE - EMPLOYEE ASSISTANCE PROGRAMS (EAP)

Committed to helping its employees maintain an optimum quality of life, the Research Foundation offers the Health Advocate & Employee Assistance Program, which is available to employees, their dependents, parents, and parents-in-law. Your EAP+Work/Life online services website has all the tools, tips, and resources you need to support your mental, emotional, physical, and financial well-being!

Health Advocate is the nation's leading healthcare advocacy and employee assistance program. The Healthcare Help service features personalized help to resolve clinical and insurance-related issues. The EAP+Work/Life program offers short-term counseling and support for personal, family, and work issues. Health Advocate is available 24/7 and ensures that all personal information is kept completely confidential.

Getting Started:

- Visit the Health Advocate website at www.HealthAdvocate.com/rfcuny or call toll-free at 866-799-2728 to reach Health Advocate's Healthcare Help and EAP+Work/Life services.

Feature 1: Healthcare Help - Provides the right answers at the right time

You have unlimited access to a highly trained Personal Health Advocate (PHA) who can help you navigate the healthcare and insurance systems efficiently and dependably. The PHA can help you find the right providers, negotiate fees on uncovered medical bills, locate second opinions, provide cost comparisons for medical procedures, and much more.

Feature 2: EAP+Work/Life - Real-life help

A licensed EAP professional can provide short-term counseling by phone or e-mail to help you better cope with personal, family, and work issues. Work/Life specialists can help you locate the right support services, from childcare and eldercare to legal help.

EARNED SAFE AND SICK TIME ACT (ESSTA)

On May 5, 2018, an amendment to the New York City Earned Sick Time Act (ESTA) took effect, expanding the law to allow paid leave to be used by employees when they or their family members are victims of family offense matters (which include disorderly conduct, harassment, and other offenses), sexual offenses, stalking, and human trafficking. The amendment also expands the definition of "family member" under the Act. The law is now known as the "Earned Safe and Sick Time Act (ESSTA)."

STATUTORY BENEFITS

WORKERS' COMPENSATION

(Work related illness/injury)

Although RFCUNY strives to have an injury-free workplace, accidents occasionally happen. RFCUNY has a Workers' Compensation program that provides benefits for any employee who is unable to work as a result of a work-related illness or injury. If the Workers' Compensation claim is approved, the employee is deemed compensable for any medical services incurred as a result of the injury.

Carrier	Hartford
Eligibility	All employees
Weekly Benefit Amount	2/3 of average weekly salary, up to $1,125.46
Waiting Period	Seven (7) days from the day of the incident. Benefits begin on the eighth day.

Note

1. If an employee has accrued time and leave, salary will continue to be paid in full by RFCUNY for the time allotted by those balances. Once Workers' Compensation leave is confirmed by the Workers' Compensation Board, any used time and leave will be credited back to the employee and payments will be paid directly from the Workers' Compensation carrier.
2. An employee's medical expenses will be reimbursed whether or not there was time lost from work.
3. If the employee's claim qualifies under FMLA, it will run concurrent with Workers' Compensation.

How to File a Workers' Compensation Claim

1. If an employee incurs an injury of any type on the job, the incident must be immediately reported to the supervisor.
2. The employee must complete the "Employee's Notice of Injury" form and submit it to the office of Human Resources within 30 days.
3. The employee will be assigned a claim number and must refer to this number when seeking medical attention. The employee does not pay for medical services. Shortly after the employee receives the claim number, a letter will be sent from our Workers' Compensation carrier with instructions on how to submit claims for medical services incurred as a result of the injury.
4. The employee must provide a "Fitness for Duty" certificate from the attending physician stating the employee's ability to return to work.

For more information, please contact the Leaves Administration team at 212-417-8600 and select Time and Leave from the menu options or you may email #LeavesAdministration@rfcuny.org.

SHORT TERM DISABILITY

(Non-occupational illness/injury)

Short Term Disability (STD) insurance provides income replacement for up to 26 weeks for an injury or illness suffered off-the-job. An employee who is disabled due to an injury or illness unrelated to the workplace for six (6) or more consecutive workdays may be eligible for STD.

Weekly Benefit Amount	50% of average weekly salary, up to $170
Waiting Period	Seven (7) calendar days from the day the employee is unable to work. Benefits begin on the eighth day.
Maximum Period of STD Coverage	26 weeks (including usage of accrued sick hours)

How to File a Short-Term Disability Claim

The employee and the employee's physician must complete a NYS DB-450 form. Form DB-450, Application for Leave under FMLA (if applicable), and corresponding WH-380E form (if applicable) must be sent to Human Resources to review the claim and file for NYS Disability benefits. RFCUNY is required to file claims thirty (30) days after the commencement of the disability. Late submissions of claims may result in delays of payments and possible rejection of claims.

Upon returning to work, employees must provide an RF Fitness for Duty Certification or letter/ note from their treating physician in order to return to work. An employee may not return to their position without this Fitness for Duty Notice.

Benefits

Sick time will be paid from the first day of the leave if the employee has time and leave accruals available. Once sick time has been exhausted, Annual leave may be used and the NYS Disability benefit will then be paid directly to the employee up to a maximum of twenty-six (26) weeks. These benefits are fifty percent (50 %) of the employee's weekly wage, up to a maximum of $170 per week.

For more information, please contact the Leaves Administration team at 212-417-8600 and select Time and Leave from the menu options or you may email #LeavesAdministration@rfcuny.org.

NEW YORK STATE PAID FAMILY LEAVE (PFL)

Effective January 1, 2018, employees will be eligible for Paid Family Leave (PFL) as permitted under the New York Paid Family Leave Benefits Law. After this date, eligible Part-time and Full-time employees may take Paid Family Leave under certain conditions, including: (i) to care for a family member with a serious health condition, (ii) to bond with a child after birth or placement for adoption or foster care within the first 12 months after the birth or placement, or (iii) because of any qualifying exigency arising from the fact that an employee's spouse, domestic partner, child or parent is on active duty (or has been notified of an impending call or order to active duty) in the armed forces of the United States.

Eligibility:

- Employees with a regular work schedule of 20 or more hours per week are eligible after 26 weeks of employment.
- Employees with a regular work schedule of less than 20 hours per week are eligible after 175 days worked.

Paid Family Leave will phase in over 4 years with a gradually increasing benefit amount and duration, as depicted below.

Effective Date	Maximum Length of Paid Leave	Amount of PFL Benefits (expressed as % of the employee's average weekly wage (AWW))	Maximum Amount of PFL Benefits Payable (expressed as % of the NY AWW)
January 1, 2018	8 weeks	50%	50%
January 1, 2019	10 weeks	55%	55%
January 1, 2020	10 weeks	60%	60%
January 1, 2021-Present	12 weeks	67%	67%

The 2025 payroll contribution is 0.388% of your weekly wage and is capped at an annual maximum of $354.53.

Requests for PFL leave should be submitted to #leavesadministration@rfcuny.org.

LONG TERM DISABILITY

RFCUNY offers eligible Full-time employees Long Term Disability (LTD) coverage. This coverage is provided through Prudential Insurance Company at no cost to the employee.

LTD insurance provides employees with an ongoing source of income if they remain totally disabled and unable to work due to an illness or injury.

Eligibility	Full-time Employees
Employment Waiting Period	1st of the month following one year of service in an eligible class
Monthly Benefit Amount	60 % of your monthly wage
Maximum Monthly Benefit	$15,000
Minimum Monthly Benefit	$50
Elimination Period	180 Days
Mental Illness Limitation (including drug and alcohol)	24 Month Maximum

Maximum Period for Benefits:

Your Age on Date Disability Begins	Your Maximum Benefit Duration
Under age 60	To age 65
Age 60 but under age 65	4 ½ Years
Age 65 but under age 68 ½	To age 70
Age 68 ½ and over	1 Year

Employees hired after July 1, 1994 with eight or more years of service:

If the employee is receiving payments for disability under the plan and has been continuously disabled for at least 180 days, please contact the #LeavesAdministration@rfcuny.org for more information.

PAID TIME OFF (TIME AND LEAVE ACCRUALS)

The paid time off accruals as detailed in the Time Off and Leave Benefits policy applies to all RFCUNY employees unless otherwise provided for in collective bargaining agreements. Unless expressly provided for otherwise, it does not apply to Graduate Research Assistants, students on stipends or on the CUNY College Work Study Program, or to foreign nationals employed outside the United States, its territories, or Canada. The benefits or policies stated herein are not intended to be contractual in nature. They do not confer any right or privilege, but are informational only. The RF retains the absolute right to amend or terminate any benefit or policy at any time. See *RFCUNY's Policy 506 Time Off and Leave Benefits* for more details.

The following time and leave eligibility rules and accrual rates apply to all full-time and part-time RFCUNY employees, unless otherwise provided for in an applicable collective bargaining agreement. Please note that RFCUNY Central Office employee accruals may vary slightly from what is listed below. Please contact the Office of Human Resources for more information.

Full Time and Part Time A Annual and Sick Leave Eligibility Rules and Accrual Rates

Years of Service	**Annual Leave Accrual Rates**		**Sick Leave Accrual Rates**	
	Days	Per hours worked	Days	Per hours worked
Less than 3 years	15	0.057692	20	0.078571
3 years or more but less than 8	22	0.084615	20	0.078571
years 8 years or more	25	0.096154	20	0.078571

2025 Payroll Calendar			
Period	**For_Period_Ending**	**Timesheet Due**	**Pay Date**
1	12/29/2024	12/30/2024	1/8/2025
2	1/12/2025	1/13/2025	1/22/2025
3	1/26/2025	1/27/2025	2/5/2025
4	2/9/2025	2/10/2025	2/19/2025
5	2/23/2025	2/24/2025	3/5/2025
6	3/9/2025	3/10/2025	3/19/2025
7	3/23/2025	3/24/2025	4/2/2025
8	4/6/2025	4/7/2025	4/16/2025
9	4/20/2025	4/21/2025	4/30/2025
10	5/4/2025	5/5/2025	5/14/2025
11	5/18/2025	5/19/2025	5/28/2025
12	6/1/2025	6/2/2025	6/11/2025
13	6/15/2025	6/16/2025	6/25/2025
14	6/29/2025	6/30/2025	7/9/2025
15	7/13/2025	7/14/2025	7/23/2025
16	7/27/2025	7/28/2025	8/6/2025
17	8/10/2025	8/11/2025	8/20/2025
18	8/24/2025	8/25/2025	9/3/2025
19	9/7/2025	9/8/2025	9/17/2025
20	9/21/2025	9/22/2025	10/1/2025
21	10/5/2025	10/6/2025	10/15/2025
22	10/19/2025	10/20/2025	10/29/2025
23	11/2/2025	11/3/2025	11/12/2025
24	11/16/2025	11/17/2025	11/26/2025
25	11/30/2025	12/1/2025	12/10/2025
26	12/14/2025	12/15/2025	12/23/2025

Independence Day	7/4/2024
Labor Day	9/2/2024
Columbus Day	10/14/2024
Thanksgiving Holiday	11/28/2024
Thanksgiving Holiday	11/29/2024
Christmas Holiday	12/24/2024
Christmas Holiday	12/25/2024
New Year's Holiday	12/31/2024
New Year's Holiday	1/1/2025
Martin L. King, Jr.'s Birthday	1/20/2025
Lincoln's Birthday	2/12/2025
President's Day	2/17/2025
Memorial Day	5/26/2025
Juneteenth	6/19/2025