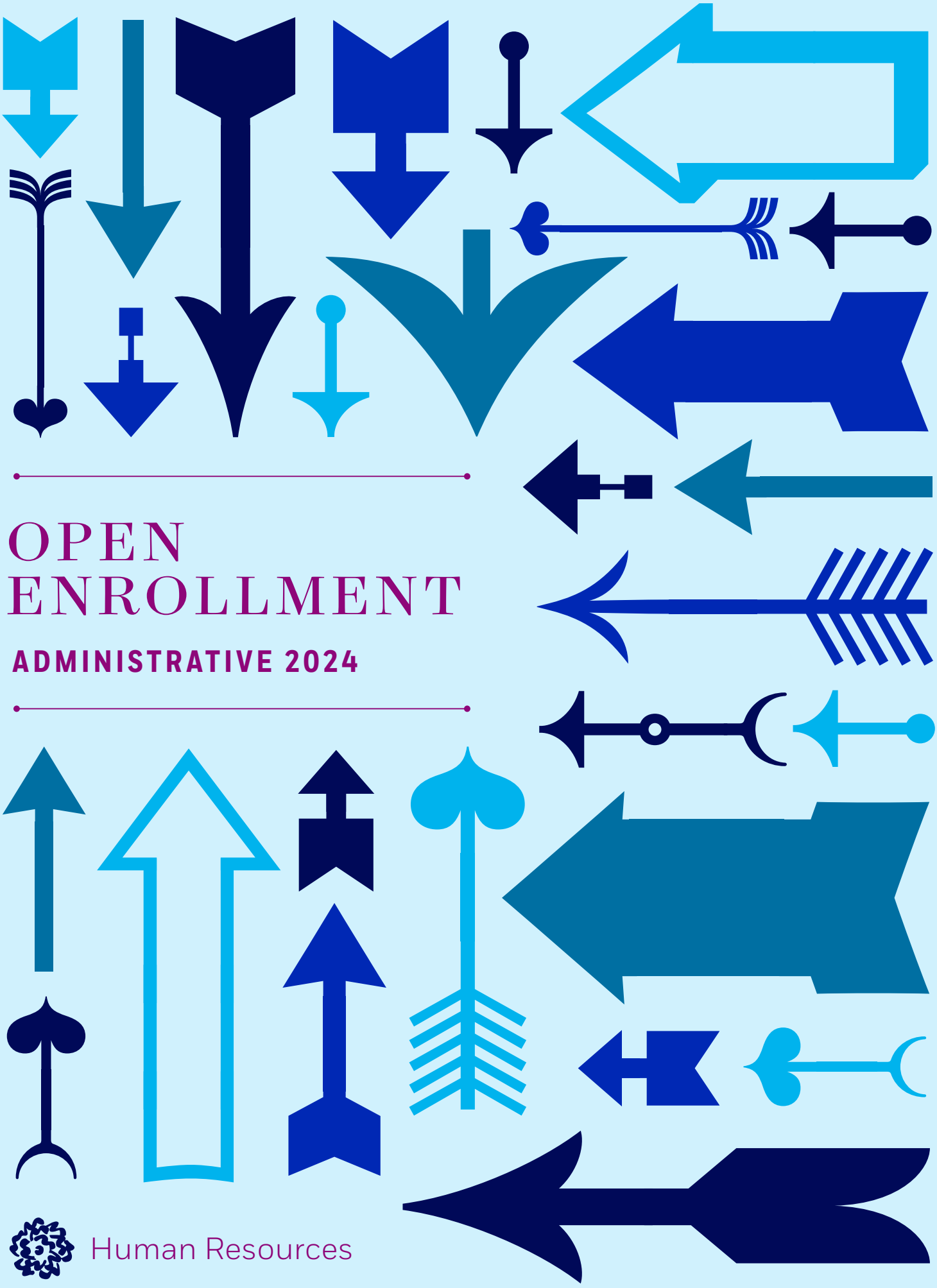


OPEN ENROLLMENT

ADMINISTRATIVE 2024

Human Resources

Table of Contents

Introduction

David Rhodes, President

I hope this finds you and your family healthy, safe and well.

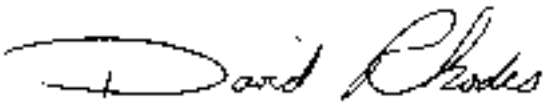
In recent years when the world has encountered much uncertainty, it is important to know there are some things you can rely on, which is SVA's commitment to you and your families.

An integral part of our commitment is our goal is to offer a comprehensive benefit package that contributes to your wellbeing and that of your family.

Like last year, we continue to see a shift in utilization that necessitated a thorough review of the plans specifically, premiums. There will be modest increases of 10% and 5% to semi-monthly premiums to the High Deductible and Open Access plans. The dental plan premiums will also see an increase to the Dental PPO plan and a decrease to the Dental Care plan. You will also see an added benefit to the vision plan. The overall plan designs will remain unchanged for health or dental.

We recommend you use open enrollment as an opportunity to review your benefit options and make the necessary decisions for yourself and your covered dependents. We will be holding virtual information sessions during November to assist you in understanding the benefits offered that best fit your budget,

Thank you for being part of the SVA community. Stay healthy, safe and well.



What's New

- The Integrated OAP and High Deductible plan offers the same coverage as last year, with the exception of an increase to the semi-monthly premium.

- SVA will continue to offer PPO and DMO plans, including the same coverage as last year. However, there will be a modest increase to the PPO and a decrease to the DMO plans.

Your 2024 Benefits

SVA offers a wide range of benefits to ensure the safety, well-being and security of its employees and their families. We also recognize that as life changes, so do the benefits you need, and we continually seek to improve upon our benefit offerings.

The following pages are a general summary of your benefits. A more complete description of your benefits and the terms under which they are provided (including limitations and exclusions) are contained in the plan documents. If there are any discrepancies between the information in this booklet and the provisions of the plan documents, the plan documents prevails. Contact hrbenefits@sva.edu if you would like to review a copy of the summary plan descriptions for medical and dental coverage.

You can view your current benefits, enroll for the first time or terminate benefits offered by SVA by following the steps below.

To access your current benefits or make changes online:

- Go to myid and log-in with your username and password
- Go to the MyServices app in the myid dashboard and click login
- Click on Employee menu and then Benefits Menu
- Click on View Benefits under the Current Benefits menu to view your current elections
- Click on Benefit Enrollment to make changes and follow the prompts
- Click 'confirm' for your changes to be saved.

If you choose to print a copy of your benefit elections for your records, go to Print, Page Layout and choose Landscape. It is highly recommended that you keep a copy for your records.

***Note:** If you are accessing the site from a non-SVA computer you will be asked to re-enter your username and password to view the plan descriptions, rates and beneficiary forms.

Your 2024 Benefits Check List

- Premiums
- Co-payments, deductibles and other costs
- Flexible Spending Accounts
- Health Savings Account
- Know All Your Options

Health and Wellness

Medical Insurance

After one month of continuous employment, regular, full-time staff are eligible to enroll in SVA's health insurance plans. After 90 days, regular, part-time staff who work 20 hours per week are also eligible to join the plan. SVA offers two plan options: one referral-free Integrated OAP plan, and a High Deductible Health Plan (HDHP). Employees may also elect coverage for a spouse, children or a domestic partner.

Flexible Spending Accounts (FSA)

All eligible administrative employees enrolled in a health plan can contribute to a pre-tax savings account to pay for out-of-pocket health and dependent care expenses that are not covered by the health, vison or dental plans. Employees determine the amount of their annual deduction (up to $3,200 for healthcare and $5,000 for dependent care), which will be deducted from their paycheck in equal installments throughout the year.

Health Savings Account (HSA)

All eligible administrative employees enrolled in the High Deductible Health Plan (HDHP) can contribute to a special, tax-advantaged account that can be used to pay for qualified medical expenses. Employees contribute money to their HSA, where it earns interest tax-free. Funds are not taxed when used to pay for qualified medical expenses. However, when used for expenses other than medical, the funds are taxed. Employees determine the amount of their annual deduction ($4,150 for single and $8,300 for family), which will be deducted from their paycheck in equal installments throughout the year.

Dental Insurance

After one month of employment, regular, full-time staff members are eligible to enroll in SVA's dental insurance plans. After 12 months, regular, part-time staff members who work a minumum of 1,000 hours/ calendar year are also eligible to join. Individual and family coverage is available in either Cigna's PPO plan or Cigna's Dental Care plan. Both plans are employee-paid.

Voluntary Vision Care Plan

Eligible administrative employees may enroll in the voluntary vision plan, VSP Signature Vision Care. This benefit provides comprehensive eye health care that includes an annual vision exam with your choice of in, or out-of-network providers, and eyewear to suit any budget. Employees may purchase employee only coverage as well as coverage for eligible dependents.

Voluntary Short-Term Disability Program

Eligible administrative employees may enroll in the enriched voluntary short-term disability program. Employees are able to purchase up to 40%, 50% or 60% of their weekly salary that is payable tax-free in the event of a non-work related injury or illness diagnosed by a medical professional beginning with the eighth consecutive day of disability and continuing for up to 26 weeks. *Please note, your benefit amount will be reduced if you are receiving other income sources such as: social security, retirement, workers compensation, etc.*

Long-Term Disability (LTD)

Long-Term Disability coverage is provided at the College's expense for regular, full-time employees starting after one month of employment, and regular, part-time employees, who work a minimum of 1,000 hours/ calendar year, after 12 months of employment. LTD coverage begins after an employee has been disabled for six consecutive months. Employees have the option to pay their own LTD premiums via payroll deduction. By paying the premium the employee can collect this benefit tax-free. To find out how to make this change, contact hrbenefits@sva.edu. *Please note, your benefit amount will be reduced if you are receiving other income sources such as: social security, pension, workers compensation, etc.*

Eligibility

If you are a regular full-time administrative employee, you are eligible to participate in the Medical, Dental, Vision, Life, AD&D, Voluntary Life, Voluntary Short-Term Disability and Long-Term Disability insurance plans after completing one month of employment. If you meet these requirements and are not participating in one or more of the above, open enrollment is your opportunity to sign up!

Likewise, if you are a regular part-time administrative employee and work a minimum of 1,000 hours/calendar year, you are eligible to participate in the medical plan after a 90 day waiting period.

You can also elect coverage for a spouse, domestic partner or children in the medical, dental and vision plans. Explore your benefit options. Read on to learn how to enroll.

How To Enroll

If you are a current participant in the medical, dental, vision, voluntary life insurance and voluntary short-term disability plans and do not wish to make any changes to your existing benefits, you need not do anything—your coverage will remain in effect without interruption.

If you are an eligible employee and would like to join a plan, you will need to complete the appropriate steps on-line located on myid. Likewise, if you would like to move from one plan to another, or discontinue a benefit altogether, you will need to indicate this change online.

- Go to myid and log-in with your username and password
- Go to the MyServices app in the myid dashboard
- Click on Employee menu and then Benefits Menu
- Click on View Benefits under the Current Benefits menu to view your current elections
- Click on Benefit Enrollment to make changes and follow the prompts
- Click 'confirm' for your changes to be saved

Finally, if you intend to participate in the Flexible Spending Account in 2024 you must complete the Cigna Healthcare Flexible Spending Account Enrollment form, regardless of your participation in 2023. This is an annual enrollment and does not automatically carry over. The due date for all changes is November 30, 2023.

Note: Per IRS regulations (Section 125) regarding pre-tax benefits, if you miss this enrollment period you will not be able to change coverage or participate in the medical, dental, vision or supplemental life insurance plans until the next open enrollment in November 2024, or within 31 days of a qualifying event. Examples of a qualifying event include, but are not limited to: change in marital status, change in number of dependents, and changes which cause you to be eligible or ineligible for other medical coverage. For more information, download the Health Savings Accounts and Other Tax-Favored Health Plans PDF on irs.gov.

Medical Plan Choices

SVA provides medical coverage to full- and part-time administrative staff who have met eligibility requirements. Employees may elect coverage for a spouse, children or domestic partner. SVA offers two plan choices through Cigna HealthCare: Integrated Open Access Plus and a High Deductible Health Plan (HDHP). If you are enrolling a family member (eligible members listed above), you must provide documentation that details your relationship to that person (i.e., marriage certificate, domestic partnership agreement, birth certificate, adoption paperwork).

Premium costs vary by plan choice and level of coverage; however, SVA pays for approximately 80% of premium costs. For specific details about each plan's coverage, employees are encouraged to view the benefit summaries in this booklet.

Integrated OAP

The Integrated Open Access Plus Option offers coverage for medical care through "in-network" and "out-of-network" providers and does not require you to select a primary physician or obtain referrals for specialist care. If you select an in-network provider, the plan pays a greater share of the costs than if you select an out-of-network provider.

In-network coverage features two co-pay amounts, one for primary care ($25) and another for specialist care ($40). All claims are processed by the provider so the participant does not have to submit a form for reimbursement. If you select an out-of-network provider, you must satisfy an annual deductible and are responsible for co-insurance payments up to the out-of-pocket maximum amount.

High Deductible Health Plan (HDHP)

The High Deductible Health Plan (HDHP) offers the convenience of referral-free access to doctors. The plan also offers the freedom to choose the providers you prefer—even if they aren't part of the network. The HDHP features two deductibles, single ($1500) and family ($3000). After the deductible is met the plan pays 100% for in-network.

The plan provides conventional health coverage with a savings account to help you pay for the cost of your health care services.

Please go to page 33 for the Summary of Benefits for the High Deductible Health Plan and the Integrated OAP.

To Consider

Cigna offers a variety of additional benefits to employees enrolled under any of the two medical plans:

1) Through online registration, myCigna.com allows you to access and manage information specific to the medical plan you have elected. The myCigna.com website helps you identify health risks, learn about treatments and medications and compare local providers to ensure you and your dependents are receiving the highest level of care.

2) The Cigna Healthcare 24-Hour Health Information Line offers answers to your health questions 24 hours a day, nationwide. Calls are toll-free from anywhere in the U.S. You may contact the information line at 1.800.564.8982.

Log on to myCigna.com, or call 1.800.870.3470 to locate participating providers.

Medical Plan Design Summary

For a more detailed description of these plans, please refer to the Summary of Benefit Coverage in this booklet.

PLAN PROVISIONS		
	INTEGRATED OAP OPTION	
PLAN HIGHLIGHTS	**IN-NETWORK**	**OUT-OF-NETWORK**
Annual Deductible	$1,500/3,000	$2,000/$5,000
Annual Out-of-Pocket Maximum	$2,500/5,000	$4,000/$10,000
Co-insurance	90% after deductible	60% of R&C* fees after deductible
Physician Office Visit	$25 co-pay PCP; $40 co-pay specialist	60% of R&C* fees after deductible
Prescription Drug Card	$5 co-pay generic, $25 co-pay Name Brand Formulary, $40 Name Brand Non Formulary	Not Covered
HOSPITAL/SURGICAL		
Inpatient Surgery	90% after deductible to Annual Out of Pocket Maximum	60% of R&C fees after deductible
Inpatient Hospital Facility	90% after deductible to Annual Out of Pocket Maximum	60% of R&C fees after deductible
Outpatient Surgery	90% after deductible to Annual Out of Pocket Maximum	60% of R&C fees after deductible
Outpatient Hospital Services	90% after deductible to Annual Out of Pocket Maximum	60% of R&C fees after deductible
Emergency Room	$25 co-pay (waived if admitted)	$25 co-pay (waived if admitted)
In Patient Professional Services (Radiologists, Pathologists, and Anesthesiologists)	90% after deductible to Annual Out of Pocket Maximum	60% of R&C fees after deductible
Out Patient Professional Services (Radiologists, Pathologists, and Anesthesiologists)	90% after deductible to Annual Out of Pocket Maximum	60% of R&C fees after deductible
Lab & X-Ray	90% after deductible to Annual Out of Pocket Maximum	60% of R&C fees after deductible
Advanced Radiology (MRI, MRA, CAT Scan, PET Scan, etc.)	90% after deductible to Annual Out of Pocket Maximum	60% of R&C fees after deductible
MENTAL/NERVOUS		
Inpatient Mental/Nervous	90%	60% of R&C fees after deductible
Outpatient Mental/Nervous Facility	90%	60% of R&C fees after deductible
Office Visits	$40 co-pay, then 100%	60% of R&C fees after deductible
ALCOHOL/SUBSTANCE ABUSE		
Inpatient Alcohol/Substance Abuse	90%	60% of R&C fees after deductible
Outpatient Alcohol/Substance Abuse Facility	90%	60% of R&C fees after deductible
Office Visits	$40 co-pay, then 100%	60% of R&C fees after deductible
MISCELLANEOUS		
Chiropractic Care	Not Covered	Not Covered
Massage Therapy	Not Covered	Not Covered
Acupuncture	Not Covered	Not Covered
Vision	One exam per calendar year—maximum of $150 per year	One exam per calendar year—maximum of $150 per year
Home Health Care	90%, 120 days per year	90% 120 days per year
Skilled Nursing Facility	90%, 100 days per year	90% 100 days per year
Hospice Facility	90% after deductible	90% after deductible

PLAN PROVISIONS		
	HIGH DEDUCTIBLE HEALTH PLAN	
PLAN HIGHLIGHTS	**IN-NETWORK**	**OUT-OF-NETWORK**
Annual Deductible	$2,000/4,000	$2,500/5,000
Annual Out-of-Pocket Maximum	$2,000/4,000	$4,000/8,000
Co-insurance	N/A	70%
Physician Office Visit	100% after deductible	70%
Prescription Drug Card	100% after deductible	Not Covered
HOSPITAL/SURGICAL		
Inpatient Surgery	100% after deductible	70% after deductible
Inpatient Hospital Services	100% after deductible	70% after deductible
Outpatient Surgery	100% after deductible	70% after deductible
Outpatient Hospital Services	100% after deductible	70% after deductible
Emergency Room	Waived if Admitted	Waived if Admitted
WELLNESS BENEFITS		
Well Baby Care	100%	100%
Annual Physical Exam *(applies to all covered dependents through age 26 and includes routine immunizations)*	100% No Calendar Year Max	100% No Calendar Year Max
Adult Preventive Care for Employee and All Dependents	100% No Calendar Year Max	100% No Calendar Year Max
MENTAL/NERVOUS		
Inpatient Mental/Nervous	100% after deductible	70% after deductible
Outpatient Mental/Nervous Facility	100% after deductible	70% after deductible
Office Visits	100% after deductible	70% after deductible
ALCOHOL/SUBSTANCE ABUSE		
Inpatient Alcohol/Substance Abuse	100% after deductible	70% after deductible
Outpatient Alcohol/Substance Abuse Facility	100% after deductible	70% after deductible
Office Visits	100% after deductible	70% after deductible
MISCELLANEOUS		
Chiropractic Care	Not Covered	Not Covered
Massage Therapy	Not Covered	Not Covered
Acupuncture	Not Covered	Not Covered
Vision	One exam per calendar year—maximum of $150 per year	One exam per calendar year—maximum of $150 per year
Home Health Care	100% after deductible, 120 days per year	70% after deductible, 120 days per year
Skilled Nursing Facility	100% after deductible, 100 days per year	70% after deductible, 100 days per year
Hospice Facility	100% after deductible	70% after deductible

Rates Effective January 1, 2024

* HDHP and OAP/Out of Network Charges are Subject to Usual and Customary Reimbursement Levels

Disclaimer: This is an overview only of the plans offered by SVA. Should there be a difference between what is displayed here and the actual Cigna SPD; the Cigna SPD will prevail.

Preventive Health Coverage

Preventive health coverage is one of the most important benefits of your health plan. Getting the right preventive services at the right time can help you stay healthy by preventing diseases or by detecting a health problem at a stage that may be easier to treat.

However, because certain services can be done for preventive or diagnostic reasons, it's also important you understand exactly what preventive care is and which services your health plan covers as preventive services so you don't end up with unexpected out-of-pocket costs.

What is preventive care?

Preventive care services are those provided when you don't have any symptoms of a disease or medical condition and are not already diagnosed with the condition for which the preventive service would be provided. Preventive care helps you to prevent some illnesses, such as the flu, by getting a vaccine against the disease. It also helps to detect illness that is present, but where there aren't any symptoms.

During your visit, your doctor will determine what tests or health screenings are right for you based on your age, gender, personal health history and current health. Even if you're in the best shape of your life, a serious condition with no signs or symptoms may put your health at risk. Through preventive exams and routine health screenings, your doctor can detect early warning signs of more serious problems.

The plan offered covers preventive care services. The Patient Protection and Affordable Care Act requires that preventive care services be covered with **no patient cost-sharing (deductible, coinsurance or copayment).** If your plan has both in-network and out-of-network coverage, the preventive care services are likely covered with no patient cost-sharing only when you receive it from an in-network health care professional. For plans that are exempt or not required to comply with the Act yet, you may be responsible for paying a portion of the cost of preventive care services from in-network and out-of-network health care professionals as applicable.

Non-preventive or diagnostic services/supplies that are provided at the time of a preventive care office visit will be considered under your standard medical coverage. This means you may be required to pay a deductible, copay or coinsurance amount for covered services or supplies that are not preventive.

Please refer to your plan materials for specific details about the coverage and cost-share responsibilities under your plan.

Services and supplies considered as preventive care under your plan can be found on mycigna.com. For more information please view the Preventative Care PDF.

Prescription Drug Plan Choices

RxBenefits (who has partnered with Express Scripts) will continue to be your pharmacy benefit administrator. Express Scripts is one of the largest prescription plan providers in the United States and participates in a large pharmacy network throughout the United States.

Your prescription coverage will not change. You will continue to use the prescription plan ID card or will be mailed a new plan Id card if enrolling for the first time.

Employees and their dependents covered under any of the two medical plans offered by SVA receive additional benefits through the Prescription Drug Plan. The plan features three tiers, or categories, of prescription drugs:

- **Generic (first-tier) drugs:** Generic drugs are those whose active ingredients, dosage, quality and strength are identical to those of its brand counterpart. These medications are covered at the generic co-payment or co-insurance and typically cost less than brand drugs.
- **Brand (second- and third-tier) drugs:** Brand drugs are those which may or may not have an equally effective generic equivalent. These medications are covered at the brand formulary and non-formulary co-payment or co-insurance under a three-tier plan.

Prescription Drug Costs

Co-payments for prescription drugs vary across the two medical plan choices (Integrated OAP and High Deductible Health Plan). Please refer to the Medical Plan Design Summary chart on the following page for more information about the costs associated with your specific plan or click the Staff Resources tile on your dashboard to access the summary plan description for the coverage option you have elected.

Note: If an emergency situation arises and you are not able to use a participating pharmacy, you are responsible for paying the full price of the prescription at the time it is filled. Please contact RxBenefits to obtain instructions for reimbursement for emergency prescriptions.

Participating Pharmacies and Prescription Drug Coverage

It is important to note that the prescription drug benefits under each of the two medical plans only provide coverage for in-network, or participating pharmacies. You may locate participating pharmacies and search for preferred drug list medications by visiting Express Scripts Open Enrollment Information.

For a list of preferred formulary exclusions, please visit Prescription Exclusions.

Obtaining Medications and Supplies

Express Scripts prescription drug plans offer two ways to obtain medications and supplies. You may visit a participating pharmacy or take advantage of a home delivery program. To save time on trips to the pharmacy, this feature offers convenient home delivery of up to a 90-day supply of medication. Members may also save on prescriptions filled through the Express Scripts Home Delivery program based on the specific medical plan they have elected. Visit www.Express-Scripts.com to get started. For more information on Home Delivery from the Express Scripts Pharmacy, please refer to the Getting Started Home Delivery Guide and Home Delivery Brochure.

Maximum Reimbursable Charge

Under your plan, you can visit doctors and other health care professionals who do not participate in the Cigna network. If you receive out of network medical care, your share of the costs will be higher compared with what you'd pay for in-network care and you will be responsible for all charges above the maximum reimbursable charge. **A maximum reimbursable charge is determined by the services billed and the geographical area.**

Please note, when you or your doctor file a medical claim and Cigna determines the doctor's fee exceeds the maximum reimbursable charge, you are responsible for paying any charges ABOVE the maximum reimbursable amount.

These charges are not applied to your out of pocket maximum or deductibles. Out-of-network providers are not bound to the contractual rates and discounts that in-network providers have agreed to through insurance and can choose to bill at more competitive rates compared to other doctors in their area.

Note: These rates are generally higher than what insurance carriers negotiate as savings for using network providers.

Example

Let's say that you visited a doctor out-of-network for a minor surgical procedure and you have met the plan's out-of-network deductible and/or out-of-pocket maximum.

Out-of-Network

- Doctor Charge: ...$1,500
- MAXIMUM REIMBURSABLE CHARGE: ...$1,000
- Health Plan Pays 70%: ...$700
- Your 30% Co-Insurance: ...$300
- Balance Billing : $500 (potential doctor bill) + $300 (co-insurance) =$800

The amount of $500 is the amount ABOVE the MAXIMUM REIMBURSABLE CHARGE or what the plan is willing to pay for the service. Since this amount is above the MAXIMUM REIMBURSABLE CHARGE it would not count towards your annual out of pocket maximum or deductibles.

Maximum Reimbursable Charge can also be referred to as Usual, Customary and Reasonable Charges.
Please refer to PDF on the next page for additional information.

Maximum Reimbursable Charge

Understanding our out-of-network claims.

Out-of-network care

Under your plan, you can visit doctors and other health care professionals who do not participate in the Cigna network. When you receive non-emergency, out-of-network medical care, it's important to remember two things:

- Your share of the costs (e.g., coinsurance and deductibles) will be *higher* compared with what you'd pay for in-network care.
- You'll also be responsible for all charges above the **maximum reimbursable charge.**

What is a maximum reimbursable charge?

When you receive **out-of-network medical care** from a **non-participating doctor or other health care professional,** there's a limit to the amount of money that will be reimbursed. For example, your doctor might charge $100 for treatment, but the most your plan will pay is $80. This amount is called the **maximum reimbursable charge.**

How is a maximum reimbursable charge determined?

A maximum reimbursable charge is determined in one of two ways:

1. Using a percentage (selected by your employer) of a fee schedule developed by Cigna using a methodology similiar to the one used by Medicare.
2. For some covered services, a reimbursement schedule is not available. In these cases, the maximum reimbursable charge is based on what other doctors in your area typically charge for the same service.

What if my doctor charges more than the maximum reimbursable charge?

When you or your doctor files a medical claim and we determine the doctor's fee exceeds the maximum reimbursable charge:

- You are responsible for paying any charges *above* the maximum reimbursable amount. These charges don't apply to your out-of-pocket maximum or deductibles.
- Your costs for out-of-network covered services could be high.

Know before you go

It makes sense to plan ahead. If you'd like to know *in advance* whether a proposed charge is within the Cigna maximum reimbursable amount, call the toll-free number on the back of your ID card. Please make sure you have the following information when you call:

1. The doctor's name and tax ID number
2. The place of service (ZIP code)
3. The doctor's procedure code

Choosing a Cigna doctor

To find a participating doctor that best meets your needs, use the directory on **myCigna.com.** There, you'll find complete profiles, including education, languages spoken, hospital affiliations and detailed maps with directions. Online tools will also help you find estimated average cost ranges for common procedures, medical services and conditions.

Cigna®

571657 f 11/11

If you choose out-of-network care …

- **Know your coverage.** Check your plan materials to verify that you have out-of-network coverage. Make sure you understand the details of your plan, including your deductible and coinsurance.
- **Know what you may be required to pay.** Even a simple trip to the doctor's office can cost you hundreds of dollars. Ask the doctor or facility about their billed charges for the services you may need.
- **Ask if price is negotiable.** Many doctors and hospitals offer discounts on their services. Ask if they're willing to negotiate the charges. Think about getting a second opinion and another price.
- **Consider payment alternatives.** Ask if the doctor or facility is willing to work out a payment schedule with you. If you have a Flexible Spending Account, apply that money toward out-of-network expenses.

We're here for you 24/7/365. For answers to all your questions and concerns, call the toll-free number on the back of your Cigna ID card whenever it's convenient for you. Remember, some services may require precertification, so be sure to call if you're unsure.

Staying in-network: a cost effective option

When you receive in-network care, your doctor and Cigna have already agreed on a fee that will be covered under your plan, so payment is not limited to the maximum reimbursable charge.

Cost comparison: in-network vs. out-of-network

The examples below compare costs for typical services. For specific expenses under your plan, please see your plan materials.

When you receive non-emergency covered services from out-of-network doctors/facilities:

- Your share of the costs (e.g., coinsurance and deductibles) is higher when compared with what you pay for in-network care.
- Charges above your maximum reimbursable amount are not covered. The out-of-network doctor/facility can bill you, and you will be responsible for any amount above that maximum. You'll also pay applicable deductible and coinsurance amounts.

Doctor office visit	In-network	Out-of-network
Covered doctor charges	Billed charge: $270; Cigna discounted charge: $108	$270
Maximum reimbursable charge under your plan	N/A	$147
Amount above maximum reimbursable charge	N/A	$123
Your coinsurance obligation[1]	20% of $108 = $22	40% of $147 = $59
Your total cost	$22	$182*
Outpatient services (assuming plan deductibles have been met)	**In-network**	**Out-of-network**
Covered hospital charges	Billed charge: $3,401; Cigna discounted charge: $1,701	$3,401
Maximum reimbursable charge under your plan	N/A	$1,000
Amount above maximum reimbursable charge	N/A	$2,401
Your coinsurance obligation[1]	20% of $1,701 = $340	40% of $1,000 = $400
Your total cost	$340	$2,801*
Inpatient services (assuming plan deductibles have been met)	**In-network**	**Out-of-network**
Covered hospital charges	Billed charge: $13,628; Cigna discounted charge: $6,815	$13,628
Maximum reimbursable charge under your plan	N/A	$7,108
Amount above maximum reimbursable charge	N/A	$6,520
Your coinsurance obligation[1]	20% of $6,815 = $1,363	40% of $7,108 = $2,843
Your total cost	$1,363	$9,363*

[1] Assumes coinsurance of 20% for in-network services and 40% for out-of-network services.
* The doctor or facility may bill you for the difference between the maximum reimbursable charge and the billed charges.

2024 Medical Plan Premiums

PLAN	COVERAGE	PAYROLL DEDUCTION	
		SEMI-MONTHLY	ANNUALLY
INTEGRATED OAP	Single	$72	$1,728
	Employee & Child	$127	$3,048
	Employee & Children	$180	$4,320
	Employee & Spouse	$211	$5,064
	Family	$273	$6,552
HIGH DEDUCTIBLE HEALTH PLAN	Single	$53	$1,272
	Employee & Child	$94	$2,256
	Employee & Children	$131	$3,144
	Employee & Spouse	$154	$3,696
	Family	$201	$4,824

The last day to enroll is **November 30, 2023**.
Your benefit will become effective **January 1, 2024**.

Flexible Spending Accounts (FSA)

SVA offers employees enrolled in SVA's health plan the opportunity to participate in FSA for Healthcare Reimbursement Account and or a Dependent Care Reimbursement Account. FSA for Health Care Reimbursement account provides employees a way to pay for eligible out-of-pocket health care and dependent care expenses not covered by your health plan on a pre-tax basis through payroll deductions. This means that the contributions you make to your flexible spending accounts are deducted before taxes are calculated on your pay.

Healthcare Account

The FSA for healthcare can be used for eligible health-related expenses not covered by your health plan. Eligible expenses can be for yourself, your spouse, or other eligible family members as defined by IRS regulations—even if they are not covered under SVA's health plan.

You can contribute up to $3,200 annually in pre-tax dollars to FSA. The amount you elect to contribute will be deducted from your paycheck in equal installments throughout the year. FSA for healthcare and dependent care is a "use it or lose it" benefit. Any funds not used, will be forfeited. SVA has a 2 ½ month grace period whereby you continue to incur eligible expenses through March 15 of the following year. Reimbursement claims must be submitted no later than March 31. Medication expenses may be reimbursed from the account if the medicine or drug:

- Requires a prescription
- Is an OTC medicine or drug and the individual obtains a prescription
- Or is insulin

For more detailed information, please view the Flexible Spending Account Brochure.

What Is a prescription?

For purposes of these rules, the IRS clarifies that a prescription means a written or electronic order for a medicine or drug that meets the legal requirements of a prescription in the state in which the medical expense is incurred and that is issued by an individual who is legally authorized to issue a prescription in that state.

Examples of expenses that can be covered by the Healthcare Account:

- Co-payments and deductibles
- Vision care, including the cost of eyeglasses and contact lenses
- Acupuncture
- Orthodontic care
- Other IRS approved medical costs

You may also refer to the IRS publication 502—Medical Expenses, accessible through irs.gov or by calling 800.829.3676 for more information and examples of expenses that are covered.

Dependent Care Account

The dependent care reimbursement account can be used for eligible dependent care expenses. The age limit for dependent children is 13 years of age.

The maximum pre-tax annual contribution is $5,000 for individuals or married couples filing jointly or $2,500 for a married person filing separately. The amount you elect to contribute will be deducted from your paycheck in equal installments throughout the year.

Examples of expenses that can be covered by the Dependent Care Account:

- Licensed day care centers or nursery schools
- Dependent care in your home or dependent care in another person's home (if fewer than seven children are being cared for)
- A disabled spouse or parent who is claimed as a dependent on your federal income tax return

You may also refer to the IRS publication 503—Dependent Care Expenses, accessible through www.irs.gov or by calling

1.800.829.3676, for more information and examples of expenses that are covered.

Note: Annual re-enrollment in the FSA is required per IRS regulations. Previous years elections will not default. Re-enrollment is required via the open enrollment online portal. Once an annual FSA amount is elected, a participant cannot increase or decrease the amount for the rest of the plan year unless they meet a "qualifying event."

Examples of a Qualifying Event:

- Marriage
- Birth of a Child
- Divorce or Legal separation
- Death
- Change in Residence

Notice must be sent to hrbenefits@sva.edu within 31 days of the qualifying event.

Getting Reimbursed

You will receive a debit card when you enroll in the FSA. You may use the card to pay for qualified health care expenses at authorized health care providers and pharmacies. When the card is used, funds are automatically deducted from your FSA and you pay nothing out of your pocket at the time of service, as long as there is enough money in your FSA to pay for the charge. If you do not use your debit card, you must submit claims directly to your FSA to receive reimbursement.

To submit a claim go to myCigna.com and click "Online Reimbursement Request".

If you have any FSA questions or would like to check the balance of your account, contact Cigna Healthcare FSA Claims at 1.800.244.6224 or online at www.myCigna.com.

The worksheet will help you estimate your upcoming health care expenses that are eligible for reimbursement through the Flexible Spending Account.

This program is governed by the IRS and is subject to minimum and maximum contribution amounts. Tax law requires that an employee's choices in a FSA be made in advance of the plan year. This means that after the effective date of the plan, no changes can be made until the next enrollment period unless an IRS qualifying event occurs.

For more information, download the Health Savings Accounts and Other Tax-Favored Health Plans PDF on irs.gov.

The last day to enroll is **November 30, 2023**.
Your benefit will become effective **January 1, 2024**.

Health Savings Account (HSA)

SVA offers employees enrolled in the High Deductible Health Plan (HDHP) the option of contributing to a special, tax-advantaged account that can be used to pay for qualified medical expenses. Employees contribute money to their HSA, where it earns interest on a Federal level and in most states (NJ for example is not tax free). Funds are not taxed when withdrawn to pay for qualified medical expenses.

To be eligible for an HSA, employees:

- Must be covered by a High Deductible Health Plan (HDHP)
- Cannot have other health insurance coverage, such as a spouse's plan, that is not HDHP
- Cannot be claimed as a dependent on another person's tax return
- **Cannot open a new HSA or contribute to an existing HSA once enrolled in Medicare**

Employees determine the amount of their deduction (up to $4,150 for single and a catch-up contribution of $1,000 for those 55 and older, or $8,300 for family and a catch-up contribution of $1,000 for those 55 and older for 2024), which is deducted from your designated checking account either one time or every month.

The Health Savings Account can be used for qualified medical expenses not covered by the health plan. The following list gives a general overview of qualified expenses. This list is not all-inclusive, and is subject to change by the IRS.

The HSA may be used to cover medication expenses if the medicine or drug:

- Requires a prescription
- Is an OTC medicine or drug and the individual obtains a prescription
- Or is insulin

Examples of qualified medical expenses that can be covered by the Health Savings Account:

- Covered medical services used to satisfy your Cigna deductible
- Acupuncture
- Alcoholism treatment
- Bandages
- Birth Control Pills
- Braces
- Chiropractor
- Eyeglasses

Note: Any HSA funds used for non-qualified expenses are taxable. You may also refer to the IRS publication 502—Medical and Dental Expenses, accessible through www.irs.gov or by calling 800.829.3676 for more information and examples of expenses that are covered.

What happens to unused funds?

An HSA is generally exempt from tax. Employees are permitted to take a distribution from their HSA at any time; however, only those amounts used exclusively to pay for qualified medical expenses are tax- free. Funds that remain at the end of the year are carried over to the next year.

The Affordable Care Act allows parents to add their dependent children (up to age 26) to their health plans however; the IRS has not changed its definition of a dependent for health savings accounts. This means that a person could have their 25-year-old child covered on their high deductible health plan, but if the adult child is self-supporting or does not qualify as a tax deduction, that child cannot use funds from the parent's HSA debit card. However, an adult child who is covered under a parent's high deductible plan but is not a tax dependent can open their own HSA and contribute up to the full family maximum.

A person you claim as a dependent or qualifying child for income tax purposes must meet each of the following criteria (IRC Sec. 152, IRS Notice 2008-5):

- Bears a relationship to the taxpayer in one of the following ways: – A child (including a legally adopted or foster child)
- The qualifying child has a gross income for the calendar year that is less than the exemption amount allowed for the tax year by the IRS.
- The qualifying child must derive over one-half of their support for the calendar year from the taxpayer (special rules may apply to children of divorce, children with disabilities or other situations).
- The qualifying child must meet certain age requirements. He or she is under 19 or under 24 if a full-time student.
- He or she cannot be a qualifying child of any other taxpayer for the taxable year.

If your child is not claimed as your dependent, we recommend you consider having them apply for a HSA debit card independently through the HSA Portal. They qualify for a HSA debit card since they are enrolled in a high deductible plan through SVA. For more information, download the latest publication Health Savings Accounts and Other Tax-Favored Health Plans PDF on irs.gov.

They can use the HSA debit card to pay for eligible expenses , such as dental and vision. When applying for the debit card, they may need to refer to their CIGNA ID card for information regarding their group number, member ID and plan effective date.

The last day to enroll is **November 30, 2023**.
Your benefit will become effective **January 1, 2024**.

HSA Employer Contribution

Individuals who enroll in the High Deductible Health Plan (HDHP) will be receiving a one-time employer contribution to their HSA account! The amount you receive will be based upon your **final base salary** as of 12.31.2023. This contribution will be funded to your account in the beginning of January 2024.

HSA CONTRIBUTION	SALARY BANDS
$1,200	$0-$5,000
$1,150	$5,001-$10,000
$1,100	$10,001-$15,000
$1,050	$15,001-$20,000
$1,000	$20,001-$25,000
$950	$25,001-$30,000
$900	$30,001-$35,000
$850	$35,001-$40,000
$800	$40,001-$45,000
$750	$45,001-$50,000
$700	$50,001-$55,000
$650	$55,001-$60,000
$600	$60,001-$65,000
$550	$65,001-$70,000
$500	$70,001-$75,000
$450	$75,001-$80,000
$400	$80,001-$85,000
$350	$85,001-$90,000
$300	$90,001-$95,000
$250	$95,001-$100,000
$200	$100,001-$105,000
$150	$105,001-$110,000
$100	$110,001-$115,000
$50	$115,001-$120,000

Health Savings and Flexible Spending Worksheet

How much should you contribute to your Flexible Spending or Health Savings Account?

Use this worksheet to help estimate your health care costs in Worksheet. Remember that money remaining in your Flexible Spending Account at the end of the year is forfeited so be conservative in your estimates. Money remaining in your Health Savings Account will roll over.

Covered Expense	Description	Your Estimate
Annual plan deductibles	Applies to both your medical and dental plan deductibles.	$
Doctor Visits	In-network co-pays or other expenses related to doctor visits.	$
Routine physical exam	In-network co-pays or other expenses related to doctor visits.	$
Prescription drugs (Including oral contraceptives)	Co-pays for generic and brand name or Tel-Drug 90-day supply.	$
Emergency Room	In-network co-pays or other expenses related to hospital visits.	$
Dental Care	Annual deductible for basic and major services in the PPO only; 50% out-of-pocket for orthodontic services DHMO and PPO.	$
Vision Care	In-network co-pays or other expenses for annual eye exam, glasses, LASIK and contact lenses.	$
Other Planned Uncovered Expenses	Eligible over the counter medications with a prescription.	$
Total estimated health-care expenses (maximum varies based on HSA or FSA limits)		$

Dental Plan Choices

Employees of SVA are eligible to participate in SVA's dental insurance plan after one month of employment as a regular full-time administrative employee or after 12 months as a regular part-time employee working a minimum of 1,000 hours/calendar year. Dependents of eligible employees may also participate. If you are enrolling a family member, you must provide documentation that details your relationship to that person (i.e., marriage certificate, domestic partnership agreement, birth certificate, adoption paperwork). The Cigna plan is a comprehensive dental program that helps employees meet their dental insurance needs. The benefits include:

- Flexibility to use an in-network or out-of-network dentist in the PPO
- Significantly enhanced benefits in the Dental Care Plan network
- The option of two plan choices: the Dental Care Plan Network or the PPO Plan
- Orthodontia covered for dependent children through age 26 and adults under the PPO and Dental Care Plan option
- Calendar year maximum of $2,500 for PPO Plan
- If you are enrolled in the Dental Care Plan, you will receive an ID card. No ID cards for the PPO plan.

The entire cost of participation in the dental program is paid by the employee and is deducted on a pre-tax basis from the employee's paycheck.

You can view the benefit summaries for both plans included in this booklet.

The last day to enroll is **November 30, 2023**. Your benefit will become effective on **January 1, 2024**.

Dental Plan Premiums

DPPO	PAYROLL DEDUCTIONS	
LEVEL OF COVERAGE	SEMI-MONTHLY	ANNUALLY
EMPLOYEE	$32.43	$778.32
EMPLOYEE & 1 DEPENDENT	$60.48	$1,451.52
EMPLOYEE & FAMILY	$99.79	$2,394.96

DMO	PAYROLL DEDUCTIONS	
LEVEL OF COVERAGE	SEMI-MONTHLY	ANNUALLY
EMPLOYEE	$9.54	$228.96
EMPLOYEE & 1 DEPENDENT	$17.78	$426.72
EMPLOYEE & FAMILY	$29.34	$704.16

Rates Effective January 1, 2024

VSP® Signature Vision Care Plan

VSP® Signature Vision Care Plan includes:

- Value and Savings
- Personalized Care
- Great Eyewear — from classic styles to the latest designer frames
- Choice of Providers
- No claim forms to complete
- Online access at vsp.com to review plan coverage, find a VSP Doctor, view the latest eye health and wellness and benefit information
- No ID card required

Vision Plan Semi-monthly Premiums

EMPLOYEE: $3.98	**EMPLOYEE + 1:** $7.97	**FAMILY:** $12.41

The last day to enroll is **November 30, 2023**. Your benefit will become effective on **January 1, 2024**.

Domestic Partner Coverage

SVA extends medical and dental plan eligibility to domestic partners of full- and part-time administrative staff. Employees who wish to provide coverage for their partners must provide documentation of their domestic partnership, which may include registration of the partnership if they live in a state that provides for such registration.

Domestic partners, for enrollment purposes, are defined as two unrelated individuals who are:

- At least 18 years of age and mentally competent to sign the required affidavit
- Sharing the necessities of life, living together and have had an emotional and financial commitment to one another for a minimum of 12 consecutive months
- Neither is currently married nor legally separated from someone else

Employees who meet these qualifications may submit an enrollment form for medical and/or dental coverage for their partner along with:

- A completed and notarized Declaration of Domestic Partnership
- A completed Declaration of Domestic Partnership for Benefits Eligibility
- Two forms of documentation as evidence that the partners are committed to one another (Examples: joint-tenancy lease, jointly-held mortgage, joint checking account, bills or driver's license showing the same address, an insurance policy or will indicating the partner as beneficiary, or a copy of a registration certificate)

Additional Guidelines Regarding Coverage

- Termination of the partnership, and thus benefits for the partner, will need to be communicated in writing and the Declaration of Termination of Domestic Partnership submitted within 31 days of status change
- An employee will be eligible to seek benefits for another domestic partner 12 months from the date indicated on the Declaration of Termination
- If the partnership is, at any time, found not to be in accordance with the guidelines for coverage, domestic partner benefits will be terminated retroactively and SVA is entitled to seek reimbursement for any claims and/or premium paid on the partner's behalf

Domestic Partner Taxation

If you cover a domestic partner under the medical, dental or vision plan, the following applies to you:

The IRS does not recognize domestic partners as a spouse under federal tax laws. Federal regulations require all domestic partner coverage be deducted on a post-tax basis and that the fair market value of domestic partner coverage must be imputed from the employee's income.

What does this mean?

Your individual employee deduction is deducted on a pre-tax basis, but your domestic partner's portion of the deduction must be deducted on a post-tax basis (i.e. after-tax). You must also pay taxes on the employer's cost of domestic partner coverage.

Domestic Partnership Post-Tax Deduction

There will be separate deductions on your paycheck for medical, dental and vision.

How will the imputed income affect my paycheck?

To impute the income is to take the employer cost of the domestic partner's coverage and include it in the employee's paycheck to be taxed. Once the income is entered as earnings (under the earnings section on your paycheck), the same amount is taken out as a post-tax deduction (under the deduction section on your paycheck).

To determine the imputed income portion - we simply take the difference of the employer cost of the employee coverage and the employee's post tax deduction for the dependent coverage and the resulting number is the "fair market value."

Important Issues to Note

Because domestic partners do not satisfy the definition of a dependent under Section 152 of the Internal Revenue Code, the value of coverage for an employee's partner is taxable to the employee and considered income.

Please also note the following

- Coverage will not be extended to the children of an employee's domestic partner, unless the children have been legally adopted by the employee
- Termination of coverage for a domestic partner does not qualify that person for continuation of coverage under the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA)
- Coverage will not be extended to a domestic partner under the Family and Medical Leave Act (FMLA) of 1993 as the act does not include unmarried domestic partners within its definition of "spouse"
- Domestic partners are not recognized as eligible dependents under the Flexible Spending Program

*Current employer average cost is 80% .

Life, Accidental Life, Death & Dismemberment (AD&D)

Life, Insurance and AD&D insurance is provided at SVA's expense for regular full-time employees after one month of employment. Regular part-time employees who work a minimum of 1000 hours/ calendar year are covered after 12 months. The benefit amount for basic life insurance is 2x your base salary ($50,000 minimum). Part-time employees who meet eligibility requirements are given a fixed $50,000 of coverage. In addition, employees have the option to purchase supplemental life insurance and dependent life insurance at their own expense. These rates are based on elected coverage amounts and age. A group certificate of insurance is available upon request to explain your coverage in detail.

If you would like to update your basic beneficiary or elect voluntary life insurance, please contact hrbenefits@sva.edu.

Note: Life insurance coverage reduces by 50% at age 70. All coverage cancels at retirement.

Employee Supplemental Life Insurance

Supplemental life insurance is employee paid and a designated beneficiary receives compensation (the person, persons, or legal entity who receives a benefit payment) if you die while you are covered by the policy. You must select your beneficiary [ies] when you complete your enrollment application; selections are legally binding. You can purchase supplemental life insurance in increments of 1x-4x your annual salary, not to exceed $500,000. **For coverage amounts in excess of $250,000 (guaranteed issue) you will be required to provide evidence of insurability by completing a Statement of Health form**. Email hrbenefits@sva.edu to request the form. You may enroll for, or make changes to your supplemental life insurance during Open Enrollment each year, and it will remain in effect for the entire year unless you have a qualifying event. If you already have supplemental life insurance coverage and do not wish to make any changes, your coverage and coverage for eligible dependents will automatically continue subject to the terms of the contract. A one-time special enrollment for supplemental coverage will take place this year. All eligible employees who are not currently enrolled may elect to participate for 2024. Thereafter, enrollment is only open to new hires and if a current employee has a qualifying event.

Spouse Supplemental Life Insurance

If you elect supplemental life insurance for yourself, you may choose to purchase spouse supplemental life insurance in increments of $10,000, to a maximum of $250,000. Coverage cannot exceed 50% of the amount of your employee supplemental life insurance coverage. **If you are electing coverage for the first time, or electing to increase your current coverage, your spouse will be required to provide evidence of insurability by completing a Statement of Health form that that meets the insurance carrier's requirements**. Email hrbenefits@sva.edu to request the form.

Child[ren] Supplemental Life Insurance

You may choose to purchase child[ren] supplemental life insurance coverage in the amount of $10,000 for each child — no medical information is required.

Child[ren] must be unmarried and are covered from 2 weeks to 19 years old , or 25 years if a full-time student.

[1] Unmarried child[ren] over age 19 may be covered if they are disabled and primarily dependent upon the employee for financial support. Child[ren] from 2 weeks to 6 months are limited to a reduced benefit of $1,000.

Calculating the Cost of Your Coverage

Follow These Steps

Step 1

$ _____ Your Yearly Salary

x _____ **1, 2, 3 or 4** *(salary multiples)*

= $ _____ Amount of Coverage You Want

Step 2

Round to the ***Next Higher $1,000*** *e.g. $214,300 becomes* ***$215,000***

Step 3

_____ (Your Coverage Amount) ÷ 1000 = _____ (Employee Units)

Step 4

_____ (Employee Units) x $_____ (Employee Cost Per Unit*) = $_____

Step 5

_____ (Spouse Units) x $_____ (Spouse Cost Per Unit*) = $_____(+)

Step 6

_____ (Child(ren) Units) x $_____ (Child(ren) Cost Per Unit) = $_____(+)

Step 7

= $_____ **Total Monthly Cost**

**See Table.*

Employee Age	Employee Monthly Cost per $1,000 Unit	Spouse Monthly Cost per $10,000 Unit
Under 30	$.084	$.840
30 to 34	.114	1.140
35 to 39	.134	1.340
40 to 44	.154	1.540
45 to 49	.224	2.240
50 to 54	.354	3.540
55 to 59	.664	6.640
60 to 64	.664	6.640
65 to 69	1.014	10.140
70 to 74	1.964	19.640
75 & over	3.194	31.940

The monthly cost for children is $.20 per $1,000 of coverage. One premium will insure all your eligible children, regardless of the number of children you have.

* *Costs are subject to change.*

When You Reach Age 70

By the time you reach age 70, chances are that your children will be grown and your mortgage paid. At age 70, providing you are still employed, your coverage will decrease to 50% of the benefit amount.

Note: Your deduction is based on your age and salary. It is subject to change with salary increases and/or moving to a new age bracket.

401 (K) Plan
A tax-deferred retirement savings plan

ELIGIBILITY

All administrative employees who are at least 21 years of age are eligible to participate in the 401(K) plan. Employees may join the plan on January 1st, April 1st, July 1st and October 1st of each year. Under the terms of the plan, an employee can defer a percentage of their pre-tax compensation through payroll deductions to the extent allowable by IRS regulations and plan definitions.

SVA will make a safe harbor matching contribution equal to 100% of your salary deferrals that do not exceed 3% of your compensation, plus 50% of your salary deferrals that exceed 3% of your compensation but do not exceed 4% of your compensation.

The safe harbor matching contribution is determined on a payroll pay period basis and calculated based on your compensation and deferrals.

The limit on employee elective deferrals (for traditional and safe harbor plans) is: $23,000 per year for employees under the age of 50. Employees 50 years or older, may contribute an additional $7,500 in catch up contributions bringing their total annual contribution limit to $30,500.

A link to a 401k calculator has been provided to better assist you: www.paycheckcity.com/calculator/401k

HOW TO ENROLL

To enroll for the first-time:

1. Go to enroll.voya.com
2. To log-in to the site you will need the following information:
3. Plan Number: 559685
4. Verification Number: 55968599

To make changes to your current elections/contribution:

1. Go to voyaretirement.voya.com
2. Follow the prompts and enter your username and password.
3. Note: If you are accessing your account for the first time, your username is your SSN and your temporary PIN is the month and year of your date of birth.

SEMI-MONTHLY GROSS PAY FOR $50,000 ANNUAL SALARY	DEFERRAL ELECTION %	YOUR DEFERRAL TO THE PLAN	EMPLOYER MATCH PER PAY PERIOD COLUMN
$2,083.33	1%	$20.83	$20.83
$2,083.33	2%	$41.67	$41.67
$2,083.33	3%	$62.50	$62.50
$2,083.33	3.5%	$72.92	$62.50
$2,083.33	4%	$83.33	$72.92
$2,083.33	4.5%	$93.75	$72.92
$2,083.33	5%	$104.17	$83.33
$2,083.33	15%	$312.50	$83.33

This contribution is 100% vested.

New York State Paid Family Leave Law

New York State employers must provide Paid Family Leave coverage for their employees. Paid Family Leave coverage is funded by the employee via payroll contributions. **This premium deduction is mandatory per New York State.** Deductions will begin in your first paycheck.

The coverage will provide paid time off so an employee can:

- bond with a newly born, adopted, or foster child
- care for a family member with a serious health condition, or
- assist loved ones when a family member is deployed abroad or is on active military duty

ELIGIBILITY

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

BENEFITS

Employees taking Paid Family Leave receive 67% of their average weekly wage, up to a cap of 67% of the current New York State Average Weekly Wage (NYSAWW). For 2024, the NYSAWW is $1,718.15, which means the maximum weekly benefit is $1,151.16.

HOW TO APPLY

1. Employee must notify HR Benefits at least 30 days prior to leave, when practical.
2. Employee obtains supporting documentation for leave.
3. Employee fills out claim form.

Please note: New York State Paid Family Leave is calculated based on a 12-month period for benefits using a rolling 12-month period measured backward from any day that leave is taken. Beginning January 1, 2018, we will also be calculating FMLA based on this method.

Calculating the cost of your New York State Paid Family Leave Coverage

	Description	Employee Calculation
	Example: $40,000/52=$769.23 -Weekly Benefit Earnings	$
1	Enter your weekly benefit earnings	$
2	Rate Factor (in cents) 0.373%	0.373%
3	Calculate: Weekly Benefit (#1) x Rate Factor (#2)	$
4	Monthly Premium -- Calculate: #3 x 52 weeks / 12 months	$
	Semi Monthly Premium-- # 4 divided by 2 pay checks	$
Note	The weekly PFL benefit is capped at $1,151.16 (67% of the NYSAWW).	$

BENEFIT SUMMARY

Administered by - Cigna Health and Life Insurance Co.
For - School of Visual Arts LLC
Open Access Plus HDHPQ Plan
HDHPQ Plan
Effective - 01/01/2024

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 - Employee Only: $2,000 Family Maximum: $4,000	Individual - Employee Only: $2,500 Family Maximum: $5,000

- Only the amount you pay for in-network covered expenses counts towards your in-network deductible. Only the amount you pay for out-of-network covered expenses counts towards your out-of-network deductible.
- Plan deductible always applies before any benefit copay/deductible or coinsurance.
- Plan deductible does not apply to in-network preventive services.
- All family members contribute towards the family deductible. An individual cannot have claims covered under the plan coinsurance until the total family deductible has been satisfied.
- This plan includes a combined Medical/Pharmacy plan deductible.

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

Plan Highlights	In-Network	Out-of-Network
Plan Out-of-Pocket Maximum	Individual - Employee Only: $2,000 Family Maximum: $4,000	Individual - Employee Only: $4,000 Family Maximum: $8,000

- 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.
- All eligible family members contribute towards the family out-of-pocket maximum. Once the family out-of-pocket maximum has been met, the plan will pay each eligible family member's covered expenses at 100%.
- 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 (^). Plan deductible always applies before benefit copays/deductibles.		
Physician Services - Office Visits		
Primary Care Physician (PCP) Services/Office Visit	Plan pays 100% ^	Plan pays 70% ^
Specialty Care Physician Services/Office Visit	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	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 (^). Plan deductible always applies before benefit copays/deductibles.		
Virtual Physician Services - Office Visits		
Primary Care Physician (PCP) Services/Office Visit	Plan pays 100% ^	Plan pays 70% ^
Specialty Care Physician Services/Office Visit	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	Plan pays 100% ^	Plan pays 70% ^
Preventive Care		
Preventive Care	Plan pays 100%	Plan pays 100%
• 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%	Plan pays 100%
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.		
Diagnostic Fecal Occult Cancer Test	Plan pays 100% ^	Plan pays 100% ^
• Coverage includes the associated interpretation services.		
Inpatient		
Inpatient Hospital Facility Services	Plan pays 100% ^	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 (^). Plan deductible always applies before benefit copays/deductibles.		
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.	Plan pays 100% ^	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.	Plan pays 100% ^	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.		
Inpatient Services at Other Health Care Facilities		
Skilled Nursing Facility, Rehabilitation Hospital, Sub-Acute Facilities • Annual Limit: 100 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
Outpatient Therapy Services		
Outpatient Therapy	Covered same as Physician Services - Office Visit	Covered same as Physician Services - Office Visit
Annual Limits: • All Therapies Combined - Includes Cardiac Rehabilitation, Cognitive Therapy, Occupational Therapy, Physical Therapy, Pulmonary Rehabilitation, and Speech Therapy - Unlimited days **Note:** Therapy days, provided as part of an approved Home Health Care plan, accumulate to the applicable outpatient therapy services maximum.		

Benefit	In-Network	Out-of-Network
Note: Services where plan deductible applies are noted with a caret (^). Plan deductible always applies before benefit copays/deductibles.		
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 up to a maximum of 15 visits per occurrence.		
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.		
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 (^). Plan deductible always applies before benefit copays/deductibles.		
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 **Note:** Coverage will be provided for the treatment of an underlying medical condition up to the point an infertility condition is diagnosed. Services will be covered as any other illness.		
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: 120 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	Plan pays 100% ^	Not Applicable
Non-LifeSOURCE Facility	Covered same as plan's Inpatient Hospital benefit	Covered same as plan's Inpatient Hospital benefit
Inpatient Professional Services		
LifeSOURCE Facility	Plan pays 100% ^	Not Applicable
Non-LifeSOURCE Facility	Covered same as plan's Inpatient Professional benefit	Covered same as plan's Inpatient Professional benefit
• Travel Maximum - Cigna LifeSOURCE Transplant Network® Facility Only: After the plan deductible is met, $10,000 maximum per Transplant per Lifetime		

Benefit	In-Network	Out-of-Network
Note: Services where plan deductible applies are noted with a caret (^). Plan deductible always applies before benefit copays/deductibles.		
Durable Medical Equipment • Annual Limit: Unlimited	Plan pays 100% ^	Plan pays 70% ^
Genetic Testing • Annual Limit: $2,000	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% ^
External Prosthetic Appliances (EPA) • Annual Limit: Unlimited	Plan pays 100% ^	Plan pays 70% ^
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.		
Routine Eye Care • Annual Limit: 1 eye exam up to $150 • Includes eye exam and refraction • Hardware is not covered	Plan pays 100% ^	Plan pays 70% ^

Benefit	In-Network	Out-of-Network
Note: Services where plan deductible applies are noted with a caret (^). Plan deductible always applies before benefit copays/deductibles.		
Mental Health and Substance Use Disorder		
Inpatient Mental Health	Plan pays 100% ^	Plan pays 70% ^
Outpatient Mental Health – Physician's Office	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	Plan pays 100% ^	Plan pays 70% ^
Outpatient Substance Use Disorder – Physician's Office	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.

Pharmacy

Benefits not provided by Cigna.

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.

Health Advisor - A Support for healthy and at-risk individuals to help them stay healthy • Health Assessments • Health and Wellness Coaching • Gaps in Care Coaching • Treatment Decision Support • Educate and Refer	Included

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 as the Secondary plan 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, or an Employee's Domestic Partner who is also eligible for Medicare and whose insurance is continued for any reason as provided in this plan (including COBRA continuation);
(b) an Employee, a former Employee, an Employee's Dependent, or former Employee's Dependent, 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.

Pre-Certification - Continued Stay Review - Basic Care Low Management 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.

- 50% 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-Existing Condition Limitation (PCL) does not apply.

Definitions

Coinsurance - After you've reached your 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

Exclusions

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.
- 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: rhinoplasty; blepharoplasty; acupressure; dance therapy, movement therapy; applied kinesiology; rolfing; and extracorporeal shock wave lithotripsy (ESWL) for musculoskeletal and orthopedic conditions.
- Surgical or non-surgical treatment of TMJ disorders.
- 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.
- For medical and surgical services intended primarily for the treatment or control of obesity. However, treatment of clinically severe obesity, as defined by the body mass index (BMI) classifications of the National Heart, Lung and Blood Institute guideline is covered if the services are demonstrated, through peer-

Exclusions

reviewed medical literature and scientifically based guidelines, to be safe and effective for treatment of the condition.

- 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.
- Infertility services including infertility drugs, surgical or medical treatment programs for infertility, including in vitro fertilization, gamete intrafallopian transfer (GIFT), zygote intrafallopian transfer (ZIFT), variations of these procedures, and any costs associated with the collection, washing, preparation or storage of sperm for artificial insemination (including donor fees). Cryopreservation of donor sperm and eggs is also excluded from coverage.
- Reversal of male or female voluntary sterilization procedures.
- 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.
- Hearing aids, including but not limited to semi-implantable hearing devices, audiant bone conductors and Bone Anchored Hearing Aids (BAHAs). A hearing aid is any device that amplifies sound.
- 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).
- Eye exercises and surgical treatment for the correction of a refractive error, including radial keratotomy.
- Treatment by acupuncture.
- 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.

Exclusions

- 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.

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

EHB State: NY

The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately. This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, go online at www.cigna.com/sp. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms, see the Glossary. You can view the Glossary at https://www.healthcare.gov/sbc-glossary or call 1-800-Cigna24 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	For in-network providers: $2,000/individual - employee only or $4,000/family maximum For out-of-network providers: $2,500/individual - employee only or $5,000/family maximum Combined medical/behavioral and pharmacy deductible Deductible per individual applies when the employee is the only individual covered under the plan.	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the policy, the overall family deductible must be met before the plan begins to pay.
Are there services covered before you meet your deductible?	Yes. Preventive care & immunizations.	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost-sharing and before you meet your deductible. See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/.
Are there other deductibles for specific services?	No.	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	For in-network providers: $2,000/individual - employee only or $4,000/family maximum For out-of-network providers: $4,000/individual - employee only or $8,000/family maximum Combined medical/behavioral and pharmacy out-of-pocket limit	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, the overall family out-of-pocket limit must be met.
What is not included in the out-of-pocket limit?	Penalties for failure to obtain pre-authorization for services, premiums, balance-billing charges, and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the out-of-pocket limit.

Important Questions	Answers	Why This Matters:
Will you pay less if you use a network provider?	Yes. See www.cigna.com or call 1-800-Cigna24 for a list of network providers.	This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist?	No.	You can see the specialist you choose without a referral.

All **copayment** and **coinsurance** costs shown in this chart are after your **deductible** has been met, if a **deductible** applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	No charge/visit	30% coinsurance	None
	Specialist visit	No charge/visit	30% coinsurance	None
	Preventive care/ screening/ immunization	No charge Deductible does not apply	No charge Deductible does not apply	You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	No charge	30% coinsurance	None
	Imaging (CT/PET scans, MRIs)	No charge	30% coinsurance	None
If you need drugs to treat your illness or condition More information about prescription drug coverage	Generic drugs (Tier 1)	Not covered	Not covered	Contact your employer for non-Cigna coverage that may be available.
	Preferred brand drugs (Tier 2)	Not covered	Not covered	
	Non-preferred brand drugs (Tier 3)	Not covered	Not covered	

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
is available at www.cigna.com	Specialty drugs (Tier 4)	Not covered	Not covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	No charge	30% coinsurance	None
	Physician/surgeon fees	No charge	30% coinsurance	None
If you need immediate medical attention	Emergency room care	No charge/visit	No charge/visit	Out-of-network services are paid at the in-network cost share and deductible.
	Emergency medical transportation	No charge	No charge	Out-of-network air ambulance services are paid at the in-network cost share and deductible.
	Urgent care	No charge/visit	No charge/visit	None
If you have a hospital stay	Facility fee (e.g., hospital room)	No charge	30% coinsurance	50% penalty for no out-of-network precertification.
	Physician/surgeon fees	No charge	30% coinsurance	50% penalty for no out-of-network precertification.
If you need mental health, behavioral health, or substance abuse services	Outpatient services	No charge/office visit No charge/all other services	30% coinsurance/office visit 30% coinsurance/all other services	Includes medical services for MH/SA diagnoses.
	Inpatient services	No charge	30% coinsurance	50% penalty for no out-of-network precertification. Includes medical services for MH/SA diagnoses.
If you are pregnant	Office visits	No charge	30% coinsurance	Primary Care or Specialist benefit levels apply for initial visit to confirm pregnancy.
	Childbirth/delivery professional services	No charge	30% coinsurance	

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
	Childbirth/delivery facility services	No charge	30% coinsurance	Cost sharing does not apply for preventive services. Depending on the type of services, a copayment, coinsurance or deductible may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound).
If you need help recovering or have other special health needs	Home health care	No charge	30% coinsurance	Coverage is limited to 120 days annual max. 16 hour maximum per day (The limit is not applicable to mental health and substance use disorder conditions.)
	Rehabilitation services	No charge/visit	30% coinsurance/visit	None
	Habilitation services	No charge/visit	30% coinsurance/visit	Services are covered when Medically Necessary to treat a mental health condition (e.g. autism) or a congenital abnormality.
	Skilled nursing care	No charge	30% coinsurance	50% penalty for no out-of-network precertification. Coverage is limited to 100 days annual max.
	Durable medical equipment	No charge	30% coinsurance	None
	Hospice services	No charge/inpatient services No charge/outpatient services	30% coinsurance/inpatient services 30% coinsurance/outpatient services	50% penalty for failure to precertify out-of-network inpatient hospice services.
If your child needs dental or eye care	Children's eye exam	Not covered	Not covered	None
	Children's glasses	Not covered	Not covered	None
	Children's dental check-up	Not covered	Not covered	None

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)

- Acupuncture
- Chiropractic care
- Cosmetic surgery
- Dental care (Adult)
- Dental care (Children)
- Hearing aids
- Infertility treatment
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Prescription drugs
- Private-duty nursing
- Routine foot care
- Weight loss programs

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)

- Bariatric surgery (if you qualify for coverage)
- Routine eye care (1 eye exam up to $150)

Your Rights to Continue Coverage:
There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform. Other coverage options may be available to you, too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit www.HealthCare.gov or call 1-800-318-2596.

Your Grievance and Appeals Rights:
There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information on how to submit a claim, appeal or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact: Cigna Customer service at 1-800-Cigna24. You may also contact the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform. Additionally, a consumer assistance program can help you file your appeal. Contact: Community Service Society of New York, Community Health Advocates at (888) 614-5400.

Does this plan provide Minimum Essential Coverage? **Yes**
Minimum Essential Coverage generally includes plans, health insurance available through the Marketplace or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of Minimum Essential Coverage, you may not be eligible for the premium tax credit.

Does this plan meet the Minimum Value Standards? **Yes**
If your plan doesn't meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

Language Access Services:
Spanish (Español): Para obtener asistencia en Español, llame al 1-800-244-6224.
Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-244-6224.
Chinese (中文): 如果需要中文的帮助，请拨打这个号码 1-800-244-6224.
Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-800-244-6224.

To see examples of how this plan might cover costs for a sample medical situation, see the next section.

About these Coverage Examples:

This is not a cost estimator. Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

Peg is Having a Baby
(9 months of in-network pre-natal care and a hospital delivery)

- **The plan's overall deductible** **$2,000**
- **Specialist coinsurance** **0%**
- **Hospital (facility) coinsurance** **0%**
- **Other coinsurance** **0%**

This EXAMPLE event includes services like:
Specialist office visits *(prenatal care)*
Childbirth/Delivery Professional Services
Childbirth/Delivery Facility Services
Diagnostic tests *(ultrasounds and blood work)*
Specialist visit *(anesthesia)*

Total Example Cost	**$12,700**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$2,000
Copayments	$0
Coinsurance	$0
What isn't covered	
Limits or exclusions	$30
The total Peg would pay is	$2,030

Managing Joe's type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

- **The plan's overall deductible** **$2,000**
- **Specialist coinsurance** **0%**
- **Hospital (facility) coinsurance** **0%**
- **Other coinsurance** **0%**

This EXAMPLE event includes services like:
Primary care physician office visits *(including disease education)*
Diagnostic tests *(blood work)*
Prescription drugs
Durable medical equipment *(glucose meter)*

Total Example Cost	**$5,600**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$1,140
Copayments	$0
Coinsurance	$0
What isn't covered	
Limits or exclusions	$4,300
The total Joe would pay is	$5,440

Mia's Simple Fracture
(in-network emergency room visit and follow up care)

- **The plan's overall deductible** **$2,000**
- **Specialist coinsurance** **0%**
- **Hospital (facility) coinsurance** **0%**
- **Other coinsurance** **0%**

This EXAMPLE event includes services like:
Emergency room care *(including medical supplies)*
Diagnostic test *(x-ray)*
Durable medical equipment *(crutches)*
Rehabilitation services *(physical therapy)*

Total Example Cost	**$2,800**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$2,000
Copayments	$0
Coinsurance	$0
What isn't covered	
Limits or exclusions	$10
The total Mia would pay is	$2,010

The plan would be responsible for the other costs of these EXAMPLE covered services.

Plan Name: HDHPQ Plan **Ben Ver:** 28 **Plan ID:** 17373512

BENEFIT SUMMARY

Administered by - Cigna Health and Life Insurance Co.
For - School of Visual Arts LLC
Choice Fund Open Access Plus HSA Plan
HSA Plan
Effective - 01/01/2024

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.

Your coverage includes a health savings account that you can use to pay for eligible out-of-pocket expenses.

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 - Employee Only: $2,000 Family Maximum: $4,000	Individual - Employee Only: $2,500 Family Maximum: $5,000

- Only the amount you pay for in-network covered expenses counts towards your in-network deductible. Only the amount you pay for out-of-network covered expenses counts towards your out-of-network deductible.
- Plan deductible always applies before any benefit copay/deductible or coinsurance.
- Plan deductible does not apply to in-network preventive services.
- All family members contribute towards the family deductible. An individual cannot have claims covered under the plan coinsurance until the total family deductible has been satisfied.
- This plan includes a combined Medical/Pharmacy plan deductible.

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

Plan Highlights	In-Network	Out-of-Network
Plan Out-of-Pocket Maximum	Individual - Employee Only: $2,000 Family Maximum: $4,000	Individual - Employee Only: $4,000 Family Maximum: $8,000

- 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.
- All eligible family members contribute towards the family out-of-pocket maximum. Once the family out-of-pocket maximum has been met, the plan will pay each eligible family member's covered expenses at 100%.
- 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 (^). Plan deductible always applies before benefit copays/deductibles.		
Physician Services - Office Visits		
Primary Care Physician (PCP) Services/Office Visit	Plan pays 100% ^	Plan pays 70% ^
Specialty Care Physician Services/Office Visit	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	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 (^). Plan deductible always applies before benefit copays/deductibles.		
Virtual Physician Services - Office Visits		
Primary Care Physician (PCP) Services/Office Visit	Plan pays 100% ^	Plan pays 70% ^
Specialty Care Physician Services/Office Visit	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	Plan pays 100% ^	Plan pays 70% ^
Preventive Care		
Preventive Care	Plan pays 100%	Plan pays 100%
• 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%	Plan pays 100%
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.		
Diagnostic Fecal Occult Cancer Test	Plan pays 100% ^	Plan pays 100% ^
• Coverage includes the associated interpretation services.		
Inpatient		
Inpatient Hospital Facility Services	Plan pays 100% ^	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 (^). Plan deductible always applies before benefit copays/deductibles.		
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.	Plan pays 100% ^	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.	Plan pays 100% ^	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.		
Inpatient Services at Other Health Care Facilities		
Skilled Nursing Facility, Rehabilitation Hospital, Sub-Acute Facilities • Annual Limit: 100 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 (^). Plan deductible always applies before benefit copays/deductibles.		
Outpatient Therapy Services		
Outpatient Therapy	Covered same as Physician Services - Office Visit	Covered same as Physician Services - Office Visit
Annual Limits: • All Therapies Combined - Includes Cardiac Rehabilitation, Cognitive Therapy, Occupational Therapy, Physical Therapy, Pulmonary Rehabilitation, and Speech Therapy - Unlimited days **Note:** Therapy days, provided as part of an approved Home Health Care plan, accumulate to the applicable outpatient therapy services maximum.		
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 up to a maximum of 15 visits per occurrence.		
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.		
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

Benefit	In-Network	Out-of-Network
Note: Services where plan deductible applies are noted with a caret (^). Plan deductible always applies before benefit copays/deductibles.		
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 Includes contraceptive devices as ordered or prescribed by a physician and surgical sterilization services, such as tubal ligation (excludes reversals)	Plan pays 100%	Plan pays 100%
Men's Services Includes surgical sterilization services, such as vasectomy (excludes reversals)	Coverage varies based on Place of Service	Coverage varies based on Place of Service
Infertility		
Infertility Treatment **Note:** Coverage will be provided for the treatment of an underlying medical condition up to the point an infertility condition is diagnosed. Services will be covered as any other illness.		
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 (^). Plan deductible always applies before benefit copays/deductibles.		
Other Health Care Facilities/Services		
Home Health Care • Annual Limit: 120 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	Plan pays 100% ^	Not Applicable
Non-LifeSOURCE Facility	Covered same as plan's Inpatient Hospital benefit	Covered same as plan's Inpatient Hospital benefit
Inpatient Professional Services		
LifeSOURCE Facility	Plan pays 100% ^	Not Applicable
Non-LifeSOURCE Facility	Covered same as plan's Inpatient Professional benefit	Covered same as plan's Inpatient Professional benefit
• Travel Maximum - Cigna LifeSOURCE Transplant Network® Facility Only: After the plan deductible is met, $10,000 maximum per Transplant per Lifetime		
Durable Medical Equipment • Annual Limit: Unlimited	Plan pays 100% ^	Plan pays 70% ^
Genetic Testing • Annual Limit: $2,000	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 100%
External Prosthetic Appliances (EPA) • Annual Limit: Unlimited	Plan pays 100% ^	Plan pays 70% ^
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
Routine Eye Care • Annual Limit: 1 eye exam up to $150 • Includes eye exam and refraction • Hardware is not covered	Plan pays 100% ^	Plan pays 70% ^

Benefit	In-Network	Out-of-Network
Note: Services where plan deductible applies are noted with a caret (^). Plan deductible always applies before benefit copays/deductibles.		
Mental Health and Substance Use Disorder		
Inpatient Mental Health	Plan pays 100% ^	Plan pays 70% ^
Outpatient Mental Health – Physician's Office	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	Plan pays 100% ^	Plan pays 70% ^
Outpatient Substance Use Disorder – Physician's Office	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.

Pharmacy

Benefits not provided by Cigna.

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.

Health Advisor - A Support for healthy and at-risk individuals to help them stay healthy • Health Assessments • Health and Wellness Coaching • Gaps in Care Coaching • Treatment Decision Support • Educate and Refer	Included

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 as the Secondary plan 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, or an Employee's Domestic Partner who is also eligible for Medicare and whose insurance is continued for any reason as provided in this plan (including COBRA continuation);
(b) an Employee, a former Employee, an Employee's Dependent, or former Employee's Dependent, 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.

Pre-Certification - Continued Stay Review - Basic Care Low Management 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.

- 50% 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-Existing Condition Limitation (PCL) does not apply.

Definitions

Coinsurance - After you've reached your 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

Exclusions

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.
- 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: rhinoplasty; blepharoplasty; acupressure; dance therapy, movement therapy; applied kinesiology; rolfing; and extracorporeal shock wave lithotripsy (ESWL) for musculoskeletal and orthopedic conditions.
- Surgical or non-surgical treatment of TMJ disorders.
- 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.
- For medical and surgical services intended primarily for the treatment or control of obesity. However, treatment of clinically severe obesity, as defined by the body mass index (BMI) classifications of the National Heart, Lung and Blood Institute guideline is covered if the services are demonstrated, through peer-

Exclusions

reviewed medical literature and scientifically based guidelines, to be safe and effective for treatment of the condition.

- 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.
- Infertility services including infertility drugs, surgical or medical treatment programs for infertility, including in vitro fertilization, gamete intrafallopian transfer (GIFT), zygote intrafallopian transfer (ZIFT), variations of these procedures, and any costs associated with the collection, washing, preparation or storage of sperm for artificial insemination (including donor fees). Cryopreservation of donor sperm and eggs is also excluded from coverage.
- Reversal of male or female voluntary sterilization procedures.
- 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.
- Hearing aids, including but not limited to semi-implantable hearing devices, audiant bone conductors and Bone Anchored Hearing Aids (BAHAs). A hearing aid is any device that amplifies sound.
- 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).
- Eye exercises and surgical treatment for the correction of a refractive error, including radial keratotomy.
- Treatment by acupuncture.
- 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.

Exclusions

- 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.

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

EHB State: NY

The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately. This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, go online at www.cigna.com/sp. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms, see the Glossary. You can view the Glossary at https://www.healthcare.gov/sbc-glossary or call 1-800-Cigna24 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	For in-network providers: $2,000/individual - employee only or $4,000/family maximum For out-of-network providers: $2,500/individual - employee only or $5,000/family maximum Combined medical/behavioral and pharmacy deductible Deductible per individual applies when the employee is the only individual covered under the plan.	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the policy, the overall family deductible must be met before the plan begins to pay.
Are there services covered before you meet your deductible?	Yes. Preventive care & immunizations.	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost-sharing and before you meet your deductible. See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/.
Are there other deductibles for specific services?	No.	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	For in-network providers: $2,000/individual - employee only or $4,000/family maximum For out-of-network providers: $4,000/individual - employee only or $8,000/family maximum Combined medical/behavioral and pharmacy out-of-pocket limit	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, the overall family out-of-pocket limit must be met.
What is not included in the out-of-pocket limit?	Penalties for failure to obtain pre-authorization for services, premiums, balance-billing charges, and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the out-of-pocket limit.

Important Questions	Answers	Why This Matters:
Will you pay less if you use a network provider?	Yes. See www.cigna.com or call 1-800-Cigna24 for a list of network providers.	This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist?	No.	You can see the specialist you choose without a referral.

All **copayment** and **coinsurance** costs shown in this chart are after your **deductible** has been met, if a **deductible** applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	No charge/visit	30% coinsurance	None
	Specialist visit	No charge/visit	30% coinsurance	None
	Preventive care/ screening/ immunization	No charge Deductible does not apply	No charge Deductible does not apply	You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	No charge	30% coinsurance	None
	Imaging (CT/PET scans, MRIs)	No charge	30% coinsurance	None
If you need drugs to treat your illness or condition More information about prescription drug coverage	Generic drugs (Tier 1)	Not covered	Not covered	Contact your employer for non-Cigna coverage that may be available.
	Preferred brand drugs (Tier 2)	Not covered	Not covered	
	Non-preferred brand drugs (Tier 3)	Not covered	Not covered	

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
is available at www.cigna.com	Specialty drugs (Tier 4)	Not covered	Not covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	No charge	30% coinsurance	None
	Physician/surgeon fees	No charge	30% coinsurance	None
If you need immediate medical attention	Emergency room care	No charge/visit	No charge/visit	Out-of-network services are paid at the in-network cost share and deductible.
	Emergency medical transportation	No charge	No charge	Out-of-network air ambulance services are paid at the in-network cost share and deductible.
	Urgent care	No charge/visit	No charge/visit	None
If you have a hospital stay	Facility fee (e.g., hospital room)	No charge	30% coinsurance	50% penalty for no out-of-network precertification.
	Physician/surgeon fees	No charge	30% coinsurance	50% penalty for no out-of-network precertification.
If you need mental health, behavioral health, or substance abuse services	Outpatient services	No charge/office visit No charge/all other services	30% coinsurance/office visit 30% coinsurance/all other services	Includes medical services for MH/SA diagnoses.
	Inpatient services	No charge	30% coinsurance	50% penalty for no out-of-network precertification. Includes medical services for MH/SA diagnoses.
If you are pregnant	Office visits	No charge	30% coinsurance	Primary Care or Specialist benefit levels apply for initial visit to confirm pregnancy.
	Childbirth/delivery professional services	No charge	30% coinsurance	

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
	Childbirth/delivery facility services	No charge	30% coinsurance	Cost sharing does not apply for preventive services. Depending on the type of services, a copayment, coinsurance or deductible may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound).
If you need help recovering or have other special health needs	Home health care	No charge	30% coinsurance	Coverage is limited to 120 days annual max. 16 hour maximum per day (The limit is not applicable to mental health and substance use disorder conditions.)
	Rehabilitation services	No charge/visit	30% coinsurance/visit	None
	Habilitation services	No charge/visit	30% coinsurance/visit	Services are covered when Medically Necessary to treat a mental health condition (e.g. autism) or a congenital abnormality.
	Skilled nursing care	No charge	30% coinsurance	50% penalty for no out-of-network precertification. Coverage is limited to 100 days annual max.
	Durable medical equipment	No charge	30% coinsurance	None
	Hospice services	No charge/inpatient services No charge/outpatient services	30% coinsurance/inpatient services 30% coinsurance/outpatient services	50% penalty for failure to precertify out-of-network inpatient hospice services.
If your child needs dental or eye care	Children's eye exam	Not covered	Not covered	None
	Children's glasses	Not covered	Not covered	None
	Children's dental check-up	Not covered	Not covered	None

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)

- Acupuncture
- Chiropractic care
- Cosmetic surgery
- Dental care (Adult)
- Dental care (Children)
- Hearing aids
- Infertility treatment
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Prescription drugs
- Private-duty nursing
- Routine foot care
- Weight loss programs

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)

- Bariatric Surgery (if you qualify for coverage)
- Routine eye care (1 eye exam up to $150)

Your Rights to Continue Coverage:
There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform. Other coverage options may be available to you, too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit www.HealthCare.gov or call 1-800-318-2596.

Your Grievance and Appeals Rights:
There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information on how to submit a claim, appeal or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact: Cigna Customer service at 1-800-Cigna24. You may also contact the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform. Additionally, a consumer assistance program can help you file your appeal. Contact: Community Service Society of New York, Community Health Advocates at (888) 614-5400.

Does this plan provide Minimum Essential Coverage? **Yes**
Minimum Essential Coverage generally includes plans, health insurance available through the Marketplace or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of Minimum Essential Coverage, you may not be eligible for the premium tax credit.

Does this plan meet the Minimum Value Standards? **Yes**
If your plan doesn't meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

Language Access Services:
Spanish (Español): Para obtener asistencia en Español, llame al 1-800-244-6224.
Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-244-6224.
Chinese (中文): 如果需要中文的帮助，请拨打这个号码 1-800-244-6224.
Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-800-244-6224.

To see examples of how this plan might cover costs for a sample medical situation, see the next section.

About these Coverage Examples:

This is not a cost estimator. Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

Peg is Having a Baby
(9 months of in-network pre-natal care and a hospital delivery)

The plan's overall deductible	**$2,000**
Specialist coinsurance	**0%**
Hospital (facility) coinsurance	**0%**
Other coinsurance	**0%**

This EXAMPLE event includes services like:
Specialist office visits *(prenatal care)*
Childbirth/Delivery Professional Services
Childbirth/Delivery Facility Services
Diagnostic tests *(ultrasounds and blood work)*
Specialist visit *(anesthesia)*

Total Example Cost	**$12,700**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$2,000
Copayments	$0
Coinsurance	$0
What isn't covered	
Limits or exclusions	$30
The total Peg would pay is	$2,030

Managing Joe's type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

The plan's overall deductible	**$2,000**
Specialist coinsurance	**0%**
Hospital (facility) coinsurance	**0%**
Other coinsurance	**0%**

This EXAMPLE event includes services like:
Primary care physician office visits *(including disease education)*
Diagnostic tests *(blood work)*
Prescription drugs
Durable medical equipment *(glucose meter)*

Total Example Cost	**$5,600**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$1,140
Copayments	$0
Coinsurance	$0
What isn't covered	
Limits or exclusions	$4,300
The total Joe would pay is	$5,440

Mia's Simple Fracture
(in-network emergency room visit and follow up care)

The plan's overall deductible	**$2,000**
Specialist coinsurance	**0%**
Hospital (facility) coinsurance	**0%**
Other coinsurance	**0%**

This EXAMPLE event includes services like:
Emergency room care *(including medical supplies)*
Diagnostic test *(x-ray)*
Durable medical equipment *(crutches)*
Rehabilitation services *(physical therapy)*

Total Example Cost	**$2,800**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$2,000
Copayments	$0
Coinsurance	$0
What isn't covered	
Limits or exclusions	$10
The total Mia would pay is	$2,010

The plan would be responsible for the other costs of these EXAMPLE covered services.

Plan Name: HSA Plan **Ben Ver:** 28 **Plan ID:** 17373506

BENEFIT SUMMARY

Administered by - Cigna Health and Life Insurance Co.
For - School of Visual Arts LLC
Open Access Plus Plan
OAP1 Plan
Effective - 01/01/2024

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 90%	Plan pays 60%
Maximum Reimbursable Charge	Not Applicable	90th Percentile
Plan Deductible	Individual: $1,500 Family: $3,000	Individual: $2,000 Family: $5,000

- Only the amount you pay for in-network covered expenses counts towards your in-network deductible. Only the amount you pay for out-of-network covered expenses counts towards both your in-network and 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: $2,500 Family: $5,000	Individual: $4,000 Family: $10,000

- 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 both your in-network and out-of-network out-of-pocket maximums.
- 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	$25 copay, and plan pays 100%	Plan pays 60% ^
Specialty Care Physician Services/Office Visit	$40 copay, and plan pays 100%	Plan pays 60% ^
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	$25 copay, and plan pays 100%	Not Covered
MDLIVE Primary Care Services	$25 copay, and plan pays 100%	Not Covered
MDLIVE Specialty Care Services	$40 copay, and 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	$25 copay, and plan pays 100%	Plan pays 60% ^
Specialty Care Physician Services/Office Visit	$40 copay, and plan pays 100%	Plan pays 60% ^
• 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	$25 copay, and plan pays 100%	Plan pays 60% ^
Preventive Care		
Preventive Care	Plan pays 100%	Plan pays 100%
• 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%	Plan pays 100%
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.		
Diagnostic Fecal Occult Cancer Test	Plan pays 100%	Plan pays 100%
• Coverage includes the associated interpretation services.		
Inpatient		
Inpatient Hospital Facility Services	Plan pays 90% ^	Plan pays 60% ^
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 90% ^	Plan pays 60% ^
Inpatient Professional Services	Plan pays 90% ^	Plan pays 60% ^
• For services performed by Surgeons, Radiologists, Pathologists and Anesthesiologists		
Outpatient		
Outpatient Facility Services	Plan pays 90% ^	Plan pays 60% ^
Outpatient Professional Services	Plan pays 90% ^	Plan pays 60% ^
• 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.	$25 copay, and plan pays 100% ^	$25 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 90% ^	Plan pays 90% ^
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: 100 days	Plan pays 90% ^	Plan pays 90% ^
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 90% ^	Plan pays 60% ^
Outpatient Facility	Plan pays 90% ^	Plan pays 60% ^
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 90% ^	Plan pays 60% ^
Advanced Radiological Imaging (ARI)	Includes MRI, MRA, CAT Scan, PET Scan, etc.	
Outpatient Facility	Plan pays 90% ^	Plan pays 60% ^
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	Plan pays 90% ^	Covered same as Physician Services - Office Visit
Annual Limits: • All Therapies Combined - Includes Cardiac Rehabilitation, Cognitive Therapy, Occupational Therapy, Physical Therapy, Pulmonary Rehabilitation, and Speech Therapy - Unlimited days **Note:** Therapy days, provided as part of an approved Home Health Care plan, accumulate to the applicable outpatient therapy services maximum.		
Hospice		
Inpatient Facilities	Plan pays 90% ^	Plan pays 90% ^
Outpatient Services	Plan pays 90% ^	Plan pays 90% ^
Note: Includes Bereavement counseling provided as part of a hospice program up to a maximum of 15 visits per occurrence.		
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 90% ^	Plan pays 60% ^
Physician's Office	Plan pays 100%	Plan pays 60% ^
Home	Plan pays 90% ^	Plan pays 60% ^
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	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 60% ^
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

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.		
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 Includes contraceptive devices as ordered or prescribed by a physician and surgical sterilization services, such as tubal ligation (excludes reversals)	Plan pays 100%	Coverage varies based on Place of Service
Men's Services Includes surgical sterilization services, such as vasectomy (excludes reversals)	Coverage varies based on Place of Service	Coverage varies based on Place of Service
Infertility		
Infertility Treatment **Note:** Coverage will be provided for the treatment of an underlying medical condition up to the point an infertility condition is diagnosed. Services will be covered as any other illness.		
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: 120 days (The limit is not applicable to mental health and substance use disorder conditions.) **Note:** Includes outpatient private duty nursing when approved as medically necessary	Plan pays 90% ^	Plan pays 90% ^
Organ Transplants		
Inpatient Hospital Facility Services		
LifeSOURCE Facility	Plan pays 100%	Not Applicable
Non-LifeSOURCE Facility	Covered same as plan's Inpatient Hospital benefit	Covered same as plan's Inpatient Hospital benefit
Inpatient Professional Services		
LifeSOURCE Facility	Plan pays 100%	Not Applicable
Non-LifeSOURCE Facility	Covered same as plan's Inpatient Professional benefit	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 90% ^	Plan pays 60% ^
Genetic Testing • Annual Limit: $2,000	Plan pays 90% ^	Plan pays 60% ^
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 60% ^
External Prosthetic Appliances (EPA) • Annual Limit: Unlimited	Plan pays 90% ^	Plan pays 60% ^
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
Routine Eye Care • Annual Limit: 1 eye exam up to $150 • Includes eye exam and refraction • Hardware is not covered	Plan pays 100% ^	Plan pays 60% ^

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	Plan pays 90% ^	Plan pays 60% ^
Outpatient Mental Health – Physician's Office	$40 copay, and plan pays 100%	Plan pays 60% ^
Outpatient Mental Health - MDLIVE Behavioral Services	$40 copay, and plan pays 100%	Not Covered
Outpatient Mental Health – All Other Services	Plan pays 90% ^	Plan pays 60% ^
Inpatient Substance Use Disorder	Plan pays 90% ^	Plan pays 60% ^
Outpatient Substance Use Disorder – Physician's Office	$40 copay, and plan pays 100%	Plan pays 60% ^
Outpatient Substance Use Disorder - MDLIVE Behavioral Services	$40 copay, and plan pays 100%	Not Covered
Outpatient Substance Use Disorder – All Other Services	Plan pays 90% ^	Plan pays 60% ^

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.

Pharmacy

Benefits not provided by Cigna.

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.

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 (90th) 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 as the Secondary plan 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, or an Employee's Domestic Partner who is also eligible for Medicare and whose insurance is continued for any reason as provided in this plan (including COBRA continuation);
(b) an Employee, a former Employee, an Employee’s Dependent, or former Employee’s Dependent, 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

Pre-Certification - Continued Stay Review - Basic Care Low Management 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.

- 50% 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-Existing Condition Limitation (PCL) does not apply.

Definitions

Coinsurance - After you've reached your 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.
- 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

Exclusions

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.

- The following services are excluded from coverage regardless of clinical indications: rhinoplasty; blepharoplasty; acupressure; dance therapy; movement therapy; applied kinesiology; rolfing; and extracorporeal shock wave lithotripsy (ESWL) for musculoskeletal and orthopedic conditions.
- Surgical or non-surgical treatment of TMJ disorders.
- 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.
- For medical and surgical services intended primarily for the treatment or control of obesity. However, treatment of clinically severe obesity, as defined by the body mass index (BMI) classifications of the National Heart, Lung and Blood Institute guideline is covered if the services are demonstrated, through peer-reviewed medical literature and scientifically based guidelines, to be safe and effective for treatment of the condition.
- 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.
- Infertility services including infertility drugs, surgical or medical treatment programs for infertility, including in vitro fertilization, gamete intrafallopian transfer (GIFT), zygote intrafallopian transfer (ZIFT), variations of these procedures, and any costs associated with the collection, washing, preparation or storage of sperm for artificial insemination (including donor fees). Cryopreservation of donor sperm and eggs is also excluded from coverage.
- Reversal of male or female voluntary sterilization procedures.
- 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

Exclusions

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.
- Hearing aids, including but not limited to semi-implantable hearing devices, audiant bone conductors and Bone Anchored Hearing Aids (BAHAs). A hearing aid is any device that amplifies sound.
- 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).
- Eye exercises and surgical treatment for the correction of a refractive error, including radial keratotomy.
- Treatment by acupuncture.
- 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.

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

EHB State: NY

The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately. This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, go online at www.cigna.com/sp. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms, see the Glossary. You can view the Glossary at https://www.healthcare.gov/sbc-glossary or call 1-800-Cigna24 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	For in-network providers: $1,500/individual or $3,000/family For out-of-network providers: $2,000/individual or $5,000/family	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible.
Are there services covered before you meet your deductible?	Yes. Preventive care & immunizations, office visits, urgent care facility visits.	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost-sharing and before you meet your deductible. See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/.
Are there other deductibles for specific services?	No.	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	For in-network providers: $2,500/individual or $5,000/family For out-of-network providers: $4,000/individual or $10,000/family Combined medical/behavioral and pharmacy out-of-pocket limit	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.
What is not included in the out-of-pocket limit?	Penalties for failure to obtain pre-authorization for services, premiums, balance-billing charges, and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the out-of-pocket limit.

Important Questions	Answers	Why This Matters:
Will you pay less if you use a network provider?	Yes. See www.cigna.com or call 1-800-Cigna24 for a list of network providers.	This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist?	No.	You can see the specialist you choose without a referral.

All **copayment** and **coinsurance** costs shown in this chart are after your **deductible** has been met, if a **deductible** applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$25 copay/visit Deductible does not apply	40% coinsurance	None
	Specialist visit	$40 copay/visit Deductible does not apply	40% coinsurance	None
	Preventive care/ screening/ immunization	No charge Deductible does not apply	No charge Deductible does not apply	You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	10% coinsurance	40% coinsurance	None
	Imaging (CT/PET scans, MRIs)	10% coinsurance	40% coinsurance	None
If you need drugs to treat your illness or condition More information about prescription drug coverage	Generic drugs (Tier 1)	Not covered	Not covered	Contact your employer for non-Cigna coverage that may be available.
	Preferred brand drugs (Tier 2)	Not covered	Not covered	
	Non-preferred brand drugs (Tier 3)	Not covered	Not covered	

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
is available at www.cigna.com	Specialty drugs (Tier 4)	Not covered	Not covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	10% coinsurance	40% coinsurance	None
	Physician/surgeon fees	10% coinsurance	40% coinsurance	None
If you need immediate medical attention	Emergency room care	$25 copay/visit	$25 copay/visit	Per visit copay is waived if admitted. Out-of-network services are paid at the in-network cost share and deductible.
	Emergency medical transportation	10% coinsurance	10% coinsurance	Out-of-network air ambulance services are paid at the in-network cost share and deductible.
	Urgent care	$25 copay/visit Deductible does not apply	$25 copay/visit Deductible does not apply	None
If you have a hospital stay	Facility fee (e.g., hospital room)	10% coinsurance	40% coinsurance	50% penalty for no out-of-network precertification.
	Physician/surgeon fees	10% coinsurance	40% coinsurance	50% penalty for no out-of-network precertification.
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$40 copay/office visit** 10% coinsurance/all other services **Deductible does not apply	40% coinsurance/office visit 40% coinsurance/all other services	Includes medical services for MH/SA diagnoses.
	Inpatient services	10% coinsurance	40% coinsurance	50% penalty for no out-of-network precertification. Includes medical services for MH/SA diagnoses.
If you are pregnant	Office visits	No charge Deductible does not apply	40% coinsurance	Primary Care or Specialist benefit levels apply for initial visit to confirm pregnancy. Cost sharing does not apply for
	Childbirth/delivery professional services	No charge Deductible does not apply	40% coinsurance	

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
	Childbirth/delivery facility services	10% coinsurance	40% coinsurance	preventive services. Depending on the type of services, a copayment, coinsurance or deductible may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound).
If you need help recovering or have other special health needs	Home health care	10% coinsurance	10% coinsurance	Coverage is limited to 120 days annual max. 16 hour maximum per day (The limit is not applicable to mental health and substance use disorder conditions.)
	Rehabilitation services	10% coinsurance	40% coinsurance/PCP visit 40% coinsurance/ Specialist visit	None
	Habilitation services	10% coinsurance	40% coinsurance/PCP visit 40% coinsurance/ Specialist visit	Services are covered when Medically Necessary to treat a mental health condition (e.g. autism) or a congenital abnormality.
	Skilled nursing care	10% coinsurance	10% coinsurance	50% penalty for no out-of-network precertification. Coverage is limited to 100 days annual max.
	Durable medical equipment	10% coinsurance	40% coinsurance	None
	Hospice services	10% coinsurance/inpatient services 10% coinsurance/outpatient services	10% coinsurance /inpatient services 10% coinsurance /outpatient services	50% penalty for failure to precertify out-of-network inpatient hospice services.
If your child needs dental or eye care	Children's eye exam	Not covered	Not covered	None
	Children's glasses	Not covered	Not covered	None
	Children's dental check-up	Not covered	Not covered	None

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)

- Acupuncture
- Chiropractic care
- Cosmetic surgery
- Dental care (Adult)
- Dental care (Children)
- Hearing aids
- Infertility treatment
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Prescription drugs
- Private-duty nursing
- Routine foot care
- Weight loss programs

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)

- Bariatric surgery (if you qualify for coverage)
- Routine eye care (1 eye exam up to $150)

Your Rights to Continue Coverage:
There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform. Other coverage options may be available to you, too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit www.HealthCare.gov or call 1-800-318-2596.

Your Grievance and Appeals Rights:
There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information on how to submit a claim, appeal or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact: Cigna Customer service at 1-800-Cigna24. You may also contact the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform. Additionally, a consumer assistance program can help you file your appeal. Contact: Community Service Society of New York, Community Health Advocates at (888) 614-5400.

Does this plan provide Minimum Essential Coverage? **Yes**
Minimum Essential Coverage generally includes plans, health insurance available through the Marketplace or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of Minimum Essential Coverage, you may not be eligible for the premium tax credit.

Does this plan meet the Minimum Value Standards? **Yes**
If your plan doesn't meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

Language Access Services:
Spanish (Español): Para obtener asistencia en Español, llame al 1-800-244-6224.
Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-244-6224.
Chinese (中文): 如果需要中文的帮助，请拨打这个号码 1-800-244-6224.
Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-800-244-6224.

To see examples of how this plan might cover costs for a sample medical situation, see the next section.

About these Coverage Examples:

This is not a cost estimator. Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

Peg is Having a Baby
(9 months of in-network pre-natal care and a hospital delivery)

The plan's overall deductible	$1,500
Specialist copayment	$40
Hospital (facility) coinsurance	10%
Other coinsurance	10%

This EXAMPLE event includes services like:
Specialist office visits *(prenatal care)*
Childbirth/Delivery Professional Services
Childbirth/Delivery Facility Services
Diagnostic tests *(ultrasounds and blood work)*
Specialist visit *(anesthesia)*

Total Example Cost	**$12,700**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$1,500
Copayments	$30
Coinsurance	$1,000
What isn't covered	
Limits or exclusions	$30
The total Peg would pay is	$2,530

Managing Joe's type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

The plan's overall deductible	$1,500
Specialist copayment	$40
Hospital (facility) coinsurance	10%
Other coinsurance	10%

This EXAMPLE event includes services like:
Primary care physician office visits *(including disease education)*
Diagnostic tests *(blood work)*
Prescription drugs
Durable medical equipment *(glucose meter)*

Total Example Cost	**$5,600**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$120
Copayments	$300
Coinsurance	$0
What isn't covered	
Limits or exclusions	$4,300
The total Joe would pay is	$4,720

Mia's Simple Fracture
(in-network emergency room visit and follow up care)

The plan's overall deductible	$1,500
Specialist copayment	$40
Hospital (facility) coinsurance	10%
Other coinsurance	10%

This EXAMPLE event includes services like:
Emergency room care *(including medical supplies)*
Diagnostic test *(x-ray)*
Durable medical equipment *(crutches)*
Rehabilitation services *(physical therapy)*

Total Example Cost	**$2,800**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$1,500
Copayments	$200
Coinsurance	$0
What isn't covered	
Limits or exclusions	$10
The total Mia would pay is	$1,710

The plan would be responsible for the other costs of these EXAMPLE covered services.

Plan Name: OAP1 Plan **Ben Ver:** 28 **Plan ID:** 17373509

Discrimination is against the law

Medical coverage

Cigna Healthcare complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, sex, gender identity or sexual orientation. Cigna Healthcare does not exclude people or treat them differently because of race, color, national origin, age, disability, sex, gender identity or sexual orientation.

Cigna Healthcare:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, contact customer service at the toll-free number shown on your ID card, and ask a Customer Service Associate for assistance.

If you believe that Cigna Healthcare has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance by sending an email to **ACAGrievance@Cigna.com** or by writing to the following address:

Cigna Healthcare
Nondiscrimination Complaint Coordinator
P.O. Box 188016 Chattanooga, TN 37422

If you need assistance filing a written grievance, please call the number on the back of your ID card or send an email to **ACAGrievance@Cigna.com**. You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at **https://ocrportal.hhs.gov/ocr/portal/lobby.jsf**, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, DC 20201
1.800.368.1019, 800.537.7697 (TDD)

Complaint forms are available at **https://www.hhs.gov/civil-rights/filing-a-complaint/complaint-process/index.html**

Proficiency of Language Assistance Services

English – ATTENTION: Language assistance services, free of charge, are available to you. For current Cigna Healthcare customers, call the number on the back of your ID card. Otherwise, call 1.800.244.6224 (TTY: Dial 711).

Spanish – ATENCIÓN: Hay servicios de asistencia de idiomas, sin cargo, a su disposición. Si es un cliente actual de Cigna Healthcare, llame al número que figura en el reverso de su tarjeta de identificación. Si no lo es, llame al 1.800.244.6224 (los usuarios de TTY deben llamar al 711).

Chinese – 注意：我們可爲您免費提供語言協助服務。對於 Cigna Healthcare 的現有客戶，請致電您的 ID 卡背面的號碼。其他客戶請致電 1.800.244.6224 （聽障專線：請撥 711）。

Vietnamese – XIN LƯU Ý: Quý vị được cấp dịch vụ trợ giúp về ngôn ngữ miễn phí. Dành cho khách hàng hiện tại của Cigna Healthcare, vui lòng gọi số ở mặt sau thẻ Hội viên. Các trường hợp khác xin gọi số 1.800.244.6224 (TTY: Quay số 711).

Korean – 주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 현재 Cigna Healthcare 가입자님들께서는 ID 카드 뒷면에 있는 전화번호로 연락해주십시오. 기타 다른 경우에는 1.800.244.6224 (TTY: 다이얼 711)번으로 전화해주십시오.

Tagalog – PAUNAWA: Makakakuha ka ng mga serbisyo sa tulong sa wika nang libre. Para sa mga kasalukuyang customer ng Cigna Healthcare, tawagan ang numero sa likuran ng iyong ID card. O kaya, tumawag sa 1.800.244.6224 (TTY: I-dial ang 711).

Russian – ВНИМАНИЕ: вам могут предоставить бесплатные услуги перевода. Если вы уже участвуете в плане Cigna Healthcare, позвоните по номеру, указанному на обратной стороне вашей идентификационной карточки участника плана. Если вы не являетесь участником одного из наших планов, позвоните по номеру 1.800.244.6224 (TTY: 711).

Arabic – برجاء الانتباه خدمات الترجمة المجانية متاحة لكم. لعملاء Cigna Healthcare الحاليين برجاء الاتصال بالرقم المدون على ظهر بطاقتكم الشخصية. أو اتصل ب 1.800.244.6224 (TTY: اتصل ب 711).

French Creole – ATANSYON: Gen sèvis èd nan lang ki disponib gratis pou ou. Pou kliyan Cigna Healthcare yo, rele nimewo ki dèyè kat ID ou. Sinon, rele nimewo 1.800.244.6224 (TTY: Rele 711).

French – ATTENTION: Des services d'aide linguistique vous sont proposés gratuitement. Si vous êtes un client actuel de Cigna Healthcare, veuillez appeler le numéro indiqué au verso de votre carte d'identité. Sinon, veuillez appeler le numéro 1.800.244.6224 (ATS : composez le numéro 711).

Portuguese – ATENÇÃO: Tem ao seu dispor serviços de assistência linguística, totalmente gratuitos. Para clientes Cigna Healthcare atuais, ligue para o número que se encontra no verso do seu cartão de identificação. Caso contrário, ligue para 1.800.244.6224 (Dispositivos TTY: marque 711).

Polish – UWAGA: w celu skorzystania z dostępnej, bezpłatnej pomocy językowej, obecni klienci firmy Cigna Healthcare mogą dzwonić pod numer podany na odwrocie karty identyfikacyjnej. Wszystkie inne osoby prosimy o skorzystanie z numeru 1 800 244 6224 (TTY: wybierz 711).

Japanese – 注意事項：日本語を話される場合、無料の言語支援サービスをご利用いただけます。現在の Cigna Healthcareのお客様は、IDカード裏面の電話番号まで、お電話にてご連絡ください。その他の方は、1.800.244.6224（TTY: 711）まで、お電話にてご連絡ください。

Italian – ATTENZIONE: Sono disponibili servizi di assistenza linguistica gratuiti. Per i clienti Cigna Healthcare attuali, chiamare il numero sul retro della tessera di identificazione. In caso contrario, chiamare il numero 1.800.244.6224 (utenti TTY: chiamare il numero 711).

German – ACHTUNG: Die Leistungen der Sprachunterstützung stehen Ihnen kostenlos zur Verfügung. Wenn Sie gegenwärtiger Cigna Healthcare-Kunde sind, rufen Sie bitte die Nummer auf der Rückseite Ihrer Krankenversicherungskarte an. Andernfalls rufen Sie 1.800.244.6224 an (TTY: Wählen Sie 711).

Persian (Farsi) – توجه: خدمات کمک زبانی، به صورت رایگان به شما ارائه می شود. برای مشتریان فعلی Cigna Healthcare، لطفاً با شماره ای که در پشت کارت شناسایی شماست تماس بگیرید. در غیر اینصورت با شماره 1.800.244.6224 تماس بگیرید (شماره تلفن ویژه ناشنوایان: شماره 711 را شمار ه گیری کنید).

824707a 10/23

Cigna Dental Benefit Summary
School of Visual Arts LLC
Plan Renewal Date: 01/01/2024

Insured by: Cigna Health and Life Insurance Company

This material is for informational purposes only and is designed to highlight some of the benefits available under this plan. Consult the plan documents to determine specific terms of coverage relating to your plan. Terms include covered procedures, applicable waiting periods, exclusions and limitations. **Your DPPO plan allows you to see any licensed dentist, but using an in-network dentist may minimize your out-of-pocket expenses.**

Cigna Dental PPO				
Network Options	***In-Network:*** **Total Cigna DPPO Network**		***Non-Network:*** **See Non-Network Reimbursement**	
Reimbursement Levels	Based on Contracted Fees		Maximum Reimbursable Charge	
Calendar Year Benefits Maximum Applies to: Class I, II & III expenses	$2,500		$2,500	
Calendar Year Deductible Individual Family	$50 $150		$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 Emergency Care to Relieve Pain (Note: This service is administrated at the in network coinsurance level.)	100% No Deductible	No Charge	100% No Deductible	No Charge
Class II: Basic Restorative Restorative: fillings Oral Surgery: minor and major Repairs: bridges, crowns and inlays Repairs: dentures Denture Relines, Rebases and Adjustments Crowns: prefabricated stainless steel / resin Space Maintainers: non-orthodontic	90% After Deductible	10% After Deductible	80% After Deductible	20% After Deductible
Class III: Major Restorative Inlays and Onlays Prosthesis Over Implant Crowns: permanent cast and porcelain Bridges and Dentures Endodontics: minor and major Periodontics: minor and major Anesthesia: general and IV sedation	70% After Deductible	30% After Deductible	50% After Deductible	50% After Deductible
Class IV: Orthodontia Coverage for Employee and All Dependents Lifetime Benefits Maximum: $1,500	50% No Deductible	50% No Deductible	50% No Deductible	50% No Deductible
Class V: TMJ Occlusal orthotic device and adjustment Lifetime Benefits Maximum: $2,500	70% After Deductible	30% After Deductible	70% After Deductible	30% After Deductible
Benefit Plan Provisions:				
In-Network Reimbursement	For services provided by a Cigna Dental PPO network dentist, Cigna Dental will reimburse the dentist according to a Fee Schedule or Discount Schedule.			
Non-Network Reimbursement	For services provided by a non-network dentist, Cigna Dental will reimburse according to the Maximum Reimbursable Charge. The MRC is calculated at the 80th percentile of all provider submitted amounts in the geographic area. The dentist may balance bill up to their usual fees.			

Cross Accumulation	All deductibles, plan maximums, and service specific maximums cross accumulate between in and out of network. Benefit frequency limitations are based on the date of service and cross accumulate between in and out of network.
Calendar Year Benefits Maximum	The plan will only pay for covered charges up to the yearly Benefits Maximum, when applicable. Benefit-specific Maximums may also apply.
Calendar Year Deductible	This is the amount you must pay before the plan begins to pay for covered charges, when applicable. Benefit-specific deductibles may also apply.
Late Entrant Limitation Provision	Payment will be reduced by 50% for Class III, IV and V services for 12 months for eligible members that are allowed to enroll in this plan outside of the designated open enrollment period. This provision does not apply to new hires.
Pretreatment Review	Pretreatment review is available on a voluntary basis when dental work in excess of $200 is proposed.
Alternate Benefit Provision	When more than one covered Dental Service could provide suitable treatment based on common dental standards, Cigna will determine the covered Dental Service on which payment will be based and the expenses that will be included as Covered Expenses.
Oral Health Integration Program®	The Cigna Dental Oral Health Integration Program offers enhanced dental coverage for customers with certain medical conditions. There is no additional charge to participate in the program. Those who qualify can receive reimbursement of their coinsurance for eligible dental services. Eligible customers can also receive guidance on behavioral issues related to oral health. Reimbursements under this program are not subject to the annual deductible, but will be applied to the plan annual maximum. For more information on how to enroll in this program and a complete list of terms and eligible conditions, go to www.mycigna.com or call customer service 24/7 at 1-800-Cigna24.
Timely Filing	Out of network claims submitted to Cigna after 365 days from date of service will be denied.
Benefit Limitations:	
Missing Tooth Limitation	For teeth missing prior to coverage with Cigna, the amount payable is 50% of the amount otherwise payable until covered for 12 months; thereafter, considered a Class III expense.
Oral Evaluations/Exams	2 per calendar year.
X-rays (routine)	Bitewings: 2 per calendar year.
X-rays (non-routine)	Complete series of radiographic images and panoramic radiographic images: Limited to a combined total of 1 per 36 months.
Diagnostic Casts	Payable only in conjunction with orthodontic workup.
Cleanings	2 per calendar year, including periodontal maintenance procedures following active therapy.
Fluoride Application	1 per calendar year for children under age 19.
Sealants (per tooth)	Limited to posterior tooth. 1 treatment per tooth every 36 months for children under age 14.
Space Maintainers	Limited to non-orthodontic treatment for children under age 19.
Crowns, Bridges, Dentures and Partials	Replacement every 60 months if unserviceable and cannot be repaired. Benefits are based on the amount payable for non-precious metals. No porcelain or white/tooth-colored material on molar crowns or bridges.
Denture and Bridge Repairs	Reviewed if more than once.
Denture Relines, Rebases and Adjustments	Covered if more than 6 months after installation.
Prosthesis Over Implant	Replacement every 60 months if unserviceable and cannot be repaired. Benefits are based on the amount payable for non-precious metals. No porcelain or white/tooth-colored material on molar crowns or bridges.

Benefit Exclusions:
Covered Expenses will not include, and no payment will be made for the following:

- Procedures and services not included in the list of covered dental expenses;
- Diagnostic: cone beam imaging;
- Preventive Services: instruction for plaque control, oral hygiene and diet;
- Restorative: veneers of porcelain, ceramic, resin, or acrylic materials on crowns or pontics on or replacing the upper and or lower first, second and/or third molars;
- Periodontics: bite registrations; splinting;

- Prosthodontic: precision or semi-precision attachments;
- Implants: implants or implant related services;
- Procedures, appliances or restorations, except full dentures, whose main purpose is to change vertical dimension, stabilize periodontally involved teeth or restore occlusion;
- Athletic mouth guards;
- Services performed primarily for cosmetic reasons;
- Personalization or decoration of any dental device or dental work;
- Replacement of an appliance per benefit guidelines;
- Services that are deemed to be medical in nature;
- Services and supplies received from a hospital;
- Drugs: prescription drugs;
- Charges in excess of the Maximum Reimbursable Charge.

This document provides a summary only. It is not a contract. If there are any differences between this summary and the official plan documents, the terms of the official plan documents will prevail.

Product availability may vary by location and plan type and is subject to change. All group dental insurance policies and dental benefit plans contain exclusions and limitations. For costs and details of coverage, review your plan documents or contact a Cigna representative.

A copy of the NH Dental Outline of Coverage is available and can be downloaded at Health Insurance & Medical Forms for Customers | Cigna under Dental Forms.

All Cigna products and services are provided exclusively by or through operating subsidiaries of Cigna Corporation, including Cigna Health and Life Insurance Company (CHLIC), Connecticut General Life Insurance Company, and Cigna Dental Health, Inc.

Summary of Dental Benefits and Coverage Disclosure Matrix (SDBC)

Part I: GENERAL INFORMATION

Plan Name: Cigna Dental Health of California, Inc.
Type of Product Line: DHMO
Effective Date: Beginning on or after **01/01/2024**

Name of Product: Q3-00
Plan Phone #: 1-800-Cigna24
Plan Website: www.cigna.com

THIS MATRIX IS INTENDED TO BE USED TO HELP YOU COMPARE COVERAGE BENEFITS AND WHAT YOU WILL PAY FOR COVERED SERVICES. THIS IS A SUMMARY ONLY AND DOES NOT INCLUDE THE PREMIUM COSTS OF THIS DENTAL BENEFITS PACKAGE. PLEASE CONSULT YOUR EVIDENCE OF COVERAGE AND DENTAL CONTRACT FOR A DETAILED DESCRIPTION OF COVERAGE BENEFITS AND LIMITATIONS. FOR MORE INFORMATION ABOUT YOUR COVERAGE, VISIT THE PLAN WEBSITE www.cigna.com **OR CALL** 1-800-Cigna24.

THIS MATRIX IS NOT A GUARANTEE OF EXPENSES OR PAYMENT.

Part II: DEDUCTIBLES

Deductible	In-Network	Out-of-Network
Dental	None	None
Orthodontia	None	None

- **There is no deductible.**
- A **deductible** is the amount you are required to pay for covered dental services each plan year before the plan begins to pay for the cost of covered dental treatment.
- **In-network services** are dental care services provided by dentists or other licensed dental care providers that contract with your plan to provide dental services.
- **Out-of-network services** are dental care services provided by dentists or other licensed dental care providers that are not contracted with your plan.

Part III: MAXIMUMS PLAN WILL PAY

Maximums	In-Network	Out-of-Network
Annual Maximum	Not applicable	Not applicable
Lifetime and Annual Maximum for Orthodontia	Not applicable	Not applicable

- **Annual maximum** is the maximum dollar amount your plan will pay toward the cost of dental care within a specific period of time, usually a consecutive 12-month or calendar year period. Not all services accrue to the annual maximum.
- **Lifetime maximum** means the maximum dollar amount your plan providing dental benefits will pay for the life of the enrollee. Lifetime maximums usually apply to specific services, such as orthodontic treatment.

Part IV: WAITING PERIODS

Waiting Periods: A waiting period is the amount of time that must pass before you are eligible to receive benefits or services for all or certain dental treatments. **Your dental benefit package has no waiting periods for covered services, once you are enrolled.**

Part V: WHAT YOU WILL PAY

All copayments and coinsurance costs shown in this chart apply after your deductible has been met, if a deductible applies. The Common Dental Procedures fit into one of the following applicable categories: Preventive & Diagnostic, Basic or Major. The Benefit Limitations and Exclusions column includes common limitations and exclusions only. For a full list, see the full disclosure document referenced in the Benefit Limitations and Exclusions column.

Common Dental Procedures	Category	In-Network	Out-of-Network	Benefit Limitations and Exclusions For complete coverage details, exclusions and limitations, please see your Patient Charge Schedule and your Plan Booklet.
Oral Exam	Preventive & Diagnostic	0%	Not Covered	Oral evaluations are limited to a combined total of 4 comprehensive or periodic evaluations during a 12 consecutive month period.
Bitewing X-ray	Preventive & Diagnostic	0%	Not Covered	Not applicable

Cleaning	Preventive & Diagnostic	0%	Not Covered	Limited to 2 per year; additional cleanings per year are available at the co-pay listed on your Patient Charge Schedule.
Filling	Basic	0%	Not Covered	Not applicable
Extraction, Erupted Tooth or Exposed Root	Basic	0%	Not Covered	Not applicable
Root Canal	Major	40%	Not Covered	Not applicable
Scaling and Root Planing	Basic	0%	Not Covered	Limited to 4 quadrants per consecutive 12 months
Ceramic Crown	Major	40%	Not Covered	Not applicable
Removable Partial Denture	Major	40%	Not Covered	Not applicable
Extraction, Erupted Tooth with Bone Removal	Basic	0%	Not Covered	Not applicable
Orthodontia	Orthodontia	40%	Not Covered	Co-pay reflects twenty-four (24) months of active child comprehensive treatment. Cases beyond 24 months require an additional payment by the patient.

Part VI: COVERAGE EXAMPLES

THESE EXAMPLES DO NOT REPRESENT A COST ESTIMATOR OR GUARANTEE OF PAYMENT. The examples provided represent commonly used services in the categories of Diagnostic and Preventive, Basic and Major Services for illustrative purposes and to compare this product to other dental products you may be considering. Your actual costs will likely be different from those shown in the chart below depending on the actual care you receive, the prices your providers charge and many other factors. Focus on the cost sharing amounts (deductibles, copayments and coinsurance) and the summary of excluded services under the plan.

Dana Has a Dental Appointment with a New Dentist	**Sam Needs a Tooth Filled**	**Maria Needs a Crown**
New patient exam, x-rays (full-mouth x-ray) and cleaning	Resin-based composite – one surface, posterior	Crown – porcelain/ceramic substrate

Dana's Visit	**Dana's Cost**	**Sam's Visit**	**Sam's Cost**	**Maria's Visit**	**Maria's Cost**
Total Cost of Care	In-network: $400 Out-of-network: $550	Total Cost of Care	In-network: $150 Out-of-network: $200	Total Cost of Care	In-network: $1,300 Out-of-network: $1,750
Deductible	In-network: Not applicable Out-of-network: Not Covered	Deductible	In-network: Not applicable Out-of-network: Not Covered	Deductible	In-network: Not applicable Out-of-network: Not Covered
Annual Maximum (Plan Will Pay	In-network: Not applicable Out-of-network: Not applicable	Annual Maximum (Plan Will Pay)	In-network: Not applicable Out-of-network: Not applicable	Annual Maximum (Plan Will Pay)	In-network: Not applicable Out-of-network: Not applicable

Dana's Visit	Dana's Cost	Sam's Visit	Sam's Cost	Maria's Visit	Maria's Cost
Patient Cost (copayment or coinsurance)	In-network: 0% Out-of-network: $550	Patient Cost (copayment or coinsurance)	In-network: 0% Out-of-network: $200	Patient Cost (copayment or coinsurance)	In-network: 40% Out-of-network: $1,750
In this example, Dana would pay (includes copays/coinsurance and deductible, if applicable):	**In-network:** $0 **Out-of-network:** $550	**In this example, Sam would pay (includes copays/coinsurance and deductible, if applicable):**	**In-network:** $0 **Out-of-network:** $200	**In this example, Maria would pay (includes copays/coinsurance and deductible, if applicable):**	**In-network:** $520 **Out-of-network:** $1,750

Summary of what is not covered or subject to a limitation:	Oral evaluations are limited to a combined total of 4 comprehensive or periodic evaluations during a 12 consecutive month period. A complete series of full mouth X-rays are limited to 1 every 3 years. Cleanings are limited to 2 per year; additional cleanings per year are available at the co-pay listed on your Patient Charge Schedule.	Summary of what is not covered or subject to a limitation:	Not Applicable	Summary of what is not covered or subject to a limitation:	Not Applicable

DISCRIMINATION IS AGAINST THE LAW.

Dental coverage

Cigna Healthcare complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Cigna Healthcare does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

Cigna Healthcare:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, contact customer service at the toll-free number shown on your ID card, and ask a Customer Service Associate for assistance.

If you believe that Cigna Healthcare has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance by sending an email to **ACAGrievance@Cigna.com** or by writing to the following address:

Cigna Healthcare
Nondiscrimination Complaint Coordinator
P.O. Box 188016
Chattanooga, TN 37422

If you need assistance filing a written grievance, please call the number on the back of your ID card or send an email to **ACAGrievance@Cigna.com**.
You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at **https://ocrportal.hhs.gov/ocr/portal/lobby.jsf**, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, DC 20201
1.800.368.1019, 800.537.7697 (TDD)

Complaint forms are available at
http://www.hhs.gov/ocr/office/file/index.html

Your VSP Vision Benefits Summary

SCHOOL OF VISUAL ARTS LLC and VSP provide you with an affordable vision plan.

PROVIDER NETWORK:
VSP Signature
EFFECTIVE DATE:
01/01/2024

vsp vision care

BENEFIT	DESCRIPTION	COPAY	FREQUENCY
Your Coverage with a VSP Provider			
WELLVISION EXAM	• Focuses on your eyes and overall wellness • Routine retinal screening	$10 Up to $39	Every calendar year
ESSENTIAL MEDICAL EYE CARE	• Retinal imaging for members with diabetes covered-in-full • Additional exams and services beyond routine care to treat immediate issues from pink eye to sudden changes in vision or to monitor ongoing conditions such as dry eye, diabetic eye disease, glaucoma, and more. • Coordination with your medical coverage may apply. Ask your VSP network doctor for details.	$20 per exam	Available as needed
PRESCRIPTION GLASSES		**$25**	See frame and lenses
FRAME†	• $170 Featured Frame Brands allowance • $150 frame allowance • 20% savings on the amount over your allowance • $150 Walmart/Sam's Club frame allowance • $80 Costco frame allowance	Included in Prescription Glasses	Every calendar year
LENSES	• Single vision, lined bifocal, and lined trifocal lenses • Impact-resistant lenses for dependent children	Included in Prescription Glasses	Every calendar year
LENS ENHANCEMENTS	• Standard progressive lenses • Premium progressive lenses • Custom progressive lenses • Average savings of 40% on other lens enhancements	$0 $80 - $90 $120 - $160	Every calendar year
CONTACTS (INSTEAD OF GLASSES)	• $150 allowance for contacts; copay does not apply • Contact lens exam (fitting and evaluation)	Up to $60	Every calendar year
ADDITIONAL SAVINGS	**Glasses and Sunglasses** • Extra $20 to spend on Featured Frame Brands. Go to **vsp.com/offers** for details. • 30% savings on unlimited additional pairs of prescription or non-prescription glasses/sunglasses, including lens enhancements, from the same VSP provider on the same day as your WellVision Exam. Or get 20% savings from a VSP provider within 12 months of your last WellVision Exam.		
	Laser Vision Correction • Average of 15% off the regular price; discounts available at contracted facilities. • After surgery, use your frame allowance (if eligible) for sunglasses from any VSP doctor		
	Exclusive Member Extras for VSP Members • Contact lens rebates, lens satisfaction guarantees, and more offers at **vsp.com/offers**. • Save up to 60% on digital hearing aids with TruHearing®. Visit **vsp.com/offers**/special-offers/hearing-aids for details. • Enjoy everyday savings on health, wellness, and more with VSP Simple Values.		

YOUR COVERAGE GOES FURTHER IN-NETWORK

With so many in-network choices, VSP makes it easy to get the most out of your benefits. You'll have access to preferred private practice, retail, and online in-network choices. Log in to **vsp.com** to find an in-network provider.

†Only available to VSP members with applicable plan benefits. Frame brands and promotions are subject to change.
‡Savings based on doctor's retail price and vary by plan and purchase selection; average savings determined after benefits are applied. Ask your VSP network doctor for more details.
+Coverage with a retail chain may be different or not apply.

VSP guarantees member satisfaction from VSP providers only. Coverage information is subject to change. In the event of a conflict between this information and your organization's contract with VSP, the terms of the contract will prevail. Based on applicable laws, benefits may vary by location. In the state of Washington, VSP Vision Care, Inc., is the legal name of the corporation through which VSP does business. TruHearing is not available directly from VSP in the states of California and Washington. Premier Edge is not available for some members in the state of Texas.

To learn about your privacy rights and how your protected health information may be used, see the VSP Notice of Privacy Practices on **vsp.com**.

Classification: Restricted

A Look at Your VSP Vision Coverage

With VSP and SCHOOL OF VISUAL ARTS LLC, your health comes first.

As a member, you'll get access to savings and personalized vision care from a VSP network doctor for you and your family.

vsp vision care

Value and savings you love.

Save on eyewear and eye care when you see a VSP network doctor. Plus, take advantage of Exclusive Member Extras which provide offers from VSP and leading industry brands totaling over $3,000 in savings.

Provider choices you want.

vsp PREMIER edge

With thousands of choices, getting the most out of your benefits is easy at a VSP Premier Edge™ location.

Shop online and connect your benefits.

eyeconic a vsp vision company

Eyeconic® is the preferred VSP online retailer where you can shop in-network with your vision benefits. See your savings in real time when you shop over 70 brands of contacts, eyeglasses, and sunglasses.

Quality vision care you need.

You'll get great care from a VSP network doctor, including a WellVision Exam®. An annual eye exam not only helps you see well, but helps a doctor detect signs of eye conditions and health conditions, like diabetes and high blood pressure.

Using your benefit is easy!

Create an account on **vsp.com** to view your in-network coverage, find the VSP network doctor who's right for you, and discover savings with exclusive member extras. At your appointment, just tell them you have VSP.

More Ways to Save

Extra

$20

to spend on Featured Frame Brands†

bebe · Calvin Klein · COLE HAAN · DRAGON · FLEXON · LONGCHAMP PARIS · and more

See all brands and offers at **vsp.com/offers**.

+

Up to

40%

Savings on lens enhancements‡

Create an account today.

Contact us: **800.877.7195** or **vsp.com**

Useful Phone Numbers and Websites

HUMAN RESOURCES DEPARTMENT/BENEFITS	hrbenefits@sva.edu
CIGNA HEALTH CARE & DENTAL CUSTOMER SERVICE	1.800.244.6224 www.cigna.com
EXPRESS SCRIPTS HOME DELIVERY PHARMACY	1.800.334.8134 www.Express-Scripts.com
CIGNA 24-HOUR HEALTH INFO LINE	1.800.564.8982
CIGNA FSA CLAIMS	1.800.244.6224 www.myCigna.com
CIGNA HSA BANK	1.800.357.6246
HEALTHEQUITY/WAGEWORKS (TRANSITCHEK) ENROLLMENT & CUSTOMER SERVICE CENTER	1.877.924.3967 www.healthequity.com/wageworks
DOMESTIC PARTNER REGISTRATION	New York: www.cityclerk.nyc.gov New Jersey: www.state.nj.us/health/vital/marriage_apply.shtml
NY GROUP LIFE GROUP BENEFIT SOLUTIONS (VOLUNTARY SHORT-TERM DISABILITY)	1.800.36.CIGNA www.mynylgbs.com
NY LIFE GROUP BENEFIT SOLUTIONS (NYS DISABILITY)	1.800.362.4462 www.mynylgbs.com
VSP VISION PLAN	1.800.877.7195 www.vsp.com

Glossary

Active, Full-Time Employee
An SVA employee who works a minimum of 35 hours per week on a continuous basis.

Active, Part-Time Employee
An SVA employee who works a minimum of 20 hours per week on a continuous basis.

Beneficiary
A person designated by a participant, or by the terms of an employee benefit plan, to receive benefits under a health benefits plan.

Benefit Year
An SVA benefit year runs January 1 through December 31.

Benefits
The portion of the costs of covered services paid by a health plan. For example, if a plan pays the remainder of a doctor's bill after an office visit co-payment has been made, the amount the plan pays is the "benefit." Or, if the plan pays 80% of the reasonable and customary cost of covered services, that 80% payment is the "benefit."

Benefits Package
A compilation of benefits options offered by an employer.

Brand Name Drug
A drug manufactured by a pharmaceutical company which has chosen to patent the drug's formula and register its brand name.

Cigna
Connecticut General Insurance Company of North America.

Cigna Home Delivery Pharmacy
The Cigna mail-order prescription service that dispenses medications to covered persons for up to a 90-day supply.

Co-insurance
The portion of eligible expenses that plan members are responsible for paying, most often after the deductible is met.

Coordination of Benefits
A provision that applies when a person is covered under more than one group health benefit plan. It requires that payment of benefits be coordinated by all plans to eliminate over-insurance or duplication of benefits.

Co-payment or Co-pay
Amount that a plan member must pay the provider at the time of service.

Covered Services
Hospital, medical and other health care services incurred by the enrollee that are entitled to a payment of benefits under a health benefit contract.

Deductible
The dollar amount that a plan member must pay for eligible health expenses before a traditional health plan will begin reimbursement of eligible claims.

Dependent
A person eligible for coverage under an employee benefits plan based on their relationship to the employee. Examples: spouses, children, adopted children and domestic partners.

Explanation of Benefits (EOB)
A statement provided by a health care administrator that explains the benefits provided, the allowable reimbursement amounts, any deductibles, co-insurance or other adjustments taken and the net amount paid.

Flexible Spending Account (FSA)
An account that reimburses the participant for qualified health costs or dependent care expenses through one pre-tax savings account. At the end of the plan year, unused dollars are forfeited by the account holder.

Generic Drug
A prescription drug that has the same active ingredient formula as a brand name drug.

Group Health Coverage
A health benefit plan that covers a group of people as permitted by state and federal law.

High Deductible Health Plan (HDHP)
The High Deductible Health Plan (HDHP) is an alternative option that allows employees to contribute to a special, tax-advantaged Health Savings Account (HSA) that can be used to pay for qualified medical expenses.

In-Network Provider
Any health care provider (physician, hospital, etc.) that belongs to a health plan's contracted network. Staying in-network gives members the advantage of significant discounts.

Maintenance Medication
Medications that are prescribed for long-term treatment of chronic conditions such as diabetes, high blood pressure or asthma. At SVA, maintenance medications are available through Tel-Drug Rx, Cigna's mail-order service, for up to a 90-supply and at participating network retail pharmacies for up to a 30-day supply.

Mental/Nervous (Behavioral Care)
Assessment and therapeutic services used in the treatment of mental health and substance abuse problems.

Open Enrollment
A period when eligible employees and dependents can enroll in, or make changes in, a health benefits plan.

Out-of-Network Provider
Any health care provider that does not belong to a health plan's contracted network.

Out-of-Pocket
Co-payments, deductibles, or fees paid by participants for health services.

Out-of-Pocket Maximum
The most a plan member will pay per year for reasonable and customary health expenses before the plan pays 100% of covered health expenses for the rest of that year.

Participating Provider
A physician, hospital, pharmacy, laboratory, or other appropriately licensed facility or provider of health services or supplies that has entered into an agreement with a health plan to provide services or supplies to a patient enrolled in a health benefit plan.

Pre-Existing Condition
A health condition (other than a pregnancy) or medical problem that was diagnosed or treated before enrollment into a health plan.

Open Access Plus (OAP)
A specific type of health plan with a contracted network of physicians. Within SVA's OAP plans, members can visit physicians both in and out of the network (an annual deductible and out-of-pocket maximum applies to out-of-network visits), and can visit specialists without a referral. Members do not need to choose a primary physician for coverage.

Provider Directory
Listings of providers who have contracted with a health plan to provide care to its participants. You can search Cigna's provider directory at www.cigna.com.

Reasonable and Customary (R&C)
The maximum fee that a health plan will reimburse an out-of-network provider for a given service.