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, or www.equityleague.org. 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 Cigna at 1-800-Cigna24 and/or ProAct at 1-833-636-1400 to request a copy.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	For in-network providers **$0** person/**$0** family. For out-of-network providers **$350** person/**$700** family. Co-payments don't apply toward satisfying the deductible.	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, emergency room visits, urgent care facility visits are covered before you meet your deductible.	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply.
Are there other deductibles for specific services?	Yes, **$100**/individual or **$200**/family for prescription drugs – this deductible does not apply to generic prescription drugs; $**50**/individual for out-of-network Home health care services. There are no other specific deductibles.	You must pay all of the costs for these services up to the specific deductible amount before this plan begins to pay for these services.
What is the out-of-pocket limit for this plan?	For in-network providers **$0**/individual or **$0**/family. For out-of-network providers **$5,000**/individual or **$10,000**/family. For in-network prescription drugs - **$4,000**/individual; For out-of-network prescription drugs - **$4,000**/ individual.	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?	Deductibles, 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 for medical care. However, there is a separate out-of-pocket-limit for prescription drugs that is described on page three of this summary.
Will you pay less if you use a network provider?	Yes. See **www.myCigna.com or call 1-800-Cigna24** for a list of Cigna 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 I need a referral to see a specialist?	No. You don't need a referral to see a specialist.	You can see the specialist you choose without permission from this plan.

Questions: To learn about the Health Fund's medical, prescription, vision or separate dental benefits, you can also call the Fund Office at 212.869.9380 or www.equityleague.org.

All **co-payments** 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 with an In-Network Provider (You will pay the least)	What You Will Pay with an Out-of-Network Provider (You will pay the most)	Limitations, Exceptions, & Other Important Information
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$25 co-payment/visit	30% co-insurance	None
	Specialist visit	$25 co-payment/visit	30% co-insurance	None
	Other practitioner office visit	$15 co-payment/visit for a chiropractor/acupuncturist	30% co-insurance	None
	Preventive care/screening Immunization	$25 co-payment/visit No charge for immunizations	30% co-insurance	You may have to pay for services that aren't preventive. Ask your provider if the services you need are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	No charge	30% co-insurance	None
	Imaging (CT/PET scans, MRIs)	No charge	30% co-insurance	Precertification is required. In the event no precertification is done, treatment for these services may be denied and/or not covered at all.
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at https://secure.proactrx.com/ or www.equityleague.org or call 1-833-636-1400.	Generic drugs (Tier 1)	20% co-insurance but not less than $10 co-payment/ prescription (retail), $20 co-payment/prescription (home delivery or 90 day retail pharmacy locations)	30% co-insurance	Prescription drugs are reimbursed at **0%** co-insurance after you have reached the **$4,000** annual out-of-pocket maximum for drugs. Coverage is limited up to a 30 day supply (retail) and up to a 90 day supply (home delivery and 90 day retail pharmacy locations).
	Preferred brand drugs (Tier 2)*	25% co-insurance but not less than $20/prescription (retail), $40 co-payment/ prescription (home delivery or 90 day retail pharmacy locations)	30% co-insurance	Prescription drugs are reimbursed at **0%** co-insurance after you have reached the **$4,000** annual out-of-pocket maximum for drugs. Coverage is limited up to a 30 day supply (retail) and up to a 90 day supply (home delivery and 90 day retail pharmacy locations).
	Non-preferred brand drugs (Tier 3)*	30% co-insurance but not less than $25 co-payment/ prescription (retail), $50 co-payment/prescription (home delivery or 90 day retail pharmacy locations)	30% co-insurance	Prescription drugs are reimbursed at **0%** co-insurance after you have reached the **$4,000** annual out-of-pocket maximum for drugs. Coverage is limited up to a 30 day supply (retail) and up to a 90 day supply (home delivery and 90 day retail pharmacy locations)
	*Specialty drugs – Any Preferred or Non-Preferred Brand Name drug that is classified as a specialty medication in Tiers 2 and 3.	25% co-insurance	30% co-insurance	Prescription drugs are reimbursed at **0%** co-insurance after you have reached the **$4,000** annual out-of-pocket maximum for drugs. Coverage is limited up to a 30 day supply (retail) and up to a 90 day supply (home delivery and 90 day retail pharmacy locations)

Common Medical Event	Services You May Need	What You Will Pay with an In-Network Provider (You will pay the least)	What You Will Pay with an Out-of-Network Provider (You will pay the most)	Limitations, Exceptions, & Other Important Information
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	No charge	30% co-insurance	Precertification is required. In the event no precertification is done, treatment for these services may be denied and/or not covered at all.
	Physician/surgeon fees	No charge	30% co-insurance	Precertification is required. In the event no precertification is done, treatment for these services may be denied and/or not covered at all.
If you need immediate medical attention	Emergency room care	$50 co-payment/visit	$50 co-payment/visit; 30% co-insurance	Per visit co-payment is waived if admitted
	Emergency medical transportation	No charge	No charge	None
	Urgent care	No charge	No charge	None
If you have a hospital stay	Facility fee (e.g., hospital room)	No charge	30% coinsurance	$250 co-payment penalty for not precertifying a non-emergency inpatient admission to a health care facility (e.g., hospital, mental health/substance abuse facility)
	Physician/surgeon fee	No charge	30% coinsurance	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$25 co-payment per visit No charge/all other services	30% coinsurance/office visit 30% coinsurance/all other services	None
	Inpatient services	No charge/admission	30% coinsurance	$250 co-payment penalty for not pre-certifying a non-emergency inpatient admission to a facility.

Common Medical Event	Services You May Need	What You Will Pay with an In-Network Provider (You will pay the least)	What You Will Pay with an Out-of-Network Provider (You will pay the most)	Limitations, Exceptions, & Other Important Information
If you are pregnant	*Office visits	No charge	30% coinsurance	*Primary Care or Specialist benefit levels apply for initial visit to confirm pregnancy. 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). $250 co-payment penalty for not pre-certifying a non-emergency inpatient admission to a facility.
	Childbirth/delivery professional services	No charge	30% coinsurance	
	Childbirth/delivery facility services	No charge	30% co-insurance	
If you need help recovering or have other special health needs	Home health care	No charge	25% co-insurance after $50 home health care deductible	Coverage is limited to 200 days annual max. 16 hour maximum per day.
	Rehabilitation services	$15 co-payment/visit for Physical Therapy, $25 co-payment per visit for all other Rehabilitation Services	30% co-insurance	Coverage for Rehabilitation, including Cardiac Rehabilitation, and Physical Therapy services is limited to 60 days annual maximum. Separate per day maximums apply for certain procedures.
	Habilitation services	Not covered	Not covered	None
	Skilled nursing care	No charge	30% co-insurance	Coverage is limited to 60 days annual max
	Durable medical equipment	No charge	30% co-insurance	None
	Hospice services	No charge	30% co-insurance	None
If your child needs dental or eye care	Children's s eye exams and glasses	Eye exams once every 12 months and eyeglasses with select frames once every 24 months.	Same benefits as in-network up to an amount comparable to what is paid to in-network providers	There is a $25 copay for covered contact lenses at in-network providers. Out-of-network medically necessary contacts are reimbursed up to $225.
	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.)		
• Cosmetic surgery • Dental care (Adult and Children)* • Habilitation services	• Hearing aids • Long term care • 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.)		
• Acupuncture • Bariatric surgery	• Chiropractic care • Infertility treatment	• Private duty nursing (outpatient) • Routine eye care (Adult and Children)

***** Dental care can be covered under an optional, separate dental plan, a description of which is available at www.equityleague.org, or by calling 212-869-9380.

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 to submit a claim, appeal, or a grievance for any reason to your plan. For questions about your rights, this notice, or assistance, you can 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 the program for this plan's situs state: Department of Financial Services at (800) 342-3736. However, for information regarding your own state's consumer assistance program refer to www.healthcare.gov.

Does this plan provide Minimum Essential Coverage? **Yes**

If you don't have Minimum Essential Coverage for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

Does this plan meet the Minimum Value Standard? **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 page.

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** **$0**
- **Specialist copayment** **$25**
- **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	**$12,800**

In this example, Peg would pay:

Cost Sharing	
Deductibles*	$20
Copayments	$30
Coinsurance	$0
What isn't covered	
Limits or exclusions	$10
The total Peg would pay is	**$60**

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

- **The plan's overall deductible** **$0**
- **Specialist copayment** **$25**
- **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	**$7,400**

In this example, Joe would pay:

Cost Sharing	
Deductibles*	$100
Copayments	$900
Coinsurance	$0
What isn't covered	
Limits or exclusions	$200
The total Joe would pay is	**$1,200**

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

- **The plan's overall deductible** **$0**
- **Specialist copayment** **$25**
- **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	**$1,900**

In this example, Mia would pay

Cost Sharing	
Deductibles	$0
Copayments	$200
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$200**

*Note: This plan has other deductibles for specific services included in this coverage example. See "Are there other deductibles for specific services?" row above. The plan would be responsible for the other costs of covered services in this EXAMPLE.

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