




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.equityleague.org. You can also call Equity-League at 1-212-869-9380 or 1-800-344-5220. 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 www.dol.gov/ebsa/healthreform or call Cigna at 1-800-Cigna24 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	<u>In-network providers</u> : \$0 person/\$0 family. <u>Out-of-network providers</u> : \$500/ person or \$1,000/family.	<u>In-Network</u> : See the Common Medical Events chart below for your costs for services this plan covers. <u>Out-of-Network</u> : Generally, you must pay all of the costs from <u>providers</u> 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?	<u>In-network providers</u> : Not applicable. <u>Out-of-network providers</u> : Yes. <u>Urgent care</u> visits, are covered before you meet your deductible.	<u>In-Network</u> : This plan does not have a deductible for <u>In-Network</u> services. <u>Out-of-Network</u> : This plan covers some items and services even if you haven't yet met the deductible amount. But a <u>copayment</u> or <u>coinsurance</u> may apply. For example, this plan covers certain <u>preventive services</u> without <u>cost sharing</u> 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?	Yes, \$100/individual or \$200/family for <u>prescription drugs</u> – this deductible does not apply to generic <u>prescription drugs</u> ; \$50/individual for <u>out-of-network home health care</u> 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?	<u>In-network providers</u> : \$4,550/individual or \$9,100/family. <u>Out-of-network providers</u> : \$7,000/individual or \$14,000/family. <u>Prescription drugs</u> : \$4,000/individual or \$8,000/family.	<u>In-Network</u> : This medical plan does not have an <u>out-of-pocket limit</u> on your <u>In-Network</u> expenses. <u>Out-of-Network</u> : The <u>out-of-pocket limit</u> is the most you could pay in a year for covered services. If you have other family members in this medical plan, they have to meet their own <u>out-of-pocket limits</u> until the overall family <u>out-of-pocket limit</u> has been met.
What is not included in the out-of-pocket limit?	<u>Deductibles</u> , penalties for failure to obtain <u>preauthorization</u> for services, <u>premiums</u> , <u>balance-billing</u> charges and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the <u>out-of-pocket limit</u> for medical care.

Will you pay less if you use a <u>network provider</u>?	Yes. See www.myCigna.com or call 1-800-Cigna24 for a list of Cigna <u>network providers</u> .	This <u>plan</u> uses a <u>provider network</u> . You will pay less if you use a <u>provider</u> in the <u>plan's network</u> . You will pay the most if you use an <u>out-of-network provider</u> , and you might receive a bill from a <u>provider</u> for the difference between the <u>provider's charge</u> and what your <u>plan</u> pays (<u>balance billing</u>). Be aware your <u>network provider</u> might use an <u>out-of-network provider</u> for some services (such as lab work). Check with your <u>provider</u> before you get services.
Do you need a <u>referral</u> to see a <u>specialist</u>?	No.	You can see the <u>specialist</u> 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
		<u>Network Provider</u> (You will pay the least)	<u>Out-of-Network Provider</u> (You will pay the most)	
If you visit a health care <u>provider's</u> office or clinic	Primary care visit to treat an injury or illness	\$35 <u>co-payment</u> /visit; Cigna Telehealth Connection Services: No charge	30% <u>co-insurance</u>	None
	<u>Specialist</u> visit	\$35 <u>co-payment</u> /visit; \$20 <u>co-payment</u> /visit for a chiropractor/acupuncturist	30% <u>co-insurance</u>	None
	<u>Preventive care/screening/immunization</u>	No charge	30% <u>co-insurance</u>	Age and frequency limits may apply. You may have to pay for services that aren't preventive. Ask your <u>provider</u> if the services you need are preventive. Then check what your <u>plan</u> will pay for.
If you have a test	<u>Diagnostic test</u> (x-ray, blood work)	No charge	30% <u>co-insurance</u>	None
	Imaging (CT/PET scans, MRIs)	No charge	30% <u>co-insurance</u>	Failure to <u>pre-certify</u> may result in denial of benefits and you may be required to pay 100% of the cost.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		<u>Network Provider</u> (You will pay the least)	<u>Out-of-Network Provider</u> (You will pay the most)	
<p>If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.equityleague.org or call 1-212-869-9380/1-800-344-5220.</p>	Generic drugs (Tier 1)	20% <u>co-insurance</u> but not less than \$10 <u>co-payment</u> /prescription/retail or \$20 <u>co-payment</u> /prescription/home delivery or 90-day retail pharmacy locations	30% <u>co-insurance</u>	Separate <u>prescription drug deductible</u> and <u>out-of-pocket limits</u> apply. If the overall cost of a drug is less than the minimum <u>copay</u> required, then only the actual cost of the drug will be charged.
	Preferred brand drugs (Tier 2) *	25% <u>co-insurance</u> but not less than \$20 <u>co-payment</u> /prescription/retail or \$40 <u>co-payment</u> /prescription/home delivery or 90-day retail pharmacy locations	30% <u>co-insurance</u>	No charge for ACA-required generic preventive medications or preferred drugs when a generic is not yet available (or brand/non-preferred drug if generic/preferred drug is not medically appropriate). Generic HIV pre-exposure prophylaxis (PrEP) drugs are covered under this provision with no charge.
	Non-preferred brand drugs (Tier 3) *	30% <u>co-insurance</u> but not less than \$25 <u>co-payment</u> /prescription/retail or \$50 <u>co-payment</u> /prescription/home delivery or 90-day retail pharmacy locations	30% <u>co-insurance</u>	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). Only generic drugs are covered for treatment of high blood pressure, high cholesterol, acid reflux, and/or certain drugs for eczema and psoriasis, sleep disorders, and allergies (nasal sprays), unless your physician has obtained an exception to the generic requirement. Use of Home Delivery or 90-Day retail locations is required after your first refill of a new prescription of a 30-day supply at a retail pharmacy for maintenance drugs (medications taken on a regular basis for chronic conditions).
	* <u>Specialty drugs</u> – Any Preferred or Non-Preferred Brand Name drug that is classified as a specialty medication in Tiers 2 and 3	25% <u>co-insurance</u>	30% <u>co-insurance</u>	

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		<u>Network Provider</u> (You will pay the least)	<u>Out-of-Network Provider</u> (You will pay the most)	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	No charge	30% <u>co-insurance</u>	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% <u>co-insurance</u>	
If you need immediate medical attention	<u>Emergency room care</u>	\$70 <u>co-payment</u> /visit	\$70 <u>co-payment</u> /visit	Per visit <u>co-payment</u> is waived if admitted. Professional/physician charges may be billed separately.
	<u>Emergency medical transportation</u>	No charge	30% co-insurance	Non-emergency transport (e.g., transports from hospital back home) are not covered.
	<u>Urgent care</u>	No charge	No charge; <u>deductible</u> does not apply to facility visits	None
If you have a hospital stay	Facility fee (e.g., hospital room)	No charge	30% <u>coinsurance</u>	\$250 <u>co-payment</u> penalty for not precertifying a non-emergency inpatient admission to a health care facility (e.g., hospital, mental health/substance abuse facility).
	Physician/surgeon fees	No charge	30% <u>coinsurance</u>	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	\$35 <u>co-payment</u> per office visit; No charge/all other services	30% <u>coinsurance</u>	None
	Inpatient services	No charge	30% <u>coinsurance</u>	\$250 <u>co-payment</u> penalty for not pre-certifying a non-emergency inpatient admission to a facility.
If you are pregnant	Office visits	No charge	30% <u>coinsurance</u>	\$35 <u>In-Network co-payment</u> applies to initial visit to confirm pregnancy. Depending on the type of services, a <u>copayment</u> , <u>coinsurance</u> or <u>deductible</u> may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e., ultrasound).
	Childbirth/delivery professional services	No charge	30% <u>coinsurance</u>	
	Childbirth/delivery facility services	No charge	30% <u>co-insurance</u>	

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		<u>Network Provider</u> (You will pay the least)	<u>Out-of-Network Provider</u> (You will pay the most)	
If you need help recovering or have other special health needs	<u>Home health care</u>	No charge	25% <u>co-insurance</u> after \$50 <u>home health care deductible</u>	Coverage is limited to 200 days annual max; 16-hour maximum per day.
	<u>Rehabilitation services</u>	Inpatient: No charge Outpatient: \$20 <u>co-payment</u> /visit for Physical Therapy, \$35 <u>co-payment</u> per visit for all other Rehabilitation Services	30% <u>co-insurance</u>	Coverage for Rehabilitation, including Cardiac Rehabilitation, Occupational, Speech, and Physical Therapy services are limited to 60 days annual maximum for both inpatient and outpatient treatment. Separate per-day maximums may apply for certain medical procedures. Does not apply for mental health or substance use disorder.
	<u>Habilitation services</u>	Not covered	Not covered	You must pay 100% of this service, even <u>in-network</u> .
	<u>Skilled nursing care</u>	Inpatient: No charge	Inpatient: 30% <u>co-insurance</u>	Coverage is limited to 60 days annual maximum.
	<u>Durable medical equipment</u>	No charge	30% <u>co-insurance</u>	None
	<u>Hospice services</u>	No charge	30% <u>co-insurance</u>	None
If your child needs dental or eye care	Children's eye exam	No charge; deductible does not apply.	Amounts above amount payable to <u>in-network providers</u>	Vision benefits are separately administered by Davis Vision. Eye exams once every 12 months and eyeglasses with select frames once every 24 months. \$25 <u>co-payment</u> for covered contact lenses at <u>in-network providers</u> . Amounts exceeding \$115 for contact lenses outside of the collection within an <u>in-network provider</u> office. <u>Out-of-network medically necessary</u> contacts are reimbursed up to \$225.
	Children's glasses	No charge; deductible does not apply if chosen within the frame collection. Amounts exceeding \$100 for frames outside of the frame collection within an <u>in-network provider</u> office.	Amounts above amount payable for <u>in-network</u> covered services – glasses and contacts	
	Children's dental check-up	Not covered	Not covered	You must pay 100% of this service, even <u>in-network</u> . Dental care can be covered under an optional, separate dental <u>plan</u> , a description of which is available at www.equityleague.org , or by calling 212-869-9380 or 800-344-5220.

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) (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.or 800-344-5220)
- Habilitation services
- Hearing aids
- Long term care
- Non-emergency care when traveling outside the U.S.
- Routine foot care
- Weight loss programs (except for ACA-required preventive services)

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)

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 questions about your rights, this notice, or assistance, you can contact Cigna Customer service at 1-800-Cigna24 for medical/hospital benefits and Optum RX Customer service at 1-800-797-9791 for pharmacy benefits. 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**

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, kwijigo 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 \$0
- Specialist copayment \$35
- 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
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In this example, Peg would pay:

<u>Cost Sharing</u>	
Deductibles*	\$10
Copayments	\$0
Coinsurance	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$60
The total Peg would pay is	\$70

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 \$35
- 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
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In this example, Joe would pay:

<u>Cost Sharing</u>	
Deductibles*	\$100
Copayments	\$350
Coinsurance	\$900
<i>What isn't covered</i>	
Limits or exclusions	\$0
The total Joe would pay is	\$1,350

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

- The plan's overall deductible \$0
- Specialist copayment \$35
- 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
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In this example, Mia would pay:

<u>Cost Sharing</u>	
Deductibles*	\$10
Copayments	\$290
Coinsurance	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$0
The total Mia would pay is	\$300

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