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.healthcare.gov/sbc-glossary/ or call Cigna at 1-800-Cigna24 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	In-network providers: **$0** person/**$0** family. Out-of-network providers: **$500/** person **or $1,000**/family.	In-Network: See the Common Medical Events chart below for your costs for services this plan covers. Out-of-Network: 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?	In-network providers: Not applicable. Out-of-network providers: Yes. Urgent care visits are covered before you meet your deductible.	In-Network: This plan does not have a deductible for In-Network services. Out-of-Network: 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?	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?	In-network providers: **$4,550**/individual or **$9,100**/family. Out-of-network providers: **$7,000**/individual or **$14,000**/family. Prescription drugs: **$4,000**/individual or **$8,000**/family.	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 medical 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 preauthorization 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.

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 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
		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	$35 co-payment/visit; Cigna Telehealth Connection Services: No charge	30% co-insurance	None
	Specialist visit	$35 co-payment/visit; $20 co-payment/visit for a chiropractor/acupuncturist	30% co-insurance	None
	Preventive care/screening/ immunization	No charge	30% co-insurance	Age and frequency limits may apply. 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	Failure to pre-certify 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
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
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.	Generic drugs (Tier 1)	20% co-insurance but not less than $10 co-payment/ prescription/retail or $20 co-payment/prescription/home delivery or 90-day retail pharmacy locations	30% co-insurance	Separate prescription drug deductible and out-of-pocket limits apply. If the overall cost of a drug is less than the minimum copay required, then only the actual cost of the drug will be charged. 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. 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).
	Preferred brand drugs (Tier 2) *	25% co-insurance but not less than $20 co-payment/prescription/retail or $40 co-payment/ prescription/home delivery or 90-day retail pharmacy locations	30% co-insurance	
	Non-preferred brand drugs (Tier 3) *	30% co-insurance but not less than $25 co-payment/ prescription/retail or $50 co-payment/prescription/home delivery or 90-day retail pharmacy locations	30% co-insurance	
	*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	

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
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	
If you need immediate medical attention	Emergency room care	$70 co-payment/visit	$70 co-payment/visit	Per visit co-payment is waived if admitted. Professional/physician charges may be billed separately.
	Emergency medical transportation	No charge	30% co-insurance	Non-emergency transport (e.g., transports from hospital back home) are not covered.
	Urgent care	No charge	No charge; deductible does not apply to facility visits	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 fees	No charge	30% coinsurance	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$35 co-payment per office visit; No charge/all other services	30% coinsurance	None
	Inpatient services	No charge	30% coinsurance	$250 co-payment penalty for not pre-certifying a non-emergency inpatient admission to a facility.
If you are pregnant	Office visits	No charge	30% coinsurance	$35 In-Network co-payment applies to 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). Failure to obtain precertification for stays exceeding 48 hours for vaginal birth and 96 hours for C-section will result in a $250 co-payment penalty.
	Childbirth/delivery professional services	No charge	30% coinsurance	
	Childbirth/delivery facility services	No charge	30% co-insurance	

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
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	Inpatient: No charge Outpatient: $20 co-payment/visit for Physical Therapy, $35 co-payment per visit for all other Rehabilitation Services	30% co-insurance	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.
	Habilitation services	Not covered	Not covered	You must pay 100% of this service, even in-network.
	Skilled nursing care	Inpatient: No charge	Inpatient: 30% co-insurance	Coverage is limited to 60 days annual maximum.
	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 eye exam	No charge; deductible does not apply.	Amounts above amount payable to in-network providers	Vision benefits are separately administered by Davis Vision. Eye exams once every 12 months and eyeglasses with select frames once every 12 months. $25 co-payment for covered contact lenses at in-network providers. Amounts exceeding $115 for contact lenses outside of the collection within an in-network provider office. Out-of-network medically necessary 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 in-network provider office.	Amounts above amount payable for in-network covered services – glasses and contacts	
	Children's dental check-up	Not covered	Not covered	You must pay 100% of this service, even in-network. 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.

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 Child) (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.

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**

In this example, Peg would pay:

Cost Sharing	
Deductibles*	$10
Copayments	$0
Coinsurance	$0
What isn't covered	
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**

In this example, Joe would pay:

Cost Sharing	
Deductibles*	$100
Copayments	$350
Coinsurance	$900
What isn't covered	
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**

In this example, Mia would pay:

Cost Sharing	
Deductibles*	$10
Copayments	$290
Coinsurance	$0
What isn't covered	
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.