




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, see [www.gravie.com](http://www.gravie.com) or call 1-855-451-8365. 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/pdf/sbcuniformglossary.pdf](http://www.dol.gov/ebsa/pdf/sbcuniformglossary.pdf) or call 1-855-451-8365 to request a copy.

| Important Questions  | Answers   | Why This Matters:   |
|--|---|---|
| <p><b>What is the overall <a href="#">deductible</a>?</b></p>                                | <p>For <a href="#">network providers</a> \$500 individual / \$1,000 family; for <a href="#">out-of-network providers</a> \$10,000 individual / \$20,000 family</p>                  | <p>Generally, you must pay all of the costs from providers up to the <a href="#">deductible</a> amount before this <a href="#">plan</a> begins to pay. If you have other family members on the <a href="#">plan</a>, each family member must meet their own individual <a href="#">deductible</a> until the total amount of <a href="#">deductible</a> expenses paid by all family members meets the overall family <a href="#">deductible</a>.</p>   |
| <p><b>Are there services covered before you meet your <a href="#">deductible</a>?</b></p>    | <p>Yes. <a href="#">Preventive care</a> and primary care services are covered before you meet your <a href="#">deductible</a>.</p>  | <p>This <a href="#">plan</a> covers some items and services even if you haven't yet met the <a href="#">deductible</a> amount. But a <a href="#">copayment</a> or <a href="#">coinsurance</a> may apply. For example, this <a href="#">plan</a> covers certain <a href="#">preventive services</a> without <a href="#">cost-sharing</a> and before you meet your <a href="#">deductible</a>. See a list of covered <a href="#">preventive services</a> at <a href="https://www.healthcare.gov/coverage/preventive-care-benefits/">https://www.healthcare.gov/coverage/preventive-care-benefits/</a>.</p>  |
| <p><b>Are there other <a href="#">deductibles</a> for specific services?</b></p>             | <p>No.</p>  | <p>You don't have to meet deductibles for specific services.</p>  |
| <p><b>What is the <a href="#">out-of-pocket limit</a> for this <a href="#">plan</a>?</b></p> | <p>For <a href="#">network providers</a> \$1,500 individual / \$3,000 family; for <a href="#">out-of-network providers</a> Not Applicable.</p>                                      | <p>The <a href="#">out-of-pocket limit</a> is the most you could pay in a year for covered services. If you have other family members in this <a href="#">plan</a>, they have to meet their own <a href="#">out-of-pocket limits</a> until the overall family <a href="#">out-of-pocket limit</a> has been met. There is no <a href="#">out-of-pocket limit</a> for <a href="#">out-of-network providers</a>.</p>   |
| <p><b>What is not included in the <a href="#">out-of-pocket limit</a>?</b></p>               | <p><a href="#">Copayments</a> for certain services, <a href="#">premiums</a>, <a href="#">balance-billing</a> charges, and health care this <a href="#">plan</a> doesn't cover.</p> | <p>Even though you pay these expenses, they don't count toward the <a href="#">out-of-pocket limit</a>.</p>   |
| <p><b>Will you pay less if you use a <a href="#">network provider</a>?</b></p>               | <p>Yes. See <a href="http://www.cigna.com">www.cigna.com</a> for a list of <a href="#">network providers</a>.</p>   | <p>This <a href="#">plan</a> uses a provider <a href="#">network</a>. You will pay less if you use a <a href="#">provider</a> in the plan's <a href="#">network</a>. You will pay the most if you use an <a href="#">out-of-network provider</a>, and you might receive a bill from a <a href="#">provider</a> for the difference between the provider's charge and what your <a href="#">plan</a> pays (<a href="#">balance billing</a>). Be aware, your <a href="#">network provider</a> might use an <a href="#">out-of-network provider</a> for some services (such as lab work). Check with your <a href="#">provider</a> before you get services.</p> |
| <p><b>Do you need a <a href="#">referral</a> to see a <a href="#">specialist</a>?</b></p>    | <p>No.</p>  | <p>You can see the specialist you choose without a referral.</p>  |

 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<br>(You will pay the least)  | Out-of-Network Provider<br>(You will pay the most) |  |
| If you visit a health care <a href="#">provider's</a> office or clinic  | Primary care visit to treat an injury or illness       | \$25/Visit  | 50% <a href="#">coinsurance</a>                    | None   |
|   | <a href="#">Specialist</a> visit                       | \$25/Visit  | 50% <a href="#">coinsurance</a>                    | None   |
|   | <a href="#">Preventive care/screening/immunization</a> | No charge   | Not Covered  | You may have to pay for services that aren't <a href="#">preventive</a> . Ask your <a href="#">provider</a> if the services you need are preventive. Then check what your <a href="#">plan</a> will pay for. |
| If you have a test  | <a href="#">Diagnostic test</a> (x-ray, blood work)    | 10% <a href="#">coinsurance</a> after <a href="#">deductible</a>                        | 50% <a href="#">coinsurance</a>                    | <a href="#">Preauthorization</a> may be required   |
|   | Imaging (CT/PET scans, MRIs)                           | 10% <a href="#">coinsurance</a> after <a href="#">deductible</a>                        | 50% <a href="#">coinsurance</a>                    | <a href="#">Preauthorization</a> is required   |
| If you need drugs to treat your illness or condition<br>More information about <a href="#">prescription drug coverage</a> is available at <a href="tel:1-855-451-8365">1-855-451-8365</a> | Generic drugs (Tier 1)                                 | Retail: \$5/Prescription<br>Mail order: \$10/Prescription                               |  | Retail and mail order available up to 90-day supply  |
|   | Preferred brand drugs (Tier 2)                         | Retail: \$25/Prescription<br>Mail order: \$50/Prescription                              |  | Retail and mail order available up to 90-day supply  |
|   | Non-preferred brand drugs (Tier 3)                     | Retail and mail order: 50% <a href="#">coinsurance</a> after <a href="#">deductible</a> |  | Retail and mail order available up to 90-day supply  |
|   | <a href="#">Specialty drugs</a> (Tier 4)               | Retail and mail order: 10% <a href="#">coinsurance</a> after <a href="#">deductible</a> |  | Retail and mail order available up to 30-day supply  |
| If you have outpatient surgery  | Facility fee (e.g., ambulatory surgery center)         | 10% <a href="#">coinsurance</a> after <a href="#">deductible</a>                        | 50% <a href="#">coinsurance</a>                    | <a href="#">Preauthorization</a> is required   |
|   | Physician/surgeon fees                                 | 10% <a href="#">coinsurance</a> after <a href="#">deductible</a>                        | 50% <a href="#">coinsurance</a>                    | <a href="#">Preauthorization</a> is required for procedures performed outside of a physician's office  |
| If you need immediate medical attention   | <a href="#">Emergency room care</a>                    | 10% <a href="#">coinsurance</a> after <a href="#">deductible</a>                        | 50% <a href="#">coinsurance</a>                    | True emergency covered at in-network level   |
|   | <a href="#">Emergency medical transportation</a>       | 10% <a href="#">coinsurance</a> after <a href="#">deductible</a>                        | 50% <a href="#">coinsurance</a>                    | True emergency covered at in-network level   |
|   | <a href="#">Urgent care</a>                            | \$25/Visit  | 50% <a href="#">coinsurance</a>                    | None   |
| If you have a hospital stay   | Facility fee (e.g., hospital room)                     | 10% <a href="#">coinsurance</a> after <a href="#">deductible</a>                        | 50% <a href="#">coinsurance</a>                    | None   |
|   | Physician/surgeon fees                                 | 10% <a href="#">coinsurance</a> after <a href="#">deductible</a>                        | 50% <a href="#">coinsurance</a>                    | <a href="#">Preauthorization</a> is required   |

\* For more information about limitations and exceptions, see the plan or policy document at [www.gravie.com](http://www.gravie.com) or call 1-855-451-8365

| Common Medical Event  | Services You May Need                     | What You Will Pay  |  | Limitations, Exceptions, & Other Important Information   |
|---|---|--|--|--|
|   |   | Network Provider<br>(You will pay the least)                     | Out-of-Network Provider<br>(You will pay the most) |  |
| If you need mental health, behavioral health, or substance abuse services | Outpatient services                       | \$25/Visit   | 50% <a href="#">coinsurance</a>                    | <a href="#">Preauthorization</a> is required for Inpatient services  |
|   | Inpatient services                        | 10% <a href="#">coinsurance</a> after <a href="#">deductible</a> | 50% <a href="#">coinsurance</a>                    |  |
| If you are pregnant   | Office visits                             | No charge  | Not Covered  | <a href="#">Cost sharing</a> does not apply to certain <a href="#">preventive services</a> . Depending on the type of services, <a href="#">coinsurance</a> may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound). |
|   | Childbirth/delivery professional services | 10% <a href="#">coinsurance</a> after <a href="#">deductible</a> | 50% <a href="#">coinsurance</a>                    |  |
|   | Childbirth/delivery facility services     | 10% <a href="#">coinsurance</a> after <a href="#">deductible</a> | 50% <a href="#">coinsurance</a>                    |  |
| If you need help recovering or have other special health needs            | <a href="#">Home health care</a>          | 10% <a href="#">coinsurance</a> after <a href="#">deductible</a> | 50% <a href="#">coinsurance</a>                    | <a href="#">Preauthorization</a> required.<br>100 visit limit per year.  |
|   | <a href="#">Rehabilitation services</a>   | 10% <a href="#">coinsurance</a> after <a href="#">deductible</a> | 50% <a href="#">coinsurance</a>                    | 30 visit limit per therapy per year.<br><a href="#">Preauthorization</a> required for occupational or speech therapy.  |
|   | <a href="#">Habilitation services</a>     | 10% <a href="#">coinsurance</a> after <a href="#">deductible</a> | 50% <a href="#">coinsurance</a>                    | <a href="#">Preauthorization</a> required for physical therapy visits in excess of annual limit.   |
|   | <a href="#">Skilled nursing care</a>      | 10% <a href="#">coinsurance</a> after <a href="#">deductible</a> | 50% <a href="#">coinsurance</a>                    | <a href="#">Preauthorization</a> is required.<br>120-day visit limit per year.   |
|   | <a href="#">Durable medical equipment</a> | 10% <a href="#">coinsurance</a> after <a href="#">deductible</a> | 50% <a href="#">coinsurance</a>                    | None   |
|   | <a href="#">Hospice services</a>          | 10% <a href="#">coinsurance</a> after <a href="#">deductible</a> | 50% <a href="#">coinsurance</a>                    | None   |
| If your child needs dental or eye care                                    | Children's eye exam                       | No charge  | Not covered  | Limit of 1 routine exam per year   |
|   | 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 <a href="#">Plan</a> Generally Does NOT Cover (Check your policy or <a href="#">plan</a> document for more information and a list of any other <a href="#">excluded services</a> .) |  |  |
|---|--|--|
| <ul style="list-style-type: none"> <li>Cosmetic Surgery</li> <li>Weight Loss Programs</li> </ul>  | <ul style="list-style-type: none"> <li>Long Term Care</li> <li>Non-emergency care when traveling outside the U.S.</li> </ul>                           | <ul style="list-style-type: none"> <li>Bariatric Surgery</li> <li>Hearing Aids</li> </ul>  |
| Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your <a href="#">plan</a> document.)  |  |  |
| <ul style="list-style-type: none"> <li>Infertility Treatment</li> <li>Chiropractic Care</li> </ul>  | <ul style="list-style-type: none"> <li>Routine Eye Care (Adult) (one visit/year)</li> <li>Emergency care when traveling outside of the U.S.</li> </ul> | <ul style="list-style-type: none"> <li>Private Duty Nursing (inpatient only)</li> <li><a href="#">Preauthorization</a> applies to many services. Please check your plan document for a complete list.</li> </ul> |

\* For more information about limitations and exceptions, see the plan or policy document at [www.gravie.com](http://www.gravie.com) or call 1-855-451-8365

**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: the Department of Labor's Employee Benefits Security Administration at 1-(866)-444-EBSA ext. 3272. 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](http://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 more information about your rights, this notice, or assistance, contact: Gravie Administrative Services LLC at 1-855-451-8365 or the Department of Labor's Employee Benefits Security Administration at 1-(866)-444-EBSA ext. 3272

**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 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 Gravie Administrative Services LLC at 1-855-451-8365.]

[Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa Gravie Administrative Services LLC at 1-855-451-8365.]

[Chinese (中文): 如果需要中文的帮助, 请拨打这个号码 Gravie Administrative Services LLC at 1-855-451-8365.]

[Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijigo holne' Gravie Administrative Services LLC at 1-855-451-8365.]

—————*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](#) \$500
- [Specialist copayment](#) \$25
- 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*)

|                           |                 |
|---------------------------|-----------------|
| <b>Total Example Cost</b> | <b>\$12,840</b> |
|---------------------------|-----------------|

**In this example, Peg would pay:**

| <i>Cost Sharing</i>               |                |
|-----------------------------------|----------------|
| Deductibles                       | \$500          |
| Copayments                        | \$350          |
| Coinsurance                       | \$650          |
| <i>What isn't covered</i>         |                |
| Limits or exclusions              | \$60           |
| <b>The total Peg would pay is</b> | <b>\$1,560</b> |

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

- The [plan's](#) overall [deductible](#) \$500
- [Specialist copayment](#) \$25
- 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*)

|                           |                |
|---------------------------|----------------|
| <b>Total Example Cost</b> | <b>\$7,460</b> |
|---------------------------|----------------|

**In this example, Joe would pay:**

| <i>Cost Sharing</i>               |                |
|-----------------------------------|----------------|
| Deductibles*                      | \$500          |
| Copayments                        | \$530          |
| Coinsurance                       | \$292          |
| <i>What isn't covered</i>         |                |
| Limits or exclusions              | \$55           |
| <b>The total Joe would pay is</b> | <b>\$1,377</b> |

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

- The [plan's](#) overall [deductible](#) \$500
- [Specialist copayment](#) \$25
- 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*)

|                           |                |
|---------------------------|----------------|
| <b>Total Example Cost</b> | <b>\$2,010</b> |
|---------------------------|----------------|

**In this example, Mia would pay:**

| <i>Cost Sharing</i>               |              |
|-----------------------------------|--------------|
| Deductibles*                      | \$500        |
| Copayments                        | \$75         |
| Coinsurance                       | \$121        |
| <i>What isn't covered</i>         |              |
| Limits or exclusions              | \$0          |
| <b>The total Mia would pay is</b> | <b>\$696</b> |