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 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 or call 1-855-451-8365 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	For network providers: $2,000 individual / $4,000 family. For out-of-network providers $10,000 individual / $20,000 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, 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 and primary care services 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. 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 network providers $6,500 individual / $13,000 family; for out-of-network providers Not Applicable.	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. There is no out–of–pocket limit for out-of-network providers.
What is not included in the out-of-pocket limit?	Copayments for certain 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.
Will you pay less if you use a network provider?	Yes. See www.cigna.com 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
		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	30% coinsurance after deductible	50% coinsurance	None
	Specialist visit	30% coinsurance after deductible	50% coinsurance	None
	Preventive care/screening/ immunization	No charge	Not covered	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)	30% coinsurance after deductible	50% coinsurance	Preauthorization may be required
	Imaging (CT/PET scans, MRIs)	30% coinsurance after deductible	50% coinsurance	Preauthorization is required
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at 1-855-451-8365	Generic drugs (Tier 1)	Retail and mail order: 30% coinsurance after deductible		Retail and mail order available up to 90-day supply
	Preferred brand drugs (Tier 2)	Retail and mail order: 30% coinsurance after deductible		Retail and mail order available up to 90-day supply
	Non-preferred brand drugs (Tier 3)	Retail and mail order: 50% coinsurance after deductible		Retail and mail order available up to 90-day supply
	Specialty drugs (Tier 4)	Retail and mail order: 30% coinsurance after deductible		Retail and mail order available up to 30-day supply
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	30% coinsurance after deductible	50% coinsurance	Preauthorization is required for procedures performed outside of a physician's office
	Physician/surgeon fees	30% coinsurance after deductible	50% coinsurance	
If you need immediate medical attention	Emergency room care	30% coinsurance after deductible	50% coinsurance	True emergency covered at in-network level
	Emergency medical transportation	30% coinsurance after deductible	50% coinsurance	True emergency covered at in-network level
	Urgent care	30% coinsurance after deductible	50% coinsurance	None

* For more information about limitations and exceptions, see the plan or policy document at 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 (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you have a hospital stay	Facility fee (e.g., hospital room)	30% coinsurance after deductible	50% coinsurance	None
	Physician/surgeon fees	30% coinsurance after deductible	50% coinsurance	Preauthorization is required
If you need mental health, behavioral health, or substance abuse services	Outpatient services	30% coinsurance after deductible	50% coinsurance	Preauthorization is required for Inpatient services
	Inpatient services	30% coinsurance after deductible	50% coinsurance	
If you are pregnant	Office visits	No charge	Not Covered	Cost sharing does not apply to certain preventive services. Depending on the type of services, coinsurance may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound).
	Childbirth/delivery professional services	30% coinsurance after deductible	50% coinsurance	
	Childbirth/delivery facility services	30% coinsurance after deductible	50% coinsurance	
If you need help recovering or have other special health needs	Home health care	30% coinsurance after deductible	50% coinsurance	Preauthorization required. 100 visit limit per year.
	Rehabilitation services	30% coinsurance after deductible	50% coinsurance	30 visit limit per therapy per year. Preauthorization required for occupational or speech therapy. Preauthorization required for physical therapy visits in excess of annual limit.
	Habilitation services	30% coinsurance after deductible	50% coinsurance	
	Skilled nursing care	30% coinsurance after deductible	50% coinsurance	Preauthorization is required. 120-day visit limit per year.
	Durable medical equipment	30% coinsurance after deductible	50% coinsurance	None
	Hospice services	30% coinsurance after deductible	50% coinsurance	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 Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)		
• Cosmetic Surgery • Weight Loss Programs	• Long Term Care • Non-emergency care when traveling outside the U.S.	• Bariatric Surgery • Hearing Aids
Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)		
• Infertility Treatment • Chiropractic Care	• Routine Eye Care (Adult) (one visit/year) • Emergency care when traveling outside of the U.S.	• Private Duty Nursing (inpatient only) • Preauthorization applies to many services. Please check your plan document for a complete list.

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 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, kwiijigo 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.

* For more information about limitations and exceptions, see the plan or policy document at www.gravie.com or call 1-855-451-8365

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 copayment	$0
Hospital (facility) coinsurance	30%
Other coinsurance	30%

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	**$12,840**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$2,000
Copayments	$0
Coinsurance	$3,234
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$5,294**

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 copayment	$0
Hospital (facility) coinsurance	30%
Other coinsurance	30%

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	**$7,460**

In this example, Joe would pay:

Cost Sharing	
Deductibles*	$2,000
Copayments	$0
Coinsurance	$1,622
What isn't covered	
Limits or exclusions	$55
The total Joe would pay is	**$3,677**

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

The plan's overall deductible	$2,000
Specialist copayment	$0
Hospital (facility) coinsurance	30%
Other coinsurance	30%

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	**$2,010**

In this example, Mia would pay:

Cost Sharing	
Deductibles*	$2,000
Copayments	$0
Coinsurance	$3
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$2,003**

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