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, visit https://**www.gravie.com**/. 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 855.451.8365 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	In-network providers **$2,000** individual / **$4,000** family. 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. This plan's deductible is non-embedded.
Are there services covered before you meet your deductible?	Yes. Preventive 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 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?	In-network providers **$6,500** individual / **$13,000** family (**$6,500** per family member). In-network family out-of-pocket is embedded. 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?	Premiums, balance-billing charges, penalties on preauthorization services 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.PreferredOne.com** or call 855.451.8365 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
		In-Network Provider	Out-of-Network Provider	
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 after deductible	Online Care is a covered benefit only when provided through MDLive ($45/visit)
	Specialist visit	30% coinsurance after deductible	50% coinsurance after deductible	---------- 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 needed are preventive. Then check what your plan will pay for. Some over-the-counter (OTC) drugs can be obtained with a prescription at the preventive level of coverage.
If you have a test	Diagnostic test (x-ray, blood work)	30% coinsurance after deductible	50% coinsurance after deductible	---------- None ----------
	Imaging (CT/PET scans, MRIs)	30% coinsurance after deductible	50% coinsurance after deductible	---------- None ----------
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at 855.451.8365	Generic drugs	30% coinsurance after deductible	Not covered	Retail and mail order available up to 90-day supply.
	Preferred brand drugs	30% coinsurance after deductible	Not covered	Retail and mail order available up to 90-day supply.
	Non-preferred brand drugs	50% coinsurance after deductible	Not covered	Retail and mail order available up to 90-day supply.
	Specialty drugs	30% coinsurance after deductible	Not covered	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 after deductible	---------- None ----------
	Physician/surgeon fees	30% coinsurance after deductible	50% coinsurance after deductible	---------- None ----------
If you need immediate medical attention	Emergency room services	30% coinsurance after deductible	30% coinsurance after deductible	Services in connection with an Emergency are covered at in-network level.
	Emergency medical transportation	30% coinsurance after deductible	30% coinsurance after deductible	Services in connection with an Emergency are covered at in-network level.
	Urgent care	30% coinsurance after deductible	50% coinsurance after deductible	---------- None ----------

* For more information about limitations and exceptions, see the plan or policy document at https://www.gravie.com/.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider	Out-of-Network Provider	
If you have a hospital stay	Facility fee (e.g., hospital room)	30% coinsurance after deductible	50% coinsurance after deductible	Pre-authorization may be required
	Physician/surgeon fees	30% coinsurance after deductible	50% coinsurance after deductible	---------- None ----------
If you have mental health, behavioral health, or substance abuse needs	Outpatient services	30% coinsurance after deductible	50% coinsurance after deductible	Online Care is a covered benefit only when provided through MDLive
	Inpatient services	30% coinsurance after deductible	50% coinsurance after deductible	Pre-authorization may be required
If you are pregnant	Office visits	No charge	50% coinsurance after deductible	Cost sharing does not apply for preventive services. Depending on the type of services, copayment, coinsurance, deductible 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 after deductible	---------- None ----------
	Childbirth/delivery facility services	30% coinsurance after deductible	50% coinsurance after deductible	Pre-authorization may be required
If you need help recovering or have other special health needs	Home health care	30% coinsurance after deductible	50% coinsurance after deductible	100 visit limit per year.
	Rehabilitation services	30% coinsurance after deductible	50% coinsurance after deductible	30 visit limit per year. Pre-authorization may be required for occupational or speech therapy. Pre-authorization may be required for physical therapy visits in excess of the annual limit.
	Habilitation services	30% coinsurance after deductible	50% coinsurance after deductible	30 visit limit per year. Pre-authorization may be required for occupational or speech therapy. Pre-authorization may be required for physical therapy visits in excess of the annual limit.
	Skilled nursing care	30% coinsurance after deductible	50% coinsurance after deductible	120 days per member per year. Pre-authorization may be required
	Durable medical equipment	30% coinsurance after deductible	50% coinsurance after deductible	Limits may apply.
	Hospice service	30% coinsurance after deductible	50% coinsurance after deductible	---------- None ----------

* For more information about limitations and exceptions, see the plan or policy document at https://www.gravie.com/.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider	Out-of-Network Provider	
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 ----------

* For more information about limitations and exceptions, see the plan or policy document at https://www.gravie.com/.

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.)

- Acupuncture
- Bariatric surgery
- Cosmetic Surgery (unless determined to be reconstructive)
- Hearing aids
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Routine foot care (except certain conditions)
- Weight loss programs (except preventive obesity counseling/screening)

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)

- Chiropractic care
- Infertility treatment
- Routine eye care (Adult)

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 the agency is the Department of Labor's Employee Benefits Security Administration at 1.866.444.EBSA (3272) /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 more information about your rights, this notice, or assistance, you can contact Gravie Customer Service at 855.451.8365 or the Department of Labor's Employee Benefits Security Administration at 1.866.444.EBSA (3272) /www.dol.gov/ebsa/healthreform.

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 Coverage 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 855.451.8365
Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 855.451.8365
Chinese (中文): 如果需要中文的帮助，请拨打这个号码 855.451.8365
Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 855.451.8365

* For more information about limitations and exceptions, see the plan or policy document at https://www.gravie.com/.

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 coinsurance	**30%**
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	**$12,800**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$2,000
Copayments	$0
Coinsurance	$3,240
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	$5,300

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 coinsurance	**30%**
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	**$7,400**

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 coinsurance	**30%**
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	**$1,900**

In this example, Mia would pay:

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

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