
 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 <a href="#">deductible</a> ?	In-network <a href="#">providers</a> \$2,000 individual / \$4,000 family (\$2,000 per family member). In-network family <a href="#">deductible</a> is embedded. Out-of-network <a href="#">providers</a> \$10,000 individual / \$20,000 family.	Generally, you must pay all of the costs from <a href="#">providers</a> 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> .
Are there services covered before you meet your <a href="#">deductible</a> ?	Yes. <a href="#">Preventive care</a> services are covered before you meet your <a href="#">deductible</a> .	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 preventive services without cost-sharing and before you meet your <a href="#">deductible</a> . See a list of covered preventive services at <a href="http://www.healthcare.gov/coverage/preventive-care-benefits/">www.healthcare.gov/coverage/preventive-care-benefits/</a> .
Are there other <a href="#">deductibles</a> for specific services?	No.	You don't have to meet <a href="#">deductibles</a> for specific services.
What is the <a href="#">out-of-pocket limit</a> for this <a href="#">plan</a> ?	In-network <a href="#">providers</a> \$4,000 individual / \$8,000 family (\$4,000 per family member). In-network family <a href="#">out-of-pocket</a> is embedded. Out-of-network <a href="#">providers</a> Not applicable.	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</a> limits 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 out-of-network <a href="#">providers</a> .
What is not included in the <a href="#">out-of-pocket</a> limit?	<a href="#">Premiums</a> , balance-billing charges, and health care this <a href="#">plan</a> doesn't cover.	Even though you pay these expenses, they don't count toward the <a href="#">out-of-pocket limit</a> .
Will you pay less if you use a <a href="#">network provider</a> ?	Yes. See <a href="http://www.aetna.com/asa">www.aetna.com/asa</a> or call 855.451.8365 for a list of <a href="#">network providers</a> .	This <a href="#">plan</a> uses a <a href="#">provider 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 <a href="#">provider's</a> charge and what your <a href="#">plan</a> pays (balance billing). 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.
Do you need a <a href="#">referral</a> to see a <a href="#">specialist</a> ?	No.	You can see the <a href="#">specialist</a> you choose without a <a href="#">referral</a> .

 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 <a href="#">provider's</a> office or clinic	Primary care visit to treat an injury or illness	\$30 copay/visit (deductible does not apply)	50% coinsurance after deductible	Online Care is a covered benefit only when provided through MDLive (No Charge)
	Specialist visit	\$50 copay/visit (deductible does not apply)	50% coinsurance after deductible	----- None -----
	Preventive care/screening/immunization	No charge (deductible does not apply)	50% coinsurance after deductible	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)	20% coinsurance after deductible	50% coinsurance after deductible	----- None -----
	Imaging (CT/PET scans, MRIs)	20% coinsurance after deductible	50% coinsurance after deductible	----- None -----
If you need drugs to treat your illness or condition  More information about <a href="#">prescription drug coverage</a> is available at 855.451.8365	Generic drugs	Retail: \$10 copay. Mail: \$20 copay.	Not covered	Retail and mail order available up to 90-day supply.
	Preferred brand drugs	Retail: \$50 copay. Mail: \$100 copay.	Not covered	Retail and mail order available up to 90-day supply.
	Non-preferred brand drugs	Retail and mail order: 50% coinsurance after deductible	Not covered	Retail and mail order available up to 90-day supply.
	Specialty drugs	Retail and mail order: 20% 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)	20% coinsurance after deductible	50% coinsurance after deductible	----- None -----
	Physician/surgeon fees	20% 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	
<b>If you need immediate medical attention</b>	Emergency room services	\$500 copay/visit (deductible does not apply)	\$500 copay/visit (deductible does not apply)	Services in connection with an Emergency are covered at in-network level.
	Emergency medical transportation	20% coinsurance after deductible	20% coinsurance after deductible	Services in connection with an Emergency are covered at in-network level. Prior authorization recommended for non-emergency ambulance.
	Urgent care	\$75 copay/visit (deductible does not apply)	50% coinsurance after deductible	----- None -----
<b>If you have a hospital stay</b>	Facility fee (e.g., hospital room)	20% coinsurance after deductible	50% coinsurance after deductible	Prior authorization may be required
	Physician/surgeon fees	20% coinsurance after deductible	50% coinsurance after deductible	----- None -----
<b>If you have mental health, behavioral health, or substance abuse needs</b>	Outpatient services	\$30 copay/visit (deductible does not apply)	50% coinsurance after deductible	Online Care is a covered benefit only when provided through MDLive
	Inpatient services	20% coinsurance after deductible	50% coinsurance after deductible	Prior authorization may be required
<b>If you are pregnant</b>	Office visits	No charge (deductible does not apply)	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	20% coinsurance after deductible	50% coinsurance after deductible	----- None -----
	Childbirth/delivery facility services	20% coinsurance after deductible	50% coinsurance after deductible	Prior authorization may be required

\* 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	
<b>If you need help recovering or have other special health needs</b>	Home health care	20% coinsurance after deductible	50% coinsurance after deductible	100 visit limit per year.
	Rehabilitation services	20% coinsurance after deductible	50% coinsurance after deductible	Prior authorization is recommended for physical, occupational and speech therapy.
	Habilitation services	20% coinsurance after deductible	50% coinsurance after deductible	Prior authorization is recommended for physical, occupational and speech therapy.
	Skilled nursing care	20% coinsurance after deductible	50% coinsurance after deductible	120 days per member per year. Pre-authorization may be required
	Durable medical equipment	20% coinsurance after deductible	50% coinsurance after deductible	Limits may apply.
	Hospice service	20% coinsurance after deductible	50% coinsurance after deductible	----- None -----
<b>If your child needs dental or eye care</b>	Children's eye exam	No charge (deductible does not apply)	50% coinsurance after deductible	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)
- Dental care (Adults)
- 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](http://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](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, 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](http://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, kwijigo holne' 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 <a href="#">plan's</a> overall <a href="#">deductible</a>	\$2,000
■ Specialist copayment	\$50
■ Hospital (facility) coinsurance	20%
■ Other coinsurance	20%

**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>\$12,700</b>
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**In this example, Peg would pay:**

<i>Cost Sharing</i>	
Deductibles	\$2,000
Copayments	\$10
Coinsurance	\$1,900
<i>What isn't covered</i>	
Limits or exclusions	\$60
<b>The total Peg would pay is</b>	<b>\$3,970</b>

### Managing Joe's type 2 Diabetes

(a year of routine in-network care of a well-controlled condition)

■ The <a href="#">plan's</a> overall <a href="#">deductible</a>	\$2,000
■ Specialist copayment	\$50
■ Hospital (facility) coinsurance	20%
■ Other coinsurance	20%

**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>\$5,600</b>
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**In this example, Joe would pay:**

<i>Cost Sharing</i>	
Deductibles	\$800
Copayments	\$500
Coinsurance	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$30
<b>The total Joe would pay is</b>	<b>\$1,330</b>

### Mia's Simple Fracture

(in-network emergency room visit and follow up care)

■ The <a href="#">plan's</a> overall <a href="#">deductible</a>	\$2,000
■ Specialist copayment	\$50
■ Hospital (facility) coinsurance	20%
■ Other coinsurance	20%

**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>\$2,800</b>
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**In this example, Mia would pay:**

<i>Cost Sharing</i>	
Deductibles	\$2,000
Copayments	\$200
Coinsurance	\$90
<i>What isn't covered</i>	
Limits or exclusions	\$0
<b>The total Mia would pay is</b>	<b>\$2,290</b>