**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 www.gravie.com/. For 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 855.451.8365 to request a copy.

| Important Questions | Answers | Why This Matters: |
|---|---|---|
| **What is the overall deductible?** | In-network providers: $3,000 individual/$6,000 family. Out-of-network providers: $10,000 individual/$20,000 family. | See the Common Medical Events chart below for a summary of coverage provided by this plan. For some services, a copayment or payment toward the out-of-pocket may apply. |
| **Are there services covered before you meet your deductible?** | Yes. In-network preventive care services, office visits (primary and specialty care), on-line care through Gravie's telemedicine service provider, labs and related imaging work, urgent care visits and generic prescriptions are covered at no cost. The no cost portion only applies to labs/imaging related to the office visit. | This plan covers some items and services even if you haven't met the deductible amount. For example, this plan covers certain preventive services without cost-sharing. See a list of covered preventive services at www.healthcare.gov/coverage/preventive-care-benefits/. Copay/coinsurance may apply to some services. |
| **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: $3,000 individual / $6,000 family ($3,000 per family member). Out-of-network providers: Not applicable. For ease of reference, your out-of-pocket maximum will be referred to as OOPM through this document. | 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. The in-network OOPM is the same as the deductible. 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, 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.aetna.com/asa 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.

| | | What You Will Pay | | |
|---|---|---|---|---|
| **Common Medical Event** | **Services You May Need** | **In-Network Provider (You will pay the least)** | **Out-of-Network Provider (You will pay the most)** | **Limitations, Exceptions, & Other Important Information** |
| **If you visit a health care provider's office or clinic** | **Primary care visit to treat an injury or illness** | No charge | 50% coinsurance after deductible | Access to lower-cost online care services may be available through Gravie's telemedicine service provider. Dialysis, chemotherapy, radiation and certain injectable drugs are not free when administered at an office or clinic. For more information, you can contact Gravie Customer Service at 855.451.8365. |
| | **Specialist visit** | No charge | 50% coinsurance after deductible | Access to lower-cost online care services may be available through Gravie's telemedicine service provider. Dialysis, chemotherapy, radiation and certain injectable drugs are not free when administered at an office or clinic. |
| | **Preventive care/screening /immunization** | No charge | 50% coinsurance after deductible | 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)** | Office/Clinic: No charge.<br>Hospital: No charge after OOPM | 50% coinsurance after deductible | No charge services limited to tests done within office or clinic. OOPM applies to tests associated with a hospitalization. Prior authorization may be required. |
| | **Imaging (CT/PET scans, MRIs)** | Office/Clinic: No charge.<br>Hospital: No charge after OOPM | 50% coinsurance after deductible | No charge services limited to tests done within office or clinic. OOPM applies to tests associated with a hospitalization. Prior authorization may be required. |
| **If you need drugs to treat your illness or condition More information about prescription drug coverage is available at 855.451.8365** | **Generic drugs** | Retail, 30-day supply: No charge<br>Retail, 90-day supply: No charge<br>Mail, 90-day supply: No charge | Not covered | Retail and mail order available up to 90-day supply. |
| | **Preferred brand drugs** | Retail, 30-day supply: $75 copay<br>Retail,90-day supply: $150 copay<br>Mail, 90-day supply: $150 copay | Not covered | Retail and mail order available up to 90-day supply. |
| | **Non-preferred brand drugs** | Retail, 30-day supply: $100 copay<br>Retail, 90-day supply: $200 copay<br>Mail, 90-day supply: $200 copay | Not covered | Retail and mail order available up to 90-day supply. |
| | **Specialty drugs** | Retail, 30-day supply: $125 copay<br>Mail, 30-day supply: $125 copay | Not covered | Retail and mail order available up to 30-day supply. |

| Common Medical Event | Services You May Need | What You Will Pay | | Limitations, Exceptions, & Other Important Information |
|---|---|---|---|---|
| | | In-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 after OOPM | 50% coinsurance after deductible | Prior authorization may be required for certain outpatient surgery procedures. |
| | Physician/surgeon fees | No charge after OOPM | 50% coinsurance after deductible | None |
| If you need immediate medical attention | Emergency room services | $250 copay | $250 copay | Services in connection with an Emergency are covered at in-network level. |
| | Emergency medical transportation | No charge after OOPM | No charge after OOPM | Services in connection with an Emergency are covered at in-network level. |
| | Urgent care | No charge | 50% coinsurance after deductible | None |
| If you have a hospital stay | Facility fee (e.g., hospital room) | No charge after OOPM | 50% coinsurance after deductible | Prior authorization may be required |
| | Physician/surgeon fees | No charge after OOPM | 50% coinsurance after deductible | None |
| If you need mental health, behavioral health, or substance abuse services | Outpatient services | Office/Clinic: No charge. Hospital: No charge after OOPM | 50% coinsurance after deductible | Access to lower-cost online care services may be available through Gravie's telemedicine service provider |
| | Inpatient services | No charge after OOPM | 50% coinsurance after deductible | Prior 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. |
| | Childbirth/delivery professional services | No charge after OOPM | 50% coinsurance after deductible | None |
| | Childbirth/delivery facility services | No charge after OOPM | 50% coinsurance after deductible | Prior authorization may be required |
| If you need help recovering or have other special health needs | Home health care | No charge after OOPM | 50% coinsurance after deductible | 100 visit limit per year. |
| | Rehabilitation services | Office/Clinic: No charge. Hospital: No charge after OOPM | 50% coinsurance after deductible | Prior authorization is recommended for physical, occupational and speech therapy. |
| | Habilitation services | Office/Clinic: No charge. Hospital: No charge after OOPM | 50% coinsurance after deductible | Prior authorization is recommended for physical, occupational and speech therapy. |
| | Skilled nursing care | No charge after OOPM | 50% coinsurance after deductible | 120 days per member per year. Prior authorization may be required |
| | Durable medical equipment | No charge after OOPM | 50% coinsurance after deductible | Limits may apply. Prior authorization may be required. |
| | Hospice service | No charge after OOPM | 50% coinsurance after deductible | Prior authorization may be required. |

| Common Medical Event | Services You May Need | What You Will Pay: In-Network Provider (You will pay the least) | What You Will Pay: Out-of-Network Provider (You will pay the most) | Limitations, Exceptions, & Other Important Information |
|---|---|---|---|---|
| If your child needs dental or eye care | Children's eye exam | No charge | 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 |

## 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
- Private-duty nursing (Inpatient Only)
- 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

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.

### Language Access Services:

[Spanish (Español): Para obtener asistencia en Español, llame al 763.847.4477 / 800.997.1750]

[Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 763.847.4477 / 800.997.1750]

[Chinese (中文): 如果需要中文的助 763.847.4477 / 800.997.1750]

[Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 763.847.4477 / 800.997.1750]

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 | $3,000 |
| Specialist copay | $0 |
| 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 | **$3,000** |
| Copayments | **$0** |
| Coinsurance | **$0** |
| **What isn't covered** | |
| Limits or Exclusions | **$60** |
| **The total Peg would pay is** | **$3,060** |

### Managing Joe's Type 2 Diabetes

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

| | |
|---|---|
| The plan's overall deductible | $3,000 |
| Specialist copay | $0 |
| 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 | **$800** |
| Copayments | **$1000** |
| Coinsurance | **$0** |
| **What isn't covered** | |
| Limits or Exclusions | $30 |
| **The total Joe would pay is** | **$1,830** |

### Mia's Simple Fracture

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

| | |
|---|---|
| The plan's overall deductible | $3,000 |
| Specialist copay | $0 |
| Hospital (facility) copay | $250 |
| Other coinsurance | 0% |

**This EXAMPLE event includes services like:**

Emergency room care (including medical supplies)
Diagnostic tests (x-ray)
Durable medical equipment (crutches)
Rehabilitation services (physical therapy)

| | |
|---|---|
| **Total Example Cost** | **$2,800** |

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

| Cost Sharing | |
|---|---|
| Deductibles | **$1200** |
| Copayments | **$300** |
| Coinsurance | **$0** |
| **What isn't covered** | |
| Limits or Exclusions | **$0** |
| **The total Mia would pay is** | **$1,500** |

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