



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/](http://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](http://www.healthcare.gov/sbc-glossary) or call 855.451.8365 to request a copy.

| Important Questions   | Answers  | Why This Matters:  |
|---|--|--|
| <b>What is the overall <a href="#">deductible</a>?</b>                                | In- <a href="#">network providers</a> : \$7,900 individual/\$15,800 family. Out-of- <a href="#">network providers</a> : \$10,000 individual/\$20,000 family.   | See the Common Medical Events chart below for a summary of coverage provided by this <a href="#">plan</a> . For some services, a <a href="#">copayment</a> or payment toward the out-of-pocket may apply.  |
| <b>Are there services covered before you meet your <a href="#">deductible</a>?</b>    | Yes. In-network <a href="#">preventive care</a> services, office visits (primary and specialty care), on-line care through Gravie's telemedicine service provider, labs and related imaging work, <a href="#">urgent care</a> visits and generic prescriptions are covered at no cost. The no cost portion only applies to labs/imaging related to the office visit. | This <a href="#">plan</a> covers some items and services even if you haven't met the <a href="#">deductible</a> amount. For example, this <a href="#">plan</a> covers certain preventive services without <a href="#">cost-sharing</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> . Copay/ <a href="#">coinsurance</a> may apply to some services.  |
| <b>Are there other <a href="#">deductibles</a> for specific services?</b>             | No.  | You don't have to meet <a href="#">deductibles</a> for specific services.  |
| <b>What is the <a href="#">out-of-pocket limit</a> for this <a href="#">plan</a>?</b> | In- <a href="#">network providers</a> : \$7,900 individual / \$15,800 family (\$7,900 per family member). Out-of- <a href="#">network providers</a> : Not applicable. For ease of reference, your out-of-pocket maximum will be referred to as OOPM through this document.   | 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. The in-network OOPM is the same as the deductible. There is no <a href="#">out-of-pocket limit</a> for out-of- <a href="#">network providers</a> .   |
| <b>What is not included in the <a href="#">out-of-pocket limit</a>?</b>               | Premiums, 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> .  |
| <b>Will you pay less if you use a <a href="#">network provider</a>?</b>               | 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 <a href="#">plan's 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. |
| <b>Do you need a <a href="#">referral</a> to see a <a href="#">specialist</a>?</b>    | 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<br>(You will pay the least)  | Out-of-Network Provider<br>(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       | No charge  | 50% <a href="#">coinsurance</a> after <a href="#">deductible</a> | 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. |
|  | <a href="#">Specialist</a> visit                       | No charge  | 50% <a href="#">coinsurance</a> after <a href="#">deductible</a> | 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.  |
|  | <a href="#">Preventive care/screening/immunization</a> | No charge  | 50% <a href="#">coinsurance</a> after <a href="#">deductible</a> | 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% <a href="#">coinsurance</a> after <a href="#">deductible</a> | No charge services limited to tests done within office or clinic. OOPM applies to tests associated with a <a href="#">hospitalization</a> . Prior authorization may be required.  |
|  | Imaging (CT/PET scans, MRIs)                           | Office/Clinic: No charge.<br>Hospital: No charge after OOPM  | 50% <a href="#">coinsurance</a> after <a href="#">deductible</a> | No charge services limited to tests done within office or clinic. OOPM applies to tests associated with a <a href="#">hospitalization</a> . Prior authorization may be required.  |
| If you need drugs to treat your illness or condition<br>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.  |
|  | <a href="#">Specialty drugs</a>                        | 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.  |

\* For more information about limitations and exceptions, see the [Plan](#) or policy document at [www.gravie.com](http://www.gravie.com)

| Common Medical Event  | Services You May Need                            | What You Will Pay   |  | Limitations, Exceptions, & Other Important Information  |
|---|--|---|--|---|
|   |  | In-Network Provider<br>(You will pay the least)             | Out-of-Network Provider<br>(You will pay the most)               |   |
| If you have outpatient surgery  | Facility fee (e.g., ambulatory surgery center)   | No charge after OOPM  | 50% <a href="#">coinsurance</a> after <a href="#">deductible</a> | Prior authorization may be required for certain outpatient surgery procedures.  |
|   | Physician/surgeon fees                           | No charge after OOPM  | 50% <a href="#">coinsurance</a> after <a href="#">deductible</a> | None  |
| If you need immediate medical attention                                   | <a href="#">Emergency room services</a>          | \$250 copay   | \$250 copay  | Services in connection with an Emergency are covered at in-network level.   |
|   | <a href="#">Emergency medical transportation</a> | No charge after OOPM  | No charge after OOPM   | Services in connection with an Emergency are covered at in-network level.   |
|   | <a href="#">Urgent care</a>                      | No charge   | 50% <a href="#">coinsurance</a> after <a href="#">deductible</a> | None  |
| If you have a hospital stay   | Facility fee (e.g., hospital room)               | No charge after OOPM  | 50% <a href="#">coinsurance</a> after <a href="#">deductible</a> | Prior authorization may be required   |
|   | Physician/surgeon fees                           | No charge after OOPM  | 50% <a href="#">coinsurance</a> after <a href="#">deductible</a> | None  |
| If you need mental health, behavioral health, or substance abuse services | Outpatient services                              | Office/Clinic: No charge.<br>Hospital: No charge after OOPM | 50% <a href="#">coinsurance</a> after <a href="#">deductible</a> | Access to lower-cost online care services may be available through Gravie's telemedicine service provider   |
|   | Inpatient services                               | No charge after OOPM  | 50% <a href="#">coinsurance</a> after <a href="#">deductible</a> | Prior authorization may be required   |
| If you are pregnant   | Office visits                                    | No charge   | 50% <a href="#">coinsurance</a> after <a href="#">deductible</a> | Cost sharing does not apply for preventive services. Depending on the type of services, <a href="#">copayment</a> , <a href="#">coinsurance</a> , <a href="#">deductible</a> may apply. |
|   | Childbirth/delivery professional services        | No charge after OOPM  | 50% <a href="#">coinsurance</a> after <a href="#">deductible</a> | None  |
|   | Childbirth/delivery facility services            | No charge after OOPM  | 50% <a href="#">coinsurance</a> after <a href="#">deductible</a> | Prior authorization may be required   |
| If you need help recovering or have other special health needs            | <a href="#">Home health care</a>                 | No charge after OOPM  | 50% <a href="#">coinsurance</a> after <a href="#">deductible</a> | 100 visit limit per year.   |
|   | Rehabilitation services                          | Office/Clinic: No charge.<br>Hospital: No charge after OOPM | 50% <a href="#">coinsurance</a> after <a href="#">deductible</a> | Prior authorization is recommended for physical, occupational and speech therapy.   |
|   | <a href="#">Habilitation services</a>            | Office/Clinic: No charge.<br>Hospital: No charge after OOPM | 50% <a href="#">coinsurance</a> after <a href="#">deductible</a> | Prior authorization is recommended for physical, occupational and speech therapy.   |
|   | <a href="#">Skilled nursing care</a>             | No charge after OOPM  | 50% <a href="#">coinsurance</a> after <a href="#">deductible</a> | 120 days per member per year. Prior authorization may be required   |
|   | <a href="#">Durable medical equipment</a>        | No charge after OOPM  | 50% <a href="#">coinsurance</a> after <a href="#">deductible</a> | Limits may apply. Prior authorization may be required.  |
|   | <a href="#">Hospice service</a>                  | No charge after OOPM  | 50% <a href="#">coinsurance</a> after <a href="#">deductible</a> | Prior authorization may be required.  |

\* For more information about limitations and exceptions, see the [Plan](#) or policy document at [www.gravie.com](http://www.gravie.com)

| Common Medical Event                   | Services You May Need      | What You Will Pay                               |  | Limitations, Exceptions, & Other Important Information |
|--|----------------------------|---|--|--|
|  |                            | In-Network Provider<br>(You will pay the least) | Out-of-Network Provider<br>(You will pay the most)               |  |
| If your child needs dental or eye care | Children's eye exam        | No charge                                       | 50% <a href="#">coinsurance</a> after <a href="#">deductible</a> | 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>• Acupuncture</li> <li>• Dental care (Adults)</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> <li>• Routine foot care (except certain conditions)</li> </ul> | <ul style="list-style-type: none"> <li>• Cosmetic Surgery (unless determined to be reconstructive)</li> <li>• Long-term care</li> <li>• Weight loss programs (except preventive obesity counseling/screening)</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>• Chiropractic care</li> <li>• Routine eye care (Adult)</li> </ul>                                    | <ul style="list-style-type: none"> <li>• Infertility treatment</li> </ul> | <ul style="list-style-type: none"> <li>• Private-duty nursing (Inpatient Only)</li> </ul> |

### 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

[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): 如果需要中文的帮助 763.847.4477 / 800.997.1750]

[Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijigo 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 <a href="#">plan's</a> overall <a href="#">deductible</a> | \$7,900 |
| ■ <a href="#">Specialist copay</a>                              | \$0     |
| ■ Hospital (facility) <a href="#">coinsurance</a>               | 0%      |
| ■ Other <a href="#">coinsurance</a>                             | 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)

|                           |                 |
|---------------------------|-----------------|
| <b>Total Example Cost</b> | <b>\$12,700</b> |
|---------------------------|-----------------|

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

| Cost Sharing                      |                |
|-----------------------------------|----------------|
| <a href="#">Deductibles</a>       | \$7,900        |
| <a href="#">Copayments</a>        | \$0            |
| <a href="#">Coinsurance</a>       | \$0            |
| What isn't covered                |                |
| Limits or Exclusions              | \$60           |
| <b>The total Peg would pay is</b> | <b>\$7,960</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> | \$7,900 |
| ■ <a href="#">Specialist copay</a>                              | \$0     |
| ■ Hospital (facility) <a href="#">coinsurance</a>               | 0%      |
| ■ Other <a href="#">coinsurance</a>                             | 0%      |

#### This EXAMPLE event includes services like:

[Primary care physician](#) office visits (including disease education)  
[Diagnostic tests](#) (blood work)  
[Prescription drugs](#)  
[Durable Medical Equipment \(glucose meter\)](#)

|                           |                |
|---------------------------|----------------|
| <b>Total Example Cost</b> | <b>\$5,600</b> |
|---------------------------|----------------|

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

| Cost Sharing                      |                |
|-----------------------------------|----------------|
| <a href="#">Deductibles</a>       | \$800          |
| <a href="#">Copayments</a>        | \$1000         |
| <a href="#">Coinsurance</a>       | \$0            |
| What isn't covered                |                |
| Limits or Exclusions              | \$30           |
| <b>The total Joe would pay is</b> | <b>\$1,830</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> | \$7,900 |
| ■ <a href="#">Specialist copay</a>                              | \$0     |
| ■ Hospital (facility) <a href="#">copay</a>                     | \$250   |
| ■ Other <a href="#">coinsurance</a>                             | 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)

|                           |                |
|---------------------------|----------------|
| <b>Total Example Cost</b> | <b>\$2,800</b> |
|---------------------------|----------------|

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

| Cost Sharing                      |                |
|-----------------------------------|----------------|
| <a href="#">Deductibles</a>       | \$1200         |
| <a href="#">Copayments</a>        | \$300          |
| <a href="#">Coinsurance</a>       | \$0            |
| What isn't covered                |                |
| Limits or Exclusions              | \$0            |
| <b>The total Mia would pay is</b> | <b>\$1,500</b> |

The [plan](#) would be responsible for the other costs of these EXAMPLE covered services.