




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> \$4,500 individual / \$9,000 family (\$4,500 per family member). In-network family <a href="#">deductible</a> is embedded. Out-of- <a href="#">network providers</a> \$10,000 individual / \$20,000 family.	Generally, you must pay all of the costs from providers 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 deductible.
<b>Are there services covered before you meet your <a href="#">deductible</a>?</b>	Yes. <a href="#">Preventive care</a> services are covered before you meet your deductible.	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 <a href="#">cost-sharing</a> and before you meet your deductible. 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> .
<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> \$6,500 individual / \$13,000 family (\$6,500 per family member). In-network family out-of-pocket is embedded. Out-of- <a href="#">network 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 limits</a> 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- <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 (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 copay/visit ( <a href="#">deductible</a> does not apply)	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
	<a href="#">Specialist</a> visit	\$50 copay/visit ( <a href="#">deductible</a> does not apply)	50% <a href="#">coinsurance</a> after <a href="#">deductible</a>	None
	<a href="#">Preventive care/screening/immunization</a>	No charge ( <a href="#">deductible</a> does not apply)	50% <a href="#">coinsurance</a> after <a href="#">deductible</a>	You may have to pay for services that aren't preventive. Ask your <a href="#">provider</a> if the services needed are preventive. Then check what your <a href="#">plan</a> 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% <a href="#">coinsurance</a> after <a href="#">deductible</a>	50% <a href="#">coinsurance</a> after <a href="#">deductible</a>	None
	Imaging (CT/PET scans, MRIs)	20% <a href="#">coinsurance</a> after <a href="#">deductible</a>	50% <a href="#">coinsurance</a> after <a href="#">deductible</a>	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	Retail, 30-day supply: \$10 copay Retail, 90-day supply: \$20 copay Mail, 90-day supply: \$20 copay	Not covered	Retail and mail order available up to 90-day supply.
	Preferred brand drugs	Retail, 30-day supply: \$50 copay Retail, 90-day supply: \$100 copay Mail, 90-day supply: \$100 copay	Not covered	Retail and mail order available up to 90-day supply.
	Non-preferred brand drugs	Retail and mail order: 50% <a href="#">coinsurance</a> after <a href="#">deductible</a>	Not covered	Retail and mail order available up to 90-day supply.
	<a href="#">Specialty drugs</a>	Retail and mail order: 20% <a href="#">coinsurance</a> after <a href="#">deductible</a>	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% <a href="#">coinsurance</a> after <a href="#">deductible</a>	50% <a href="#">coinsurance</a> after <a href="#">deductible</a>	None
	Physician/surgeon fees	20% <a href="#">coinsurance</a> after <a href="#">deductible</a>	50% <a href="#">coinsurance</a> after <a href="#">deductible</a>	None
If you need immediate medical attention	<a href="#">Emergency room services</a>	\$500 copay/visit ( <a href="#">deductible</a> does not apply)	\$500 copay/visit ( <a href="#">deductible</a> does not apply)	Services in connection with an Emergency are covered at in-network level.
	<a href="#">Emergency medical transportation</a>	20% <a href="#">coinsurance</a> after <a href="#">deductible</a>	20% <a href="#">coinsurance</a> after <a href="#">deductible</a>	Services in connection with an Emergency are covered at in-network level. Prior authorization recommended for non-emergency ambulance.
	<a href="#">Urgent care</a>	\$75 copay/visit ( <a href="#">deductible</a> does not apply)	50% <a href="#">coinsurance</a> after <a href="#">deductible</a>	None

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 a hospital stay	Facility fee (e.g., hospital room)	20% <a href="#">coinsurance</a> after <a href="#">deductible</a>	50% <a href="#">coinsurance</a> after <a href="#">deductible</a>	Prior authorization may be required
	Physician/surgeon fees	20% <a href="#">coinsurance</a> after <a href="#">deductible</a>	50% <a href="#">coinsurance</a> after <a href="#">deductible</a>	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	\$30 copay/visit ( <a href="#">deductible</a> does not apply)	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	20% <a href="#">coinsurance</a> after <a href="#">deductible</a>	50% <a href="#">coinsurance</a> after <a href="#">deductible</a>	Prior authorization may be required
If you are pregnant	Office visits	No charge ( <a href="#">deductible</a> does not apply)	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. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound).
	Childbirth/delivery professional services	20% <a href="#">coinsurance</a> after <a href="#">deductible</a>	50% <a href="#">coinsurance</a> after <a href="#">deductible</a>	None
	Childbirth/delivery facility services	20% <a href="#">coinsurance</a> after <a href="#">deductible</a>	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>	20% <a href="#">coinsurance</a> after <a href="#">deductible</a>	50% <a href="#">coinsurance</a> after <a href="#">deductible</a>	100 visit limit per year.
	Rehabilitation services	20% <a href="#">coinsurance</a> after <a href="#">deductible</a>	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>	20% <a href="#">coinsurance</a> after <a href="#">deductible</a>	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>	20% <a href="#">coinsurance</a> after <a href="#">deductible</a>	50% <a href="#">coinsurance</a> after <a href="#">deductible</a>	120 days per member per year. Pre-authorization may be required
	<a href="#">Durable medical equipment</a>	20% <a href="#">coinsurance</a> after <a href="#">deductible</a>	50% <a href="#">coinsurance</a> after <a href="#">deductible</a>	Limits may apply.
	<a href="#">Hospice service</a>	20% <a href="#">coinsurance</a> after <a href="#">deductible</a>	50% <a href="#">coinsurance</a> after <a href="#">deductible</a>	None

\* 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 (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If your child needs dental or eye care	Children's eye exam	No charge ( <a href="#">deductible</a> does not apply)	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> .)		
• 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 <a href="#">plan</a> 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

[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>	\$4,500
■ <a href="#">Specialist copay</a>	\$50
■ Hospital (facility) <a href="#">coinsurance</a>	20%
■ Other <a href="#">coinsurance</a>	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:

Cost Sharing	
<a href="#">Deductibles</a>	<b>\$4,500</b>
<a href="#">Copayments</a>	<b>\$10</b>
<a href="#">Coinsurance</a>	<b>\$1400</b>
What isn't covered	
Limits or Exclusions	<b>\$60</b>
<b>The total Peg would pay is</b>	<b>\$5,970</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>	\$4,500
■ <a href="#">Specialist copay</a>	\$50
■ Hospital (facility) <a href="#">coinsurance</a>	20%
■ Other <a href="#">coinsurance</a>	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:

Cost Sharing	
<a href="#">Deductibles</a>	<b>\$800</b>
<a href="#">Copayments</a>	<b>\$500</b>
<a href="#">Coinsurance</a>	<b>\$0</b>
What isn't covered	
Limits or Exclusions	<b>\$30</b>
<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>	\$4,500
■ <a href="#">Specialist copay</a>	\$50
■ Hospital (facility) <a href="#">coinsurance</a>	20%
■ Other <a href="#">coinsurance</a>	20%

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

Cost Sharing	
<a href="#">Deductibles</a>	<b>\$2500</b>
<a href="#">Copayments</a>	<b>\$200</b>
<a href="#">Coinsurance</a>	<b>\$0</b>
What isn't covered	
Limits or Exclusions	<b>\$0</b>
<b>The total Mia would pay is</b>	<b>\$2,700</b>

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