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 $2,000 individual / $4,000 family ($2,000 per family member). In-network family deductible is embedded. 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. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible.
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 $4,000 individual / $8,000 family ($4,000 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, 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.

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 you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$30 copay/visit (deductible does not apply)	50% coinsurance after deductible	Access to lower-cost online care services may be available through Gravie's telemedicine service provider
	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 prescription drug coverage is available at 855.451.8365	Generic drugs	Retail, 30-day supply: $0 copay Retail, 90-day supply: $0 copay Mail, 90-day supply: $0 copay	Not covered	Retail and mail order available up to 90-day supply.
	Preferred brand drugs	Retail, 30-day supply: $30 copay Retail, 90-day supply: $60 copay Mail, 90-day supply: $60 copay	Not covered	Retail and mail order available up to 90-day supply.
	Non-preferred brand drugs	Retail, 30-day supply: $100 copay Retail, 90-day supply: $200 copay Mail, 90-day supply: $200 copay	Not covered	Retail and mail order available up to 90-day supply.
	Specialty drugs	Retail, 30-day supply: $250 copay Mail, 30-day supply: $250 copay	Not covered	Retail and mail order available up to 90-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
If you need immediate medical attention	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

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 you have a hospital stay	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
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$30 copay/visit (deductible does not apply)	50% coinsurance after deductible	Access to lower-cost online care services may be available through Gravie's telemedicine service provider
	Inpatient services	20% coinsurance after deductible	50% coinsurance after deductible	Prior authorization may be required
If you are pregnant	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
If you need help recovering or have other special health needs	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

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 (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

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. 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	$2,000
Specialist copay	$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)

Total Example Cost	**$12,700**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$2,000
Copayments	$10
Coinsurance	$1900
What isn't covered	
Limits or Exclusions	$60
The total Peg would pay is	**$3,970**

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 copay	$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)

Total Example Cost	**$5,600**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$800
Copayments	$500
Coinsurance	$0
What isn't covered	
Limits or Exclusions	$30
The total Joe would pay is	**$1,330**

Mia's Simple Fracture
(in-network emergency room visit and follow up care)

The plan's overall deductible	$2,000
Specialist copay	$50
Hospital (facility) coinsurance	20%
Other coinsurance	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)

Total Example Cost	**$2,800**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$2000
Copayments	$200
Coinsurance	$90
What isn't covered	
Limits or Exclusions	$0
The total Mia would pay is	**$2,290**

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