**Summary of Benefits and Coverage: What this Plan Covers & What You Pay for Covered Services**
Gravie Comfort $7,900 OOPM Aetna Signature Administrators®
SamanieGO Express, Inc

Coverage Period: 8/1/2026 - 7/31/2027
Coverage for: Ind + Family
Plan Type: PPO

**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, you can contact Gravie Care® at 866.863.6232, weekdays, 8 a.m. to 5 p.m. CST. 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 www.healthcare.gov/sbc-glossary/ or call Gravie Care® at 866.863.6232 weekdays, 8 a.m. to 5 p.m. CST to request a copy.

| Important Questions | Answers | Why This Matters: |
|---|---|---|
| What is the overall deductible? | **In-Network (INN):**<br>$7,900 Individual<br>$15,800 Family<br><br>**Out-of-Network (OON):**<br>$10,000 Individual<br>$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. (The individual deductibles are embedded within the family deductible.)<br><br>**NOTE:** The deductible and the OOPM (described below) are the same amount. However, not all cost sharing amounts count toward both. Copayments do not apply to the deductible, but they do apply to the OOPM. This means it is possible to reach your OOPM through copayment alone. Once the OOPM is met, the plan pays 100% of in-network covered services for the remainder of the plan year even if your deductible has not been met. |
| Are there services covered before you meet your deductible? | Yes. In-network preventive services, office visits, certain types of labs/imaging, urgent care visits, and Tier 1 generic prescription drugs are covered at no charge before the 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 https://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 (OOPM) for this plan? | **In-Network (INN):**<br>$7,900 Individual<br>$15,800 Family<br><br>**Out-of-Network (OON):**<br>N/A - There is no Out-of-Network OOPM. | The out-of-pocket limit (OOPM) is the most you could pay in a year for covered services. If you have other family members on this plan, they have to meet their own OOPMs until the overall family OOPM has been met. The most a family will pay in a plan year is the family OOPM. (The individual OOPMs are embedded within the family OOPM.)<br>There is no out-of-network out-of-pocket limit (OOPM). |

| Important Questions | Answers | Why This Matters: |
|---|---|---|
| What is not included in the out-of-pocket limit (OOPM)? | Premiums, balance-billing charges, and health care this plan doesn't cover. Cost-Sharing for SaveOn specialty prescription drugs when opting out of the program. | 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 Gravie Care® at 866.863.6232 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 the deductible applies.

| Common Medical Event | Services You May Need | What You Will Pay | | Limitations, Exceptions, & Other Important Information |
|---|---|---|---|---|
| | | 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 | No Charge. | 50% coinsurance after the OON deductible is met. | Certain services (e.g., chemotherapy, radiation, and dialysis) will be subject to cost sharing when administered in an office/clinic. Check your plan document for details.<br><br>Certain services may require prior authorization. |
| | Specialist visit | No Charge. | 50% coinsurance after the OON deductible is met. | |
| | Preventive care/screening/ immunization | No Charge. | 50% coinsurance after the OON deductible is met. | You may have to pay for services that aren't preventive services. Ask your provider if the services needed are preventive. Then check what your plan will pay for. |
| If you have a test | Diagnostic test (basic imaging [x-ray, ultrasound], labs/bloodwork) | **Office/Clinic:** No Charge.<br><br>**Outpatient/Inpatient Hospital/Facility:** No charge | 50% coinsurance after the OON deductible is met. | Some diagnostic tests/imaging performed at an outpatient hospital/facility are also covered at no charge if billed as a stand-alone service. |

| | | | | |
|---|---|---|---|---|
| | | after the INN deductible or the OOPM, whichever is met first. | | Certain services may require prior authorization. |
| | Advanced Imaging (CT/PET scans, MRIs) | **Office/Clinic:** No Charge.<br><br>**Outpatient/Inpatient Hospital/Facility:** No charge after the INN deductible or the OOPM, whichever is met first. | | Advanced imaging may include CT/PET scans, MRIs, and/or nuclear medicine. Certain services may require prior authorization. |
| If you need drugs to treat your illness or condition More information about prescription drug coverage is available by visiting https://www.express-scripts.com/gravie or by calling Gravie Care®. | Generic drugs (Tier 1) | **30-day supply (Retail):** No Charge.<br>**90-day supply (Retail/Mail):** No Charge. | Not covered | ACA-mandated preventive drugs are covered at 100%.<br><br>Additional cost-sharing may apply for brand-name prescription drugs when a generic equivalent is available. An exceptions process is available for brand-name contraceptives when medically necessary.<br><br>With limited exceptions, over-the-counter (OTC) drugs are not covered.<br><br>The deductible does not apply to Tiers 1, 2, or 3 drugs.<br><br>For drugs eligible for the SaveOn Copay Assistance Program, your cost-sharing will be 30% of the drug cost if you opt out of SaveOn Copay Assistance. This expense does not apply toward the plan OOPM.<br><br>All specialty drugs must be filled at the designated Specialty Pharmacy (Accredo).<br><br>Certain prescription drugs may require |
| | Preferred brand drugs (Tier 2) | **30-day supply (Retail):** $75 copayment.<br>**90-day supply (Retail/Mail):** $150 copayment. | Not covered | |
| | Non-preferred brand drugs (Tier 3) | **30-day supply (Retail):** $100 copayment.<br>**90-day supply (Retail/Mail):** $200 copayment. | Not covered | |
| | Non-Formulary drugs (Tier 4) | **Retail/Mail:** No charge after the INN deductible or the OOPM, whichever is met first. | Not covered | |
| | Specialty drugs | **With SaveOn Copay Assistance Program (for eligible specialty drugs):** No Charge<br><br>**Other Specialty drugs:** No charge after the INN deductible or the OOPM, whichever is met first. | Not covered | |

| | | | | |
|---|---|---|---|---|
| | | | | prior authorization or be subject to quantity limits. |
| If you have outpatient surgery | Facility fee (e.g., ambulatory surgery center) | No charge after the INN deductible or the OOPM, whichever is met first. | 50% coinsurance after the OON deductible is met. | Certain services may require prior authorization. |
| | Physician/surgeon fees | No charge after the INN deductible or the OOPM, whichever is met first. | 50% coinsurance after the OON deductible is met. | |
| If you need immediate medical attention | Emergency room care | $500 copayment/visit. No additional cost-sharing applies. | | Emergency room care is covered as if services were provided in-network. Non-emergency care may be subject to cost-sharing. |
| | Emergency medical transportation | No charge after the INN deductible or the OOPM, whichever is met first. | | **Air Ambulance** is covered as if services were provided in-network. **Ground Ambulance** is subject to in-network cost-sharing but you may be responsible for charges in excess of the allowed amount. |
| | Urgent care | No Charge. | 50% coinsurance after the OON deductible is met. | Cost-sharing depends on how the provider bills. If an urgent care visit is billed as hospital emergency room services, the emergency room cost sharing will apply. |
| If you have a hospital stay | Facility fee (e.g., hospital room) | No charge after the INN deductible or the OOPM, whichever is met first. | 50% coinsurance after the OON deductible is met. | Prior authorization is generally required for inpatient hospitalizations. |
| | Physician/surgeon fees | No charge after the INN deductible or the OOPM, whichever is met first. | 50% coinsurance after the OON deductible is met. | |
| If you need mental health, behavioral health, or substance abuse services | Outpatient services | **Office Visit:** No Charge.<br><br>**Outpatient Hospital/Facility:** No charge after the INN deductible or the OOPM, whichever is met first. | 50% coinsurance after the OON deductible is met. | Outpatient hospital/facility services include intensive outpatient and partial hospitalization services.<br>Certain services may require prior authorization. |

| | | | | |
|---|---|---|---|---|
| | Inpatient services | No charge after the INN deductible or the OOPM, whichever is met first. | 50% coinsurance after the OON deductible is met. | Prior authorization is generally required for inpatient hospitalizations. |
| If you are pregnant | Office visits | No charge for preventive prenatal care. | 50% coinsurance after the OON deductible is met. | Cost-sharing does not apply for preventive services. Depending on the type of services, cost-sharing may apply. Maternity care may include tests and services described elsewhere in this SBC (e.g., ultrasound). |
| | Childbirth/delivery professional services | No charge after the INN deductible or the OOPM, whichever is met first. | 50% coinsurance after the OON deductible is met. | You will pay 100% of the cost until the deductible or OOPM is met. The plan provides benefits for hospitalization in connection with childbirth for 48 hours following a vaginal delivery or 96 hours following a delivery by cesarean section. Prior authorization may be required for longer stays. |
| | Childbirth/delivery facility services | No charge after the INN deductible or the OOPM, whichever is met first. | 50% coinsurance after the OON deductible is met. | |
| If you need help recovering or have other special health needs | Home health care | No charge after the INN deductible or the OOPM, whichever is met first. | 50% coinsurance after the OON deductible is met. | Limited to 100 visits per plan year. May require prior authorization. |
| | Rehabilitation services | **Office/Clinic:** No Charge.<br><br>**Outpatient/Inpatient Hospital/Facility:** No charge after the INN deductible or the OOPM, whichever is met first. | 50% coinsurance after the OON deductible is met. | Cardiac Rehabilitation services are only covered at the outpatient/inpatient hospital/facility level. Certain services may require prior authorization. |
| | Habilitation services | **Office/Clinic:** No Charge.<br><br>**Outpatient/Inpatient Hospital/Facility:** No charge after the INN deductible or the OOPM, whichever is met first. | 50% coinsurance after the OON deductible is met. | Certain services may require prior authorization. |
| | Skilled nursing care | No charge after the INN deductible or the OOPM, whichever is met first. | 50% coinsurance after the OON deductible is met. | Limited to 120 visits per plan year. Certain services may require prior authorization. |
| | Durable medical | No charge after the INN | 50% coinsurance after the OON | Limits may apply. Certain services may |

| | | | | |
|---|---|---|---|---|
| | equipment (DME) | deductible or the OOPM, whichever is met first. | deductible is met. | require prior authorization. |
| | Hospice services | No charge after the INN deductible or the OOPM, whichever is met first. | 50% coinsurance after the OON deductible is met. | Certain services may require prior authorization. |
| If your child needs dental or eye care | Children's eye exam | No Charge. | 50% coinsurance after the OON deductible is met. | One eye exam per child per plan year. |
| | Children's glasses | Not covered | | N/A |
| | Children's dental check-up | Not covered | | N/A |

## 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.)

- Abortion, except when a provider operating within the scope of their license determines that: (a) the pregnancy is a result of rape or incest; or (b) the life or health of the mother would be endangered if the fetus is carried to full term.
- Acupuncture
- Bariatric Surgery
- Cosmetic Surgery (unless reconstructive surgery)
- Dental Care (Adult, Routine)
- Hearing Aids
- Infertility Treatment
- Long-Term Care
- Non-Emergency Care when Traveling outside the U.S.
- Private-Duty Nursing
- 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
- 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. Contact the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or 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 on how to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform or call Gravie Care® at 866.863.6232, weekdays, 8 a.m. to 5 p.m. CST.

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 866.863.6232.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 866.863.6232.

Chinese (中文): 如果需要中文的帮助, 请拨打这个号码866.863.6232.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 866.863.6232.

**PRA Disclosure Statement:**

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1146. The time required to complete this information collection is estimated to average 0.08 hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

## 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** | **$7,900** |
| **Specialist cost sharing** | **$0** |
| **Hospital (facility) cost sharing** | **$0** |
| **Other cost sharing** | **$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 | $7,900 |
| Copayments | $0 |
| Coinsurance | $0 |
| *What isn't covered* | |
| Limits or exclusions | $60 |
| **The total Peg would pay is** | **$7,960** |

### Managing Joe's Type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

| | |
|---|---|
| **The plan's overall deductible** | **$7,900** |
| **Specialist cost sharing** | **$0** |
| **Hospital (facility) cost sharing** | **$0** |
| **Other cost sharing** | **$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 | $1,000 |
| Coinsurance | $0 |
| *What isn't covered* | |
| Limits or exclusions | $20 |
| **The total Joe would pay is** | **$1,820** |

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

| | |
|---|---|
| **The plan's overall deductible** | **$7,900** |
| **Specialist cost sharing** | **$0** |
| **Hospital (facility) cost sharing** | **$0** |
| **Other cost sharing** | **$0** |

**This EXAMPLE event includes services like:**
Emergency room care *(including medical supplies)*
Diagnostic test *(x-ray)*
Durable medical equipment *(crutches)*
Rehabilitation services *(physical therapy)*

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

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

| *Cost Sharing* | |
|---|---|
| Deductibles | $1,200 |
| Copayments | $400 |
| Coinsurance | $0 |
| *What isn't covered* | |
| Limits or exclusions | $0 |
| **The total Mia would pay is** | **$1,600** |

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