Gray & Son, Inc.
2023 Benefits & Enrollment Guide
Plan Year April 1, 2023 – March 31, 2024

You can also access this document from your employee portal at: www.graynson.com
To login to the portal, use your employee number (Employee ID Number) and date of birth (password).

Last Updated: February 3, 2023

GRAY & SON, INC.

2023 Benefits & Enrollment Guide

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2023 BENEFITS AND OPEN ENROLLMENT

Open enrollment for 2023 medical, dental, vision, and flexible spending benefits is from February 16, 2023, to March 13, 2023. Coverage that you elect during open enrollment will be effective April 1, 2023 and will remain in effect until March 31, 2024.

All enrollment forms must be returned to Human Resources by **March 13, 2023.**

Here are some highlights on the programs for 4/1/2023 to 3/31/2024.

Medical and Pharmacy Plans
Our Pharmacy Benefit providers are US Rx Care (for retail, mail order and specialty medicines) and ScriptSourcing for Voluntary International mail order. For 2023, we are adding PaydHealth to assist in acquiring certain high-cost specialty medicines. Participants who get their specialty drugs through PaydHealth will save money with minimal to zero copays while also reducing the costs our Plan pays for these drugs.

Each year our Medical and Pharmacy benefits cost approximately $4,500,000. For 2023 – 2024, it is estimated that the costs of these benefits will increase by approximately 11%! We are all experiencing inflation in our business and in our personal lives. However, we will not pass on the 11% to you, our participants. The company will absorb 6.5% and participants will see their rates increase by 4.5%.

Whatever you can do to improve your overall health and reduce benefits plan costs is so important. Please:

1. use CIGNA PPO In Network providers whenever possible,
2. choose generic drugs when they are available,
3. save money on co-pays by using mail order,
4. check out the Voluntary International Pharmacy program for those expensive meds that you have to take on a regular basis. Save money on co-pays and help our plan costs.
5. Get assistance under the Wellness Program to stop smoking and get your medical premiums decreased after being smoke free for 90 days!
6. If you or your spouse or dependents have Diabetes Type I or II, then we encourage you to check out and enroll in Livongo.
7. Participate in the 2023 Wellness Campaign! Earning 300 Wellness Points from 4/1 – 12/31/23 will mean you could save up to $600 on your 4/1/24 medical premiums.

BENEFIT ELIGIBILITY

If you are a regular, full time, active employee working at least 30 hours per week, you are eligible for the benefits described in this book. Most coverage is effective on the day following the Employee's completion of 90 days of continuous employment. If you are enrolling during our annual enrollment period, your elections will be effective on the first day of April.

Eligible dependents include:

- Your legally married spouse.
- Your dependent children are eligible until age 26, regardless of their marital and/or student status.
- Your disabled children of any age provided the incapacity commenced before age 26.
- Voluntary Dependent Life: Your dependent children to age 21 or under 25 if a fulltime student.

All new enrollees are required to provide documentation for dependents status, i.e., marriage and/or birth certificates as applicable.

CHANGING YOUR BENEFITS

At Open Enrollment, you may make changes to your Benefit Elections. Your elections will remain in effect and will not change until an election is made during an open enrollment period, or unless you experience a life qualifying event. If you experience a life qualifying event you can make changes to your health, dental, vision, FSA, voluntary disability, and voluntary life insurance. The election change must correspond with that gain or loss of eligibility. Qualifying Life Status Changes include:

- You, your spouse or eligible dependent terminate or begin employment.
- You, your spouse or eligible dependent experience a reduction or increase in hours of employment.
- Your marital status changes through marriage, the death of your spouse, divorce, or annulment. An ex-spouse is not an eligible dependent under our plan. Coverage will be effective for your spouse on the 1st of the month following the date of marriage.
- Your number of dependents changes because of birth, adoption, placement for adoption, or death of a dependent. Coverage will be effective on the date of birth or adoption or placement for adoption.
- Your dependent satisfies or ceases to satisfy the requirements for coverage under the plan due to attainment of age, student status, or any similar circumstances.
- You, your spouse or eligible dependent experience a change in the place of residence or work location.

You may also be permitted to change your elections for health coverage under the following circumstances.

- You or your spouse experience(s) a significant change in health coverage attributable to your spouse's employment.
- There is a judgment, decree, or order resulting from a divorce, legal separation, annulment or change in legal custody including a qualified medical child support order (as defined in ERISA) that requires accident or health coverage for an employee's child. The employee can change his or her election to (1) provide coverage for the child if the order requires coverage under the employee's plan; or, (2) cancel coverage for the child if the order requires the former spouse to provide coverage.
- Eligibility for Medicare or Medicaid.
- You have a Special Enrollment Right.

For purposes of all other benefits under the Plan you will be deemed to have a Life Status Change if the change is on account of and consistent with a change in Family Status, as determined by the Plan Administrator, in his/her discretion, under applicable law and the Plan provisions.

You must notify Human Resources within 30 days of any Status Change to make a change to your Benefits elections, except as outlined in the Notice Regarding Special Enrollment Rights.

NOTICE REGARDING SPECIAL ENROLLMENT RIGHTS

If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance or group health plan coverage, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage, or if the employer stops contributing towards yours or your dependents other coverage. However, you must request enrollment within 30 days after you or your dependents other coverage ends.

In addition, if you have a new dependent because of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents. However, you must request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption.

Two additional special enrollment events are available to you and your eligible dependents.

1. Becoming ineligible for Medicaid or the Children's Health Insurance Program (CHIP). If you or your dependents become ineligible for Medicaid or CHIP, you may be able to enroll yourself and your dependents in the Gray & Son, Inc. Flexible Benefits Plan. You must request enrollment within 60 days.

2. Becoming eligible for Premium Assistance through Medicaid or CHIP. If you or your dependents become eligible for premium assistance from Medicaid or CHIP, you may be able to enroll yourself and your dependents in the Gray & Son Inc. Flexible Benefits Plan. You must request enrollment within 60 days.

For more details about these special enrollment opportunities, please consult your Summary Plan Description. To request special enrollment contact Human Resources at Gray & Son, Inc.

MEDICAL PLAN COMPARISON

HIGHLIGHTS OF COVERAGE UNDER MEDICAL PLANS

SUMMARY OF SERVICES	High Option		Basic Option		Low Option (Individual Only)	
	In CIGNA PPO Network	Out-of-Network*	In CIGNA PPO Network	Out–of-Network*	In CIGNA PPO Network	Out–of-Network*
Deductible (Individual/ Family)	$400/ $800	$1,000/ $2,000	$750/ $1,500	$1,500/ $3,000	$2,000	$2,000
Out of Pocket Medical (Individual/ Family)	$2,400/ $4,800	$4,800/ $9,600	$3,250/ $6,500	$7,000/ $14,000	$5,000	$9,000
Out of Pocket Prescription Card	$3,300/ 6,600	n/a	$3,300/ $6,600	n/a	$1,600	n/a
Co-Insurance	90% Plan 10% Employee	70% Plan 30% Employee	80% Plan 20% Employee	60% Plan 40% Employee	80% Plan 20% Employee	60% Plan 40% Employee
INPATIENT						
Room & Board – Semi-Private	Ded & Co-Ins	Ded & Co-Ins	Ded & Co-Ins	Ded & Co-Ins	Ded & Co-Ins	Ded & Co-Ins
Surgery	Ded & Co-Ins	Ded & Co-Ins	Ded & Co-Ins	Ded & Co-Ins	Ded & Co-Ins	Ded & Co-Ins
Physician Visits	$15 PCP $30 Specialist	Ded & Co-Ins	$20 PCP $40 Specialist	Ded & Co-Ins	$20 PCP $40 Specialist	Ded & Co-Ins
OUTPATIENT						
Physician Visits - Primary Care	$15 co-pay	Ded & Co-Ins	$20 co-pay	Ded & Co-Ins	$20 co-pay	Ded & Co-Ins
GBMC PCPs	$5 co-pay	n/a	$10 co-pay	n/a	$10 co-pay	n/a
Specialist Visits	$30 co-pay	Ded & Co-Ins	$40 co-pay	Ded & Co-Ins	$40 co-pay	Ded & Co-Ins
Second Surgical	$30 co-pay	Ded & Co-Ins	$40 co-pay	Ded & Co-Ins	$40 co-pay	Ded & Co-Ins
Diagnostic/X-Ray/Lab	Co-Ins	Ded & Co-Ins	Co-Ins	Ded & Co-Ins	Co-Ins	Ded & Co-Ins
Facility Charge -- O.P. Surgery	Ded & Co-Ins	Ded & Co-Ins	Ded & Co-Ins	Ded & Co-Ins	Ded & Co-Ins	Ded & Co-Ins

SUMMARY OF SERVICES	High Option		Basic Option		Low Option (Individual Only)	
	In CIGNA PPO Network	Out-of-Network*	In CIGNA PPO Network	Out–of-Network*	In CIGNA PPO Network	Out–of-Network*
Well Care-Child Birth -- 17 years)	$0 co-pay	Ded & Co-Ins	$0 co-pay	Ded & Co-Ins	$0 co-pay	Ded & Co-Ins
OUTPATIENT						
Well Care-Adult (includes lab work)	$0 co-pay	Ded & Co-Ins	$0 co-pay	Ded & Co-Ins	$0 co-pay	Ded & Co-Ins
Routine Pap Smear	Covered 100%	Ded & Co-Ins	Covered 100%	Ded & Co-Ins	Covered 100%	Ded & Co-Ins
Routine Mammography	Covered 100%	Ded & Co-Ins	Covered 100%	Ded & Co-Ins	Covered 100%	Ded & Co-Ins
Urgent Care	$40 co-pay	$40 co-pay	$50 co-pay	$50 co-pay	$50 co-pay	$50 co-pay
Emergency Room	$150 co-pay	$150 co-pay	$150 co-pay, 80% coinsurance	$150 co-pay, 80% coinsurance	$150 co-pay, 80% coinsurance	$150 co-pay, 80% coinsurance
MENTAL HEALTH						
Inpatient - Facility	Ded & Co-Ins	Ded & Co-Ins	Ded & Co-Ins	Ded & Co-Ins	Ded & Co-Ins	Ded & Co-Ins
Inpatient/ Outpatient - Visits	$30 co-pay	Ded & Co-Ins	$40 co-pay	Ded & Co-Ins	$40 co-pay	Ded & Co-Ins
SUBSTANCE ABUSE						
Inpatient - Facility	Ded & Co-Ins	Ded & Co-Ins	Ded & Co-Ins	Ded & Co-Ins	Ded & Co-Ins	Ded & Co-Ins
Inpatient/ Outpatient - Visits	$30 co-pay	Ded & Co-Ins	$40 co-pay	Ded & Co-Ins	$40 co-pay	Ded & Co-Ins
SPECIALIST						
Chiropractor (Maximum $1,000 per plan year)	90% of the Plan's Allowable Amount after deductible	70% of the Plan's Allowable Amount after the deductible	80% of the Plan's Allowable Amount after the deductible	60% of the Plan's Allowable Amount after the deductible	80% of the Plan's Allowable Amount after the deductible	60% of the Plan's Allowable Amount after deductible

IMPORTANT: Call (800) 793-9403 prior to any planned inpatient Hospital stay or within 48 hours after an emergency admission and for certain other benefits listed in the Schedule of Benefits within the SPD to pre-certify this coverage

USING YOUR MEDICAL PLAN

Our medical plans are administered by Allegeant. Because Gray & Son, Inc. is self-insured for medical and prescription coverage, Allegeant functions as our third-party claim's administrator. They provide superior claims administration and customer service for our medical plans.

CIGNA IN-NETWORK PROVIDERS

Gray & Son, Inc. members have access to the National CIGNA PPO (Preferred Provider) network. PPO providers are doctors, hospitals and other health care providers who have contracted with CIGNA. When

you visit an In Network provider, you will not have any claim forms to complete. You will be identified by your Allegeant membership ID card. Providers will bill CIGNA directly and have agreed to accept the network's allowed amount for services. You will not be billed for any amounts above the network's allowance except for your applicable co-pays, deductibles or coinsurance under the plan.

You can locate a provider at **WWW.CIGNA.COM** click on "find a doctor", and then click on the link that reads "plans through your employer or school". Now, select your medical plan from the drop down, choose Cigna PPO. You will now be able to find a doctor in network. Information can also be obtained by contacting Allegeant at 800-793-9403.

OUT-OF-NETWORK PROVIDERS

If you use an out-of-network medical provider, you will be responsible for the higher out-of- network deductible, copays and coinsurance. Non-participating providers have no contractual status with CIGNA and may not be reimbursed directly by Allegeant. You may be responsible for paying your provider in full, and then you will be reimbursed directly by Allegeant based on the "usual, customary and reasonable charges" (UCR) for the services rendered. Allegeant utilizes Eplan to negotiate out- of -network claims when UCR is not appropriate. **Note: Renal Dialysis is not covered with providers who are out- of-network.**

HOW TO USE YOUR MEDICAL COVERAGE

Your health insurance is self-funded through Gray & Son, Inc. with Allegeant (800-793-9403) as the health claims processor. Gray & Son leases the Cigna network to provide you access to a national provider network. Cigna has affiliated/ancillary networks as well (see below for more information). Cigna network providers accept the network allowed amount and are paid under the in-network benefits.

The provider may collect applicable copayments, deductibles and/or coinsurance that are due at the time of service.

What is a Copayment? A copayment (or "copay") is a fee that you owe a doctor for certain services. The fee is a flat dollar amount.

What is a Deductible? The amount of money you must pay in covered expenses over 1 plan year. After you pay your deductible, the Gray & Son plan will start paying for certain covered expenses.

What is Coinsurance?
Coinsurance is a percentage of covered charges you owe a doctor for your care after your deductible (if applicable) is satisfied. Gray & Son pays the rest if your care is rendered by an in-network provider.

Submitting Claims: Your provider should bill all medical claims directly to Cigna using the group and member ID as well as the clam submission information on your ID card:

- EDI (electronically): Payer ID 62308
- Mail: Cigna, PO Box 188061, Chattanooga TN 37422-8061

Lab work: If your provider does lab work in their office and will be sending the sample to an outside lab for analysis, please make sure they send it to Quest Diagnostics or Lab Corp with a copy of your ID card so the billing can be submitted correctly.

Cigna Affiliated Networks: The Cigna Ancillary networks you will likely see are below. If you see a provider that is affiliated with one of these networks, the payment will be made directly to the Ancillary Network and not to the rendering provider. The Ancillary Network will reimburse the rendering provider directly.

Network	Covered Services
eviCore*	Freestanding Radiology Centers, Home healthcare, home infusion therapy, Orthotics & Prosthetics , DME (See DME document)
American Specialty Health Network (ASHN)	Chiropractors, Physical Therapists, Occupational Therapists

*eviCore does not list their providers on the Cigna website. Members/Providers who need a service which is provided by eviCore should call eviCore directly at 1-800-298-4806. eviCore will coordinate the patient's needs with a participating provider and will notify the provider who will be providing the service via letter or call if there is urgency.

PRE-CERTIFICATION GUIDELINES FOR THE GRAY & SON, INC. MEDICAL PLANS

The following must be pre-certified:

Inpatient hospital stays	Extended care facility stays	Hospice Care	Chemotherapy
Radiation Therapy	Organ Transplants	Private Duty Nursing	Maternity cases within 1st trimester of pregnancy
Intravenous Therapy		Durable Medical Equipment over $1000	

Your physician may handle this on your behalf, but it is your responsibility to confirm that authorization has been made. If certification is not made for inpatient services that are determined to be medically necessary, benefits will be reduced by $1,000 and the penalty amount does not count towards your out of pocket (OOP) maximum. Requests for pre-certification can be made by calling 800-793-9403, Option 2.

PRENOTIFICATION/OUTPATIENT REVIEW GUIDELINES

Our plan requires that you call Allegeant when your physician recommends certain out-patient procedures or services. Notification should be made prior to the date of the service or procedure for outpatient dialysis.

GENERAL NOTE ON PRECERTIFICATION OR PRENOTIFICATION

Contact the number on your ID card to request pre- certification or to provide notification of any of the services listed in the Summary Plan Description. **There may be a penalty and reduction in benefits for failing to follow the Plan guidelines for pre-certification and outpatient review**. In some cases, a retroactive review may result in a reduction of benefits paid. In other cases, benefits may be denied completely.

HEARING AID INFORMATION

Costco White Marsh, MD
9919 Pulaski Highway; Middle River, MD 21220
410-574-7563

Costco Glen Burnie, MD
575 E Ordnance Road; Glen Burnie, MD 21060
410-590-8633

Costco Lancaster, PA
1875 Hempstead Road; Lancaster, PA 17601
717-396-8460

COSTCO MEMBERSHIPS: Executive Membership - $120.00 w/ 2% cash back "Reward" on eligible Costco and Costco travel purchases. Business or Gold Membership - $60.00.

SERVICES OFFERED: Free Hearing Test (by 90 minute appointment). If hearing aids are needed, you can "try out" a pair before purchasing.

UPDATE: Employees covered under our medical plan can submit receipts directly to Allegeant and receive **$1000.00** reimbursement every 2 years for hearing aid purchases. This benefit also includes batteries.

GBMC

ARE YOU USING A GBMC PRIMARY CARE PHYSICIAN?

If you choose a GBMC Primary Care Physician, you receive a reduced co-pay for visits in all three plans:

- $5 High Option Plan
- $10 Basic or Low Option Plans

- If you are interested in learning more about GBMC Primary Care Physician, you can access all the information you need, including the ability to request an appointment online, by logging onto www.mygbmcdoctor.com.

- You can ask for assistance at GBMC by calling 443-849-GBMC.

- There are offices on the GBMC campus and throughout Baltimore County. Offices are open early in the morning, late at night and on the weekends.

You may also call Allegeant at 1-800-793-9403 (Option 1) for assistance.

FSA- FLEXIBLE SPENDING ACCOUNT

What is a Health Flexible Spending Account (FSA)?
An FSA is an employer-sponsored savings account for health care expenses. You are not taxed on the money you put into an FSA. You use the account to pay for qualified out-of-pocket health care costs, such as your deductible and copays, but not your weekly premium.

If you had an FSA during the 2022/2023 plan year and have a remaining FSA balance at the end of the plan year, then you are permitted to carryover $570 of unused FSA money into the 2023/2024 plan year.

If you elect an FSA for the 2023/2024 plan year, you will be able to carryover up to $610 of unused funds.

Opening your new FSA
At the beginning of the Plan Year, you will elect how much you want to contribute to your FSA. The amount you elect will be for the entire plan year, and Gray & Son will deduct the weekly amount from your paycheck each week.

Contributions and Making Changes
Your elected contribution amount can only be changed if you experience a qualifying life event, such as a change in family status and your FSA permits you to change your election.

The amount you choose to set aside in your FSA should be based on the amount of qualifying medical expenses you anticipate your family incurring during the plan year. Remember that it is typically best to underestimate your expenses by a little than to overestimate and lose money at the end of the year.

Contribution Limits
For year 2023 the maximum amount you can contribute to your FSA is $3,050.

Using Your Health FSA
An employee's entire annual FSA election amount, less any amount already used, must be available at any time of the plan year—even if that full amount has yet to be contributed to the account. When you are paying for a qualified medical expense, you typically have two choices: using a health payment card or requesting reimbursement.

Reimbursement
You can pay out-of-pocket for FSA expenses and then submit receipts for reimbursement. Go online to submit a reimbursement or contact Human Resources. When submitting for reimbursement, you will need your receipts and proof that what you paid for was an eligible medical expense.

Qualified Expenses
Employees may use their health FSAs to pay for or reimburse themselves for their own eligible medical expenses, as well as their spouses' and dependents' eligible medical expenses. Eligible medical expenses are unreimbursed medical care expenses. Health FSAs cannot be used to pay for non-medical expenses.

Life Events
Certain life events may affect your FSA.

Employment status changes – Your employer owns the FSA. Typically, if you leave your job before you've used the FSA funds, the employer will keep the amount left in the account. However, you may be eligible to elect COBRA and continue your FSA until the end of the year.

Death – If you die, the contributions to your FSA will stop, but your survivors can file claims until the filing deadline for any remaining eligible expenses that you or your family members incurred.

FSA- BENEFITS DEBIT CARD

The Benefits Debit Card
You will receive one card when you enroll, and you can request additional cards for your spouse and dependents who are 18 years of older.

How It Works
WEX will provide you with a debit card that you can use for eligible medical services or products. The money will then be deducted from your FSA account. Where you swipe the card will determine whether any steps are needed after that. In addition to using your benefits debit card to pay for services at your healthcare provider's office, you can also use it at the following types of merchants:

IIAS
Many merchants provide IRS-required information for documentation right at the point of sale through an Inventory Information Approval System (IIAS). An IIAS merchant auto-substantiates the claim, so you will not need to provide additional documentation on qualifying expenses.

Pharmacies
The debit card also works at pharmacies or drug stores that meet the IRS' 90 percent rule. At least 90 percent of the gross sales at these merchants come from eligible medical expenses. For a full list of IIAS and 90 percent rule merchants, visit www.wexinc.com.

Spending
Common eligible expenses for a Medical FSA are prescription drugs, hearing aids, orthopedic goods, and doctor and dentist visits. If you need to spend down your balance but are not sure what to use your funds on, you can discover thousands of eligible FSA expenses at **www.wexinc.com/insights/benefits-toolkit/eligible-expenses/**

Health Payment Card
Health care payment cards may be used only on eligible medical expenses that are not reimbursed or covered by another source. Eligible expenses do include over-the-counter medications and menstrual products. Health care payment cards may not be used to cover more than the maximum dollar amount of coverage available in your FSA. Every claim paid with a health care payment card must be reviewed and substantiated. At times receipts do not need to be submitted for verification of expenses. This applies in three situations, at a medical providers office and at 90-percent pharmacies (drug stores and pharmacies

where at least 90 percent of the store's gross receipts during the prior taxable year consisted of medical expenses):

- When the total cost of the transaction is equal to the standard copayment for the service(s) received
- When the transaction is for recurring expenses that have previously been approved
- When the merchant provides expense verification to the employer when the transaction takes place

PATIENT ADVOCATE/CARE MANAGEMENT – WHY YOU NEED TO PRE-CERTIFY OR PRE-NOTIFY WHEN YOU NEED SERVICES

The Patient Advocate Program can help medical plan participants learn more about how to use their health care benefits and make better decisions about their medical treatment. This Program acts as a patient resource to help answer your questions and help you through what is sometimes referred to as the "health care maze."

The Patient Advocate is a Nurse Case Manager who works with your Primary Care Physician. The program does not interfere with your patient/doctor relationship in any way. By working with the nurse care manager, you can strive to receive the most appropriate care while effectively using the health benefits available to you through our Medical Plan. The nurse can help arrange for services prescribed by your Physician. And, most importantly, the nurse will keep in touch with you to ask if your treatment plan is working to your satisfaction.

You begin to become involved with the program if you:

- are admitted to the Hospital, become pregnant, become aware that an organ or transplant may be needed, need specific services as identified below, are diagnosed with a serious illness or condition; or need extensive outpatient services other than inpatient Hospital, such as outpatient hospital, laboratory, X-ray, physical therapy, and doctors' visits.

HOW THE PROGRAM WORKS

The Patient Advocate Program is easy to use—just remember these few simple guidelines:

1. Call prior to any planned inpatient Hospital stay or within 48 hours after an emergency admission.
2. Call during the first three months (trimester) of a pregnancy, or as soon as the pregnancy is confirmed.
3. Call as soon as you become aware that an organ or tissue transplant may be needed. The Plan provides you access to a "center of excellence" program for treatment-intensive and costly organ and tissue transplants. This Transplant Management Program **is mandatory** and involves contracting with medical centers that have demonstrated clinical excellence in this specific field. Through accessing these "centers" you can enhance the potential for positive clinical outcomes while reducing costs for both yourself and the Plan.
4. Call to pre-certify (receive approval) for certain other benefits listed in the Schedule of Benefits. Benefits subject to precertification include, but not limited to, inpatient hospitalization, extended care facility, hospice care, chemotherapy, radiation therapy, organ transplant, private duty nursing, intravenous infusion therapy, and durable medical equipment that costs over $1000.
5. Call to pre-notify if your physician recommends you need outpatient dialysis.

Call Allegeant at 1-800-793-9403 to pre-certify or pre-notify any of the services above.

FOR EXTRAORDINARY CIRCUMSTANCES FOR COMPLEX DIAGNOSIS AND ILLNESSES

When you or a dependent are diagnosed with a serious illness or a catastrophic condition, such as a spinal cord injury, cancer, or a premature birth, a person may require long-term, perhaps lifetime care.
A Nurse Care Manager can help you to understand and use your benefits more effectively, arrange for treatment ordered by your Physician, answer questions, and refer you to Network participating Physicians.

In this situation a Nurse Care Manager is assigned to monitor the patient and explore, discuss and recommend coordinated and/or alternate types of appropriate Medically Necessary Care. The Nurse Care Manager consults with the patient, the family and the attending Physician in order to develop a plan of care for approval by the patient's attending Physician and the patient. The plan of care may include some or all of the following:

- personal support to the patient, contacting the family to offer assistance and support, monitoring Hospital, Skilled Nursing Facility, Home Health Care and Hospice Care, determining alternative care options; and assisting in obtaining any necessary equipment and services.

The Nurse Care Manager will coordinate and implement the program by providing guidance and information on available resources and suggesting the most appropriate treatment plan. The Plan Administrator, attending Physician, patient and patient's family must all agree to the alternate treatment plan. Nurse Care Managers are provided by calling Allegeant at 1-800-793-9403.

PLAN PENALTIES FOR NON-COMPLIANCE

Because the Patient Advocate Program is such an important part of the Medical Plan, all Covered Persons must follow the guidelines in order to receive full Plan benefits. If the Claims Administrator is not contacted prior to a planned Hospital admission, or within 48 hours of an emergency admission, Plan benefits will be reduced by $1,000 and the Penalty amount you pay will not count toward your Out-Of-Pocket Maximum (OOP) limits. Please be sure to call in order to receive the maximum benefit allowed under the Plan. All you need to do is make a phone call in order to avoid paying expenses for medical care that will not be covered by the Plan if notification guidelines are not followed.

PRESCRIPTION DRUG COVERAGE

Your Prescription Drug Coverage will be provided through US-Rx Care if you are enrolled in our medical plans. The cost of the prescription benefit is included in your medical plan premium.

How to Get the Most From Your Benefit, While Minimizing Your Out-Of-Pocket Cost
The pharmacy benefit plan is associated with a "formulary". The formulary determines what level copay applies to each drug covered under the plan. The employee prescription benefit plan has various copay tiers. You can request a copy of the plan formulary to share with your doctor by calling the US-RX Care Advocate line at 1-800-241-8440.

An Advocate can also reach out to your doctor on your behalf to explore lower-cost formulary options that he/she is comfortable prescribing.

Lower Cost Glucose Testing Supplies
There are many options for glucose testing technology with the highest accuracy rating and ease of use, but costs do vary widely by manufacturer. The preferred, contracted glucose testing meter and strips is the TRUE METRIX meter and test strips. Simply present your benefit card to your pharmacist when purchasing your testing supplies, and they will provide you with a FREE TRUE METRIX meter.

The test strips are covered under the plan at the Tier 1 copay. Tier 2 or Tier 3 copay may apply to other brands of test strips. The TRUE METRIX meter and test strips will be the best value.
For free test strips, and a meter, enroll in the new Livongo Diabetes management program.

If The Pharmacy Has Trouble Processing Your Coverage For A Prescription Medication
If you do pay the full cash price for a prescription without using your benefit card, you can ask the pharmacy to reprocess your prescription using your benefit card within 7-14 calendar days and get full reimbursement directly from the pharmacy for any overpaid amount, as long as the medication is covered under the plan.

PRESCRIPTION CO-PAYMENTS

	AT A RETAIL PHARMACY	THROUGH MAIL ORDER
Tier 1 – lowest cost medications and most Generic drugs	$10 up to 30-day supply; $30 for a 90-day supply $0 certain Preventive Generic drugs	$20 up to 90-day supply $0 certain Preventive Generic drugs
Tier 2 – some Generics and Preferred Brand-name drugs	$35 up to 30-day supply; $105 for a 90-day supply	$70 up to 90-day supply
Tier 3-high cost Generics and Non-preferred Brand-name drugs	$55 up to 30-day supply; $165 for a 90-day supply	$110 up to 90-day supply
Specialty Medications	$75 for 30-day supply at US-Rx Care Specialty Pharmacy	$75 each for up to 30-day supply at US-Rx Care Specialty Pharmacy

GENERIC PRESCRIPTIONS

Generic prescriptions are the equivalent of brand name drugs, with the same active ingredients and chemical purity; however, their development costs are less. Therefore, generics are priced substantially lower than their brand name counterparts. When receiving a prescription, make sure to alert your doctor or pharmacist that you are interested in receiving the generic medication.

MAIL ORDER

Your prescription benefit plan includes access to a mail-order pharmacy. The mail-order pharmacy provider is Prescription Mart, based in Beaumont, Texas. Mail order pharmacy will be a lower-cost option for your maintenance medications that you take on a regular, long-term basis when you order 90-day supplies. To enroll and place orders, call Prescription Mart at **877- 451-4994**. Then contact your doctor to have new 90-day prescription with refills sent to Prescription Mart. Your doctor can phone in your prescriptions, fax **(877-212-7258)** them to the pharmacy, or send them to the pharmacy electronically. You can also mail in hard copies of your prescriptions to **P.O. Box 12607, Beaumont, TX 77726-2607**. Faxed prescriptions can only come from a doctor's office by law.

SPECIALTY PHARMACY

Specialty medications include injectables, infused drugs or high dollar oral medications. These are provided in a 30-day supply through the appropriate Specialty provider. When prescribing a Specialty Medication, your doctor will contact US-Rx Care to obtain a Prior Authorization. To assist your physician, you can download a form for your doctor from **www.USRxCare.com/providers.**

Once your Specialty medication is authorized, your script will be sent to a Specialty pharmacy. The Specialty pharmacy will contact you to register with the pharmacy and provide your delivery and billing information. The co-payment for this level of coverage will be $75.

If you have questions about your Specialty medication, you may contact US-Rx Care at (877) 200-5533 and ask to speak with a clinical team member.

US-RX CARE- FAQ'S

What to do if you are told that your prescription was rejected:
Ask the pharmacist why it rejected and if they can resolve the rejection. Ask the pharmacist to call the US-RX Care helpline at 877-200-5533 for help to resolve the rejection.

What to do if you are told that the medication is not covered and/or a Prior Authorization is needed.
Ask the pharmacist to call the number provided in their computer system to initiate a coverage review. If this is a refill, US-Rx Care will review the prescription and authorize an interim supply until a Prior Authorization review is completed. If this is a new (first time fill) prescription, the Prior Authorization review must be completed before your prescription can be filled.

Request a Medication Review
You can also proactively contact an Advocate directly at 1-800-241-8440 for a complete medication review or to inquire about a new drug that may have been prescribed for you. It is part of the employee health benefit available to you and it's FREE!

What to do if you are told a Max Cost Limit was reached.
When a max cost limit is exceeded, Prior Authorization is required before the medication can be covered under the plan. This notification does not mean that plan benefits have been exceeded or that the medication can't be covered under the plan. It simply means that additional review is required.
Ask the pharmacist to call the number provided in their computer system to initiate a coverage review. If this is a refill, US-Rx Care will review the prescription and authorize an interim supply until a Prior Authorization review is completed. If this is a new (first time fill) prescription, the Prior Authorization review must be completed before your prescription can be filled.

What to do if you are told that your medication must be filled at a Specialty Pharmacy.
If your doctor writes a new prescription for a Specialty medication, Prior Authorization will be required for a coverage determination under the plan. If appropriate, based on national guidelines, standards of care, and current best practices, an alternative course of treatment may be recommended to your doctor on your behalf. Your doctor can initiate the Prior Authorization process for a new or existing prescription by downloading a simple form available at https://usrxcare.com/providers/. If you have any additional questions about accessing your Specialty medication, contact 877-200-5533 and ask for a Clinical Team member to return a call to you.

LIVONGO FOR DIABETES- FREE METER, TEST STRIPS & SUPPORT

This program is offered at no cost to you to help make living with Diabetes more manageable. You and your family members who have been diagnosed with Diabetes I or II can join the program if you and they are covered under the Company's medical plans.

When you enroll in Livongo, you will receive at no charge to you:

- **Connected Meter:** Automatically uploads your blood glucose readings to your secure online account and provides real-time personalized tips.
- **Support from Coaches when you need it:** Communicate with a coach anytime about diabetes questions on nutrition or lifestyle changes.
- **Unlimited testing strips at no cost to you:** when you are about to run out, Livongo ships more supplies, right to your door.

How to enroll in Livongo:

1. Visit join.livongo.com/REGCODE/register to register and answer a few questions about you and your health. Next, download the Livongo app and log in.
2. Call Livongo Member Support at 1-800-945-4355.
3. Registration code is **GRAYANDSON**

After enrolling, you will be shipped the Livongo Welcome Kit that includes the Livongo meter and all the strips and lancets you need to check your blood sugar. You will receive access to the Livongo member website, my.livongo.com, where you can personalize the program and access your readings.

You can cancel your membership at any time for any reason. Just call Livongo at 1-800-945-4355 or email help@livongo.com.

How to reorder testing strips:

1. Through your member websites at my.livongo.com
2. Through your Livongo meter
3. Through the Livongo mobile app
4. By calling Member Support at 1-800-945-4355
5. Shipping is free.

SCRIPTSOURCING- VOLUNTARY INTERNATIONAL PHARMACY

ScriptSourcing helps save employees money on name brand medications. USA consumers pay up to 16 times more than other countries for the exact same brand medications. ScriptSourcing's international pharmacy management firm has been sourcing medications internationally for employers for 20 years without incident through 4 "tier one" countries.

A "tier one" country is a country deemed by congress to have the same or higher standards as the FDA. Name-brand medications are sourced through Canada, United Kingdom, Australia, and New Zealand, i.e., English-speaking countries that negotiate directly with pharmaceutical manufacturers.

Features and Benefits

- $0 copay for maintenance name brand drugs for employees and dependents
- $0 shipping to home
- $0 out of pocket
- +70% savings
- 90 day supply mail order

ScriptSourcing's International Pharmacy program is voluntary. Please call 1-866-488-7874 if you are interested in this offer.

PAYD HEALTH- SELECT DRUGS AND PRODUCTS PROGRAM

The Paydhealth Select Drugs and Products Program provides advocacy services to assist you by identifying and facilitating your enrollment in programs that may reduce or eliminate your out-of-pocket costs for eligible specialty drugs, products, and services.

If you are prescribed a drug included on the Paydhealth Select Drugs and Products List, you must enroll in the Program to comply with benefit requirements. A Case Coordinator will contact you directly to guide you through the program. The Plan continues to offer generous healthcare benefits but needs your help to continue to meet this goal.

After enrolling in the Select Drugs and Products Program, you will be asked to complete certain documentation related to the alternate funding programs identified by your Case Coordinator. This will include providing required documents and information to the alternate funding program and may require your prescriber's participation as well. Your timely responses will help you avoid any delays in processing your documentation.

Your Case Coordinator will help you obtain your eligible specialty drugs, products or services and reduce your out-of- pocket costs by coordinating alternative forms of funding. After your acceptance into an alternate funding program, your Case Coordinator will contact you before and after each refill to ensure there is no disruption in your treatment and the funding.

Your active role in helping the Plan reduce its costs and yours is important. The Plan is sponsoring this program at no cost to you. However, you may be required to pay a portion of the cost to acquire your specialty drug, product or service depending on specific situations.

A Case Coordinator is available (8:00 am to 8:00 pm CST) at 1-877-869-7772 to guide you through the enrollment process and the program. Please respond to calls from your Case Coordinator in a timely manner.

WELLNESS- APRIL 1, 2023, TO DECEMBER 31, 2023

Here are the details on this year's Wellness Program. To be Wellness Compliant and receive your $600 premium discount effective 4/1/24, you must earn 300 wellness points.

1. Earn 300 wellness points by completing:
    - Your annual physical (100 points)
    - Your biometric screening (100 points)
    - 2 additional preventative services, i.e., dental exam, flu shot, vision exam, etc., (50 points each), or the Health Risk Assessment (100 points)

See your Wellness brochure for additional details on the program and how you can earn a $50 or $75 gift card for completing additional Wellness activities.

WHY SHOULD YOU PARTICIPATE IN THE WELLNESS PROGRAM?

- You may find out that you have some health issues that need attention.
- Get support in making some changes that may improve your health, longevity and overall quality of life
- Get the help you need to manage your conditions so that you're able to stay in the workforce longer.
- Save money! Earn points for participating and get rewarded with the best prices for health coverage.
- A healthy employee population helps the Company's finances by better controlling costs for health coverage.

WHAT'S THE TIMING FOR THE 2023 PROGRAM?

1. Our 2023 Wellness Program will run from 4/1/2023 through 12/31/2023.
2. If you do some of your annual preventive care such as you annual physical, eye exam, dental exam between 1/1/23 and 4/1/23, you will be able to use this care for points.

DENTAL PLAN

The United Concordia PPO plan offers access to the participating dentist of your choice. Diagnostic and Preventive Care is covered at 100% in-network and out-of-network with no deductible.

Most covered services require an individual deductible ($50/individual, $150/family), and then the plan pays a percentage of the covered charges based on the services that you receive. This plan will pay up to $1,250 per person per year in dental benefits.

The plan has a $1,000 per person lifetime maximum for orthodontia. Orthodontia is limited to dependent children under the age of 19. A provider list may be accessed online at **www.ucci.com** or by calling 800-332-0366. You will receive a separate United Concordia ID Card for your dental services.

Our Participating Network of Dental Providers is **Advantage Plus.** Below is a representative listing of covered services. A detailed description is available in our United Concordia Summary Plan Description.

Benefit Category	United Concordia- Advantage Plus Plan	
	In-Network	Non-Network
Class I – Diagnostic/Preventive Services *		
Exams	100%	100%
Bitewing X-rays		
All Other X-rays		
Cleanings & Fluoride Treatments		
Sealants		
Space Maintainers		
Palliative Treatment		
Class II – Basic Services		
Basic Restorative (Fillings)	80%	80%
Simple Extractions		
Endodontics		
Nonsurgical Periodontics		
Surgical Periodontics		
Complex Oral Surgery		
General Anesthesia		
Class III – Major Services		
Inlays, Onlays, Crowns	60%	50%
Prosthetics (Bridges, Dentures)		
Repairs of Crowns, Inlays, Onlays, Bridges & Dentures		
Single Tooth Implant**	60% of in-network maximum	50% of out- of -network maximum
Orthodontics for dependent children to age 19		
Diagnostic, Active, Retention Treatment	50%	50%
Maximums & Deductibles (applies to the combination of services received from network and non-network dentists)		
Annual Program Deductible (per person/per family)	$50/$150 Excludes Class I & Orthodontics	
Annual Program Maximum (per person)	$1,250 Excludes Orthodontics	
Lifetime Orthodontic Maximum (per person)	$1,000	
Reimbursement	**Advantage *Plus* 90th Percentile**	

*Class I does not count against Annual Program Maximum.

**Single Tooth Implant- The Company will pay implantology benefits for eligible Members for the following (see below) Covered Services equal to 60% In-Network of the Maximum Allowable Charge, and 50% Out-of-Network of the Maximum Allowable Charge.

- **Implant Placement-** Endosteal, Eposteal, Transosteal, Mini
- **Surgical Services-** Second stage implant surgery, Implant removal, Debridement of peri implant defects, Debridement, and osseous contouring of peri implant defect, Bone graft at time of implant placement
- **Supporting Structures,** Connecting bar, Prefabricated abutment, Custom fabricated abutment
- **Implant/Abutment Supported Prosthetics-** Removable Dentures, Fixed Dentures (Hybrid Prosthesis), Single Crowns, Fixed Partial Dentures
- **Other Implant Related Procedures-** Osseous, osteoperiosteal, or cartilage graft of the mandible or maxilla, Sinus augmentation, lateral open approach, Sinus augmentation, vertical approach, Bone replacement graft for ridge preservation

IMPACTED WISDOM TEETH- if the member has both medical and dental insurance, Impacted Wisdom Teeth are considered a medical claim. For In-Network benefits, please use a CIGNA PPO provider.

VISION PLAN

Gray & Son, Inc. provides a separate vision benefit that is offered through Superior Vision by MetLife. Our plan is Superior National Network.

How to find a provider: On the Superior web site, **WWW.SUPERIORVISION.COM** or call Customer Service at 1-800-507-3800 for help locating a provider or to answer any questions.

Superior will provide ID Cards to new members; however, you may print a replacement card from **WWW.SUPERIORVISION.COM.** After you have identified and contacted a participating provider, they will use your ID number (your Social Security number) to confirm your coverage with Superior by MetLife.

Vision Benefit Frequency:

- Eye Exam, Eyeglass Lenses, Eyeglass Frames and Contact Lenses once every 12 months

COVERAGE	IN-NETWORK	OUT-OF-NETWORK
EYE EXAMS	$10 copay	$10 copay
Eye Examination (Optometrist)	Covered in full after copay	Reimbursed up to $52
Eye Examination (Ophthalmologist)	Covered in full after copay	Reimbursed up to $60
CONTACT LENS FITTING	$25 copay	Reimbursed up to $30 (copay does not apply)
Contact Lens Fitting (Standard[2])	Covered in full	Reimbursed up to $37
Contact Lens Fitting (Specialty[2])	$50 retail allowance	Reimbursed up to $37
EYEGLASS MATERIALS (eyeglasses in lieu of contact lenses)	$25 copay	$25 copay
Lenses (Standard) Per Pair: Single Bi-focal Tri-focal Lenticular	Covered in full after copay	Reimbursed up to: Single $45 Bi-focal $65 Tri-focal $86 Lenticular $119
Standard Frames	$100 retail allowance	Reimbursed up to $64
CONTACT LENS MATERIALS (contact lenses in lieu of eyeglasses & frames)	$25 copay	$25 copay
Elective Contact Lenses	$100 retail allowance	Reimbursed up to $90
Medically Necessary Contact Lenses	Covered in full	Reimbursed up to $233
LENS UPGRADE*	Available when you use your eyeglass lens benefit	
Polycarbonate Lenses *(members age 19 and under)*	Member out-of-pocket Maximum $40	
Standard Progressive Lenses	Covered in full lined trifocal amount (subject to material copay)	Reimbursed up to $86 (subject to material copay)
Plastic Photochromic Lenses	Member out of pocket $80	

[2]**Standard** Contact Lens Fitting applies to a current contact lens user who wears disposable, daily wear, or extended wear lenses only.
[2]**Specialty** Contact Lens Fitting applies to new contact wearers and/or a member who wears toric, gas permeable, or multi-focal lenses.
***Lens Upgrade**- Look for providers in our provider directory at **https://superiorvision.com/locator/** who accept discounts, as some do not; please verify their services and discounts prior to service as they can vary.

2023/2024 BENEFIT PREMIUMS

52 Week Premium Schedule - Wellness Compliant Medical Pricing

High Option	52 Week Non-Smoker Wellness Deduction	4/1/22 – 3/31/23 Annual Premium	52 Week Smoker Wellness Deduction	4/1/22 – 3/31/23 Annual Premium
Employee	27.58	1,434.16	48.51	2,522.52
Employee + 1	104.81	5,450.12	138.17	7,184.84
Family	165.50	8,606.00	206.16	10,720.32
Basic Option				
Employee	20.69	1,075.88	39.47	2,052.44
Employee + 1	82.74	4,302.48	105.27	5,474.04
Family	125.50	6,526.00	155.71	8,096.92
Low Option				
Employee	0	0	16.03	833.56

52 Week Premium Schedule - Non-Wellness Medical Pricing

High Option	52 Week Non-Smoker Non-Wellness Deduction	4/1/22 – 3/31/23 Annual Premium	52 Week Smoker Non-Wellness Deduction	4/1/22 – 3/31/23 Annual Premium
Employee	43.61	2,267.72	65.20	3,390.40
Employee + 1	122.31	6,360.12	156.53	8,139.56
Family	184.13	9,574.76	225.78	11,740.56
Basic Option				
Employee	36.59	1,902.68	55.99	2,911.48
Employee + 1	99.82	5,190.64	123.02	6,397.04
Family	143.38	7,455.76	174.38	9,067.76
Low Option				
Employee	15.51	806.52	32.11	1,669.72

Vision	52 Week Deduction	4/1/22 – 3/31/23 Annual Premium
Employee	1.08	56.04
Employee + 1	2.24	116.40
Family	3.32	172.64

Dental	52 Week Deduction	4/1/22 – 3/31/23 Annual Premium
Employee	3.10	161.18
Employee + 1	6.39	322.36
Family	8.26	429.81

<u>36 Week Premium Schedule</u>- Wellness Medical Pricing. For employees subject to seasonal furlough.

High Option	36 Week Non-Smoker Wellness Deduction	4/1/22 – 3/31/23 Annual Premium	36 Week Smoker Wellness Deduction	4/1/22 – 3/31/23 Annual Premium
Employee	39.85	1,434.16	70.07	2,522.52
Employee + 1	151.40	5,450.12	199.57	7,184.84
Family	239.04	8,606.00	297.78	10,720.32
Basic Option				
Employee	29.88	1,075.88	57.02	2,052.44
Employee + 1	119.53	4,302.48	152.06	5,474.04
Family	181.29	6,526.00	224.90	8,096.92
Low Option				
Employee	0	0	23.15	833.56

36 Week Premium Schedule - Non-Wellness Medical Pricing

High Option	36 Week Non-Smoker Non-Wellness Deduction	4/1/22 – 3/31/23 Annual Premium	36 Week Smoker Non-Wellness Deduction	4/1/22 – 3/31/23 Annual Premium
Employee	62.99	2,267.72	94.19	3,390.40
Employee + 1	176.66	6,360.12	226.10	8,139.56
Family	265.96	9,574.76	326.12	11,740.56
Basic Option				
Employee	52.84	1,902.68	80.88	2,911.48
Employee + 1	144.18	5,190.64	177.69	6,397.04
Family	207.11	7,455.76	251.89	9,067.76
Low Option				
Employee	22.39	806.52	46.39	1,669.72

Vision	36 Week Deduction	4/1/22 – 3/31/23 Annual Premium
Employee	1.56	56.04
Employee + 1	3.23	116.40
Family	4.80	172.64

Dental	36 Week Deduction	4/1/22 – 3/31/23 Annual Premium
Employee	4.48	161.18
Employee + 1	8.96	322.36
Family	11.94	429.81

Premiums are deducted for the pay period ending April 8, 2023 (payroll check date April 14, 2023) and will continue for 36 weeks or until payroll check dated <u>December 15, 2023</u>. If you are furloughed before <u>December 9, 2023</u>, you may owe for missed premiums.

EMPLOYER PAID BASIC LIFE INSURANCE AND AD&D

Gray & Son, Inc. provides all full time employees with Basic Life Insurance. Coverage begins after 90 days of employment. Coverage is one times your annual base earnings rounded to the next highest $1000, up to a maximum benefit of $50,000. Benefits are reduced at age 70 to 50%. The Company also provides Accidental Death & Dismemberment coverage equal to one time your base earnings rounded to the next highest $1000, up to a maximum benefit of $50,000. Benefits are reduced at age 70 to 50%. This benefit is through Mutual of Omaha.

VOLUNTARY LIFE INSURANCE AND AD&D COVERAGE

Gray & Son, Inc. offer a Voluntary Supplemental Life Insurance plan through Mutual of Omaha to all full time benefit eligible employees. Employees may purchase up to $250,000 in coverage for themselves in increments of $10,000. Spouse supplemental life is available in increments of $5,000 up to the lesser of 50% of the employee's supplemental life or $125,000. Child supplemental life is available in amounts of $5,000 or $10,000. The employee is responsible for the full cost of this benefit.

When first eligible for this benefit as a new hire, you may elect up to the Guaranteed Issue amount of insurance ($100,000 for employee and $50,000 for spouse) without providing evidence of good health. Any amount exceeding the Guaranteed Issue amount will require medical underwriting.

Each year you may submit a Written Request to increase the voluntary amount of insurance by $10,000 up to the Guaranteed Issue Amount. If you do not elect coverage as a new hire and later wish to enroll, any amount of insurance requires evidence of insurability and approval by the insurance company. See Human Resources for prices and application forms. This benefit is through Mutual of Omaha.

SHORT TERM DISABILITY

Short Term Disability (STD) is a benefit paid by the company for all full time employees. It provides income replacement if you become disabled and are unable to work. You will become eligible for Short Term Disability benefits after 90 days of employment. STD benefits begin on the 8th day of absence due to sickness, non-work accidents, pregnancy, or hospitalization. Benefits are paid at 60% of your weekly earnings up to a maximum of $2,000 per week. Benefits may be paid for up to 26 weeks. This benefit is through Mutual of Omaha.

VOLUNTARY LONG TERM DISABILITY (FOR FULL TIME NON EXEMPT EMPLOYEES)

Voluntary Long Term Disability (LTD) provides income replacement if you continue to be disabled after your 26 weeks of Short Term Disability benefits are exhausted and you are medically unable to return to work.

Voluntary LTD will replace 60% of your monthly income up to a maximum of $5,000 per month. Benefits may generally be paid for up to 2 years as long as you remain totally disabled and are under a physician's care. As a new employee you may elect Voluntary Long Term Disability to be effective on the first of the month after you complete 90 days of service.

Disabilities that occur during the first 12 months of coverage due to a pre-existing condition during the 12 months prior to coverage are excluded. This benefit is through Mutual of Omaha.

KEPRO: EMPLOYEE ASSISTANCE PROGRAM- FREE TO ALL EMPLOYEES

Phone: **800-607-1522** Website: **www.EAPHelplink.com** Company Code: **WEBEAP**

COUNSELING SERVICES Up to three (3) counseling sessions are available for issues affecting employees and their dependents. Individuals may speak with a professional counselor by phone, and the Employee Assistance Program will provide a referral to see a local counselor at no cost for issues.	- Anxiety - Stress - Depression - Grief- Transition and change - Relationships- individual, marital, family - Parenting - Drug or alcohol abuse
FAMILY CAREGIVING SERVICES Confirmed referrals and information are available on a variety of family matters, including:	*Childcare and Parenting* - Prenatal care - Daycare/summer camps - Special needs services - Preparing students for college *Eldercare* - Assisted living - In-home care - Transportation services - Adult daycare
LEGAL SERVICES A 30 minute phone or in-person consultation is available to help answer basic legal questions and simplify the process of obtaining legal help. Some common legal concerns include:	- Adoption - Bankruptcy - Child custody - Criminal issues - Divorce - Estate planning - Immigration - Real estate - Tenant's rights - Mediation
FINANCIAL SERVICES A telephonic consultation with a qualified financial consultant is available to assist with a variety of financial concerns such as:	- Bankruptcy alternatives - Budgeting and cash flow - Credit issues - Identity Theft - Education funding - Income taxes - Mortgages - Retirement planning
ONLINE TOOLS AND INFORMATION EAPHelplink.com is an interactive web-based self-service solution. The site provides a wide array of life management tools to help members with a variety of personal and/or work related issues in a private and convenient manner.	- Research articles - Wellness articles - Online trainings - Monthly webinars - Self-search locators for child, academic, and adult care resources

CONFIDENTIALITY: All discussions between you and your EAP professional are confidential. Information regarding your contact with the EAP cannot be released without your written consent, except by court order, imminent threat or harm to self or others, or in situations of abuse (such as child or elder abuse).

NO OUT OF POCKET COST: Your EAP is offered at no cost. Most concerns can be resolved directly with your EAP professional, but in the case that additional services are needed, your EAP professional will work with you to identify the most appropriate and affordable community resource to help meet your needs. Please note that referral to services outside the EAP benefit may require out of pocket costs.

DURABLE MEDICAL EQUIPMENT (DME) & HOME HEALTH SERVICES

Cigna offers a network of national ancillary providers to ensure convenient access to cost effective, quality medical supplies and equipment in the comfort of your home.

What is a Durable Medical Equipment?

Medical equipment (e.g., Hospital beds, wheelchairs, etc.) which:

1. is medically necessary and prescribed by a licensed Physician
2. can withstand repeated use.
3. is primarily and customarily used to serve a medical purpose, such as treatment of an illness or injury, improvement of a malformed body member, or prevention of deterioration of the patient's medical condition.
4. is generally not useful to a person in the absence of an Illness or Injury.
5. is appropriate for use in the home; and
6. is not primarily for the convenience of the patient.

All requirements above must be met before an item can be considered Durable Medical Equipment.

Home Health Services: In home services include rehabilitation, physical therapy, cardiac and wound care as well as intravenous treatment to deliver fluids and prescription drugs.

Pre-notification: Call Allegeant at 1-800-793-9403 to pre-certify or pre-notify if your physician recommends that you receive durable medical equipment that costs **$1,000.00 or more**.

Below is a list of Durable Medical Equipment (DME) and Home Health Services offered. Please select the DME or Home Health Service that pertains to your need and call the number associated with it.

In Home- Delivery Durable Medical Equipment

Ambulatory aids

Equipment and supplies that aid with walking, such as walkers, crutches, and canes.

- eviCore- 1-800-298-4806

Beds & Accessories

Hospital beds, adjustable and electric beds, and pressure mattresses.

- eviCore- 1-800-298-4806

Breast Feeding pumps and supplies. Manual and standard electric breast pumps and replacement supplies.

Note: A physician's prescription is required.

- eviCore- 1-800-298-4806

Cardiology devices & equipment

Heart monitoring equipment and services, including arrhythmia monitors, Holter monitors, and digital and wireless monitoring.

- Advanced Cardiac Monitoring- 1-800-455-0272
- Bardy Diagnostics, Inc. dba BDx Solutions, Inc.- 1-281-453-2100
- CardioLabs, Inc.- 1-800-304-1098
- Cardionet, Inc.- 1-866-426-4402
- iRhythm Technologies- 1-888-693-2401
- Lifewatch, Inc.- 1-877-774-9846
- Pacemaker Monitoring Center, Inc. dba Cardiac Monitoring Center- 1-800-399-8622
- Preventative Services, LLC (effective 11/1/17)- 1-888-747-1422
- Remote Cardiac Services- 1-877-640-9587
- ZOLL LifeVest Holdings- 1-800-543-3267

Compression Garments
Compression (tight fitting) clothing for all areas body used to help post-surgery healing and improve circulation.

- Electromed- 1-952-758-9299
- Luna Medical, Inc.- 1-800-380-4339

Continuous Positive Airway Pressure (CPAP) equipment and sleep apnea breathing devices.
Breathing equipment and devised to help with sleep apnea and related sleeping disorders.

- eviCore- 1-800-298-4806

External prosthetics and orthotics
Artificial devices (prosthetics) to replace body parts, such as arms and legs, braces and slings, and other types of support (orthotics) to help with healing, pain relief, or physical movement.

- DJO, LLC- 1-800-336-6569
- Linkia- 1-877-754-6542
- eviCORE – 1-800-298-4806

International normalized ratio (INR) services
Rapid diagnostic test to measure clotting time for patients, using blood thinners.

- Alere Home INR monitoring- 1-800-563-5801
- Cardionet, Inc. (BioTelemetry, Inc.)- 1-866-426-4402
- mdINR- 1-800-877-4910

Medical Supplies
Disposable health care supplies including bandages, catheters, diabetes testing kits, blood glucose meters, and supplies for wound care, ostomy, and incontinence.

- 180 Medical Inc.- 1-877-688-2729
- Adapt Health Patient Care Solutions- 1-888-202-5700
- Byram Healthcare- 1-877-902-9726
- CCS Medical- 1-800-726-9811
- Edgepark Medical Supplies- 1-800-321-0591
- McKesson Patient Care Solutions, Inc.- 1-888-202-5700
- Medline Industries- 1-800-633-5463
- Solara Medical Supplies- 1-800-999-7516
- Strive Medical- 1-888-771-9229

Motorized scooter and electric wheelchairs
Motorized scooters, electric wheelchairs, lifts, ramps, and vehicle accessories to aid mobility.

- eviCore- 1-800-298-4806

Nebulizers
Portable devices and inhalers that deliver treatment using mist to help manage asthma and other breathing problems.

- eviCore- 1-800-298-4806

Oxygen and Respiratory Equipment
Oxygen tanks, respirators, and supplies (home and portable use).

- eviCore- 1-800-298-4806

Replacement hearing aid batteries
Replacement batteries for digital and digitally programmable analog hearing aids.

- Amplifon Hearing Health Care- 1-888-669-2175

Wheelchairs and accessories
Transport chairs and manual wheelchairs, including models that are lightweight, heavyweight, and recline. There are also types for sports and pediatric use.

- eviCore- 1-800-298-4806

In- home health care services
In addition to home delivery options, we also have a network of participating providers that can perform medical services in your home.

Fetal Monitoring
Use of electronic devices to check a baby's heartbeat before and during childbirth, electronic fetal monitoring (EFM), fetal stress tests, and baby heartbeat monitors.

- Optum Women's and Children's Health LLC- 1-800-950-3963
- Healthy Connections Home Care Services, Inc.- 1-888-304-1800

Home health services
Providers of in-home care for the elderly, individuals with diabetes, or other injuries. This includes rehabilitation and physical therapy, heart disease (cardiac) care, and wound care.

- Alere Women's and Children's Health LLC- 1-800-950-3963
- eviCore- 1-800-298-4806

Home infusion services
Nursing services for intravenous (IV) treatment to deliver fluids, and prescriptions, including chemotherapy, fluid replacement, HIV/AIDS drug treatment, and antibiotics.

- eviCore- 1-800-298-4806

Sleep disorder services
Testing to measure brainwaves and rapid eye movement (REM) during sleep to diagnose and manager sleep disorders.

- Watermark Medical, Inc.- 1-877-710-6999

2023 RESOURCE DIRECTORY

Allegeant
Medical Claims, Pre-Certification, Pre-Notify, Customer Service, Patient Advocate, Wellness Tracking
800-793-9403
WWW.ALLEGEANT.NET

CIGNA PPO – Medical Provider Network
Group #: GSMPI
WWW.MYCIGNA.COM
WWW.CIGNA.COM

DENTAL PROVIDER:
United Concordia
800-332-0366
WWW.UCCI.COM

VISION PROVIDER:
Superior Vision by MetLife
1-800-507-3800
WWW.SUPERIORVISION.COM

PHARMACY BENEFITS:
US- Rx Care
(877) 200-5533 (24/7)
www.USRxCare.com

US-Rx Care – Prior Authorizations (For Physician use) 1-877-200-5533

US-Rx Care: Prescription Mart – Mail Order
Phone: 1-800-630-3206
Website: www.presmartinc.com
Fax: 800-398-2860

ScriptSourcing
1-866-488-7874

Payd Health
1-877-869-7772

LIVONGO (DIABETES BENEFIT)
1-800-945-4355
www.join.livongo.com/REGCODE/register
Registration code: GRAYANDSON

EMPLOYEE ASSISTANCE PROGRAM
KEPRO
Company Code: WEBEAP
800-607-1522
WWW.EAPhelplink.com

LIFE AND DISABILITY INSURANCE:
Mutual of Omaha
Customer Service 800-769-7159
GPS.EAST@MUTUALOFOMAHA

401(K) PROFIT SHARING PLAN

Eligibility
Employees are eligible to participate in the Salary Deferral component of the Plan on the first day of the month after attaining age 21 and the completion of 90 days of service. Contributions are made through payroll deduction.

New enrollees will be automatically enrolled in the 401(K) at a 3% pre-tax deferral rate unless they contact Principal to make a change.

Effective 1/1/23, you are now able to make 2 types of salary deferrals into our 401(k) Plan

1. You may continue to make Pre-Tax deferral contributions to the Plan. With this type of contribution, you pay taxes on the money when you withdraw it, generally at retirement – not when the contribution is taken from your paycheck.

2. **New in 2023!** You may also contribute after tax money called Roth contributions into the plan. With Roth contributions, you pay taxes on the money when you contribute it – not when you withdraw it as long as you meet the following criteria:
    a. You are at least 59 1/2
    b. Your Roth account has been open for at least 5 consecutive calendar years.

In-Plan Roth Conversions
Participants in our 401(K) will also be able to do a Roth conversion in their account. This allows participants to convert a lump sum of their vested account balance from pre-tax to Roth. The converted balance is considered taxable income for the year the conversion is made. A Roth conversion can be a powerful tax planning strategy that can provide tax free income in retirement. This option allows participants to pay taxes on money now rather than leaving it in a non-Roth account and paying taxes on withdrawals after retirement.

Contribution Limits
You will be able to contribute pre-tax or Roth contributions, or a combination of the two, up to the annual IRS contribution limits. For 2023, the limits are $22,500 plus an additional $7,500 catch up Limit for participants age 50 and older.

Employer Match
Employees are eligible to participate in the Discretionary Employer Matching Contribution and Profit Sharing Contribution components of the Plan on the first day of the month following attainment of age 21 and completion of one (1) year of service. For details on the Plan including automatic enrollment and escalation and vesting, refer to the Summary Plan Description or contact Human Resources.

Before making any 401(K) decisions, it is recommended to consult with your individual tax advisor and/or financial professional.

401(K) PROFIT SHARING – CONTACT INFORMATION

PRINCIPAL
1-800-547-7754
WWW.PRINCIPAL.COM

MORGAN STANLEY SMITH BARNEY (Financial Advisors)
Steve Lowman
301-961-1823
Stephen.Lowman@morganstanley.com

WAYS TO ACCESS AND MANAGE YOUR 401(K) ACCOUNT AT PRINCIPAL

You can do all these things by phone and online!

- Check account balance
- Check investment performance
- Contribution Changes
- Request or review loan information
- Review investment options
- Manage your rollover funds
- Transfer retirement funds between available investment options

Phone Instructions	
First- Time Users	**Ongoing Account Access**
1. Call 1-800-547-7754 2. Enter your social security number. 3. Listen to the menu and select an option. 4. When prompted, establish your personal identification number (PIN) using your Account/Contract Number: **818891**	1. Call 1-800-547-7754 2. Enter your social security number when prompted. 3. Listen to the menu and select an option. 4. If prompted, entered your PIN.
Online Instructions	
First- Time Users	**Ongoing Account Access**
1. Go to principal.com/ Welcome 2. Select get started. 3. Enter your first name, last name, date of birth, mobile phone number, and your ID number or ZIP code. 4. Agree to do business electronically and click continue. 5. If you don't provide your mobile phone number, you'll need to answer a few personal questions as an alternative way to confirm it's really you. 6. Create a unique username, set a secure password and add your email address. 7. Select and answer three security questions to use if you need to call Principal. 8. You now have access to your online account, and you'll get a confirmation email within a few minutes. 9. The first time you log in, you'll need to choose where Principal should send your verification codes (text messages, voice call, or authentication app) and how often you want to use them.	1. Go to principal.com 2. Click log in. 3. Enter your username and password (click forgot password if you need to reset) and click log in. 4. If you're logging in from a new device, resetting your username or password, or you've opted to use verification codes every time you log in, you'll receive a security text message, voice call, or authentication app. 5. Enter the security code and click verify.

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 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, call (410) 771-4311. 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.dol.gov/ebsa/healthreform or call (410) 771-4311 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	In-Network Providers **$400** individual/**$800** family Out-of-Network Providers **$1,000** individual/**$2,000** 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, Primary Care Office Visit, Specialist Office Visit, Emergency Room, Urgent Care Centers, Telemedicine, Home Health Care	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 for this plan?	In-Network Providers **$2,400** individual/ **$4,800** family Out-of-Network Providers **$4,800** individual/ **$9,600** family Prescription Drug (separate) **$3,300** individual/**$6,600** family	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.
What is not included in the out-of-pocket limit?	Premiums, penalties for no pre-authorization, non-covered services, charges in excess of Plans' Allowable Amount	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. For the primary network, refer to www.Cigna.com for in-network benefits.	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		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	**GBMC PCP** $5 copayment; deductible does not apply **Non-GBMC PCP** $15 copayment; deductible does not apply	30% coinsurance	Telehealth services included.
	Specialist visit	$30 copayment; deductible does not apply	30% coinsurance	Telehealth services included.
	Specialist visit • Renal Dialysis • Chemotherapy • Radiation Therapy • Chiropractic Care • Acupuncture • Physical, Speech & Occupational Therapy	10% coinsurance	30% coinsurance	Precertification required and approval of facility prior to services rendered for Renal Dialysis. No out-of-network benefit for Renal Dialysis; Prenotification required for Chemotherapy & Radiation Therapy; Maximum $1,000 per plan year for Chiropractic Care; Maximum $1,000 per plan year for Acupuncture.
	Preventive care/screening/ immunization	No Charge	30% coinsurance	Routine GYN exam & pap smear: 1 per plan year; Routine Mammogram: Under age 40 with physician authorization; Age 40 and over: 1 per plan year; Routine Colonoscopy: 1 every 5 years ages 50 & over. 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. Telehealth services included.

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 test	Diagnostic test (x-ray, blood work)	10% coinsurance for all outpatient locations; deductible does not apply	30% coinsurance for all outpatient locations	None
	Imaging (CT/PET scans, MRIs)	10% coinsurance for all outpatient locations; deductible does not apply	30% coinsurance for all outpatient locations	
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.usrxcare.com	Lowest cost Generic drugs (Tier 1)	$10 copay (retail 30 day) $30 copay (retail 90 day) $20 copay (mail order 90 day)	Not covered	Copayments waived for certain generic fills for diabetes, hypertension & cholesterol drugs. Approved Over-the-Counter (OTC) & preventive drugs under the Patient Protection Affordable Care Act (PPACA) $0 copay. Refer to the US-Rx Care formulary list to determine the coverage and copayment that will be applied.
	Some Generics and Preferred Brand-Name drugs (Tier 2)	$35 copay (retail 30 day) $105 copay (retail 90 day) $70 copay (mail order 90 day)	Not covered	
	High cost Generics and Non-preferred Brand-Name drugs (Tier 3)	$55 copay (retail 30 day) $165 copay (retail 90 day) $110 copay (mail order 90 day)	Not covered	
	Specialty drugs (Tier 4)	$75 copayment for a 30 day supply. Must fill at designated Specialty Pharmacy.	Not covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	10% coinsurance	30% coinsurance	No charge for Well Women contraceptive services.
	Physician/surgeon fees	10% coinsurance	30% coinsurance	
If you need immediate medical attention	Emergency room care	$150 copayment; deductible does not apply	$150 copayment; deductible does not apply	None
	Emergency medical transportation	10% coinsurance	10% coinsurance	
	Urgent care	$40 copayment; deductible does not apply	$40 copayment; deductible does not apply	
If you have a hospital stay	Facility fee (e.g., hospital room)	10% coinsurance	30% coinsurance	Precertification required - $1,000 penalty for non-precertification.
	Physician/surgeon fees	10% coinsurance	30% coinsurance	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 need mental health, behavioral health, or substance abuse services	Outpatient Services	$30 copayment; deductible does not apply	30% coinsurance	Precertification required for inpatient services $1,000 penalty for non-precertification. Telehealth services for mental health included.
	Inpatient services	10% coinsurance	30% coinsurance	
If you are pregnant	Office visits	10% coinsurance	30% coinsurance	No charge for prenatal care if billed separately from delivery. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound). Precertification required if stay extends beyond the allowance under Federal Law.
	Childbirth/delivery professional services	10% coinsurance	30% coinsurance	
	Childbirth/delivery facility services	10% coinsurance	30% coinsurance	
If you need help recovering or have other special health needs	Home health care	$30 copayment; deductible does not apply	30% coinsurance	Maximum 40 visits per plan year.
	Rehabilitation services	10% coinsurance	30% coinsurance	Maximum $1,000 per plan for Chiropractic Care.
	Habilitation services	10% coinsurance	30% coinsurance	
	Skilled nursing care	10% coinsurance	30% coinsurance	Precertification required $1,000 penalty for non-precertification; Maximum 60 days per plan year.
	Durable medical equipment	10% coinsurance	30% coinsurance	Prenotification required for devices that cost more than $1,000.
	Hospice services	10% coinsurance	30% coinsurance	Precertification required $1,000 penalty for non-precertification; Maximum 180 days when combined with outpatient hospice.
If your child needs dental or eye care	Children's eye exam	Not covered	Not covered	Separate Vision Plan available
	Children's glasses	Not covered	Not covered	Separate Vision Plan available
	Children's dental check-up	Not covered	Not covered	Separate Dental Plan available

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 • Cosmetic Surgery • Hearing Aids & Fitting for Spouse or Dependent • Infertility Treatment (exam/testing only covered)	• Long-Term Care • Non-Emergency care outside of the U.S. • Renal Dialysis (out-of-network only) • Routine Dental Care	• Routine Foot Care (non-diabetic) • Routine Vision Care • Weight Loss Programs

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)		
• Acupuncture • Bariatric Surgery (requires pre-approval)	• Chiropractic Care • Hearing Aids & Fitting – Employee Only	• Hearing Examinations • Private Duty Nursing Services (precertification required)

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 those agencies is: state insurance department or the Department of Labor, Employee Benefits Security Administration at (866) 444-3272 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 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 Allegeant, (800) 793-9403. You may also contact the Department of Labor, Employee Benefits Security Administration at (866) 444-EBSA (3272) or 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 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 (800) 793-9403.
Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa (800) 793-9403.
Chinese (中文): 如果需要中文的帮助，请拨打这个号码 (800) 793-9403.
Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' (800) 793-9403.

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	$400
Specialist copayment	$30
Hospital (facility) coinsurance	10%
Other coinsurance	10%

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	**$12,800**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$400
Copayments	$40
Coinsurance	$1,100
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$1,600**

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

The plan's overall deductible	$400
Specialist copayment	$30
Hospital (facility) coinsurance	10%
Other coinsurance	10%

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	**$7,400**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$400
Copayments	$800
Coinsurance	$50
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$1,270**

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

The plan's overall deductible	$400
Specialist copayment	$30
Hospital (facility) coinsurance	10%
Other coinsurance	10%

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	**$1,900**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$400
Copayments	$200
Coinsurance	$100
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$700**

Gray & Son, Inc./Maryland Paving Management, Inc. Benefit Plan

Coverage for: Individual/Family | **Plan Type:** Basic Option

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 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, call (410) 771-4311. 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.dol.gov/ebsa/healthreform or call (410) 771-4311 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	In-Network Providers **$750** individual/**$1,500** family Out-of-Network Providers **$1,500** individual/**$3,000** 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, Primary Care Office Visit, Specialist Office Visit, Emergency Room, Urgent Care Centers, Telemedicine, Home Health Care	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 for this plan?	In-Network Providers **$3,250** individual/**$6,500** family Out-of-Network Providers **$7,000** individual/**$14,000** family Prescription Drug (separate) **$3,300** individual/**$6,600** family	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.
What is not included in the out-of-pocket limit?	Premiums, penalties for no pre-authorization, non-covered services, charges in excess of Plans' Allowable Amount	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. For the primary network, refer to www.Cigna.com for in-network benefits.	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		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	**GBMC PCP** $10 copayment; deductible does not apply **Non-GBMC PCP** $20 copayment; deductible does not apply	40% coinsurance	Telehealth services included.
	Specialist visit	$40 copayment; deductible does not apply	40% coinsurance	Telehealth services included.
	Specialist visit • Renal Dialysis • Chemotherapy • Radiation Therapy • Chiropractic Care • Acupuncture • Physical, Speech & Occupational Therapy	20% coinsurance	40% coinsurance	Precertification required and approval of facility prior to services rendered for Renal Dialysis. No out-of-network benefit for Renal Dialysis; Prenotification required for Chemotherapy & Radiation Therapy; Maximum $1,000 per plan year for Chiropractic Care; Maximum $1,000 per plan year for Acupuncture.
	Preventive care/screening/ immunization	No Charge	40% coinsurance	Routine GYN exam & pap smear: 1 per plan year; Routine Mammogram: Under age 40 with physician authorization; Age 40 and over: 1 per plan year; Routine Colonoscopy: 1 every 5 years ages 50 & over. 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. Telehealth services included.

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 test	Diagnostic test (x-ray, blood work)	20% coinsurance for all outpatient locations; deductible does not apply	40% coinsurance for all outpatient locations	None
	Imaging (CT/PET scans, MRIs)	20% coinsurance for all outpatient locations; deductible does not apply	40% coinsurance for all outpatient locations	
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.usrxcare.com	Lowest cost Generic drugs (Tier 1)	$10 copay (retail 30 day) $30 copay (retail 90 day) $20 copay (mail order 90 day)	Not covered	Copayments waived for certain generic fills for diabetes, hypertension & cholesterol drugs. Approved Over-the-Counter (OTC) & preventive drugs under the Patient Protection Affordable Care Act (PPACA) $0 copay. Refer to the US-Rx Care formulary list to determine the coverage and copayment that will be applied.
	Some Generics and Preferred Brand-Name drugs (Tier 2)	$35 copay (retail 30 day) $105 copay (retail 90 day) $70 copay (mail order 90 day)	Not covered	
	High cost Generics and Non-preferred Brand-Name drugs (Tier 3)	$55 copay (retail 30 day) $165 copay (retail 90 day) $110 copay (mail order 90 day)	Not covered	
	Specialty drugs (Tier 4)	$75 copayment for a 30 day supply. Must fill at designated Specialty Pharmacy.	Not covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance	40% coinsurance	No charge for Well Women contraceptive services.
	Physician/surgeon fees	20% coinsurance	40% coinsurance	
If you need immediate medical attention	Emergency room care	$150 copayment, 80% coinsurance; deductible does not apply	$150 copayment, 80% coinsurance; deductible does not apply	None
	Emergency medical transportation	20% coinsurance	20% coinsurance	
	Urgent care	$50 copayment; deductible does not apply	$50 copayment; deductible does not apply	

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% coinsurance	40% coinsurance	Precertification required - $1,000 penalty for non-precertification.
	Physician/surgeon fees	20% coinsurance	40% coinsurance	None
If you need mental health, behavioral health, or substance abuse services	Outpatient Services	$40 copayment; deductible does not apply	40% coinsurance	Precertification required for inpatient services $1,000 penalty for non-precertification. Telehealth services for mental health included.
	Inpatient services	20% coinsurance	40% coinsurance	
If you are pregnant	Office visits	20% coinsurance	40% coinsurance	No charge for prenatal care if billed separately from delivery. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound). Precertification required if stay extends beyond the allowance under Federal Law.
	Childbirth/delivery professional services	20% coinsurance	40% coinsurance	
	Childbirth/delivery facility services	20% coinsurance	40% coinsurance	
If you need help recovering or have other special health needs	Home health care	$40 copayment; deductible does not apply	40% coinsurance	Maximum 40 visits per plan year.
	Rehabilitation services	20% coinsurance	40% coinsurance	Maximum $1,000 per plan for Chiropractic Care.
	Habilitation services	20% coinsurance	40% coinsurance	
	Skilled nursing care	20% coinsurance	40% coinsurance	Precertification required $1,000 penalty for non-precertification; Maximum 60 days per plan year.
	Durable medical equipment	20% coinsurance	40% coinsurance	Prenotification required for devices that cost more than $1,000.
	Hospice services	20% coinsurance	40% coinsurance	Precertification required $1,000 penalty for non-precertification; Maximum 180 days when combined with outpatient hospice.
If your child needs dental or eye care	Children's eye exam	Not covered	Not covered	Separate Vision Plan available
	Children's glasses	Not covered	Not covered	Separate Vision Plan available
	Children's dental check-up	Not covered	Not covered	Separate Dental Plan available

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 • Cosmetic Surgery • Hearing Aids & Fitting for Spouse or Dependent • Infertility Treatment (exam/testing only covered)	• Long-Term Care • Non-Emergency care outside of the U.S. • Renal Dialysis (out-of-network only) • Routine Dental Care	• Routine Foot Care (non-diabetic) • Routine Vision Care • Weight Loss Programs

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)		
• Acupuncture • Bariatric Surgery (requires pre-approval)	• Chiropractic Care • Hearing Aids & Fitting – Employee Only	• Hearing Examinations • Private Duty Nursing Services (precertification required)

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 those agencies is: state insurance department or the Department of Labor, Employee Benefits Security Administration at (866) 444-3272 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 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 Allegeant, (800) 793-9403. You may also contact the Department of Labor, Employee Benefits Security Administration at (866) 444-EBSA (3272) or 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 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:
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Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa (800) 793-9403.
Chinese (中文): 如果需要中文的帮助，请拨打这个号码 (800) 793-9403.
Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' (800) 793-9403.

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	$750
Specialist copayment	$40
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	$12,800

In this example, Peg would pay:

Cost Sharing	
Deductibles	$750
Copayments	$50
Coinsurance	$2,100
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$2,960**

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

The plan's overall deductible	$750
Specialist copayment	$40
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	$7,400

In this example, Joe would pay:

Cost Sharing	
Deductibles	$750
Copayments	$800
Coinsurance	$30
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$1,600**

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

The plan's overall deductible	$750
Specialist copayment	$40
Hospital (facility) coinsurance	20%
Other coinsurance	20%

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	$1,900

In this example, Mia would pay:

Cost Sharing	
Deductibles	$750
Copayments	$300
Coinsurance	$300
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1,350**

Gray & Son, Inc./Maryland Paving Management, Inc. Benefit Plan

Coverage for: Individual | Plan Type: Low Option

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 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, call (410) 771-4311. 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.dol.gov/ebsa/healthreform or call (410) 771-4311 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	In-Network Providers **$2,000** individual Out-of-Network Providers **$2,000** individual	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, Primary Care Office Visit, Specialist Office Visit, Emergency Room, Urgent Care Centers, Telemedicine, Home Health Care	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 for this plan?	In-Network Providers **$5,000** individual Out-of-Network Providers **$9,000** individual Prescription Drug (separate) **$1,600** individual	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.
What is not included in the out-of-pocket limit?	Premiums, penalties for no pre-authorization, non-covered services, charges in excess of Plans' Allowable Amount	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. For the primary network, refer to www.Cigna.com for in-network benefits.	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		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	**GBMC PCP** $10 copayment; deductible does not apply **Non-GBMC PCP** $20 copayment; deductible does not apply	40% coinsurance	Telehealth services included.
	Specialist visit	$40 copayment; deductible does not apply	40% coinsurance	Telehealth services included.
	Specialist visit • Renal Dialysis • Chemotherapy • Radiation Therapy • Chiropractic Care • Acupuncture • Physical, Speech & Occupational Therapy	20% coinsurance	40% coinsurance	Precertification required and approval of facility prior to services rendered for Renal Dialysis. No out-of-network benefit for Renal Dialysis; Prenotification required for Chemotherapy & Radiation Therapy; Maximum $1,000 per plan year for Chiropractic Care; Maximum $1,000 per plan year for Acupuncture.
	Preventive care/screening/ immunization	No Charge	40% coinsurance	Routine GYN exam & pap smear: 1 per plan year; Routine Mammogram: Under age 40 with physician authorization; Age 40 and over: 1 per plan year; Routine Colonoscopy: 1 every 5 years ages 50 & over. 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. Telehealth services included.

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 test	Diagnostic test (x-ray, blood work)	20% coinsurance for all outpatient locations; deductible does not apply	40% coinsurance for all outpatient locations	None
	Imaging (CT/PET scans, MRIs)	20% coinsurance for all outpatient locations; deductible does not apply	40% coinsurance for all outpatient locations	
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.usrxcare.com	Lowest cost Generic drugs (Tier 1)	$10 copay (retail 30 day) $30 copay (retail 90 day) $20 copay (mail order 90 day)	Not covered	Copayments waived for certain generic fills for diabetes, hypertension & cholesterol drugs. Approved Over-the-Counter (OTC) & preventive drugs under the Patient Protection Affordable Care Act (PPACA) $0 copay. Refer to the US-Rx Care formulary list to determine the coverage and copayment that will be applied.
	Some Generics and Preferred Brand-Name drugs (Tier 2)	$35 copay (retail 30 day) $105 copay (retail 90 day) $70 copay (mail order 90 day)	Not covered	
	High cost Generics and Non-preferred Brand-Name drugs (Tier 3)	$55 copay (retail 30 day) $165 copay (retail 90 day) $110 copay (mail order 90 day)	Not covered	
	Specialty drugs (Tier 4)	$75 copayment for a 30 day supply. Must fill at designated Specialty Pharmacy.	Not covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance	40% coinsurance	No charge for Well Women contraceptive services.
	Physician/surgeon fees	20% coinsurance	40% coinsurance	
If you need immediate medical attention	Emergency room care	$150 copayment, 80% coinsurance; deductible does not apply	$150 copayment, 80% coinsurance; deductible does not apply	None
	Emergency medical transportation	20% coinsurance	20% coinsurance	
	Urgent care	$50 copayment; deductible does not apply	$50 copayment; deductible does not apply	

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% coinsurance	40% coinsurance	Precertification required - $1,000 penalty for non-precertification.
	Physician/surgeon fees	20% coinsurance	40% coinsurance	None
If you need mental health, behavioral health, or substance abuse services	Outpatient Services	$40 copayment; deductible does not apply	40% coinsurance	Precertification required for inpatient services $1,000 penalty for non-precertification. Telehealth services for mental health included.
	Inpatient services	20% coinsurance	40% coinsurance	
If you are pregnant	Office visits	20% coinsurance	40% coinsurance	No charge for prenatal care if billed separately from delivery. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound). Precertification required if stay extends beyond the allowance under Federal Law.
	Childbirth/delivery professional services	20% coinsurance	40% coinsurance	
	Childbirth/delivery facility services	20% coinsurance	40% coinsurance	
If you need help recovering or have other special health needs	Home health care	$40 copayment; deductible does not apply	40% coinsurance	Maximum 40 visits per plan year.
	Rehabilitation services	20% coinsurance	40% coinsurance	Maximum $1,000 per plan for Chiropractic Care.
	Habilitation services	20% coinsurance	40% coinsurance	
	Skilled nursing care	20% coinsurance	40% coinsurance	Precertification required $1,000 penalty for non-precertification; Maximum 60 days per plan year.
	Durable medical equipment	20% coinsurance	40% coinsurance	Prenotification required for devices that cost more than $1,000.
	Hospice services	20% coinsurance	40% coinsurance	Precertification required $1,000 penalty for non-precertification; Maximum 180 days when combined with outpatient hospice.
If your child needs dental or eye care	Children's eye exam	Not covered	Not covered	Separate Vision Plan available
	Children's glasses	Not covered	Not covered	Separate Vision Plan available
	Children's dental check-up	Not covered	Not covered	Separate Dental Plan available

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Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)		
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• Acupuncture • Bariatric Surgery (requires pre-approval)	• Chiropractic Care • Hearing Aids & Fitting – Employee Only	• Hearing Examinations • Private Duty Nursing Services (precertification required)

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Peg is Having a Baby
(9 months of in-network pre-natal care and a hospital delivery)

The plan's overall deductible	$2000
Specialist copayment	$40
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	**$12,800**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$2,000
Copayments	$50
Coinsurance	$1,800
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$3,910**

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

The plan's overall deductible	$2000
Specialist copayment	$40
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	**$7,400**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$800
Copayments	$800
Coinsurance	$20
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$1,640**

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

The plan's overall deductible	$2000
Specialist copayment	$40
Hospital (facility) coinsurance	20%
Other coinsurance	20%

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	**$1,900**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$1,600
Copayments	$300
Coinsurance	$100
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$2,000**