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

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.

For more information about limitations and exceptions, refer to the Summary Plan Description.

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	

For more information about limitations and exceptions, refer to the Summary Plan Description.

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

For more information about limitations and exceptions, refer to the Summary Plan Description.

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.

For more information about limitations and exceptions, refer to the Summary Plan Description.

PRA Disclosure Statement

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

To see examples of how this plan might cover costs for a sample medical situation, see the next section.

For more information about limitations and exceptions, refer to the Summary Plan Description.

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**