The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately.
This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, contact the Fund Office at 410-872-9541 or visit https://www.ourbenefitoffice.com/metrodcpaving/Benefits/. 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 https://www.healthcare.gov/sbc-glossary or call 410-872-9541 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	$0	See the Common Medical Events chart below for your costs for services this plan covers.
Are there services covered before you meet your deductible?	Not applicable	You don't have to meet deductibles for specific services but see the Common Medical Events chart below for your costs for services this plan covers.
Are there other deductibles for specific services?	No	You don't have to meet deductibles for specific services. This plan covers certain preventive services without cost sharing. See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/. See the Common Medical Events chart below for your costs for services this plan covers.
What is the out-of-pocket limit for this plan?	$5,000 individual/ $10,000 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 the 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, balance billed charges, and health care this plan doesn't cover.	Even though you may pay these expenses, they don't count toward the out-of-pocket limit.
Will you pay less if you use a network provider?	Yes. See www.carefirst.com or call 1-800-235-5160 for a list of network providers for Medical Services. See www.cignadentalsa.com or call 800-797-3381 for a list of network providers for Dental Services.	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). You are protected from balance billing for certain services, such as emergency services. 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.

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	First 20 visits: 20% coinsurance less $20 Basic Benefit Allowance. Visits after 20: 20% coinsurance	First 20 visits: Billed amount less 80% of UCR and less $20 Basic Benefit Allowance. Visits after 20: Billed amount less 80% of UCR	Plan does not pay office visit charges of chiropractors and podiatrists.
	Specialist visit	First 20 visits: 20% coinsurance less $20 Basic Benefit Allowance. Visits after 20: 20% coinsurance	First 20 visits: Billed amount less 80% of UCR and less $20 Basic Benefit Allowance. Visits after 20: Billed amount less 80% of UCR	Plan does not pay office visit charges of chiropractors and podiatrists.
	Preventive care/ screening/ immunizations	No Charge	Billed amount less 80% of UCR and less $100 Basic Benefit Allowance	The plan covers immunizations per the recommendations of the Centers for Disease Control. 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.
If you have a test	Diagnostic test (x-ray, blood work)	20% coinsurance less Basic Benefit Allowance of $250 per year	Billed amount less 80% of UCR and less Basic Benefit Allowance of $250 per year	Basic Benefit Allowance of $250 per year is paid at 100%; remaining cost paid at 80% of PPO rate (In-Network Provider) or 80% of UCR (Out-of-Network Provider).
	Imaging (CT/PET scans, MRIs)	20% coinsurance less Basic Benefit Allowance of $250 per year	Billed amount less 80% of UCR and less Basic Benefit Allowance of $250 per year	Basic Benefit Allowance of $250 per year is paid at 100%; remaining cost paid at 80% of PPO rate (In-Network Provider) or 80% of UCR (Out-of-Network Provider). Basic Benefit Allowance of $250 per year includes both Imaging and Diagnostic tests.

*Charges for out-of-network emergency services, air ambulance services, and care provided by an out-of-network provider at an in-network facility will be paid as required by the No Surprises Act. For more information, see the plan at https://www.ourbenefitoffice.com/metrodcpaving/Benefits/

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 drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.caremark.com	Generic drugs	$5 retail (30-day) $10 mail* (90-day)	100% if you use a pharmacy that does not participate in the Prescription Drug Program through CVS/Caremark	Prescription drugs not listed on the CVS/Caremark formulary are not covered unless approved by Prior Authorization. For a list of excluded drugs, please contact CVS/Caremark or the Fund Office. *Maintenance drugs must be purchased through the mail order pharmacy or at a CVS Retail pharmacy. *Specialty drugs must be purchased at CVS/Caremark's specialty pharmacies. *For Specialty drugs on the PrudentRx list, you must call 1-800-578-4403 to register for any available manufacturer copayment assistance program.
	Preferred brand name drugs	$10 retail (30-day) $20 mail* (90-day)		
	Non-formulary (non-preferred brand) drugs	$20 retail (30-day) $40 mail (90-day)		
	Specialty drugs on the PrudentRx List	$0 if enrolled in PrudentRx and relevant manufacturer copayment assistance program.		
	Other Specialty drugs	Copayments shown above.		
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance	Billed amount less 80% of UCR	
	Physician/surgeon fees	20% coinsurance less $1,000 per condition Basic Benefit Allowance	Billed amount less 80% of UCR and less $1,000 per condition Basic Benefit Allowance	Plan pays 100% of allowed amount up to $1,000 per condition (Basic Benefit Allowance); remaining cost paid at 80% of PPO rate (In-Network Provider) or 80% of UCR (Out-of-Network Provider).
If you need immediate medical attention	Emergency room care	20% coinsurance	20% of the Recognized Amount as coinsurance*	Out-of-Network emergency care is covered as in-network with no balance billing.*
	Emergency medical transportation	20% coinsurance	20% coinsurance plus charges over allowed amount*	See "Hospital Expense Benefits" under "Basic Benefits." Out-of-Network emergency air ambulance services are covered as in-network with no balance billing.*
	Urgent care	First 20 visits: 20% coinsurance less $20 Basic Benefit Allowance. Visits after 20: 20% coinsurance	First 20 visits: Billed amount less 80% of UCR and less $20 Basic Benefit Allowance. Visits after 20: Billed amount less 80% of UCR*	"Visits" includes any specialist visit or primary care visit to treat an injury or illness. Emergency services provided at an Out-of-Network Urgent Care center licensed to operate as a freestanding emergency department may be covered as in-network.*

*Charges for out-of-network emergency services, air ambulance services, and care provided by an out-of-network provider at an in-network facility will be paid as required by the No Surprises Act. For more information, see the plan at https://www.ourbenefitoffice.com/metrodcpaving/Benefits/

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 less $130/day in a semi-private room or $245/day in intensive care	Billed amount less 80% of UCR and less $130/day in a semi-private room or $245/day in intensive care	Max room and board benefit for semi-private room is $4,030 over 31 days. Max room and board benefit in ICU is $2,450 over 10 days. Additional hospital charges limited to $1,000 per condition. Remaining cost paid at 80% of PPO rate (In-Network Provider) or 80% of UCR (Out-of-Network Provider). Hospital stays require utilization management (UM) -- failure to follow UM procedures will cause denial of payment of $100 in addition to coinsurance.
	Physician/surgeon fees	20% coinsurance less Basic Benefit Allowance	Billed amount less 80% of UCR and less Basic Benefit Allowance*	Plan pays 100% of approved amount for surgery up to $1,000 per condition (Basic Benefit Allowance); remaining cost paid at 80% of PPO rate (In-Network Provider) or 80% of UCR (Out-of-Network Provider). Certain services received from Out-of-Network Providers while at an in-network facility may be covered as in-network.*
If you need mental health, behavioral health, or substance abuse services	Outpatient services	First 20 visits: 20% coinsurance less $20 Basic Benefit Allowance. Visits after 20: 20% coinsurance	First 20 visits: Billed amount less 80% of UCR and less $20 Basic Benefit Allowance. Visits after 20: Billed amount less 80% of UCR	
	Inpatient services	20% coinsurance less $130/day in semi-private room	Billed amount less 80% of UCR and less $130/day in semi-private room*	Max room and board benefit for semi-private room is $4,030 over 31 days. Additional hospital charges limited to $1,000 per condition. Afterwards, remaining cost paid at 80% of PPO rate (In-Network Provider) or 80% of UCR (Out-of-Network Provider). Certain services received from Out-of-Network Providers while at an in-network facility may be covered as in-network.*

*Charges for out-of-network emergency services, air ambulance services, and care provided by an out-of-network provider at an in-network facility will be paid as required by the No Surprises Act. For more information, see the plan at https://www.ourbenefitoffice.com/metrodcpaving/Benefits/

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 are pregnant	Office visits	First 20 visits: 20% coinsurance less $20 Basic Benefit Allowance. Visits after 20: 20% coinsurance	First 20 visits: Billed amount less 80% of UCR and less $20 Basic Benefit Allowance. Visits after 20: Billed amount less 80% of UCR	Cost sharing does not apply for in-network preventive services but may apply to office visits at which preventive services are received depending on how they are billed. Maternity care may include tests and services described elsewhere in the SBC (e.g., ultrasound)
	Childbirth/delivery professional services	20% coinsurance less $1,000 per "condition" Basic Benefit Allowance	Billed amount less 80% of UCR and less $1,000 per "condition" Basic Benefit Allowance*	For limitations on hospital room and board charges, see "If you have a hospital stay" above. Coverage above Basic Benefit Allowances (which vary with type of delivery) paid at 80% of PPO rate (In-Network Provider) or 80% of UCR (Out-of-Network Provider). Certain services received from Out-of-Network Providers while at an in-network facility may be covered as in-network.*
	Childbirth/delivery facility services	20% coinsurance less $1,000 per "condition" Basic Benefit Allowance	Billed amount less 80% of UCR and less $1,000 per "condition" Basic Benefit Allowance*	For limitations on hospital room and board charges, see "If you have a hospital stay" above. Coverage above Basic Benefit Allowances (which vary with type of delivery) paid at 80% of PPO rate (In-Network Provider) or 80% of UCR (Out-of-Network Provider). Out-of-Network emergency services are covered as in-network with no balance billing.*

*Charges for out-of-network emergency services, air ambulance services, and care provided by an out-of-network provider at an in-network facility will be paid as required by the No Surprises Act. For more information, see the plan at https://www.ourbenefitoffice.com/metrodcpaving/Benefits/

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 help recovering or have other special health needs	Home health care	First 30 visits per year: 20% coinsurance. After 30 visits: 100%.	First 30 visits per year: billed amount less 80% of UCR; after 30 visits: 100%.	Coverage limited to 30 Home Health Care visits/days of Home Health Care Services per year. Additional coverage subject to approval.
	Rehabilitation services	$0 for physical therapy (up to 15 visits per year); 100% for additional PT or other services	Billed amount less UCR for physical therapy (up to 15 visits per year); 100% for additional PT or other services	Coverage for physical therapy limited to fifteen (15) visits per calendar year. Other services not covered.
	Habilitation services	100%	100%	Not covered.
	Skilled nursing care	100% (unless rendered as part of Home Health Care treatment or a Qualified Hospice Care Program)	100% (unless rendered as part of Home Health Care treatment or a Qualified Hospice Care Program)	Not covered unless rendered as part of Home Health Care treatment or a Qualified Hospice Care Program.
	Durable medical equipment	20% coinsurance	Billed amount less 80% of UCR	
	Hospice services	20% coinsurance	Billed amount less 80% of UCR	Coverage limited to hospice services provided under an approved written plan of services by a Qualified Hospice Care Program.
If your child needs dental or eye care	Children's eye exam	No charge	No charge	Coverage limited to one exam per year.
	Children's glasses	No charge	No charge	Coverage limited to one pair of glasses and lenses per year.
	Children's dental check-up	No charge	No charge	Includes examinations and cleanings (limited to one every six months).

*Charges for out-of-network emergency services, air ambulance services, and care provided by an out-of-network provider at an in-network facility will be paid as required by the No Surprises Act. For more information, see the plan at https://www.ourbenefitoffice.com/metrodcpaving/Benefits/

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)		
• Acupuncture	• Habilitation services	• Non-emergency care when traveling outside the U.S.
• Bariatric surgery	• Infertility treatment	• Skilled nursing care
• Cosmetic surgery	• Long-term care	• Weight loss programs

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)		
• Chiropractic care	• Dental care and medically-necessary orthodontic care (Adult)	• Routine eye care (Adult)
• Routine foot care		• Hearing Aids

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: (1) for the Plan, 410-872-9541, (2) for the US Department of Labor, Employee Benefits Security Administration, 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform. Other coverage options may be available to you, too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit www.HealthCare.gov or call 1-800-318-2596.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information on how to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact the Plan at 410-872-9541 or by mail to the Metropolitan D.C. Paving Industry Employees Health and Welfare Fund, PO Box 564, Troy, MI 48099. You may also contact the Department of Labor's Employee Benefits Security Administration at 1-866-444-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 the Minimum Value Standards? **Yes**
If your plan doesn't meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

Language Access Services:
Para obtener asistencia en Español, llame al 410-872-9541

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

*Charges for out-of-network emergency services, air ambulance services, and care provided by an out-of-network provider at an in-network facility will be paid as required by the No Surprises Act. For more information, see the plan at https://www.ourbenefitoffice.com/metrodcpaving/Benefits/

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	$0
Specialist cost sharing	20%
Hospital (facility) cost sharing	20%
Other cost sharing	20%
Prescription co-payment (generic)	$5

This EXAMPLE event includes services like:
Specialist office visits *(prenatal care)*
Childbirth/Delivery Professional Services
Childbirth/Delivery Facility Services
Diagnostic tests *(ultrasounds and blood work)*
Specialist visit *(anesthesia)*

Total Example Cost	**$12,700**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$0
Copayments	$10
Coinsurance	$2,252
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$2,322**

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

The plan's overall deductible	$0
Specialist cost sharing	20%
Hospital (facility) cost sharing	20%
Other cost sharing	20%
Prescription co-payment (generic)	$5

This EXAMPLE event includes services like:
Primary care physician office visits *(including disease education)*
Diagnostic tests *(blood work)*
Prescription drugs
Durable medical equipment *(glucose meter)*

Total Example Cost	**$5,600**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$0
Copayments	$300
Coinsurance	$245
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$565**

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

The plan's overall deductible	$0
Specialist cost sharing	20%
Hospital (facility) cost sharing	20%
Other cost sharing	20%
Prescription co-payment (generic)	$5

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

Total Example Cost	**$2,800**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$0
Copayments	$10
Coinsurance	$377
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$387**

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