This is only a summary. If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at www.MedStarMyHealth.org or by calling 855.242.4872.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	In-network: **$0 person/$0** family, Out-of-network: **$2,000** person /**$4,000** family.	See the chart starting on page 2 for your costs for services this plan covers.
Are there other deductibles for specific services?	No.	You must pay all of the costs for these services up to the specific **deductible** amount before this plan begins to pay for these services.
Is there an out–of–pocket limit on my expenses?	Medical expenses: In-network: **$1,500 person/ $3,000** Family, Out-of-network: **$6,000 person/$12,000** family. Pharmacy: **$1,000 person** Includes deductible, co-pays and co-insurance.	The **out-of-pocket limit** is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses.
What is not included in the out–of–pocket limit?	Premiums, balance-billed charges, pharmacy costs, penalties for failure to obtain pre-authorization for services, and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the **out-of-pocket limit**.
Is there an overall annual limit on what the plan pays?	No.	The chart starting on page 2 describes any limits on what the plan will pay for *specific* covered services, such as office visits.
Does this plan use a network of providers?	Yes. See www.MedStarMyhealth.org or call 855.242.4872 for a list of participating providers.	If you use an in-network doctor or other health care **provider**, this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network **provider** for some services. Plans use the term in-network, **preferred**, or participating for **providers** in their **network**. See the chart starting on page 2 for how this plan pays different kinds of **providers**.
Do I need a referral to see a specialist?	No. You don't need a referral to see a specialist.	You can see the **specialist** you choose without permission from this plan.
Are there services this plan doesn't cover?	Yes.	Some of the services this plan doesn't cover are listed on page 5. See your certificate of coverage policy or plan document for additional information about **excluded services**.

Questions: Call **855.242.4872** or visit us at **www.MedStarMyHealth.org.**
If you find any of the underlined terms used in this form to be unclear, see the Glossary.
You can view the Glossary at **www.MedStarMyHealth.org** or call **855.242.4872** to request a copy.

- **Co-payments** are fixed dollar amounts (for example, $15) you pay for covered health care, usually when you receive the service.
- **Co-insurance** is *your* share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan's **allowed amount** for an overnight hospital stay is $1,000, your **coinsurance** payment of 20% would be $200. This may change if you haven't met your **deductible**.
- The amount the plan pays for covered services is based on the **allowed amount**. If an out-of-network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network hospital charges $1,500 for an overnight stay and the **allowed amount** is $1,000, you may have to pay the $500 difference. (This is called **balance billing**.)
- This plan may encourage you to use participating **providers** by charging you lower **deductibles**, **copayments** and **coinsurance** amounts.

Common Medical Event	Services You May Need	Your Cost If You Use an In-network Provider	Your Cost If You Use an Out-of-network Provider	Limitations & Exceptions
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	No charge	40% co-insurance after deductible	——————none——————
	Specialist visit	$30 co-pay/visit	40% co-insurance after deductible	——————none——————
	Other practitioner office visit	$30 co-pay/visit	40% co-insurance after deductible	——————none——————
	Preventive care/screening/immunization	No charge	40% co-insurance after deductible	——————none——————
If you have a test	Diagnostic test (x-ray, blood work)	$15 co-pay per test/basic imaging	40% co-insurance after deductible	*No charge for blood work.
	Imaging (CT/PET scans, MRIs)	$30 co-pay per scan/advanced imaging	40% co-insurance after deductible	——————none——————

Common Medical Event	Services You May Need	Your Cost If You Use an In-network Provider	Your Cost If You Use an Out-of-network Provider	Limitations & Exceptions
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.caremark.com or 888.771.7282	Generic drugs	$5 co-pay (30-day MedStar Pharmacy) $10 co-pay (30-day retail) $10 co-pay (90-day MedStar Pharmacy) $20 co-pay (90-day mail order or CVS retail pharmacy only)	Not covered	Covers up to a 30-day supply (retail pharmacy); 31-90 day supply (MedStar pharmacy, mail order prescription, or CVS retail pharmacy only); ***Note**: Walgreens is no longer an IN Network pharmacy* **$1,000 out-of-pocket limit**
	Preferred brand drugs	20% up to $60 (30-day MedStar pharmacy) 20% up to $65 (30-day retail) 20% up to $150 (90-day MedStar Pharmacy) 20% up to $155 (90-day mail order or CVS retail pharmacy only)	Not covered	Covers up to a 30-day supply (retail pharmacy); 31-90 day supply (MedStar pharmacy, mail order prescription, or CVS retail pharmacy only); ***Note**: Walgreens is no longer an IN Network pharmacy* **$1,000 out-of-pocket limit**
	Non-preferred brand drugs	40% up to $100 (30-day MedStar Pharmacy) 40% up to $105 (30-day retail) 40% up to $250 (90-day MedStar Pharmacy) 40% up to $255 (90-day mail order or CVS retail pharmacy only)	Not covered	Covers up to a 30-day supply (retail pharmacy); 31-90 day supply (MedStar pharmacy, mail order prescription, or CVS retail pharmacy only); ***Note**: Walgreens is no longer an IN Network pharmacy* **$1,000 out-of-pocket limit**
	Specialty drugs	40% up to $100 (30-day MedStar Pharmacy) 40% up to $105 (30-day retail) 40% up to $250 (90-day MedStar Pharmacy) 40% up to $255 (90-day mail order or CVS retail pharmacy only)	Not covered	Pricing assumes Non-Preferred Tier. For specialty drugs that are considered preferred brand drugs, your costs will be the same as preferred brand drugs. **$1,000 out-of-pocket limit**
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	$50 co-pay/surgery	40% co-insurance after deductible	——————none——————

Common Medical Event	Services You May Need	Your Cost If You Use an In-network Provider	Your Cost If You Use an Out-of-network Provider	Limitations & Exceptions
	Physician/surgeon fees	No charges	40% co-insurance after deductible	——————none——————
If you need immediate medical attention	Emergency room services	$125 co-pay/visit	$125 co-pay/visit	——————none——————
	Emergency medical transportation	No charge	No charge	——————none——————
	Urgent care	$10 co-pay/visit	40% co-insurance after deductible	——————none——————
If you have a hospital stay	Facility fee (e.g., hospital room)	$100 co-pay/admission	40% co-insurance after deductible	Pre-authorization required.
	Physician/surgeon fee	No charge	40% co-insurance after deductible	——————none——————
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	No charge	40% co-insurance after deductible	——————none——————
	Mental/Behavioral health inpatient services	$100 co-pay/admission	40% co-insurance after deductible	——————none——————
	Substance use disorder outpatient services	No charge	40% co-insurance after deductible	——————none——————
	Substance use disorder inpatient services	$100 co-pay/admission	40% co-insurance after deductible	——————none——————
If you are pregnant	Prenatal and postnatal care	Paid in full	40% co-insurance after deductible	——————none——————
	Delivery and all inpatient services	$100 co-pay	40% co-insurance after deductible	——————none——————

Common Medical Event	Services You May Need	Your Cost If You Use an In-network Provider	Your Cost If You Use an Out-of-network Provider	Limitations & Exceptions
If you need help recovering or have other special health needs	Home health care	No charge	40% co-insurance after deductible	Limited to 60 visits per year.
	Rehabilitation services	$30 co-pay/visit	40% co-insurance after deductible	Limited to 60 visits per year combined for physical and occupational therapy; Limited to 60 visits per year for speech therapy; Provider must provide a diagnostic evaluation and treatment plan prior to ordering these therapy services; Limited to 30 visits per year for therapeutic manipulation (chiropractic services).
	Habilitation services	$30 co-pay/visit	40% co-insurance after deductible	For children under the age of 19 with congenital or genetic birth defects. Preauthorization required after1st visit. Not covered for adults.
	Skilled nursing care	$100 co-pay/admission	40% co-insurance after deductible	Pre-authorization required. Limited to 30 days per year.
	Durable medical equipment	No charge	40% co-insurance after deductible	Pre-authorization required
	Hospice service	No charge	40% co-insurance after deductible	Pre-authorization required
If your child needs dental or eye care	Eye exam	Not covered	Not covered	——————none——————
	Glasses	Not covered	Not covered	——————none——————
	Dental check-up	Not covered	Not covered	——————none——————

Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover (This isn't a complete list. Check your policy or plan document for other excluded services.)

- Cosmetic Surgery
- Dental Care (adult)
- Long-term Care
- Non-emergency care when traveling outside the U.S.
- Routine Eye Care (adult)
- Routine Foot Care

Other Covered Services (This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)

- Acupuncture (if prescribed for rehabilitation purposes)
- Bariatric Surgery (if performed at a MedStar Center of Excellence)
- Chiropractic Care
- Hearing Aids (for children under 18 years old)
- Weight Loss (for morbid obesity at MedStar Centers of Excellence only)
- Infertility treatment
- Private Duty Nursing
- Nutrition Therapy (12 visits per year maximum, subject to medical necessity)

Your Rights to Continue Coverage:

If you lose coverage under the plan, then, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a **premium**, which may be significantly higher than the premium you pay while covered under the plan. Other limitations on your rights to continue coverage may also apply.

For more information on your rights to continue coverage, contact the plan at 855.242.4872. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 866.444.3272 or www.dol.gov/ebsa, or the U.S. Department of Health and Human Services at 877.267.2323 x61565 or www.cciio.cms.gov.

Your Grievance and Appeals Rights:

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to **appeal** or file a **grievance**. For questions about your rights, this notice, or assistance, you can contact the Corporate Benefits Office in Baltimore, MD at 410.993.2929 or in Arlington, VA at 703.558.1300. 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 Coverage Provide Minimum Essential Coverage?

The Affordable Care Act requires most people to have health care coverage that qualifies as "minimum essential coverage." **This plan or policy does provide minimum essential coverage.**

Does this Coverage Meet the Minimum Value Standard?

The Affordable Care Act establishes a minimum value standard of benefits of a health plan. The minimum value standard is 60% (actuarial value). **This health coverage does meet the minimum value standard for the benefits it provides.**

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

About these Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.

This is not a cost estimator.

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care will also be different.

See the next page for important information about these examples.

Having a baby
(normal delivery)

- **Amount owed to providers:** $7,540
- **Plan pays** $7,250
- **Patient pays** $290

Sample care costs:

Hospital charges (mother)	$2,700
Routine obstetric care	$2,100
Hospital charges (baby)	$900
Anesthesia	$900
Laboratory tests	$500
Prescriptions	$200
Radiology	$200
Vaccines, other preventive	$40
Total	**$7,540**

Patient pays:

Deductibles	$0
Copays	$140
Coinsurance	$0
Limits or exclusions	$150
Total	**$290**

Managing type 2 diabetes
(routine maintenance of a well-controlled condition)

- **Amount owed to providers:** $5,400
- **Plan pays** $4,940
- **Patient pays** $460

Sample care costs:

Prescriptions	$2,900
Medical Equipment and Supplies	$1,300
Office Visits and Procedures	$700
Education	$300
Laboratory tests	$100
Vaccines, other preventive	$100
Total	**$5,400**

Patient pays:

Deductibles	$0
Copays	$380
Coinsurance	$0
Limits or exclusions	$80
Total	**$460**

Questions and answers about the Coverage Examples:

What are some of the assumptions behind the Coverage Examples?

- Costs don't include **premiums**.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network **providers**. If the patient had received care from out-of-network **providers**, costs would have been higher.

What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how **deductibles**, **co-payments**, and **co-insurance** can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

Does the Coverage Example predict my own care needs?

✘ **No.** Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

Does the Coverage Example predict my future expenses?

✘ **No.** Coverage Examples are **not** cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your **providers** charge, and the reimbursement your health plan allows.

Can I use Coverage Examples to compare plans?

✓ **Yes.** When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

Are there other costs I should consider when comparing plans?

✓ **Yes.** An important cost is the **premium** you pay. Generally, the lower your **premium**, the more you'll pay in out-of-pocket costs, such as **co-payments**, **deductibles**, and **co-insurance**. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.