MedStar Select Plan
2013 Benefits Booklet

Effective January 1, 2013

Evolent Health, Inc.
800 N. Glebe Road, 5th Floor
Arlington, VA 22203
In partnership with UPMC Health Plan, Inc.

This Benefits Booklet describes the MedStar Select Plan (sometimes referred to as the Plan), which is part of the following "Wrap Plans", sponsored by MedStar Health, Inc.:

- MedStar Health, Inc. FlexStar Cafeteria Plan
- MedStar Health and Welfare Benefit Plan
- VNA, Inc. Employee Benefits Plan
- MedStar Health, Inc. Associates Benefit Plan
- The MedStar-Georgetown Medical Center Flexible Benefits Plan

This Benefits Booklet should be read together with the Summary Plan Description (SPD) for the Wrap Plan. The benefits under the Plan are not insured with Evolent Health, Inc. (Evolent) or any of its affiliates. Rather, benefits under the Plan are self-funded obligations of the Plan Sponsor. Evolent, in partnership with UPMC Health Plan, Inc. (UPMC), provides administrative claims payment services only and does not assume any financial risk or obligation with respect to claims.

Please read this Benefits Booklet carefully and together with the Wrap Plan SPD, which this Benefits Booklet supplements. The Wrap Plan SPD describes the terms of the Plan other than information about specific benefits and exclusions, which are described herein. In the event of a conflict between this Benefits Booklet and the terms in the Wrap Plan document and/or SPD, the Wrap Plan document and/or SPD will control.

The Plan Sponsor expects the Plan to be continued indefinitely, but the Plan Sponsor reserves the right to amend or terminate the Plan at any time. Amendments shall be made only in accordance with the provisions of the Wrap Plan.

Evolent Health, Inc.

Table of Contents

Welcome to MedStar Select

The MedStar Select Plan provides members with access to comprehensive and competitive medical benefits. It is built around the MedStar Select Provider Network, including MedStar physicians and hospitals as well as key community clinical partners. The Plan covers the greater Baltimore and Washington, DC regions as well as Southern Maryland. The Plan is designed to be patient-centered and physician-driven with innovative, coordinated care programs. As a member, you have access to comprehensive benefits with no or low out-of-pocket costs for many services, including emergency care, urgent care, routine office visits, inpatient hospitalizations and outpatient surgeries. No referrals are required to see specialists, and you have coverage for emergency services both in and out of the service area. This document is designed to help you get the most out of your coverage through the Plan, including detailed information about covered healthcare services.

Member Services staff are available to assist you Monday through Friday, 7 a.m. to 7 p.m. and Saturday, 8 a.m. to 3 p.m. The Member Services telephone number is on the back of the MedStar Select Plan Member ID Card. If you have not received a MedStar Select Plan Member ID Card or cannot locate it, please call 855.242.4872. You can also learn more about benefits by visiting www.MedStarMyHealth.org.

How to Use Your Benefits Booklet

Your Benefits Booklet establishes the terms of coverage for the MedStar Select Plan. It outlines what services are covered and what services are not covered. It also explains the procedures that you must follow to ensure that the healthcare services you receive will be covered under the Plan. Remember to read the Benefits Booklet in conjunction with the Wrap Plan SPD.

Use this Benefits Booklet as a comprehensive resource to help you access benefits, plan for medical expenses, understand Plan policies and determine levels of coverage for healthcare services. For example, if you require an inpatient hospitalization and would like to know what services will be covered while you are in the hospital, turn to page 19 under “Description of Covered Services” for this information, including room and board details. Then, look on page 34 under “Schedule of Benefits” to determine out-of-pocket costs and prior-authorization requirements. If you need to determine how your covered dependent living away from home will access services, look on page 10, “How to Access Care When You Are Away from Home.”

The coverage described in this Benefits Booklet is at all times administered in compliance with applicable laws and regulations, including, but not limited to, the Patient Protection and Affordable Care Act, the Health Care and Education Reconciliation Act of 2010, and the implementing regulations thereunder (PPACA), ERISA, HIPAA, the Uniformed Services Employment and Reemployment Rights Act of 1994, the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended (COBRA), the Newborns’ and Mothers’ Health Protection Act of 1996, as amended, the Women’s Health and Cancer Rights Act of 1998, the Mental Health Parity Act of 1996, the Mental Health Parity and Addiction Equity Act of 2008, the Genetic Information Nondiscrimination Act of 2008, and the Family and Medical Leave Act of 1993, as amended. If at any time any part or provision of this Benefits Booklet is in conflict with any applicable law, regulation, or other controlling authority, the requirement of that authority shall prevail.

The Plan may not cover all of your healthcare expenses. Read this document carefully to determine which healthcare services are covered.

Terms and Definitions to Help You Understand Your Benefits Booklet

The following are some important and frequently used terms and definitions that the MedStar Select Plan uses in this Benefits Booklet and when administering your benefits.

Allowed Amount – The maximum amount that the claims administrator determines is reasonable for covered services provided to a member. If a provider charges more than the allowed amount, the patient may have to pay the difference. The allowed amount may also be subject to cost sharing. Terms used interchangeably with allowed amount are allowed charge, eligible expense, maximum allowable, payment allowance and negotiated rate. For participating providers, this is the contracted rate that your provider is to be paid for the service(s). For non-participating providers, this is the R&C Amount. This amount can be paid by any combination of Plan, spending account, and member payments.

Associate – The person who is eligible for coverage under the Plan due to employment with the Plan Sponsor and who is enrolled for coverage.

Benefit Limit – The maximum amount that the Plan will pay for a specific procedure or event, or during a specific time (e.g., one year or the lifetime of the covered individual).

Benefit Period – The period for which you are eligible for coverage during the Plan's plan year, during which charges for covered services must be incurred in order to be eligible for payment by the Plan. A charge will be considered incurred on the date you receive the service, or supply, for which the charge is made.

Claims Administrator – Evolent Health, Inc. with respect to administration of the Plan, as delegated by MedStar.

Co-insurance – Your share of the costs of a covered service, calculated as a percent of the allowed amount for the service.

Co-payment – The specified dollar amount that you pay at the time of service for certain covered benefits. Co-payments do not apply toward your co-insurance or out-of-pocket limit. You are expected to pay your co-payment at the time of service. Refer to the Schedule of Benefits beginning on page 34 to determine co-payment amounts.

Covered Benefit or Covered Service – Costs incurred by you that will be reimbursed through the Plan. The healthcare service or supply that meets the requirements set forth in this Benefits Booklet, including, but not limited to, medical necessity and prior authorization, if applicable.

Deductible – The amount of out-of-pocket expense that an individual or family must pay before a benefit plan begins payment. The deductible is usually a flat dollar amount per calendar year or event. There are no deductibles under the Plan.

Dependent – A person who relies on, or obtains benefit coverage through, an associate member. Eligible dependents are a spouse, same sex domestic partner; any child of the associate or domestic partner under the age of 26, or if over the age of 26 any child who is mentally or physically incapable of self-support, provided such mental or physician condition commenced before the child attained age 26.. For more information on who is an eligible dependent under the Plan, consult the Wrap Plan SPD.

Experimental/Investigational – The use of any treatment, service, procedure, facility, equipment, drug, device, or supply (intervention) that is not determined by the Claims Administrator or its designated agent to be medically effective for the condition (including diagnosis and stage of illness) being treated. The Claims Administrator will consider an intervention to be experimental/investigational if, at the time of service:

- The intervention does not have FDA approval to be marketed for the specific relevant indication.
- Available scientific evidence and/or prevailing peer reviewed medical literature does not indicate that the treatment is safe and effective for treating or diagnosing the relevant medical condition or illness.
- The intervention is not proven to be as safe or as effective in achieving an outcome equal to or exceeding the outcome of alternative therapies.
- The intervention has not been shown to improve health outcomes.
- The effectiveness of the intervention has not been replicated outside of the research setting.

If an intervention is determined to be experimental/investigational at the time of service, it will not be covered retroactively if, at a later date, it no longer meets the definition of experimental/investigational set forth above.

Medical Necessity or Medically Necessary – Services covered under the Plan that are determined to be:

- Commonly recognized throughout the provider's specialty as appropriate for the diagnosis and/or treatment of your condition, illness, disease, or injury.
- Provided in accordance with standards of good medical practice and consistent with scientifically based guidelines of medical, research, or healthcare coverage organizations or governmental agencies that are accepted by the Plan.
- Reasonably expected to improve an individual's condition or level of functioning.
- In conformity, at the time of treatment, with medical management criteria/guidelines adopted by the Plan or its designee.
- Provided not only as a convenience or comfort measure or to improve physical appearance.
- Rendered in the most cost-efficient manner and setting appropriate for the delivery of the health service.

The Claims Administrator reserves the right to determine whether a healthcare service meets these criteria. Authorizations for coverage based upon medical necessity will be made by the Claims Administrator, at its discretion, with input from the treating provider. Note that the fact that a provider orders, prescribes, recommends, or approves a healthcare service does not mean that the service is medically necessary or a covered benefit for purposes of coverage.

MedStar – MedStar Health, Inc.

Member – An associate or dependent currently enrolled in the Plan and for whom a premium is paid.

Out-of-pocket limit – The maximum dollar amount for which you are responsible during a benefit period before the Plan will pay 100% for your covered benefits. Co-payments do not count towards your out-of-pocket limit. See the Schedule of Benefits on page 35 for out-of-pocket limit amounts.

Participating Provider – A provider who has entered into an agreement with the Plan to render covered services to members and is a member of the MedStar Select Provider Network.

Plan – The MedStar Select Plan.

Plan of Treatment – The plan written by a healthcare provider to show the member's diagnoses and treatment needed.

Plan Sponsor – MedStar.

Prior Authorization or Pre-Authorization – The process of obtaining authorization from the Plan for inpatient or outpatient health care prior to receipt of the care. Notification allows the Plan to authorize payment, as well as to recommend alternate courses of treatment. However, pre-authorization is not a guarantee of coverage. Failure to obtain prior authorization may result in a financial penalty to either the provider or the member.

Service Area – The Plan's primary service area, which consists of the greater Baltimore and Washington, DC regions as well as Southern Maryland. These are the areas where most of the participating providers are located.

Specialist – A healthcare professional who focuses on a particular area of medical care or patients. A specialist usually has advanced clinical training and postgraduate education in this area of care.

You – An associate member.

How to Determine Member Eligibility

Eligibility

MedStar has the sole and complete authority to make determinations regarding eligibility and enrollment for membership in the Plan. You are eligible for coverage if you are an associate of MedStar and/or meet the eligibility requirements established by MedStar. The eligibility requirements are described in the Wrap Plan SPD. To request this document or confirm eligibility requirements, contact your Human Resources (HR) department.

If you meet the eligibility requirements established by MedStar, you will be covered under the Plan during an applicable enrollment (or election) period when these conditions are also met:

- You elect coverage under the Plan and complete the enrollment process.
- MedStar notifies the Plan.
- Your required contribution is processed through payroll.

Your eligible dependents are also entitled to share the benefits of your membership. MedStar determines who is an eligible dependent, but dependents generally include your spouse, domestic partner, children up to age 26, and disabled children over the age of 26. To qualify as a disabled child, other criteria must also be met.

Review the Wrap Plan SPD for more information about the Plan's eligibility requirements.

Enrollment in the Plan

You will be provided with benefit and enrollment information when you first become eligible to enroll in the Plan. You will need to enroll in a manner determined by MedStar. To complete the enrollment process, you will need to provide all requested information for yourself and your eligible dependents.

How to Access Healthcare Services and Covered Benefits

Choosing a Healthcare Provider

The Plan is a health benefit plan that uses an exclusive network of providers, the MedStar Select Provider Network. This means that you must use MedStar affiliated providers (i.e., participating providers) to access covered services. Except for emergency services, the Plan will not cover services obtained from providers outside of the MedStar Select Provider Network.

The MedStar Select Provider Network includes hundreds of physicians and other professional providers and all MedStar hospitals. All of the participating providers are carefully evaluated before they are accepted into the network. MedStar performs a review process, called credentialing, to make sure that providers meet the Plan's provider participation standards. To find a participating provider in your area, refer to the MedStar Select Plan Provider Directory at www.MedStarMyHealth.org or call Member Services for assistance.

Remember, except in an emergency or under certain circumstances (outlined on page 9), you must use participating providers to ensure the Plan will pay for covered services. If you do not use a participating provider, the Plan will not cover those services and you will have to pay out-of-pocket for those services.

Transitioning to the MedStar Select Provider Network

If you are a new member, you may be receiving care from a provider outside of the MedStar Select Provider Network. The Plan recognizes that in some special circumstances, it may be necessary for members to continue care with a provider outside of the network for a brief period of time while care is transitioned to a provider in the MedStar Select Provider Network. The Transition of Care (TOC) process is intended to facilitate members in making a smooth, effective transition to in-network care.

When you enroll in the Plan, if you are currently in active, ongoing treatment with a provider that is not participating in the MedStar Select Provider Network, you may be able to continue this treatment, which will be paid at an in-network rate, for a period of up to 60 days from the effective date of your enrollment. The MedStar Select Plan Medical Management staff in consultation with you and your provider, may extend the TOC period if it is determined to be medically appropriate after an updated review of clinical information is provided by you and your provider.

Note that TOC coverage only applies to services included under the Plan. In addition, although benefits will be paid at an in-network rate, you will be responsible for any costs in excess of the recognized charge.

When a member requests a TOC in the first trimester of pregnancy, the Plan will work with the member to find a provider in the MedStar Select Provider Network to deliver obstetrical care. If you are in the second or third trimester of pregnancy on the effective date of your enrollment in the Plan, the TOC period will extend through postpartum care for the delivery of your child. Members undergoing a course of ongoing treatment for a chronic or acute condition may also qualify for a TOC period.

You must complete and submit a TOC application and obtain prior authorization from the Medical Management Department to continue treatment. To begin this process, contact Member Services or visit www.MedStarMyHealth.org to download the TOC application.

Referrals

You are permitted to self-direct your care as long as you use the MedStar Select Provider Network. This means you do not need referrals to obtain care from a specialist in the MedStar Select Provider Network.

Exceptions
Certain exceptions exist for members to go out of the MedStar Select Provider Network if they need access to high-end specialty care not available through the MedStar Select Provider Network. The healthcare service will need to be reviewed and approved by a MedStar Select Plan Medical Director to determine medical necessity. Contact Member Services to determine if you qualify.

Emergency Services
All members have coverage for emergency services. If emergency services are received at a non-MedStar facility within the service area, when medically appropriate, the member will be stabilized and transported to a MedStar facility.

Emergency services are any healthcare service provided after sudden onset of a medical condition that manifests itself by acute symptoms of sufficient severity or severe pain such that a prudent layperson who possesses an average knowledge of health and medicine could reasonably expect the absence of immediate medical attention to result in:

- Placing the health of the individual (or with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy.
- Serious impairment to bodily functions.
- Serious dysfunction of any bodily organ or part.

Emergency transportation provided by an ambulance service constitutes an emergency service.

Remember, providers outside of the MedStar Select Provider Network are not obligated to contact the Plan and do not have to comply with the Plan's policies and procedures regarding medical necessity or billing members. You may receive services that are not medically necessary and that will not be covered under the Plan. You will be financially responsible for any non-covered services.

Urgent Care
Urgent Care is care received for an unexpected illness or injury that is not life threatening but requires immediate outpatient medical care that cannot be postponed (e.g. a high fever) and requires prompt medical attention to avoid complications and unnecessary suffering or severe pain. You should contact your treating provider within 24 hours or a reasonable time of receiving Urgent Care to arrange or obtain necessary follow-up care. Urgent Care facilities in the MedStar Select Provider Network include PromptCare and Righttime Medical Care. Retail clinics are not included.

Mental Health and Substance Abuse
The Plan delegates administration of your mental health and substance abuse services, including behavioral health treatment, to Magellan Behavioral Health (Magellan). Magellan is not associated with Evolent or UPMC. To search for providers in the Magellan network, visit the Behavioral Health Network found at www.MedStarMyHealth.org.

Pharmacy Benefits
Pharmacy and prescription drug benefits are covered under an additional, freestanding program administered by CVS/Caremark. Even though this Benefits Booklet contains certain information regarding pharmacy and prescription drug benefits, such benefits are not administered by the Claims Administrator. To be eligible for these benefits, you must purchase your outpatient prescription drugs from a MedStar pharmacy, a participating pharmacy or through the mail-order program. You will receive a separate CVS/Caremark member ID card, in addition to your MedStar Select Plan ID card, which you will present at participating pharmacies when you are purchasing your prescriptions. Visit www.Caremark.com for more information or to find a participating pharmacy.

How to Access Care When You Are Away from Home

With the Plan, you have access to affordable healthcare services outside of the service area. If you are traveling out of town and need to see a doctor, or have covered dependents living outside of the MedStar Select Provider Network, including college students, benefits are paid at the same level that you receive when you are at home when you use the Plan's national network and follow the directions on your member ID card. You do not need to fill out additional paperwork or pay up front for your healthcare services, except for out-of-pocket expenses such co-payments, co-insurance and non-covered services. This coverage, through a national network, is available within the U.S.

Dependents
Covered dependents must have an address that is outside of the service area to be covered outside of the MedStar Select Provider Network. College students who are living out of the service area have coverage for routine services and emergency services. However, if attending college in the service area, they only have coverage for emergency services outside of the MedStar Select Provider Network.

How to Access Coverage
1. Call Member Services at 855.242.4872 to find national network doctors and hospitals in the area where you are located.
2. When traveling out of town, make sure to bring your MedStar Select Plan Member ID card.
3. If you need to see a doctor, present your ID card. The card will have the billing information needed by the healthcare provider to avoid any confusion when you are accessing services.

International Coverage
If you are traveling outside of the U.S. and have a medical emergency, seek immediate care. While coverage for routine and Urgent Care is not available, the Plan will cover care for an emergency service at the same level as if you were in the U.S.

Depending on where you receive services, you may have to make financial arrangements directly with the provider at the time of care. When you return home, immediately submit for reimbursement with the Out-of-Network Claim Form, and you may be reimbursed for your expenses for an emergency service at the level benefits would be paid in the U.S., based on a claim review by the Claims Administrator.

Keep in mind, if you or your dependents will be living abroad for an extended period, carefully consider your Plan choices, since only Emergency Services are covered outside of the U.S. under the Plan.

When You Receive Medical Care Outside of the U.S.
- Make sure you receive a copy of all of your medical records from your treating physician.
- Double-check that the medical record includes your name, date of service, a description of services and the charges.

Submitting Your Claim
Use the Out-of-Network Claim Form found on *My*Health OnLine at www.MedStarMyHealth.org to submit your claim. Proof of payment is required. You are covered for Emergency Services at the same benefit level that you receive under the Plan in the U.S., so Plan limits do apply internationally, including:

- Co-payments.
- Coordination of benefits.
- Non-covered services/supplies.

When You Need to Get Prior Authorization before Accessing Care

Certain covered services require prior authorization from the Plan's Medical Management Department. This means that you or your attending provider must obtain approval for coverage of these services before you receive the services. If you are going to receive these services, make sure you are communicating with your doctor about any prior authorization requirements, as failure to get approval will result in denial of coverage–and you will have to pay out of pocket. If you are unsure if a service requires prior authorization, you can always call Member Services and a representative will assist you.

When you or your provider request prior authorization, the Medical Management Department may ask you or your provider for additional information necessary to make the coverage decision. Such additional information includes, but is not limited to, medical records. In the event that you or your providers do not provide the requested information, the Medical Management Department may deny the request for coverage.

Certain covered services also require a plan of treatment to be submitted and approved by the Claims Administrator to obtain coverage. A penalty or denial of coverage may apply if you or your providers do not get a plan of treatment approved when required. Approval for coverage is based on medical necessity as determined by the Claims Administrator.

This is not a complete list of covered services requiring prior authorization, but some common requirements include:

- Inpatient hospitalizations
- Gastric bypass surgery
- Infertility services
- Home health care
- Private duty nursing
- Skilled nursing facility
- Hospice care
- Transplantation services

Covered Services Requiring an Approved Plan of Treatment after 10 Visits

- Physical therapy
- Occupational therapy
- Therapeutic manipulation (Chiropractic)

How to Obtain Prior Authorization

To request approval for a covered service, contact the MedStar Select Medical Management Department at 855.242.4875.

Concurrent Reviews

Sometimes the Medical Management Department will review services that you are receiving throughout a course of treatment. This may occur while you are a patient at a hospital. This method of review is used to assess the medical necessity of the length of stay in a facility and or the level of care being provided to you. The Medical Management staff reviews your plan of treatment and ongoing progress with the hospital or facility staff or other professional provider. Based upon this information, the Medical Management staff will determine if it is medically necessary to extend your care or suggest an alternate level of care.

Retrospective or Post-Service Reviews

In limited circumstances, the MedStar Select Plan's Medical Management, Quality Audit, and Fraud and Abuse Departments will use a retrospective review when a service has been rendered without the required authorization or in cases where further clarification regarding medical necessity or appropriate reimbursement is needed.

Discharge Planning
Discharge planning is a review of your case prior to discharge from a hospital or other facility. The purpose of the review is to assess your needs during and after discharge to make sure that you will have the care that you need when you leave the hospital or other facility. Discharge planning occurs throughout your stay at a hospital or other facility and is coordinated with input from your attending provider and other facility staff responsible for your care. Information considered during discharge planning includes, but is not limited to:

- Your level of function before and after your admission.
- Your ability to care for yourself and whether you have others to care for you.
- Your living arrangements before and after your admission.
- Any special equipment or safety needs.
- The need to refer you to a care management program.

Claims and Appeals Procedures

See the Wrap Plan SPD for a detailed description of how to file a claim for benefits, and the claims and appeals process under the Plan.

Coordination of Benefits

In addition to your Plan coverage, you may have additional health coverage under another plan through your spouse, domestic partner, another employer, or a government-sponsored program such as Medicare or Medical Assistance. If you have health coverage from more than one plan, the Plan will coordinate the benefits with the other plan and determine which plan is your primary coverage. This is to ensure that no one makes duplicate payments for the same medical services.

The Plan follows standard industry guidelines to determine which of your health plans is responsible for your primary coverage. The following are standard guidelines:

- If your other valid coverage does not include a coordination of benefits provision, that coverage pays first and this Plan pays secondary benefits.
- The coverage that you have through your employer is your primary coverage, even if you have additional coverage through your spouse or domestic partner. The coverage that your spouse or domestic partner provides is secondary.
- If you have multiple active health plans through multiple employers, the plan that has been active the longest is your primary coverage.
- If you have both Medical Assistance and commercial health coverage, your commercial is always your primary coverage.
- If you have a baby, your newborn is covered under the birth mother's benefits for the first 31 days of the baby's life. If the birth mother does not have health coverage, then the baby is covered under the other parent's health coverage for the first 31 days of the baby's life. For coverage to continue beyond the 31st day, the child must be added to the plan during the first 31 days.
- If your child is covered under the health plan of more than one parent or guardian, your child's primary coverage is the plan of the parent or guardian whose birth date falls earliest in the calendar year (except to the extent that a court decree requires otherwise). If the other health plan coverage does not follow the birthday rule, then the male parent's coverage is primary.
- If you and the child's other parent are divorced or separated or not living together, and your child is covered under both of your health plans, your child's primary coverage is the plan of the parent who has custody of the child, unless the judicial system has issued a court order stating otherwise. If you and another parent share joint custody, and a court decree does not specify

which parent is responsible for the health plan coverage of the child, the rules described in the previous bullet point apply.

If you or your provider receive more than you should have when your benefits are coordinated, you or your provider will be expected to repay the overpayment. It is the policy of the Claims Administrator to review all other health coverage prior to releasing a claim for payment. If other health coverage is found after a payment has been made, a review will determine which plan pays first and what action will be taken in regards to any claims in question. Whenever payments should have been made by the Plan, but the payments have been under another benefit plan, the Plan has the right to pay to the benefit plan that has made such payment any amount that the Claims Administrator determines to be appropriate under the terms of this Benefits Booklet. Any amounts paid shall be considered to be benefits paid in full under this Benefits Booklet.

In the event that the Plan makes payment for covered services in excess of the amount of payment pursuant to this Benefits Booklet, irrespective of to whom those amounts were paid, the Plan will have the right to recover the excess amount from any person or entity to or for whom such payments were made. Upon reasonable request by the Plan or its agent, you must execute and deliver such documents as may be required and do whatever else is reasonably necessary to secure the Plan's rights to recover the excess payments. The Plan is not required to determine whether or not you have other healthcare benefits or insurance or the amount of benefits payable under any other health care benefits or insurance. The Plan will only be responsible for coordination of benefits to the extent that information regarding your other health coverage is provided to the Plan or MedStar by you, your employer or plan sponsor, another insurance company, or any other entity or person authorized to provide such information.

Remember, it is the member's responsibility to notify the Plan or MedStar with any changes to other health coverage. Visit www.MedStarMyHealth.org to download a form that is available to assist with coordination. You may also call Member Services 855.242.4872 for more information

How to Access Your Benefit Information

As a member, you have convenient access to online services and benefits information at any time. Visit www.MedStarMyHealth.org to login to *My*Health OnLine and:

- View an online directory of providers in the MedStar Select Provider Network.
- Review your medical history, benefits, co-payments, and eligibility
- Find your Explanation of Benefits (EOB)
- Request a new or replacement member ID card and print a temporary member ID card
- Update contact information, such as your email address or phone number
- Live chat or send a secure message to Member Services, and locate Member Services contact information
- Access health promotion resources, tools and expert health information
- Download common member forms and documents, including:
    - Out of Network Claim Form
    - Coordination of Benefits Verification Form
    - Transition of Care Application
    - Provider Nomination Form
    - Notice of Privacy Practices
    - Member Request for Confidential Communication Concerning PHI Form
    - Member Authorization to Use/Disclose PHI Form
    - Personal Representative Designation Form

Explanation of Benefits
After you receive medical care, an Explanation of Benefits (EOB) is available. Your EOB details the cost of your care, what the Plan covers, and any charges that are your responsibility. The EOB also shows you, in the column marked "Billed Amount," the actual cost of the health care you received. This figure indicates the amount you would have to pay if you did not have health coverage. The EOB also indicates whether your claim was denied and the reason(s) your claim was denied. The EOB is not a bill. Your doctor, hospital, or other healthcare provider will bill you separately for any co-payment or co-insurance amounts that you owe to them.

It can be confusing when you receive multiple EOBs in the mail after treatment, especially if you are not certain if you owe a payment or not. To make it easier to understand, and to also eliminate paper waste, the Plan only sends you a paper EOB in the mail at home if you have a financial obligation.

At *My*Health OnLine, www.MedStarMyHealth.org, you have full access to all of your EOBs. These paperless features provide a simple and convenient way for you access your bill and determine any financial responsibility for a co-payment, co-insurance or other out-of-pocket expense.

What to Do if a Claim is Denied
For information on the claims and appeals procedures under the Plan, consult the Wrap Plan SPD.

Protecting Your Privacy and Confidentiality

You retain the right to have all your personal information and records safeguarded and kept private and confidential. Review the Wrap Plan SPD for more information about the Plan's Privacy Policies.

Description of Covered Services

The Plan provides coverage for the following healthcare services when those services are medically necessary. Refer to the Schedule of Benefits on page 34 for co-payments and co-insurance amounts, as well as any benefit limits related to covered services. You must obtain care from providers in the MedStar Select Provider Network to obtain coverage for these healthcare services except in a true emergency or when prior authorized by the Plan. Keep in mind, a doctor's statement that you should have certain services does not mean the services are medically necessary and therefore covered under this Plan.

Acupuncture
The Plan covers acupuncture treatment only for the following conditions when medically necessary. Prior authorization is required.

- Nausea and vomiting of pregnancy (hyperemesis gravidarum)
- Post-operative nausea and vomiting
- Post-chemotherapy nausea and vomiting

Ambulance Services
The Plan covers emergency ambulance services by a specially designed and equipped vehicle from your home or the scene of an accident or medical emergency to a hospital capable of treating your medical condition, between hospitals, and between a hospital and a skilled nursing facility.

Cancer Treatment
Cancer chemotherapy and cancer hormone treatments, which have been approved by the U.S. Food and Drug Administration for general use the in treatment of cancer, whether performed in a physician's office, in an outpatient department of a hospital, in a hospital as a hospital inpatient, or in any other medically necessary treatment setting, are covered.

Clinical Trials
Participation in clinical trials requires prior authorization review for medical necessity and all Plan limitations apply. Prior authorization is required. The clinical trial must be registered on the clinicaltrials.gov website and approved by the appropriate institutional review board. If your participation in the clinical trial is approved by the Plan, the Plan covers routine clinical services as well as medically necessary services to treat complications arising from participation in the clinical trial.

Colorectal Cancer Screening
Benefits for non-symptomatic members age 50 and over:

- An annual fecal occult blood test
- A sigmoidoscopy, a screening barium enema, or a test consistent with approved medical standards practices to detect colon cancer, at least once every five years
- A colonoscopy at least once every 10 years.

Benefits for covered symptomatic members:

- A colonoscopy, sigmoidoscopy, or any combination of colorectal cancer screening tests at a frequency determined by a treating physician
- Benefits for covered non-symptomatic members who are at high or increased risk for colorectal cancer and are under 50 years of age
- A colonoscopy or any combination of colorectal cancer screening tests in accordance with the American Cancer Society guidelines on screening for colorectal cancer published as of January 1, 2008, or as subsequently amended

Diabetes Treatment, Equipment, Supplies and Self-Management Education
Except to the extent already covered under another plan or program, including prescription drug coverage, the Plan covers the following services when required for the treatment of diabetes, when medically necessary, and when prescribed by a physician who is authorized to prescribe such services under the law.

Equipment and supplies:

- Blood glucose monitors
- Monitor supplies
- Insulin
- Injection aids
- Syringes
- Insulin infusion devices
- Pharmacological agents for controlling blood sugar
- Orthotics

The following outpatient diabetes self-management training and education services will be covered when your physician certifies that you require diabetes education as an outpatient:

- Medically necessary visits upon the diagnosis of diabetes
- Subsequent visits when your physician: (1) identifies or diagnoses a significant change in your symptoms or condition that necessitates changes in your self-management or (2) identifies a new, medically necessary medication or therapeutic process relating to your treatment and/or management of diabetes.

An outpatient diabetes self-management training and education program is a program of self-management, training, and education, including medical nutrition therapy, for the treatment of diabetes. This program must be conducted under the supervision of a healthcare professional with expertise in diabetes. Outpatient diabetes education services will be covered subject to policies and procedures established by the Plan.

Diagnostic Services
The Plan covers the following diagnostic services when medically necessary and ordered by a professional provider and rendered by a participating laboratory or other provider.

- Diagnostic imaging including x-ray, ultrasound.
- Advanced imaging, including magnetic resonance imaging (MRI), PET, CT, nuclear medicine.
- Diagnostic pathology consisting of laboratory and pathology tests.
- Diagnostic medical procedures consisting of electrocardiogram, electroencephalogram, and other electronic diagnostic medical procedures and physiological medical testing approved by the Plan.
- Allergy testing consisting of percutaneous, intracutaneous and patch tests.

Lower tech imaging and advanced imaging have different co-payment amounts, so make sure to check the Schedule of Benefits on page 34 carefully. If you are not sure if a needed diagnostic service qualifies as advanced imaging, contact Members Services at 855.242.4872.

Durable Medical Equipment (DME)
The Plan covers the rental or, at the Claims Administrator's discretion, the purchase of DME for therapeutic use when prescribed by a licensed professional provider if such services are medically necessary. Examples of DME are hospital beds, wheelchairs, ventilators, oxygen tanks or concentrators, crutches, walkers, canes, commodes, and suction machines. The Plan's payment for durable medical equipment includes related charges for handling, delivery, mailing and shipping, and taxes.

Except as set forth above, the Plan covers repairs if the repair cost is less than 50 percent of the cost of a new item. The Plan covers replacement of the DME when the cost to repair the item is 50 percent or more of the price of a new item; or it is medically necessary to replace the DME due to a change in your medical condition; or the item was lost or stolen and you provide appropriate documentation (for example, a police report) of the events and circumstances of the loss. The decision of whether or not to repair or replace the DME is at the sole discretion of the Claims Administrator.

Emergency Dental Services Related to Accidental Injury
The Plan only covers dental services necessary to treat an accidental injury to sound, natural teeth when the services are obtained within the first 72 hours following the accidental injury. This coverage applies only to the emergency therapy rendered for and made necessary by the injury. These services include services obtained in an emergency room. Injury as a result of chewing or biting is not considered an accidental injury. The Plan does not provide coverage for any follow-up care related to the accidental injury, including, but not limited to, orthodontia, post-orthodontics, and restorative procedures.

General Anesthesia for Dental Care
Covered anesthesia services for dental care apply to only those procedures that are medically necessary and are appropriate for treatment of disease or injury. Prior authorization is required. Additionally, coverage of anesthesia services depends upon whether the primary surgical procedure being performed is covered. Generally, if the primary procedure is not covered, the administration of anesthesia is not covered. However, there are exceptions to this in situations where anesthesia related to non-covered dental services may be covered based on circumstances that warrant deep sedation or general anesthesia.

Sedation and anesthesia for procedures performed on dental patients in nontraditional settings have increased over the past several years. These services could be in the office, outpatient surgical facility or hospital. Care must be provided by qualified and appropriately trained individuals in accordance with state regulations and professional society guidelines.

All locations that administer general anesthesia must be equipped with anesthesia emergency drugs, appropriate resuscitation equipment and properly trained staff to skillfully respond to anesthetic emergencies.

Charges incurred in connection with non-covered dental services are routinely not covered except in the following circumstances:

1. Children five years of age and under:

    - When there is more than one simple extraction
    - When a surgical extraction is performed
    - If the child is extremely unmanageable using local anesthesia

2. For members of any age, requests will be reviewed for medical necessity on a case by case basis for any of the following conditions:

    - When the member has medical conditions that preclude the use of local anesthesia
    - When there is severe infection at the oral injection site
    - For a member who is unmanageable using local anesthesia
    - Have any of the following documented conditions:
        - Mental retardation
        - Diagnosed mental health condition
        - Physical conditions that limit functionality

When there are multiple extractions in more than one quadrant of the mouth. If the treatment is simple or surgical extractions:

1. Two or more quadrants must have had at least two teeth extracted per quadrant
2. Three or more quadrants have had at least one tooth extracted per quadrant.

Habilitative Services for Children
Coverage of habilitative services for children under the age of 19 with a congenital or genetic birth defect, including:

- Autism or an autism spectrum disorder
- Cerebral palsy
- Intellectual disability
- Down syndrome
- Spina bifida
- Hydroencephalocele
- Congenital or genetic developmental disabilities

"Habilitative services" means services, including occupational therapy, physical therapy, and speech therapy, for the treatment of a child with a congenital or genetic birth defect to enhance the child's ability to function.

Coverage is not required for services delivered through early intervention or school services. Beginning on Nov. 1, 2013, a determination of whether habilitative services are medically necessary and appropriate to treat autism and autism spectrum disorders will be made in accordance with regulations adopted by the Maryland Insurance Administration.

Home Health Care
The Plan covers the following services that you may receive from a home health care agency or hospital program for home health care when medically necessary. Prior authorization is required.

- Skilled nursing services provided by a registered nurse or practical nurse, except for private duty nursing services
- Skilled rehabilitation services.
- Physical therapy, occupational therapy, and speech therapy.
- Non-disposable medical and surgical supplies provided by the home health care agency or hospital program for home health care, including oxygen.
- Medical and social service consultations.
- Health aide services when you are receiving skilled nursing or therapy care.

Home health care services, when necessary, will have input from the *My*Health care manager.

You must be confined to home due to a medical condition. Home cannot be an institution, convalescent home or any rehabilitation services. Home health care has to be a substitute for hospital care or for care in a skilled nursing facility. To qualify, you must require and continue to require skilled nursing or rehabilitative services.

Home Visits Following Childbirth
Home visits following childbirth, including any services required by the attending healthcare provider:

- For you and your newborn who remain in the hospital for at least 48 hours after an uncomplicated vaginal delivery, or 96 hours after an uncomplicated cesarean section, one home visit following childbirth, if prescribed by the healthcare provider
- For you if, in consultation with your healthcare provider, you request a shorter hospital stay (less than 48 hours following an uncomplicated vaginal delivery or 96 hours following an uncomplicated cesarean section):
    - One home visit following childbirth scheduled to occur within 24 hours after discharge.

- An additional home visit following childbirth if prescribed by your healthcare provider.

A healthcare provider may be an obstetrician, pediatrician, other physician, certified nurse-midwife, or pediatric nurse healthcare provider, attending your or your newborn.

Hospice Care
The Plan covers services provided by a Plan hospice program or a hospital program providing hospice care services and supplies on either an inpatient or outpatient basis when medically necessary. Prior authorization is required. Hospice care is designed to provide palliative and supporting care to terminally ill patients and their families. You are covered for hospice care when you have a life expectancy of 180 days or less, as determined by your physician. Hospice care will be covered for six months from the date on which you enter the hospice program. Hospice coverage may be extended if ordered and approved by your physician. Hospice care must be ordered, directed, and approved by your physician and coordinated by an interdisciplinary team.

Hospital Services
The Plan covers the following services that you receive in a hospital or ambulatory surgical facility if such services are medically necessary, as outlined in the Schedule of Benefits on page 34.

Inpatient only (Hospital)
- Room and board
  - A semiprivate room and board.
  - A private room and board when determined to be medically necessary.
  - A bed in a special or intensive care unit when your condition requires constant attendance and treatment for a prolonged period of time.
- General nursing care
- Ancillary services and supplies

Inpatient and outpatient (Hospital or Ambulatory Surgical Facility)
- Pre-admission testing, including tests and studies that are required before your admission to the hospital.
- Drugs and medicines provided to you while in the hospital or ambulatory surgical facility.
- Use of operating and delivery rooms and supplies.
- Diagnostic services and testing.
- Therapy services.
- Services and supplies for surgery, including removal of sutures, anesthesia, and anesthesia supplies and services furnished by an employee of the hospital or ambulatory surgical facility other than the surgeon or assistant at surgery.
- Administration and processing of blood and blood products.

Infertility Services
Benefits are available for the diagnosis and treatment of infertility including medically necessary, non-experimental/investigational artificial insemination/intrauterine insemination and in-vitro fertilization. The oocytes (eggs) must be naturally produced by the member or spouse and fertilized with sperm naturally produced by the member or spouse. Benefits for Artificial Insemination (AI) and In-Vitro Fertilization (IVF) are combined and limited to four attempts per year and six attempts per lifetime. Prior authorization is required.

Inpatient Medical Services
The Plan covers the following services that you may receive from a professional provider while you are an inpatient in a hospital or other facility for a condition not related to surgery, pregnancy, or a behavioral health condition, if such services are medically necessary:
- Visits by the admitting physician to follow your care.
- Intensive medical care when your condition requires constant attendance and treatment by a professional provider for a prolonged period of time.

- Consultation services when requested by your attending physician.
- Visits by a professional provider, to examine a newborn infant while the mother is an inpatient.

Maternity Services and Newborn Care
The Plan covers services necessary to provide comprehensive care for both mothers and babies. If you believe that you may be pregnant, contact your treating provider or an obstetrician or nurse-midwife. If your provider determines that you are pregnant, you are eligible for coverage of prenatal care, including medically necessary sonograms, delivery, postpartum care, and care for your newborn while you are in the hospital.

You will receive coverage for hospital services associated with delivery of your baby for at least 48 hours following a vaginal delivery and for at least 96 hours following a cesarean section. For information regarding coverage for maternity home healthcare visits, please refer to the "Home Visits Following Childbirth" section of this "Description of Covered Services".

Additional covered services include:

- Medically necessary inpatient/outpatient healthcare provider services for a newborn with congenital or comorbid conditions.
- Circumcision.
- Elective abortions.
- Universal hearing screening of newborns provided by a hospital before discharge or in an office or other outpatient setting.

Medical/Surgical Services
The Plan covers the following surgical services that you receive from a professional provider, if such services are medically necessary.

- Surgery performed by a professional provider, including pre- and post-operative office visits. Surgery includes the following procedures. Oral surgery is covered only for the following procedures in an outpatient setting or in an inpatient setting when such setting is determined to be medically necessary. All other oral surgery and related services are excluded from coverage.
    - Extraction of impacted third molars that are partially or totally covered by bone
    - Excision of malignant lesions/tumors of the mandible, mouth, lip, or tongue
    - Incision of accessory sinuses, mouth, salivary glands, or ducts
    - Manipulation of dislocations of the jaw
    - Reconstruction to repair a non-dental physiological condition that has resulted in a severe functional impairment
    - Orthodontic treatment of congenital cleft palates involving the maxillary arch, performed in conjunction with bone graft surgery to correct bony deficits associated with extremely wide clefts that affected the alveolus
    - Surgery for temporomandibular joint disease

- Mastectomy and Breast Reconstruction: The Plan covers a mastectomy with a diagnosis of breast cancer when performed on an inpatient or outpatient basis, as well as any surgery needed to re-establish symmetry or alleviate functional impairment. This includes:
    - All stages of reconstruction of the breast on which the mastectomy was performed
    - Surgery and reconstruction of the other breast to produce a symmetrical appearance
    - Prostheses
    - Treatment of physical complications at all stages of the mastectomy, including lymphedema
    - One home health care visit, if requested by your physician, following a hospital discharge that occurs within 48 hours of admission for the mastectomy

- Surgical assistant services, meaning the services of a physician who actively assists the operating surgeon who is performing covered surgery, only in the event that an intern, resident, or house staff member is not available.
- A second surgical opinion from a professional provider and related diagnostic services to confirm the need for elective covered surgery. The second opinion must be from a physician other than the physician who initially recommended the elective surgery. Elective surgery is non-emergency surgery, or surgery that can be delayed.

Mental Health, Including Behavioral Health Treatment
Mental health benefits are administered by Magellan. The Plan covers the following services when medically necessary to treat behavioral health conditions if the services are provided by a hospital or other facility:

- Inpatient facility services are covered and may be subject to the benefit limits which, if applicable, would be set forth in the Schedule of Benefits on page 34. These services include a semiprivate room and board; individual, group, and family psychotherapy or counseling; medications and electroconvulsive therapy; medical supplies and services; and diagnostic and other therapeutic services.
- Outpatient facility services are covered and may be subject to benefit limits which, if applicable, would be set forth in the Schedule of Benefits on page 34.
- Psychological and neuropsychological testing is covered and may be subject to benefit limits which, if applicable, would be set forth in the Schedule of Benefits on page 34.

Nutritional Services
Nutritional counseling consists of the assessment of a person's overall nutritional status followed by the assignments of an individualized diet, counseling, and/or nutrition therapies to treat a chronic illness or condition. The Plan will cover twelve visits per benefit period with a dietitian or facility-based program that is ordered by a participating physician and offered by a provider. Medical nutrition therapy to treat a chronic illness or condition, which includes nutrition assessment and nutritional counseling by a dietitian or facility-based program that is ordered by a participating physician and offered by a provider. The Plan will cover medically necessary services directly related to the following specific medical conditions and subject to the following benefit limits:

- Heart Disease, Symptomatic HIV/AIDS, and Celiac Disease
    - Limited to two visits per benefit period.
- Morbid Obesity
    - Limited to an initial assessment and five follow-up visits for a total of six visits per benefit period
- Chronic Renal Disease, Diabetes Mellitus, and High Risk Obstetrical Symptomatic Conditions
    - The Plan covers unlimited number of visits when medically necessary.

Nutritional Supplements and Therapy
The Plan will cover medically necessary medical foods and nutritional therapy when ordered and supervised by a healthcare provider qualified to provide the diagnosis and treatment of conditions, as determined by The Plan. Prior authorization is required.

Organ and Transplantation Services
The Plan will cover services provided by a hospital that are directly related to organ, tissue, or bone transplantation when medically necessary. Prior authorization is required. If a human organ or tissue transplant is provided from a living donor to a human transplant recipient:

- When both the donor and the recipient are members, each is entitled to the benefits of this Benefits Booklet
- When only the recipient is a member, both the donor and the recipient are entitled to the benefits of this Benefits Booklet subject to the following additional limitations:

- The donor benefits are limited to only those not provided or available to the donor from any other source, including, but not limited to, other insurance coverage, or any government program
- Benefits provided to the donor will be charged against the recipient's coverage under this Benefits Booklet

When only the donor is a member, the donor is entitled to the benefits of this Benefits Booklet, subject to the following additional limitations:

- The benefits are limited to only those not provided or available to the donor from any other source in accordance with the terms of this Benefits Booklet.
- No benefits will be provided to the non-member transplant recipient.
- If any organ or tissue is sold rather than donated to the member recipient, no benefits will be payable for the purchase price of such organ or tissue. However, other costs related to evaluation and procurement are covered to the member recipient's benefit limit as set forth in the Schedule of Benefits.

Orthotics and Prosthetics (Corrective Appliances)
Orthotics and prosthetics are corrective appliances or devices that restore basic bodily function. Prosthetics replace all or part of the function of a missing body part or a permanently useless or malfunctioning body part. Prosthetics may be implantable devices or an equivalent external device. Examples of prosthetics are artificial limbs, artificial eyes, external breast prosthesis, hip/knee prosthetics, and penile prosthesis orthotics are used to restrict, modify, or eliminate motion of a misaligned, weak, or diseased body part, prevent deformity or injury, and aid in proper functioning of normal activities.

Orthotics are rigid or semi-rigid supportive devices (e.g., leg braces). The Plan will cover the purchase, fitting, and necessary adjustments to orthotics and prosthetics when they are medically necessary. Note that the Plan only covers orthopedic shoes and shoe inserts if you have diabetes or peripheral vascular disease to prevent foot injury and/or disease.

Repair costs will be covered when the cost is less than 50 percent of the cost of a replacement item. Replacement coverage may be provided when the cost to repair the damaged item exceeds 50 percent of the price of a new item, it is medically necessary due to a change in your medical condition, repair of the item is not a feasible option, or the item is lost or stolen and you provide appropriate documentation of the events and circumstances of the loss. The decision to cover repair or replacement is at the sole discretion of the Claims Administrator.

Outpatient Medical Care
Outpatient medical care consists of visits to a professional provider's office, whether a treating provider or specialist, for an illness or injury not related to surgery, pregnancy, or behavioral health condition. Your benefit plan covers the evaluation, examination, services, and supplies necessary to diagnose and treat basic medical illnesses, diseases, and injuries, if such services are medically necessary.

Podiatry Services
The Plan will cover podiatry services that are determined by the Claims Administrator to be medically necessary, provided that (1) such services are provided by a participating podiatrist and (2) you have diabetes or peripheral vascular disease, or another qualifying medical condition, which, in the Claims Administrator's discretion, warrants specialized care. Covered services may include open cutting procedures and removal of nail roots, if determined to be medically necessary by the Claims Administrator.

Preventive Care
Preventive health screening examinations and certain other preventive services are covered for adults when performed by a participating provider who is credentialed by the Plan as a Primary Care Provider (PCP). Preventive pediatric care and immunizations are covered when performed by a provider who is credentialed by the Plan as a PCP. Coverage includes, but is not limited to:

- Well-child and preventive/health screening examinations (except as indicated in the Exclusions section of this Benefits Booklet and diagnostic services for children, including complete medical history, height and weight measurement, and counseling when appropriate.
- Pediatric immunizations, when performed and billed by a hospital, facility, physician, or other professional provider, which conform to the standards established by the Centers for Disease Control and Prevention and the U.S. Department of Health and Human Services, other controlling federal agency, or as otherwise required under law.
- Certain vision, hearing, and dental screenings for children when provided by an in-network pediatrician or other primary care provider as required by the Patient Protection and Affordable Care Act (ACA).
- One biometric set of screenings per year, either through your PCP or on-site at work, through the wellness program.

"Preventive health services," as that term is defined by the Patient Protection and Affordable Care Act of 2010, as amended, and implementing regulations thereunder. For more information about the specific preventive health services that are covered, visit http://www.healthcare.gov/center/regulations/prevention/recommendations.html.

Prescription Drugs
Pharmacy and prescription drug benefits are covered under an additional, freestanding program administered by CVS/Caremark. Even though this Benefits Booklet contains certain information regarding pharmacy and prescription drug benefits, such benefits are NOT administered by Evolent. You will need to contact CVS/Caremark at the number on your CVS/Caremark member ID card to determine if your drug is in the formulary, requires prior authorization or to determine any other coverage limits. See the Schedule of Benefits on page 34 for co-payments that apply to the prescription drug coverage.

Private Duty Nursing Services
The Plan covers services provided by an actively practicing registered nurse or practical nurse when medically necessary. Prior authorization is required. The ordering physician must obtain prior authorization from the Medical Management Department for such services.

Skilled Nursing Facility Services
The Plan covers services rendered while you are an inpatient in a skilled nursing facility when medically necessary and:

- The admission is arranged or ordered by your attending physician.
- Your medical condition is such that you require skilled care 24 hours per day.
- The skilled services are provided either directly by or under the supervision of a medical professional (for example, a registered nurse, physical therapist, practical nurse, occupational therapist, speech pathologist, or audiologist) and the treatment is documented in your medical record.
- The care could not be performed by a non-healthcare individual instructed to deliver such services.

Prior authorization is required. Skilled nursing services must be provided with the expectation that you have restorative potential in a reasonable and generally predictable period of time and you continue to make substantial improvement in your level of functioning. Once a maintenance level has been established and/or no further progress is being attained, the care and services provided no longer constitute skilled nursing or rehabilitation and will be considered to be custodial care. See the Schedule of Benefits on page 34 for benefit limits regarding the maximum number of inpatient skilled nursing facility days that are covered under the Plan.

Substance Abuse Services
Substance abuse services are administered by Magellan. The Plan covers the following services when medically necessary that are obtained from a participating hospital or other facility provider.

- Inpatient and non-hospital detoxification services are covered and may be subject to benefit limits, which, if applicable, would be set forth in the Schedule of Benefits on page 34
- Inpatient and non-hospital residential rehabilitation therapy is covered and may be subject to benefit limits, which, if applicable, would be set forth in the Schedule of Benefits on page 34. Covered inpatient services include room and board; physician, psychologist, nurse, and certified addictions counselor services; diagnostic x-ray; psychiatric, psychological, and medical laboratory testing; medications; equipment use; and supplies
- Outpatient rehabilitation services are covered and may be subject to benefit limits which, if applicable, would be set forth in the Schedule of Benefits on page 34. Outpatient services include individual and group counseling and psychotherapy; psychiatric and psychological testing; and family counseling for the treatment of alcohol and drug abuse

Therapeutic Manipulation (Chiropractic)
Therapeutic manipulation consists of services related to attempts at restoring normal function by manipulation and treatment of the structures of the spine. This includes the relationship between the articulations of the vertebral column, as well as other articulations, and the neuro-musculoskeletal system and the role of these relationships in the restoration and maintenance of health. Therapeutic manipulation focuses on the detection and/or correction by manual or mechanical means of structural imbalance, distortion, or subluxation in the human body for the purpose of removing nerve interference, and the effects thereof, where such interference is the result of or related to distortion, misalignment, or subluxation of or in the vertebral column.

The Plan will cover the following services directly related to therapeutic manipulation when medically necessary: evaluation, spinal x-rays, vertebral adjustment or manipulation, therapeutic exercise, and adjunctive procedures. You must obtain services from a provider who is licensed to provide such services. Treatment plan required after 10 visits.

For members who are less than 13 years of age, the provider must obtain prior authorization from the Medical Management Department for therapeutic manipulation services.

Therapy Services
The Plan covers the following therapy services that are medically necessary:

- **Physical Therapy (PT), Occupational Therapy (OT)—**Your provider must provide a diagnostic evaluation prior to ordering these therapy services to establish whether these services are medically necessary. The ordering provider must anticipate that these services will result in substantial improvement to your medical condition. Treatment plan required after 10 visits for physical therapy. See the Schedule of Benefits on page 34 for benefit limits regarding these services.
- **Speech Therapy (ST) —**Your ordering provider must provide a diagnostic evaluation prior to ordering these therapy services to establish whether these services are medically necessary. Your provider must anticipate that these services will result in substantial improvement to your medical condition. See the Schedule of Benefits on page 34 for benefit limits regarding these services.
- **Cardiac and Pulmonary Rehabilitation—**These services are covered when medically necessary and ordered by a physician and non-custodial. See the Schedule of Benefits on page 34 for applicable benefit limits.
- **Radiation Therapy, Chemotherapy, Dialysis Treatment, and Infusion Therapy—**These services are covered when provided at the appropriate level of care.

- **Pain Management and Rehabilitation Outpatient Programs—**These services are covered if you are diagnosed with refractory chronic pain of at least six months duration. Your ordering provider must demonstrate that he or she anticipates these services to result in substantial improvement to your medical condition.

Vision Services for a Medical Condition
Prescription eyewear and the fitting and adjustment of contact lenses are covered only if you have cataracts, keratoconus, or aphakia. If you have one of these qualifying conditions, prescription lenses and contact lenses are limited to one pair of standard contact lenses OR one pair of standard eyeglasses per benefit period. You will be responsible for any and all upgrades.

Women's Care
- Screening—Gynecological Examinations and Pap Smears: All female members have direct access to and are covered for an annual screening — gynecological examination, which includes a pelvic examination, breast examination, and Pap smear, in accordance with the recommendations of the American College of Obstetricians and Gynecologists or as otherwise required by the Patient Protection and Affordable Care Act.
- Mammograms: All women are covered for one annual screening mammogram if ordered by a physician.

Services Excluded from Coverage through the Plan

Not all healthcare services are covered services. The following is a list of services that are not covered under the Plan. If you are not sure if a service is covered, call Member Services to find out if that service is covered under the Plan.

1. **Alternative Medicine—**Acupuncture, except as set forth in this Benefits Booklet. Acupressure, aromatherapy, ayurvedic medicine, guided imagery, herbal medicine, homeopathy, massage therapy, naturopathy, relaxation therapy, transcendental meditation, or yoga.

2. **Behavioral Health Services:**
    - Any psychotherapy, psychiatric care, or treatment services for mental health or substance use which are court-ordered, unless such services are medically necessary.
    - Inpatient or outpatient treatment related to mental retardation or pervasive developmental disorder. Inpatient or outpatient treatment for autism, which extends beyond traditional medical management.
    - Treatment for personality disorders where that is the primary diagnosis.
    - Eligibility for and maintenance of Social Security disability benefits does not determine whether the Plan will cover specific behavioral health or substance abuse treatment services. Medical necessity criteria will be used to determine whether specific treatment services are covered.
    - Any treatment/services related to personal or professional growth/development, educational or professional training or certification, or treatment services required for investigative purposes related to employment.
    - Any services necessary to obtain or maintain employment or insurance or for judicial or administrative proceedings, including, but not limited to, adjudication of marital, child support, or custody cases.
    - Methadone maintenance for the treatment of chemical dependency.
    - Treatment for chronic behavioral conditions, once you have been restored to the pre-crisis level of function.
    - Marriage or family counseling, except when rendered in connection with services provided for a treatable mental disorder.
    - Chronic maintenance therapy, except in the case of serious mental illness.
    - Aversion therapy, bioenergetic therapy, carbon dioxide therapy, confrontation therapy, crystal healing therapy, cult deprogramming, electrical aversion therapy for alcoholism, narcotherapy, orthomolecular therapy, primal therapy, expressive therapies, such as art or psychodrama, and hyperbaric or other therapy.
    - Sex therapy without a diagnosis as defined by the most current version of the Diagnostic and Statistical Manual of Mental Disorders (DSM).
    - Sedative action electrostimulation therapy.
    - Sensitivity training.
    - 12-step model programs as sole therapy for conditions, including, but not limited to, eating disorders or addictive gambling.
    - Treatment or consultation provided by the members' parents, siblings, children, current or former spouse or domiciliary partner.
    - Truancy or disciplinary problems not associated with a treatable mental disorder.
    - Psychoanalysis or other therapies that are not short-term or crisis-oriented.
    - Psychological and neuropsychological testing for learning disabilities or problems, other school-related issues, to obtain or maintain employment, to submit a disability application for a mental or emotional condition, and any other testing that does not require administration by a behavioral health professional, including self-test reports.
    - Long-term residential treatment services for behavioral health disorders, including, but not limited to, substance use and eating disorders.

- Intensive health coaching services, resource coordination activity, behavioral health rehabilitation services for children and adolescents, and summer camp programs are not covered services.
- Respite services.

3. **Blood—**Non-purchased blood or blood products, including autologous donations.

4. **Corrective Appliances—**Corrective appliances primarily intended for athletic purposes or related to a sports medicine treatment plan and other appliances or devices, or any related services, including, but not limited to, children's corrective shoes, arch supports, special clothing or bandages of any type, back braces, lumbar corsets, hand splints, shoe inserts, or orthopedic shoes, unless otherwise set forth herein.

5. **Cosmetic Surgery—**Surgical or other services for cosmetic purposes performed to repair or reshape a body structure for the improvement of the person's appearance or for psychological or emotional reasons and from which no improvement in physiological function can be expected, except as such surgery or services are required to be covered by law. Excluded services include, but are not limited to, port wine stains, augmentation procedures, reduction procedures, and scar revisions.

6. **Court Ordered—**Court-ordered services when your physician or other professional provider determines that those services are not medically necessary.

7. **Custodial Care—**Custodial care, domiciliary care, residential care, or protective and supportive care, including, but not limited to, respite care, rest cures, educational services, convalescent care, dietary services, homemaker services, maintenance therapy, and food or home-delivered meals.

8. **Dental Care—**Except as otherwise set forth in this document, services directly related to care, treatment, removal, or replacement of teeth, the treatment of injuries to or diseases of the teeth, gums, or structures directly supporting or attached to the teeth, including, but not limited to, treatment of dental abscesses or granuloma, treatment of gingival tissues (other than for tumors), and dental examinations.

9. **Vision:**
    - Eyeglasses and contact lenses and vision examinations, including those for prescribing or fitting eyeglasses or contact lenses (except where you have cataracts, keratoconus, or aphakic).
    - Services for the correction of myopia, hyperopia, or astigmatism, including, but not limited to, radial keratotomy.
    - Vision training for certain diagnoses.
    - Orthoptics.

10. **Employment Related or Employer Sponsored Services:**

    - For any illness or bodily injury that occurs in the course of employment, if benefits or compensation is available in whole or in part, pursuant to any federal, state, or local government's workers' compensation, or occupational disease, or similar type of legislation. This exclusion applies whether or not you claim those benefits or compensation.
    - Services that you receive from a dental or medical department, operated in whole or in part by, or on behalf of, an employer, mutual benefit association, labor union, trust, or similar entity.
    - Services which are experimental/investigational in nature as determined by the Claims Administrator.

11. **Experimental/Investigational—**Services that are experimental/investigational in nature as determined by the Claims Administrator.

12. **Food Supplements/Vitamins—**Food, food supplements, vitamins, and other nutritional and over-the-counter electrolyte supplements, except otherwise set forth herein.

13. **Genetic Counseling and Testing—**Genetic counseling and testing not medically necessary for treatment of a defined medical condition, except when such coverage is required by PPACA.

14. **Growth Hormones—**Growth hormone therapy unless prescribed for Classic Growth Hormone Deficiency, Turner's syndrome, or certain other diagnoses as determined by the Claims Administrator and authorized in accordance with applicable policy and procedure.

15. **Hearing Aids—**Hearing aids, examinations for the prescription or fitting of hearing aids, and batteries for hearing aids, except for hearing aids and examinations as provided for children under 18 years of age.

16. **Hearing Examinations—**Hearing examinations and related services, except when such coverage is required by PPACA.

17. **Home Care—**Home care for chronic conditions such as permanent, irreversible disease, injuries, or congenital conditions requiring long periods of care or observation.

18. **Home Medical Equipment—**Comfort or convenience items, for your comfort or convenience or the comfort or convenience of your caretaker, including, but not limited to, fitness club memberships, air conditioners, televisions, telephones, dehumidifiers, air purifiers, food blenders, exercise equipment, orthopedic mattresses, home or automobile modifications, whirlpools, barber or beauty service, guest service or similar items, even if recommended by a professional provider. Medical equipment and supplies that are (a) expendable in nature (i.e., disposable items such as incontinent pads, catheters, irrigation kits, disposable electrodes, ace bandages, elastic stockings, and dressings) and (b) primarily used for non-medical purposes, regardless of whether recommended by a professional provider.

19. **Immunizations and Drugs—**Physical examinations and immunizations required by foreign travel, school, or employment, except as required by PPACA.

20. **Inpatient/Outpatient Healthcare Provider Services:**

    - Medical care for inpatient stays primarily for diagnostic services or observation (observation is only covered at the observation rate).
    - Medical care for inpatient stays that are primarily for rehabilitation services, except inpatient comprehensive physical rehabilitation services.
    - A private room, when the hospital has a semi-private room available (Payment will be based on the average semi-private room rate).

21. **Medical/Dental Services not Identified as "Covered" in Benefits Booklet—**Any other medical or dental service or treatment, except as provided in this Benefits Booklet or as mandated by law.

22. **Medical Devices and Supplies—**Durable medical equipment or supplies associated or used in conjunction with non-covered items or services.

23. **Medically Unnecessary Services—**Services that are not medically necessary as determined by the Claims Administrator.

24. **Medicare—**Services for which or to the extent that payment has been made pursuant to Medicare coverage, when Medicare coverage is primary; however, this exclusion does not apply when your employer or group plan sponsor is required to offer you all of the benefits set forth in this Benefits Booklet by law and you elect this coverage as your primary coverage.

25. **Medicare Eligibility—**Any amounts that you are required to pay under the deductible and/or co-insurance provisions of Medicare or Medicare supplement coverage.

26. **Mental Retardation—**Inpatient or outpatient treatment related to mental retardation or pervasive developmental disorder that extends beyond traditional medical management.

27. **Military Service:**

- Care for military service-connected disabilities and conditions for which you are legally entitled to services and for which facilities are reasonably accessible to you.
- Services that are provided to members of the armed forces and the National Health Service or to individuals in Veterans Administration facilities for military service-related illness or injury, unless you have a legal obligation to pay.

28. **Miscellaneous—**Any services, supplies, or treatments not specifically listed in the Benefits Booklet as covered benefits, services, supplies, or treatments, unless they are preventive care services.

- Services and supplies that are not provided or arranged by a participating provider and/or authorized for payment in accordance with Medical Management Department policies and process.
- Any services related to or necessitated by an excluded item or non-covered service.
- Services provided by a non-licensed practitioner or practitioner not recognized by the Plan.
- Services which are primarily educational in nature, including, but not limited to, vocational rehabilitation or recreational or educational therapy.
- Services rendered prior to the effective date of your coverage or incurred after the date of termination of your coverage, except as provided elsewhere in this Benefits Booklet.
- Services for which you otherwise would have no legal obligation to pay.
- Charges for telephone consultations.
- Charges for failure to keep a scheduled appointment.
- Concierge fees or boutique medical practice membership fees.
- Educational therapies intended to improve academic performance.
- Financial/legal services.
- Services performed by a professional provider enrolled in an education or training program when such services are related to the education or training program.
- Charges for completion of any insurance form or copying of medical records.
- Personal comfort items, including when used in an impatient hospital setting, including telephones, televisions, laundry charges or guest trays.
- Services rendered by a professional provider who is a member of your immediate family. Immediate family is defined as the member's spouse, child, stepchild, parent, sibling, son-in-law, daughter-in-law, mother-in-law, father-in-law, sister-in-law, brother-in-law, or grandparent.
- Services that are submitted by two different professional providers for the same services performed on the same date for the same individual.
- Services for, or related to, any illness or injury suffered after the effective date of your coverage that is the result of any act of war.
- Vocational rehabilitation and employment counseling.

29. **Motor Vehicle Accident/Workers' Compensation—**Treatment or services for injuries resulting from the maintenance or use of a motor vehicle if such treatment or service is paid or payable under a motor vehicle insurance policy, including, but not limited to, a qualified plan of self-insurance, or any fund or program for the payment of extraordinary medical benefits established by law, including medical benefits payment in any manner under the Maryland Motor Vehicle Financial Responsibility Law or equivalent law of another state.

30. **Non-Medical Items—**Health club memberships, air conditioners, televisions, telephones, dehumidifiers, air purifiers, food blenders, exercise equipment, orthopedic mattresses, home or automobile modifications, whirlpools, barber or beauty service, guest service or similar items, even if recommended by a physician.

31. **Nutritional Supplements—**Blenderized food, baby food, or regular shelf food when used with an enteral system; milk- or soy-based infant formula with intact proteins; any formula, when used for the convenience of you or your family members; nutritional supplements or any other substance utilized for the sole purpose of weight loss or gain, or for caloric supplementation, limitation, or maintenance; oral semisynthetic intact protein/protein isolates, natural intact protein/protein isolates, and intact protein/protein isolates; food additives, including, but not limited to, thickeners, vitamins, fiber supplements, calorie or protein supplements and lactose digestion products, and normal food products used in the dietary management of rare hereditary genetic metabolic disorders.

32. **Oral Surgery—**Services, including or related to oral surgery, except as otherwise outlined in this document. Exclusions include, but are not limited to:

    - Services that are part of an orthodontic treatment program
    - Services required for correction of an occlusal defect
    - Services encompassing orthognathic or prognathic surgical procedures
    - Treatment of temporomandibular joint syndrome or temporomandibular joint disorders, except as set forth in this Benefits Booklet under the covered benefits section
    - Removal of asymtomatic, non-impacted third molars
    - Orthodontia and related services

33. **Organ and Tissue Transplants:**

    - Services for or related to any organ transplant except those deemed medically necessary and non-experimental/investigational by the Plan
    - Any organ transplant or procurement done outside of the continental U.S.
    - An organ transplant relating to a condition arising from employment
    - Organ and tissue transplant covered services, if there are research funds available to pay for the services
    - Expenses incurred while searching for a suitable donor

34. **Over-The-Counter Drugs—**Food, food supplements, vitamins, and other nutritional and over-the-counter electrolyte supplements, except otherwise outlined in this document.

35. **Physical Examinations—**Physical examinations, immunizations, or behavioral health services obtained for the completion of forms and preparation of specialized reports solely for insurance, licensing, employment, or other non-preventive or medically necessary purposes, including, but not limited to, premarital examinations, physicals for employment, school, camp, and participation in sports or travel except as otherwise outlined in this document or when such coverage is required by PPACA.

36. **Podiatry Services—**Palliative or cosmetic foot care, including, but not limited to:

    - Treatment of weak, strained, flat, unstable, or unbalanced feet
    - Metatarsalgia or bunions (except open cutting procedures)
    - Treatment of corns, calluses, or toenails (except removal of nail roots if determined to be medically necessary by the Claims Administrator). Supportive orthotic devices for the foot are excluded unless you have diabetes or peripheral vascular disease.

37. **Rehabilitative Therapy—**Rehabilitative therapy services, including, but not limited to, physical therapy, occupational therapy, and speech therapy provided to correct or alleviate developmental delay, school-related problems, apraxic disorders (not caused by accident or episodic illness), stuttering, speech delay, articulation disorder, functional dysphonia, or speech problems resulting from psychoneurotic or personality disorders. Physical, occupational, and speech rehabilitation therapy services provided in excess of the maximum number of visits per benefit period, as indicated in the schedule of benefits; cardiac rehabilitation services provided in excess of 12 weeks; pulmonary rehabilitation services provided in excess of 24 visits per benefit period; rehabilitation therapy services not expected to result in ongoing substantial improvement in your medical condition; and services provided after a maintenance level has been established.

38. **Reversal of Voluntary Sterilization Procedures—**Services to reverse sterilization.

39. **Sex Transformation Services and Procedures—**Treatment leading or related to transsexual surgery, except for sickness or injury resulting from such treatment or surgery.

40. **Surrogate Motherhood—**Services and supplies associated with surrogate motherhood, including, but not limited to, all services and supplies relating to conception, prenatal care, delivery, and postnatal care of a member acting as a surrogate mother.

41. **Temporomandibular Joint Syndrome—**Treatment of temporomandibular joint syndrome or temporomandibular joint disorders, regardless of the nature of the problem, except as set forth in this Benefits Booklet and MedStar Select Plan Policy.

42. **Transportation—**Non-emergent transportation, by any means, including via ambulance provider, unless such transportation is Prior Authorized by the Medical Management Department.

43. **Treatment Outside the U.S.—**Treatment for non-emergent or non-urgent services received outside the U.S.

44. **Weight Reduction—**Weight reduction programs, including all related diagnostic testing and other services, except as outlined in this document for morbid obesity or when coverage is required by PPACA. Antiobesity medication, including, but not limited to, appetite suppressants and lipase inhibitors, but you should check with your pharmacy benefit plan to see if these medications are covered.

Wellness Services

Members have access to health and wellness resources through the MedStar *My*Health Program. The program provides tools, education and information to help you preserve and improve your health. The *My*Health suite of programs and services emphasize wellness and help you live healthier and more productive lives. Participation in the *My*Health program is optional and at no additional cost to you.

Wellness services include:

- **MedStar *My*Health OnLine,** www.MedStarMyHealth.org, a secure website providing comprehensive wellness resources—including a *My*Health Questionnaire, health trackers and tools to help you achieve your goals, and review expert health information
- ***My*Health Questionnaire,** an online health assessment that provides you with a snapshot of your overall wellness, complete with personalized results and interactive tools.
- **Health coaching,** through Coach on Call, a personalized support service. Health coaches help you understand your *My*Health Questionnaire score, offer resources and help motivate you to make healthy changes.
- **WebMD**, you can explore expert information from WebMD, one of the most trusted names in health and wellness on MedStar *My*Health OnLine.
- ***My*Community,** find discounts for community activities, including gym memberships, yoga classes, dance lessons, and massage services.
- **Biometric screenings,** a simple finger-prick test and you will receive your results in about 15 minutes.

More on the *My*Health Questionnaire
The *My*Health Questionnaire will ask about your daily lifestyle habits, including nutrition, physical activity, stress, tobacco use and personal safety, as well as medical history, preventive screenings, any current health conditions and results from recent medical tests. This tool supports you in determining what healthy steps you can take to improve your well-being. Specifically, it will assess 12 important health and lifestyle factors:

- Exercise
- Weight
- Nutrition
- Tobacco use
- Stress
- Emotional health
- Alcohol use
- Substance abuse
- Safety
- Blood sugar
- Blood pressure
- Cholesterol

After completing the questionnaire, you receive a baseline score and an easy-to-understand, personalized action plan based on your responses. The customized report provides details on your current health status for each of the 12 assessed health and lifestyle factors. You'll receive instant feedback on how changing your behavior now affects your chance of developing health conditions in the future. The summary report and personalized action plan suggest next steps, personal insight and additional resources for you based on your results.

More on Health Coaching
Health coaching, through Coach on Call, is a personalized support resource to help you achieve your health goals. You can confidentially reach out to and work with a health coach to successfully eat healthier, manage stress, lose weight, increase physical activity, or capably manage a health condition like asthma or diabetes. Health coaches educate, offer resources and help motivate you to make healthy changes. To speak with a Coach on Call, call 855.242.4874, Monday through Friday, from 7 a.m. to 7 p.m. and Saturday, from 8 a.m. to 3 p.m.

More on Biometric Screenings
If you don't know your blood pressure, cholesterol, blood sugar, body mass index and other important personal health numbers, this is your chance to get a no-cost screening. You have access to one biometric set of screenings per year, either through your primary care physician or on-site at work, through the wellness program. These key indicators help to measure your risk for heart disease, diabetes, stroke, heart attack, and other major conditions. It's a simple finger-prick test and you will receive your results in about 15 minutes.

Care Management Services

MedStar *My*Health Hospital Transition Program
Designed to enhance in-hospital patient education, care coordination, discharge teaching, transition management and follow up for members within an observation or inpatient stay. The program provides you with a team of resources, including a MedStar *My*Health Transition Care Coordinator, to better prepare you for discharge to home, coordinate follow-up care, support adherence to care and treatment plans, and ultimately reduce readmissions to the hospital.

MedStar *My*Health Complex Care Program
This program enhances the member experience through a collaborative, multi-disciplinary care management approach, improving the quality of care and managing your medical costs. The MedStar *My*Health care management team consists of personnel including Medical Director leadership, along with RN care managers, social workers, clinical nutritionists and pharmacists. The care management team works with PCPs, specialists and home care agencies to coordinate follow-up care and support adherence to care and treatment plans.

If you are managing multiple chronic conditions and qualify for these services, a *My*Health care manager will reach out to you.

Schedule of Benefits

The Plan only pays for covered services. Any healthcare service not included in the description of covered services, or listed in the exclusions, is not covered by the Plan.

This section helps you understand what your financial responsibility (if any) will be under the covered services. It includes what you will have to pay for covered health services, including any co-payments or co-insurance. It also outlines any limits to these covered services (including dollar or visit maximums), and any responsibility you have for obtaining a prior authorization or a plan of treatment.

CO-PAYMENTS	
Primary Care Co-Payments Per visit co-payment applies to covered services by a physician with a specialty of: Family Practice, General Practice, Internal Medicine, Pediatrics, Physician's Assistant, OB/GYN, and covered services by a Nurse Practitioner	**$0 per visit**
Specialty Care Per visit co-payment applies to covered services by all other practitioners	**$20 per visit**
Emergency Care	**$100 per visit** *Waived if admitted as inpatient
Urgent Care	**$10 per visit**
Inpatient Hospitalization *(Prior authorization required)*	**$100 per admission**
Outpatient Surgery	**$50 per surgery**

DEDUCTIBLES	
Per Individual	**$0**
Per Family Family deductible (any type of coverage which is not individual is considered family)	**$0**

CO-INSURANCE MAXIMUM	
Per Individual	**$1,000**
Per Family Family co-insurance maximum information (any level of coverage which is not individual is considered family): The family co-insurance maximum is calculated in the aggregate. A family member may not contribute more than the individual co-insurance maximum to the family co-insurance maximum.	**$2,000**

The following amounts are included/excluded from the co-insurance maximum:	Included	Excluded
Amounts in excess of the allowed amount	No	Yes
Inpatient co-payments	No	Yes
Non-Inpatient co-payments	No	Yes
Mental Health and Substance Abuse admission co-payments	No	Yes
Co-insurance (member's share)	Yes	No
Pharmacy drugs for IVF	No	Yes

LIFETIME MAXIMUM
The Lifetime Maximum for covered services is unlimited per member. The Lifetime Maximum delivers no rights to benefits after a member loses eligibility for coverage or is no longer covered under the Plan.

Preventative Services will be covered in compliance with requirements under PPACA.	
Pediatric Care and Immunizations: Preventive/health screening examination Pediatric immunizations Well-baby visits	Paid in full
Adult Care and Immunizations: Preventive/health screening examination Adult Immunizations required to be covered at no cost-sharing by PPACA Adult Immunizations not required to be covered by PPACA	Paid in full
Women's Care: Screening Gynecological Exam Screening Pap Test and Screening Mammogram	Paid in full
Allergy Services	
Diagnostic testing	Primary Care Physician, paid in full Specialist, paid in full after $20 co-pay
Treatment including injections and serum	Primary Care Physician, paid in full Specialist, paid in full after $20 co-pay
Diagnostic Services	
Advanced imaging (e.g., PET, MRI, CT, etc.)	Paid in full after $30 co-pay
Other imaging (e.g., X-ray, Sonogram, etc.)	Paid in full after $15 co-pay
Lab and other services	Paid in full
Home Health Care Services	
Home health care *(Pre-authorization required; 60 visits per year)*	Paid in full
Private duty nursing *(Pre-authorization required)*	Paid in full after 10% co-insurance
Skilled nursing facility (*Pre-authorization required*)	Paid in full after $100 co-pay per admission
Hospital Facility/Surgical Procedures	
Semi-Private Room, Private Room (if medically necessary), Surgery, Pre-Admission Testing	
Outpatient surgery	Paid in full after $50 co-pay per surgery
Inpatient hospitalization (*Pre-authorization required*)	Paid in full after $100 co-pay per admission
Medical rehabilitation coverage *(Medically necessary care–non custodial; limited to 30 days per illness or injury)*	Paid in full
Anesthesia, assistant surgeon	Paid in full
Gastric bypass (*Pre-authorization required*)	Paid in full, only performed at MedStar Center of Excellence

Hospital Physician Services	
Services performed by surgeons, surgical assistants, radiologists, pathologists, and anesthesiologists	
Inpatient	Paid in full
Outpatient	Paid in full
Immunizations and Inoculations	
For common communicable diseases, tests and serum	Paid in full
Medical Therapy Services	
Chemotherapy, radiation therapy, dialysis treatment, infusion therapy	Paid in full
Mental Health and Substance Abuse	
Mental health/substance abuse Inpatient hospital/facility and professional services	Paid in full after $100 co-pay per admission
Partial hospitalization facility and physician services	Paid in full
Office visits for mental health and substance abuse	Paid in full
Reproductive Health	
Maternity care	Paid in full after $100 co-pay, waived for participants in the *My*Health Maternity Program
Infertility services *(Pre-authorization required; Benefits for Artificial Insemination (AI) and In Vitro Fertilization (IVF) are combined and limited to four attempts per year and six attempts per lifetime.)*	50% co-insurance
Therapy Services	
Physical and occupational (*Limited to 60 visits per year combined; Treatment plan required after 10 visits)*	Paid in full after $20 co-pay
Speech therapy *(Limited to 60 visits per year)*	Paid in full after $20 co-pay
Cardiac rehabilitation coverage	Paid in full
Pulmonary rehabilitation coverage	Paid in full
Therapeutic manipulation *(Chiropractic; Limited to 30 visits per year; Treatment plan required after 10 visits)*	Paid in full after $20 co-pay

Acupuncture *(Prior authorization required; For Medically necessary care)*	Paid in full after $20 co-pay
Other Medical Services	
Ambulance Services	Paid in full
Hospice care *(Pre-authorization required)*	Paid in full
Dental services related to accidental injury	Paid in full after 10% co-insurance
Durable medical equipment	Paid in full
Organ transplants *(Pre-authorization required)*	Paid in full
Nutritional counseling	Paid in full
Diabetic equipment, supplies, and education	Paid in full
Glucometer, test strips, lancets, insulin, and syringes	Paid in full

Pharmacy Benefits-Administered by CVS/Caremark under Separate Plan		
Retail Copays:	**MedStar Pharmacy**	**Non-MedStar Pharmacy**
Retail generics (0-30 days)	$5 co-pay	$10 co-pay
Retail brand (0-30 days)	$25 co-pay	$35 co-pay
Retail non-preferred brand (0-30 days)	$50 co-pay	$70 co-pay
Retail generics (31-60 days)	$10 co-pay	n/a
Retail brand (31-60 days)	$50 co-pay	n/a
Retail non-preferred brand (31-60 days)	$100 co-pay	n/a
Retail generics (61-90 days)	$10 co-pay	n/a
Retail brand (61-90 days)	$50 co-pay	n/a
Retail non-preferred brand (61-90 days)	$120 co-pay	n/a
Mail Order Copays:		
Mail generics (90-day supply)	$20 co-pay	$20 co-pay
Mail preferred-brand (90-day supply)	$70 co-pay	$70 co-pay
Mail non-preferred brand (90-day supply)	$140 co-pay	$140 co-pay
Maximum out-of-pocket limit for RX	$1,000	$1,000