MedStar Select

MedStar Select Plan

MedStar Washington Hospital Center - Union

2017 Benefits Booklet

Effective January 1, 2017

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
- The MedStar-Georgetown Medical Center Flexible Benefits Plan
- MedStar Health, Inc. Associates Benefit Plan

This Benefits Booklet should be read together with the Summary Plan Description (SPD) for the Wrap Plan. The benefits under the Plan are the self-funded obligations of the Plan Sponsor, MedStar Health, Inc. Evolent Health provides certain administrative services and does not assume any financial risk or fiduciary obligation with respect to claims or associated services.

Please carefully read the Wrap Plan SPD and this supplementary Benefits Booklet. 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.

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MedStar Select

Your MedStar Select Plan

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. Throughout this booklet, mentions of the "Plan" refer to the MedStar Select Plan.

The Plan covers the greater Baltimore and Washington, D.C., 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 25 under "Description of Covered Services" for this information, including room and board details. Then, look under the "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 Reside Outside of the MedStar Service Area or You Are Away from Home."

The coverage described in this Benefits Booklet is administered in compliance with applicable laws and regulations at all times including, but not limited to, the Affordable Care Act (ACA); the Health Care and Education Reconciliation Act of 2010, and the implementing regulations thereunder; the Employee Retirement Income Security Act (ERISA); the Health Insurance Portability and Accountability Act (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 important and frequently used terms and definitions that the MedStar Select Plan uses throughout this Benefits Booklet and when administering your benefits.

Allowed amount – The contracted or negotiated rate with providers. When a contracted or negotiated amount does not exist, the allowed amount is based on what providers in the geographic area typically charge for the same or similar medical service.

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

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

Benefit period – The time period that you are eligible for coverage during the Plan's plan year. Charges for covered services must be incurred during the benefit period 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.

Claims administrator – As delegated by MedStar, Evolent Health LLC is the claims administrator for the MedStar Select Plan.

Coinsurance – Your share of the costs of a covered service, calculated as a percent of the allowed amount for the service. Coinsurance payments apply toward your out-of-pocket maximum.

Copayment – The specified dollar amount that you pay at the time of service for certain covered benefits. Copayments apply toward your out-of-pocket maximum. You are expected to pay your copayment at the time of service. Refer to the Schedule of Benefits to determine copayment 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.

Dependent – A person who relies on, or obtains benefit coverage through, an associate member. Eligible dependents generally include a (same or opposite sex) spouse and any child of the associate or spouse 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 physical condition began before the child turned 26 years old and the child had health insurance coverage when he or she became disabled and thereafter. For more information about 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 or 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.

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

Medical necessity or medically necessary – Services covered under the Plan 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. 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 is considered 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.

MyHealth Care Advisors – A registered nurse who works directly with MedStar plan members and their physicians/providers, providing health management education, support, care coordination and advocacy to the member in conjunction with a team of allied health professionals which includes pharmacists, registered dieticians and social workers.

Out-of-network provider — A provider or facility working within the scope of its license that is not a contracted provider with the health plan network.

Out-of-pocket maximum – The maximum

dollar amount that you are responsible to pay during the benefit period before the Plan will pay 100% for your covered benefits. See the Schedule of Benefits for out-of-pocket maximum amounts. Payments you make toward your coinsurance and copayments all count toward the out-of-pocket maximum.

The family out-of-pocket maximum is the maximum amount per family, which is an aggregate of payment contributions from covered individual members in the family. An individual's maximum out-of-pocket amount is capped at the "per individual" maximum, regardless of whether he or she is enrolled in family coverage. In addition, an individual family member may not contribute more than the individual out-of-pocket maximum to the family out-of-pocket maximum.

Plan – The MedStar Select Plan.

Plan Administrator – MedStar Health, Inc.

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

Plan Sponsor – MedStar Health, Inc.

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 responsibility to either the provider or the member.

Service area – The Plan's primary service area, which consists of the greater Baltimore and Washington, D.C., regions, as well as Southern Maryland. These are the areas where most of the in-network providers are located.

Specialist – A healthcare professional that 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 participating in the MedStar Select Plan.

How to Determine Member Eligibility

ELIGIBILITY

MedStar Health, Inc. ("MedStar") has the sole and complete authority to make determinations regarding eligibility and enrollment for membership in the Plan. You and your dependents are eligible for coverage if you and your dependents meet the eligibility requirements established by MedStar.

Eligible dependents generally include a (same or opposite sex) spouse and any child of the associate or spouse 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 physical condition began before the child turned 26 years old and the child had health insurance coverage when he or she became disabled and thereafter. For more information about who is an eligible dependent under the Plan, consult the Wrap Plan SPD.

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.

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 has been paid

NEWBORN ENROLLMENT

Newborns are automatically covered for 31 days from birth under the mother's coverage if the mother is a MedStar Select member, unless you notify us that the child will not be covered under the Plan. If you do not add the newborn to the Plan prior to the 32nd day from birth by following the process outlined in the enrollment information originally provided to you by the Plan, coverage will no longer be available and claims from that point forward will deny.

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. To receive the highest level of benefits for covered services, you should use in-network facilities and providers. Except for emergency services or services as described in the section entitled "How to Access Care When You Reside Outside of the MedStar Service Area or You are Away From Home," the Plan will cover services obtained from providers outside of the MedStar Select Provider Network as out-of-network benefits.

The MedStar Select Provider Network includes hundreds of physicians and other professional providers and all MedStar hospitals. All of the in-network 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 an in-network provider in your area, refer to the MedStar Select Plan Provider Directory at **www.MedStarMyHealth.org** or call Member Services at **855-242-4872** for assistance.

Whether you are choosing your own healthcare provider or if your participating provider directs you to seek care from any other healthcare provider, it is your responsibility to verify the provider is participating with the MedStar Select Provider Network either by referring to the Provider Directory at **www.MedStarMyHealth.org** or by calling Member Services at **855-242-4872.** If you do not use an in-network provider, you will have to pay higher out-of-pocket costs for those covered services.

Remember, except in an emergency or under certain circumstances as explained on page 10 you must use in-network providers to ensure you receive the highest benefit from the Plan for covered services. If you do not use an in-network provider, the Plan will cover those services but you will have to pay higher out-of-pocket costs for those covered services.

TRANSITIONING TO THE MEDSTAR SELECT PROVIDER NETWORK

If you are a new member, your current healthcare providers might be outside of the MedStar Select Provider Network. We recognize 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 you transition 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.

If you enroll in MedStar Select and are currently receiving active, ongoing treatment from 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 current 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 allowed amount.

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.

SPECIAL NETWORK EXCEPTIONS

Certain exceptions exist to allow members to go outside the MedStar Select Provider Network if they need access to high-end specialty care that is not available through the MedStar Select Provider Network. The healthcare service should be reviewed and approved in advance to determine Medical Necessity. Contact Member Services to determine whether 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 may be 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 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. It is your responsibility to notify the Plan of out-of-network services that you obtain. In the event you receive non-covered services from the out-of-network provider, you may be held financially responsible.

Coverage for non-emergency services received from an out-of-network provider is available as defined by your out-of-network benefits.

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 (for example, 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

after receiving Urgent Care to arrange or obtain necessary follow-up care. Urgent Care facilities in the MedStar Select Provider Network can be located by contacting Member Services at **855-242-4872** or searching for a provider at **www.MedStarMyHealth.org**.

MENTAL HEALTH AND SUBSTANCE ABUSE

The Plan delegates administration of mental health and substance abuse services, including behavioral health treatment, to Magellan Health, Inc.

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, these benefits are not administered by the Plan's claims administrator. To be eligible for these benefits, you must purchase your outpatient prescription drugs from a MedStar pharmacy, an in-network 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 in-network pharmacies when you purchase your prescriptions. Visit CVS/Caremark at www.caremark.com for more information or to find a participating pharmacy.

How to Access Care When You Reside Outside of the MedStar Service Area or You Are Away from Home

With MedStar Select, you have access to affordable healthcare services outside of the MedStar Select Provider Network. If you or your dependents reside outside of the service area (including college students) or are traveling out of town and need to see a doctor, benefits are paid at the in-network benefit level 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 regular out-of-pocket expenses such as copayments, coinsurance and expenses for non-covered services. This coverage, through a national network, is available inside the United States.

Coverage may also be available if you do not use one of the Plan's national network providers. However, you will have to pay higher out-of-pocket costs, including a deductible and coinsurance as defined in your out-of-network benefits, and all expenses for non-covered services.

HOW TO ACCESS COVERAGE

- You can search for a provider within the MedStar Select Provider Network on *My*Health OnLine at **www.MedStarMyHealth.org**.
- If you need support with your search, or if you require a provider out of the MedStar Select service area, call Member Services at **855-242-4872** to find national network doctors and hospitals in the area where you are located.
- When traveling out of town, make sure to bring your MedStar Select Plan member ID card.
- 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 receive healthcare services. If you cannot locate your ID card, you may print a temporary card online at www.MedStarMyHealth.org or you may call Member Services and request a duplicate card. In the event you fail to present your ID card at the time of service,

you may be held financially responsible for the services received.

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 a request for reimbursement using the Out-of-Network Claim Form, and we will determine if you can be reimbursed for your emergency service expenses at the same level of benefits that would be paid in the U.S. Our claims administrator will perform a claim review to determine whether your expenses are reimbursable.

Keep in mind, if you or your dependents will be living abroad for an extended period, you should carefully consider your Plan choices, as only emergency services are covered outside of the U.S. under this 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. Plan limits do apply internationally, including:

- Copayments
- Coordination of benefits
- Non-covered services and supplies

When you obtain services from any out-of-network provider, you have 365 days from the date the service was incurred to submit an out-of-network claim form for the reimbursement of services.

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. A service that requires prior authorization is treated as a pre-service claim by the Plan. Pre-service claims decisions and notification timeframes are further discussed below.

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 may result in denial of coverage and you will have to pay out of pocket. If you are unsure if a service requires prior authorization, call Member Services at **855-242-4872** [TTY **855-250-5604**] or refer to the *Quick Reference Guide* link found online at **www.medstarprovidernetwork.com** under the MedStar Select section**.** This website also houses policies relating to the services that require prior authorization and can be accessed via the *Medical Policies Requiring Prior Authorization* link.

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.

Some, but not all, commonly utilized services that require prior authorization:

Inpatient Admissions:

- Hospital Admissions (elective and acute; excludes deliveries)
- Long Term Acute Care (LTAC) Admissions
- Rehabilitation Facility Admissions
- Skilled Nursing Facility (SNF) Admissions

Outpatient Services:

- Hospice Care
- Home Health Care
- Infertility Services
- Private Duty Nursing

Surgical Procedures:

- Abdominoplasty/Panniculectomy
- Transplants (bone marrow, stem cell and solid organ)
- Weight Reduction Surgery

Durable Medical Equipment (DME) and Ancillary Services:

- Any DME item with an allowable amount of $500 or higher
- DME capped rentals
- Continuous Glucose Monitoring, Long Term, Interstitial
- External Insulin Pumps (for children under 13)

Other Services:

- Ambulance, Ground Non-Emergent
- Emergent and Non-Emergent Air Transportation
- Prosthetic and Related Supplies

The complete list of services requiring prior authorization can be obtained as outlined above. That list is subject to change as the Plan's medical policy guidelines are updated.

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 the level of care being provided to you. The Medical Management staff reviews your treatment plan 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 POSTSERVICE 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 need
- The need to refer you to a care advising program

EXPEDITED CLAIMS FOR URGENTLY NEEDED SERVICES

The Plan expedites claims that are considered urgent. Generally, an urgent situation is one in which following the Plan's standard review processes could cause you to:

- Seriously jeopardize your life or health
- Seriously jeopardize your ability to regain maximum function
- Be subjected to severe pain that could not be adequately managed without the care or treatment that is the subject of the claim in the opinion of a physician with knowledge of your medical condition

The Plan will defer to your physician's determination, if any, that a claim qualifies for expedited review.

If the claim is for urgently needed services or items, the reviewer will notify you of the Plan's benefit determination (whether adverse or not) as soon possible, taking into account the medical demands, but not later than 72 hours after the Plan receives the claim.

The Complaint and Grievance Process

If you have a dispute or objection regarding a provider or the coverage, operations or the management policies of the MedStar Select Plan, you may submit a complaint to MedStar Select. You may submit a complaint about issues including, but not limited to, quality of care or service, benefits exclusions, rescissions, denial of coverage or coordination of benefits.

You may either file a complaint verbally over the phone with the Member Services department by calling the phone number on the back of your member identification card or by sending a written complaint to

MedStar Select Plan
MSC: MS01
P. O. Box 689
Pittsburgh, PA 15230

You may also send any other written information that you have to support your complaint. In the complaint, you may indicate the remedy, resolution or corrective action that you seek from MedStar Select. At any time during the complaint process, you may choose to designate a representative to act on your behalf. You must notify MedStar Select in writing that you are designating someone to represent you. Also, at any time during the complaint process, upon your request, MedStar Select can make available, at no charge, a MedStar Select employee to assist you or your representative in preparing the complaint. This employee will not have previously participated in any of MedStar Select's decisions regarding your complaint.

A complaint is not a substitute for a claim appeal. If you have an issue with a claim determination, please refer to the Appeals Procedures below.

Appeals Procedures

The following refers to your rights related to benefit determinations. If you have concerns regarding quality of care or service, please refer to the Complaints and Grievances section above.

RESOLVING DISPUTES

At times, you may not be satisfied with a decision that MedStar Select makes regarding your coverage or with the healthcare services you have received. As a member of MedStar Select, you have the right to appeal an adverse benefit determination.

ADVERSE BENEFIT DETERMINATION

For purposes of this Appeal Procedures section, any denial, reduction, or termination of, or a failure by the Plan to provide or make payment (in whole or in part) for, a benefit is an adverse benefit determination. This includes any decision that is based on a determination of an individual's eligibility to participate in a benefit under the Plan, as well as any cancelation of coverage.

Generally, a cancelation of coverage is a termination of coverage that is retroactively effective and is due to fraud or misrepresentation of a material fact. Note that a termination of coverage for failure to pay any required premiums is not considered a cancelation and is not subject to these claims procedures, even if it is effective retroactively to the date through which coverage was paid. Whether a termination of coverage is considered a "cancelation," and therefore subject to these claims procedures, will be determined by the reviewer based on applicable law.

In such a case, the reviewer will provide you with sufficient advance notice of the adverse benefit determination prior to the reduction or termination of the benefit. This advance notice allows you to appeal and obtain a determination of the review of that adverse benefit determination before the benefited is terminated or reduced.

MANNER AND CONTENT OF ADVERSE BENEFIT DETERMINATION

If the reviewer denies a claim in whole or in part, you will be provided with a written or electronic notice of an adverse benefit determination that includes:

- A description of the specific reasons for the denial
- A reference to any Plan provision or insurance contract provision upon which the denial was based
- A description of any additional information that you must provide in order to perfect the claim (including an explanation of why the information is needed)
- Notice that you have a right to request a review of the claim denial and information about the steps to be taken if you wish to request a review of the claim denial
- A statement of your right to bring a civil action under a federal law called ERISA §502 following any denial on review of the initial denial

In the case of a denial of health benefits both of the following will also be provided to you:

- A copy of any rule, guideline, protocol or other similar criterion relied upon in making the adverse benefit determination (or a statement that the same will be provided upon request by you and without charge)
- If the adverse benefit determination is based on the Plan's medical necessity, experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment applying to the exclusion or limit to your medical circumstances (or a statement that the same will be provided upon request by you and without charge)

For an adverse benefit determination concerning a health claim involving urgently needed services or items, the information described in this section may be provided to you orally within the permitted time frame, provided that a written or electronic notification in accordance with this Section is furnished not later than three days after the oral notification.

APPEALS OF INITIAL ADVERSE BENEFIT DETERMINATIONS

If you submit a claim for benefits and it is initially denied under the procedures described above, you may request an appeal of that denial under the following procedures.

If your initial claim for health benefits is denied, you may request a review of that denial by submitting the request in writing to the reviewer no later than 180 days after you receive the notice of an adverse benefit determination. Except as provided below for an expedited review of a denied claim or urgently needed services or items, a request for review must be submitted to the reviewer in writing.

You may request an expedited review of a denied claim for urgently needed services or items. Such a request may be made to the reviewer orally or in writing and all necessary information, including the Plan's determination on review, will be communicated to you by the Plan via telephone, facsimile or other similarly expeditious method.

In addition to providing the right to review documents and submit comments as described above, a review will meet the following requirements:

- The Plan will provide a review that does not afford deference to the initial adverse benefit determination. This review will be conducted by an individual who did not make the initial determination that is the subject of the appeal, nor is a subordinate of the individual who made the determination.
- A healthcare professional who has appropriate training and experience in the field of medicine involved in the medical judgment will be consulted before any appeal decision is made that is based in whole or in part on a medical judgment, including determinations with regard to whether a particular treatment, drug or other item is experimental, investigational or not medically necessary or appropriate. The professional engaged for purposes of a consultation in the preceding sentence shall be an individual who was neither consulted in connection with the initial determination that is the subject of the appeal nor the subordinate of any such individual.
- The Plan will identify the medical or vocational experts whose advice was obtained on behalf of the Plan in connection with the review determination, without regard to whether the advice was relied upon in making the review determination.
- The Plan will allow you to review the claim file and to present evidence and testimony and will comply with the following additional requirements:
  - The Plan will provide you, free of charge, with any new or additional evidence considered, relied upon, or generated by the Plan in connection with the claim sufficiently in advance of the Plan's deadline for providing notice of a final denial of a claim (as described in these claims procedures and applicable regulations). This gives you a reasonable opportunity to respond before that date.
  - Before the Plan issues a final decision on review based on a new or additional rationale, you will be provided, free of charge, with the rationale for the Plan's decision sufficiently in advance of the Plan's deadline for providing notice of a final denial of a claim (as described in these claims procedures and

applicable regulations). This gives you a reasonable opportunity to respond before that date.

DEADLINE FOR APPEAL DECISIONS

For claims that qualify for expedited review as discussed below, the reviewer will notify you of the Plan's determination on review as soon as possible, taking into account the medical urgency, but not later than 72 hours after the Plan receives your request for review of the initial adverse benefit determination.

For a pre-service health claim, the reviewer will notify you of the Plan's determination on review within a reasonable period of time appropriate to the medical circumstances, but never later than 15 days after the Plan receives your request for review of the initial adverse benefit determination.

For a post-service health claim, the reviewer will notify you of the Plan's benefit determination on review within a reasonable period of time, but never later than 30 days after the Plan receives your request for review of the initial adverse benefit determination.

MANNER AND CONTENT OF APPEAL DECISION NOTICE

Upon completion of the review of the first level appeal, the reviewer will provide you with a notice of his or her decision on review in writing or by electronic notification. The notice will include:

- A description of the decision
- A description of the specific reasons for the decision
- A reference to any relevant Plan provisions or insurance contract provisions on which the decision is based
- A statement that you are entitled to receive, upon request and without charge, reasonable access to and copies of all documents, records and other information in the Plan's files that are relevant to your claim for benefits
- A statement that if your initial appeal is denied, you will have the right to file one additional internal level of appeal within 30 days through the MedStar Human Resource Benefits department, in accordance with the procedures described above. In order to exercise your right to this second level of appeal, submit a request over the phone to the Member Services department by calling the phone number on the back of your member identification card or by sending a written request to MedStar Health, C/O VP – Compensation, Benefits and HR Technology, 10980 Grantchester Way, Columbia, MD 21044
- If applicable, a statement describing your right to bring an action for judicial review under ERISA §502(a)
- If an internal rule, guideline, protocol or other similar criterion was relied upon in making the adverse determination on review, a statement that a copy of the rule, guideline, protocol or other similar criterion will be provided at no charge upon your request.
- If the adverse benefit determination being reviewed is based on medical necessity, experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment on which the determination was based, applying the terms of the Plan to your medical circumstances, will be provided to you, or a statement that such an explanation will be provided at no charge upon your request will be provided to you.

  For any adverse benefit determination involving medical coverage, any notice of an adverse benefit determination will be provided in a culturally and linguistically appropriate manner in accordance with applicable law regarding such notices. In addition to other requirements described

above, this notice will provide

- Information sufficient to identify the claim involved, including the date of service, the healthcare provider and the claim amount (if applicable)
- A summary of the decision, including disclosure of any denial code used (and an explanation of its meaning) and a description of the Plan's standard, if any, that was used in denying the claim
- A description of available internal appeals and external review processes, including information regarding how to initiate an appeal
- Information (including contact information) about the availability of any applicable office of health insurance consumer assistance or ombudsman established pursuant to the Affordable Care Act (ACA) to assist individuals with internal claims and appeals and external review processes
- A statement describing the availability, upon request, of any applicable diagnosis code (and an explanation of its meaning) and any applicable treatment code (and an explanation of its meaning)

The Plan will ensure that claims and appeals are decided in a manner that ensures the independence and impartiality of individuals involved in claims decisions. Decisions regarding hiring, compensation, termination, promotion or similar matters will not be made based on the likelihood that any person involved in making claims decisions will support the denial of benefits.

CALCULATION OF TIME PERIODS

For purposes of the time periods specified in this Claims and Appeals Procedures Section, the period during which a benefit determination must be made begins when a claim or appeal is filed in accordance with the Plan procedures, without regard to whether all the information necessary to make a decision accompanies the claim.

If a period of time is extended because you fail to submit all information necessary for an initial claim that is for services or items that are not considered urgent, or you fail to submit all information necessary for an appeal of an adverse benefit determination for benefits other than health benefits, the period for making the determination shall be "frozen" from the date the notification requesting the additional information is sent to you until the date you respond.

YOUR FAILURE TO FOLLOW PROCEDURES

To receive Plan benefits, you must follow the procedures described in the Plan. If you do not follow the Plan's claims procedures, you may lose your right to a benefit under the Plan, including any right you may have to file a legal action for benefits.

PLAN'S FAILURE TO FOLLOW PROCEDURES

If the Plan fails to substantially follow the claims procedures described above, you will be deemed to have exhausted the administrative remedies available under the Plan and will be entitled to pursue any available remedy under ERISA on the basis that the Plan has failed to provide a reasonable claims procedure that would yield a decision on the merits of the claim. In this case, you will be deemed to have exhausted the Plan's internal claims and appeals process if the Plan fails to strictly adhere to the applicable requirements of the U.S. Department of Labor's claims procedure regulations except for certain minor violations.

For this purpose, the Plan's failure to comply with the claims procedure regulations is considered a minor violation if all of the following apply:

- The violation does not cause, and is not likely to cause, prejudice or harm to you

- The violation was for good cause or due to matters beyond the control of the Plan
- The violation occurred as part of an ongoing, good faith exchange of information between the Plan and you
- The violation is not part of a pattern or practice of violations by the Plan

If an issue arises regarding whether this "minor violation" exception applies, you may request a written explanation of the violation from the Plan and the Plan will provide the explanation within 10 days, including the specific reasons, if any, for asserting that the violation should not cause the Plan's internal claims and appeals process to be deemed exhausted.

If an external reviewer or a court rejects your request for immediate review on the basis that the Plan met the standards for the minor violation exception, you will be permitted to resubmit and pursue the internal appeal of the claim. In such case, within a reasonable time after the external reviewer or court rejects the claim for immediate review (not to exceed 10 days), the Plan will provide you with notice of the opportunity to resubmit and pursue the internal appeal of the claim. Time periods for re-filing the claim will begin upon your receipt of the notice.

In cases where you have exhausted the Plan's internal claims procedures, you have the right to pursue any available remedy under ERISA. If the claim involves coverage that is subject to the ACA you may pursue any remedy available under any external review process provided under federal or state law in accordance with the ACA.

EXTERNAL REVIEW

The Plan will comply with the applicable requirements of an external review process that applies under federal or state law. For any non-grandfathered coverage that is self-funded, unless the Plan is eligible for and elects to participate in a different external review process that is available under federal or state law and that is considered adequate for purposes of the Affordable Care Act, the Plan will comply with federal regulations at 29 CFR 2590.715-2719 and the interim procedures for federal external review set forth in Department of Labor Technical Release 2010-01 as modified by Technical Release 2011-02, as summarized in this Section, until those procedures are replaced by other guidance.

The Plan will begin complying with any new guidance for external review on or before the date that those requirements become applicable.

External review is not available for all adverse benefit determinations. For example, external review is not available for an adverse benefit determination based on a determination that you fail to meet the requirements for eligibility under the terms of the Plan. All levels of appeals must be exhausted before an external review can be submitted.

External review is available only for any final internal adverse benefit determination (or internal adverse benefit determination on a claim for urgently needed services or items that qualifies for the expedited external review described below) that:

- Involves medical judgment (including, but not limited to, those based on the Plan's requirements for medical necessity, appropriateness, healthcare setting, level of care or effectiveness of a covered benefit, or that a treatment is experimental or investigational), as determined by the external reviewer
- Involves a rescission of coverage
- Is eligible for external review in accordance with applicable guidance (as determined by the Plan at the time of the request for external review)

A request for external review must be submitted to the Plan no later than four months after you receive notice of an adverse benefit determination for which external review is available.

Within five business days after the date the

Plan receives a request for external review, the Plan will complete a preliminary review of the request to determine whether:

- You are or were covered under the Plan at the time the healthcare item or service was requested or, for a post-service claim, you were covered under the Plan at the time the healthcare item or service was provided
- The adverse benefit determination does not relate to your failure to meet the requirements for eligibility under the terms of the Plan
- You have exhausted the Plan's internal appeal process (or that you are not required to exhaust the internal appeals process under applicable regulations)
- You have provided all of the information and the forms required to process an external review

Within one business day after the Plan completes the preliminary review, the Plan will issue a notice in writing to you. If the request is complete but is not eligible for an external review, the notice will describe the reasons an external review is not available and, if applicable, will include contact information for the Employee Benefits Security Administration.

If the request is not complete, the notice will describe the information or materials needed to make the request complete and the Plan will allow you to perfect the request for external review within the four-month filing period or, if later, within the 48 hours after you receive the notice.

External reviews are conducted by independent third parties called independent review organizations. The Plan will assign each external review to an independent review organization (IRO) that is accredited by URAC or a similar nationally recognized accrediting organization to conduct the external review. The Plan will contract with at least three different IROs, will take action against bias to insure the independence of each IRO and will rotate review assignments among them (or the Plan will incorporate other independent, unbiased methods for selecting IROs, such as random selection, and will document such methods). No IRO will be eligible for any financial incentives from the Plan or the Employer based on the likelihood that the IRO will support the denial of benefits.

Per contractual agreement between the Plan and the IRO, the IRO that handles external reviews and the Plan are required to comply with the following external review requirements:

- The IRO will consult with legal experts where appropriate to make coverage determinations under the Plan.
- The Plan will notify you in writing of the request's eligibility and acceptance for external review. This notice will include a statement that you may submit additional information in writing to the Plan within 10 business days following the date you receive the notice. The IRO must consider such additional information in conducting the external review if submitted timely and may accept and consider additional information submitted after 10 business days (but is not required to accept additional information after 10 business days).
- Within five business days following the date the review is assigned to the IRO, the Plan will provide to the IRO the documents and any information considered in making the adverse benefit determination under review. Failure by the Plan to provide the documents and information in a timely manner must not delay the conduct of the external review. If the Plan fails to timely provide the documents and information, the IRO may terminate the external review and make a decision to reverse the adverse benefit determination. Within one business day after making the decision, the IRO must notify you and the Plan.

- After receiving any information submitted by you, the IRO must forward the information to the Plan within one business day. Upon receipt of any such information, the Plan may reconsider its adverse benefit determination that is under review but any reconsideration by the Plan will not delay the external review. The external review may be terminated in such cases only if the Plan decides to reverse its adverse benefit determination and provide coverage or payment. Within one business day after making such a decision, the Plan will provide written notice of its decision to you and the IRO. The IRO must terminate the external review upon receiving the notice from the Plan.
- The IRO will review all information and documents received within the required timeframes. In reaching a decision, the IRO will not be bound by any decisions or conclusions reached during the Plan's internal claims and appeals process. In addition to the documents and information provided, the IRO, to the extent the information or documents are available and the IRO considers them appropriate, will consider the following in reaching a decision:
  - Your medical records
  - The attending healthcare professional's recommendations
  - Reports from appropriate healthcare professionals and other documents submitted by the Plan, you or your treating provider
  - The terms of the Plan, unless the terms are inconsistent with applicable law
  - Appropriate practice guidelines, which must include applicable evidence-based standards and may include any other practice guidelines developed by the federal government and/or national or professional medical societies, boards and associations
  - Any applicable clinical review criteria developed and used by the Plan, unless the criteria are inconsistent with the terms of the Plan or with applicable law
  - The opinion of the clinical reviewer for the IRO after considering the information or documents available to the clinical reviewer to the extent the clinical reviewer considers them appropriate
- The IRO must provide written notice of the final external review decision within 45 days after the IRO receives the request for external review. The IRO must deliver the notice of the final external review decision to you and the Plan. The IRO's notice will include:
  - A general description of the reason for the request for external review, including information sufficient to identify the claim (including the date or dates of service, the healthcare provider, the claim amount, if applicable, the diagnosis code and its corresponding meaning, the treatment code and its corresponding meaning and the reason for the previous denial)
  - The date the IRO received the assignment to conduct the external review and the date of the IRO decision
  - References to the evidence or documentation, including the specific coverage provisions and evidence-based standards, considered in reaching its decision
  - A discussion of the principal reason or reasons for its decision, including the rationale for its decision and any evidence-based standards that were relied on in making a decision
  - A statement that the determination is binding except to the extent that other remedies may be available under state or federal law to either the Plan or you

- A statement that judicial review may be available to you
- Current contact information, including the phone number, for any applicable office of health insurance consumer assistance or ombudsman established under ACA

- The IRO must maintain records of all claims and notices associated with the external review process for six years following the date of its final decision. An IRO must make such records available for examination by you, the Plan or a state or federal oversight agency upon request, except where such disclosure would violate state or federal privacy laws.

An external review decision is binding on the Plan, as well as you, except to the extent other remedies are available under state or federal law, and except that the requirement that the decision be binding does not preclude the Plan from making payment on the claim or otherwise providing benefits at any time.

Upon receiving a notice of a final external review decision reversing an internal adverse benefit determination, the Plan will provide any benefits (including making payment on the claim) pursuant to the final external review decision without delay, regardless of whether the Plan intends to seek judicial review of the external review decision and unless or until there is a judicial decision otherwise.

EXPEDITED EXTERNAL REVIEW

You may make a request to the Plan for an expedited external review at the time you receive an adverse benefit determination that otherwise qualifies for external review (as described above) and that is either of the following:

- An adverse benefit determination if your physician certifies you have a medical condition for which, in the opinion of your physician, the time frame for completing an expedited internal appeal under the Plan's normal procedures would seriously jeopardize your life or health, or would jeopardize your ability to regain maximum function, and you have filed a request for an expedited internal appeal
- A final adverse benefit determination, if your physician certifies you have a medical condition for which the time frame for completing a standard external review would seriously jeopardize your life or health, or would jeopardize your ability to regain maximum function, or if the final internal adverse benefit determination concerns an admission, availability of care, continued stay or healthcare item or service for which you received emergency services, but has not been discharged from a facility

The normal procedures for external review (as described above) apply to expedited external review except as otherwise provided in this section.

Immediately upon receipt of a request for expedited external review, the Plan must determine whether the request is eligible for standard external review.

The Plan will immediately send you a notice of its eligibility determination that meets the preliminary review notice requirements described above.

Upon a determination that a request is eligible for expedited external review the Plan will assign an IRO. The Plan will provide or transmit all necessary documents and information considered in making the adverse benefit determination that is being reviewed to the IRO electronically or by telephone or facsimile or any other expeditious method.

The Plan's contract with the IRO will require the IRO to provide notice of its final external review decision as expeditiously as your medical condition or circumstances require, but no later than 72 hours after the IRO receives the request for expedited external review. If the notice is not in writing, within

48 hours after the date of providing that notice, the IRO will be required to provide written confirmation of the decision to you and the Plan.

CIVIL ACTION RIGHTS

You also may have rights under section 502(a) of the Employee Retirement Income Security Act (ERISA). Remember that you generally must exhaust your administrative remedies with MedStar Health Plan prior to exercising your right to file a claim in a court of competent jurisdiction under ERISA. For questions about your rights, or for assistance, you can contact the Employee Benefits Security Administration at **866-444-EBSA** (**3272**).

REQUESTING A REVIEW OF ADVERSE BENEFIT DETERMINATION

You may submit a request to appeal an adverse benefit determination by sending a written request to

MedStar Select Claims
MSC: MS01
P.O. Box 689
Pittsburgh, PA 15230

You may also send any other written information that you have to support your request for review. You may indicate in your request the remedy, resolution or corrective action that you seek from MedStar Select.

If the member wishes to exercise his or her right to the second internal appeal by MedStar's Human Resource department, he or she should contact or submit a request in writing to the Plan Administrator as follows:

MedStar Health
C/O, VP – Compensation, Benefits and HR Technology
10980 Grantchester Way
Columbia, MD 21044

FOR MORE INFORMATION

If there are questions concerning the Appeal Process, please call the Member Services department at **855-242-4872**.

To file an appeal for a behavioral health claim, contact Magellan Health at **800-424-4648**.

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 to ensure that no one makes duplicate payments for the same medical services.

The Plan follows standard NAIC 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 commercial health coverage and Medicare/Medicaid, your commercial coverage is always your primary coverage.
- If your child is covered under the health plan of more than one parent or guardian, your child's primary coverage

is through 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 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 through 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 have coverage as an employee, that coverage pays before coverage for a former employee, retiree, or COBRA participant.

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 healthcare 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 your responsibility to notify the Plan or MedStar with any changes to your 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, copayments and eligibility
- Find your Explanation of Benefits (EOB)
- Request a new or replacement member ID card and print a temporary member ID card
- 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 explains 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 reasons your claim was denied. The EOB is not a bill. Your doctor, hospital, or other healthcare provider will bill you separately for any copayment or coinsurance 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 eliminate paper waste, MedStar Select only sends you a paper EOB in the mail at home if you have a financial obligation.

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

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

MedStar Select provides coverage for the following healthcare services when those services are medically necessary. Refer to the Schedule of Benefits for copayments and coinsurance 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 the highest in-network benefit for these healthcare services except in a true emergency or with prior authorization 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 may not be covered under this Plan.

The below covered services do not represent an all-inclusive list. If you require a service that is not listed or if you have a question regarding your coverage, please contact Member Services at **855-242-4872.**

ABORTION

The Plan covers abortion services only when it is medically necessary or related to a missed abortion.

ACUPUNCTURE

The Plan covers acupuncture treatment

when it is medically necessary and rendered by a medical doctor, licensed and/or accredited acupuncturist.

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. Transportation must be medically necessary to obtain coverage.

CANCER TREATMENT

Cancer chemotherapy and cancer hormone treatments, which have been approved by the U.S. Food and Drug Administration for general use in the 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

Coverage applies to certain clinical trials that treat cancer or other life-threatening diseases. Participation in clinical trials requires prior authorization review for medical necessity and all Plan limitations apply. 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.

Coverage will be provided for phase I, II, III or IV clinical trials related to prevention, detection or treatment of cancer or other life-threatening disease if the study is any of the following:

- Federally funded or federally approved
- Conducted under an FDA investigational new drug (IND) application
- A drug trial that is exempt from the FDA IND application

For the most current and detailed information on coverage requirements under federal law, visit: https://www.dol.gov/sites/default/files/ebsa/about-ebsa/our-activities/resource-center/faqs/aca-part-31.pdf.

The following will not be covered related to clinical trials:

- The treatment, device or service that's being studied and is usually covered by the trial's sponsor
- Items and services only needed for data collection and analysis and are not used in direct patient care
- Any service that's clearly not in line with widely accepted and established standards of care for a certain diagnosis

COLORECTAL CANCER SCREENING

Covered benefits for non-symptomatic members age 50 and over include

- 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

Covered benefits for covered symptomatic members include

- 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

Only an insulin pump and associated parts are covered under the MedStar Select Plan. Other diabetic supplies such as syringes, test strips, injection aids, insulin, monitors and medication to control blood sugar are not covered under the medical benefits of the MedStar Select Plan, but are covered under the pharmacy benefits, provided by CVS/Caremark. See the Pharmacy section of this document for more details.

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 identifies one of the following:
  - A significant change in your symptoms or condition that necessitates changes in your self-management
  - 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 or 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

Low-tech imaging and advanced imaging may have different copayment amounts, so be sure to check the Schedule of Benefits carefully. If you are not sure if a needed diagnostic service qualifies as advanced imaging, contact Member 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. Prior authorization is required for certain items. To determine which DME items require prior authorization, contact Member Services at **855-242-4872**. 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.

FOOT CARE SERVICES

The Plan will cover foot care services that are determined by the claims administrator to be medically necessary, provided that you have diabetes or peripheral vascular disease, or another qualifying medical condition that, 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.

GENERAL ANESTHESIA SERVICES

Covered when ordered by the attending doctor and managed by another doctor who customarily bills for such services. Anesthesia services managed by a certified registered nurse anesthetist (CRNA) are also covered. Anesthesia services include the following procedures, which are administered to induce muscle relaxation, loss of feeling or loss of consciousness:

- Spinal or regional anesthesia
- Injection or inhalation of a drug or other agent (local infiltration is excluded)

Anesthesia provided in an office setting by an anesthesiologist is not covered. However, pain management provided in an office setting is covered by any other provider type.

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, as indicated by the diagnosis code included on the claim. 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 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:

- 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

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
- For a member with 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:

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

HABILITATIVE SERVICES FOR CHILDREN

Habilitative services are covered for children under the age of 19 and prior authorization is required after the first visit. This plan considers “Habilitative services” to mean services intended to enhance ability to function, including occupational therapy, physical therapy and speech therapy for the treatment of a child with a congenital or genetic birth defect, such as

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

Coverage is not required for services delivered through early intervention or school services.

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 and any federal laws that may apply.

HEARING SERVICES FOR CHILDREN

The Plan provides hearing services for children 18 years of age and under. Coverage is limited to:

- Screening examination
- Audiometric testing
- One hearing aid for each impaired ear once every 36 months from the first covered benefit

The following non-routine hearing care services related to the covered hearing aid are not covered including, but not limited to:

- Assessment
- Fitting
- Orientation
- Conformity
- Evaluation

HOME HEALTH CARE

The Plan covers the following services that

you may receive from a home healthcare agency or hospital program for home health care when medically necessary:

- 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 healthcare 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 healthcare services, when necessary, will have input from the *My*Health Care Advisor.

For home health services to be covered, the member must be confined to the home due to a medical condition. The home cannot be an institution, convalescent home or any rehabilitation services facility. 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, are covered for:

- One home visit following childbirth if prescribed by the 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 scheduled to occur within 24 hours after discharge and one additional home visit following childbirth if prescribed by your healthcare provider 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)

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 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.

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 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 the 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. Coverage allows for the use of donor egg and sperm. However, the procurement of the donor egg and sperm are not covered. 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.

Services related to diagnostic tests and procedures necessary to determine infertility include:

- Hysterosalpingogram
- Hysteroscopy
- Endometrial biopsy
- Laparoscopy
- Sono-hysterogram
- Post-coital tests
- Testis biopsy
- Semen analysis
- Blood tests
- Ultrasound
- Other medically necessary diagnostic tests and procedures, unless excluded by law

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 co-morbid conditions
- Circumcision
- Universal hearing screening of newborns provided by a hospital before discharge or in an office or other outpatient setting

NEWBORN ENROLLMENT

Newborns are automatically covered for 31 days from birth under the mother's coverage if the mother is a MedStar Select member, unless you notify us that the child will not be covered under the Plan. If you do not add the newborn to the Plan prior to the 32nd day from birth by following the process outlined in the enrollment information originally provided to you by the Plan, coverage will no longer be available and claims from that point forward will deny.

MEDICAL/SURGICAL SERVICES

The Plan covers the following surgical services that you receive from a professional provider, if such services are medically necessary. Coverage extends to pre-operative and post-operative office visits.

- Mastectomy and breast reconstruction when medically necessary and when performed on an inpatient or outpatient basis, as well as any surgery needed to re-establish symmetry or alleviate functional impairment, including
  - 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 healthcare 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.
- 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

Behavioral Health services are administered by Magellan Health. 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, subject to the benefit limits as set forth in the Schedule of Benefits. These services include:
  - a semiprivate room and board
  - individual, group, and family psychotherapy or counseling
  - medications and electroconvulsive therapy
  - medical supplies and services
  - diagnostic and other therapeutic services
- Outpatient facility services, subject to benefit limits as set forth in the Schedule of Benefits
- Psychological and neuropsychological testing, subject to benefit limits as set forth in the Schedule of Benefits

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 visits 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, is also covered.

The Plan allows a total maximum of 12 visits annually per member. Additional visits may be approved when medically necessary.

For any questions regarding coverage, please contact Member Services at **855-242-4872**.

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.

ORAL SURGERY

Oral surgery is covered only for the following procedures in an outpatient setting or in an inpatient setting when 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

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 (for example, 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.

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. 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 Affordable Care Act (ACA)
- One biometric set of screenings per year through your PCP

"Preventive health services" are services that meet all of the following criteria:

- Evidence-based items or preventive services that have an "A" or "B" rating from the United States Preventive Services Task Force
- Immunizations recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention
- Evidence-informed preventive care services and screenings provided for in the comprehensive guidelines supported by the Health Resources and Services Administration for infants, children and adolescents
- Additional preventive care and screenings not described above as provided for in the comprehensive guidelines supported by the Health Resources and Services Administration for women
- The current recommendations of the United States Preventive Services Task Force regarding breast cancer screening, mammography and prevention, other than those issued in or around November 2009

An item, service or screening shall only be considered a Preventive Health Service during the time the ACA requires the item, service or screening to be covered by the Plan.

For more information about the specific preventive health services that are covered, visit **www.healthcare.gov/prevention**.

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 Health or MedStar Health. 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 or requires prior authorization and to determine any other coverage limits. See the Schedule of Benefits for copayments 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.

SEX TRANSFORMATION SERVICES AND PROCEDURES

The Plan covers treatment leading up to or related to transsexual surgery, when medically necessary.

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 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
- Care could not be performed by a non-healthcare individual instructed to deliver such services

Prior authorization is required. Up to 30 days of skilled nursing services are covered per plan year. 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.

SUBSTANCE ABUSE SERVICES

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

- Inpatient and nonhospital detoxification services, subject to benefit limits as set forth in the Schedule of Benefits if applicable
- Inpatient and non-hospital residential rehabilitation therapy, subject to benefit limits as set forth in the Schedule of Benefits if applicable
- 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, subject to benefit limits as set forth in the Schedule of Benefits if applicable, including individual and group counseling and psychotherapy, psychiatric and psychological testing and family counseling for the treatment of alcohol and drug abuse

TEMPOROMANDIBULAR JOINT SYNDROM (TMJ)

Medical and surgical treatment of temporomandibular joint syndrome or temporomandibular joint disorders is covered when determined to be medically appropriate.

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. Up to 30 visits will be covered per plan year. 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 when 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. See the Schedule of Benefits 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 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 for applicable benefit limits.

Radiation Therapy, Chemotherapy, Dialysis Treatment and Infusion Therapy: These services are covered when provided at the appropriate level of care.

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.

If a human organ or tissue transplant is provided from a living donor to a human transplant recipient 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

The following are terms, conditions and definitions used to describe transplant services covered under the Plan:

Medically appropriate: The recipient or self-donor meets the criteria for a transplant set by the Plan.

Professional provider transplant services: All medically necessary services and supplies provided by a provider in connection with a covered transplant except donor costs and antirejection drugs.

Benefits for antirejection drugs: For antirejection drugs following the transplant, services will be limited to prescription drugs, if covered under the contract.

Prior authorization requirement: All transplant procedures must receive prior authorization for type of transplant, be medically necessary, and not be experimental according to criteria set by us.

NOTE: The prior authorization requirements are a part of the benefit administration of the contract and are not a treatment suggestion. The actual course of medical treatment that you choose remains a matter strictly between you and your doctor.

Your doctor must submit a complete medical history, including current diagnosis and name of the surgeon who will perform the transplant. The surgery must be done at a recognized transplant center. The donor, donor recipient and the transplant surgery must meet required medical selection criteria as set by the Plan.

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.

WEIGHT REDUCTION SURGERY

MedStar Select covers surgery for morbid obesity at MedStar Centers of Excellence. Current Bariatric Centers are MedStar Franklin Square Medical Center and MedStar Washington Hospital Center. Coverage will be considered after review on an individual basis for specific indications defined in the MedStar Select medical policies.

WOMEN'S CARE

All female members have direct access to and are covered for an annual

gynecological examination, which includes a pelvic examination, breast examination and Pap smear in accordance with the recommendations of the American College of Obstetricians and Gynecology.

One annual mammogram screening, if ordered by a physician, is covered under the plan.

Other covered services include women's preventive health services listed as a preventive care benefit.

Services Excluded from Coverage

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.

ABORTION

Elective abortions are not covered. Coverage is only allowed when medically necessary as indicated in the Covered Services section above.

ALTERNATIVE MEDICINE

Acupressure, aromatherapy, ayurvedic medicine, guided imagery, herbal medicine, homeopathy, massage therapy, naturopathy, relaxation therapy, transcendental meditation or yoga are not covered.

BEHAVIORAL HEALTH SERVICES

The following behavioral health services are not covered under the Plan:

- Treatment for personality disorders where that is the primary diagnosis
- 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
- 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
- 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
- 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

- Intensive health coaching services, resource coordination activity, behavioral health rehabilitation services for children and adolescents and summer camp programs
- Respite services
- Educational services and treatment of behavioral disorders and services for remedial education or childhood autism, except what is covered for neurological disorders and behavioral issues
- Hyperkinetic syndromes

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.

BLOOD

Non-purchased blood or blood products, including autologous donations are not covered.

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.

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.

COURT ORDERED

Any court-ordered service that your physician or other professional provider determines is not medically necessary.

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.

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.

VISION

The following vision services are not covered under this plan:

- Routine vision exams
- 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, hyperopi, or astigmatism including, but not limited to, radial keratotomy

- Vision training
- Orthoptics

EMPLOYMENT RELATED OR EMPLOYER SPONSORED SERVICES

The following employment related or employer sponsored services are not covered:

- 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.

EXPERIMENTAL/INVESTIGATIONAL

Services that are experimental/investigational in nature as determined by the claims administrator are not covered.

FOOD SUPPLEMENTS/VITAMINS

Food, food supplements, vitamins and other nutritional and over-the-counter electrolyte supplements, except if otherwise set forth herein.

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 ACA.

GROWTH HORMONES

Growth hormone therapy unless prescribed for Classic Growth Hormone Deficiency, Turner Syndrome or certain other diagnoses as determined by the claims administrator and authorized in accordance with applicable policy and procedure.

HEARING AIDS

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

HEARING EXAMINATIONS

Hearing examinations and related services, except when such coverage is required by ACA.

HOME CARE

Home care for chronic conditions such as permanent, irreversible disease, injuries or congenital conditions requiring long periods of care or observation are not covered.

HOME MEDICAL EQUIPMENT

Comfort or convenience items, for you or 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 expendable in nature (i.e., disposable items such as incontinent pads, catheters, irrigation kits, disposable electrodes, ace bandages, elastic stockings, and dressings) and primarily used for non-medical purposes are not covered, regardless of whether they are recommended by a professional provider.

IMMUNIZATIONS AND DRUGS

Physical examinations and immunizations required for foreign travel, school, or employment, except as required by ACA.

INPATIENT/OUTPATIENT HEALTHCARE PROVIDER SERVICES

The following services are not covered:

- 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.)

MEDICAL/DENTAL SERVICES NOT IDENTIFIED AS "COVERED" IN THE BENEFITS BOOKLET

Any other medical or dental service or treatment, except as provided in this Benefits Booklet or as mandated by law, are not covered.

MEDICAL DEVICES AND SUPPLIES

Durable medical equipment or supplies associated or used in conjunction with non-covered items or services are not covered.

MEDICALLY UNNECESSARY SERVICES

Services that are not medically necessary as determined by the claims administrator are not covered.

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.

MEDICARE ELIGIBILITY

Any amounts that you are required to pay under the deductible and/or coinsurance provisions of Medicare or Medicare supplement coverage.

MILITARY SERVICE

The following military services are not covered:

- 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

MISCELLANEOUS

Any services, supplies, or treatments not specifically listed in the Benefits Booklet as covered benefits or preventive care services are not covered, such as

- 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 that 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 completing any insurance form or copying medical records
- Personal comfort items including when used in an inpatient hospital setting, such as telephones, televisions, laundry charges or guest trays
- Services rendered by a professional provider who is a member of your immediate family, which 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
- Marital counseling
- Wilderness programs
- Boarding schools

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. This includes medical benefits payment in any manner under the Maryland Motor Vehicle Financial Responsibility Law or equivalent law of another state.

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.

NUTRITIONAL SUPPLEMENTS

The following nutritional supplements are not covered:

- Blended 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 used 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

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 asymptomatic, non-impacted third molars
- Orthodontia and related services

OVER-THE-COUNTER DRUGS

Food, food supplements, vitamins and other nutritional and over-the-counter electrolyte supplements, except otherwise outlined in this document.

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 ACA.

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.

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 are not covered. Rehabilitation therapy services not expected to result in ongoing substantial improvement in your medical condition are not covered. Services provided after a maintenance level has been established are not covered.

REVERSAL OF VOLUNTARY STERILIZATION PROCEDURES

Services to reverse sterilization are not covered.

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 are not covered.

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, are not covered.

TRANSPLANT SERVICES

The following transplant services are not covered under this plan:

- 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

TRANSPORTATION

Non-emergent transportation, by any means, including via ambulance provider is not covered, unless such transportation is pre-authorized by the Medical Management department.

TREATMENT OUTSIDE THE U.S.

Treatment for non-emergent or non-urgent services received outside the U.S. are not covered.

WEIGHT REDUCTION SERVICES

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

WIGS

Wigs are not 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 and 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
- **WebMD**, one of the most trusted names in health and wellness on MedStar *My*Health OnLine where you can explore expert information
- ***My*Community**, where you can find discounts for community activities, including gym memberships, yoga classes, dance lessons and massage services

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 your medical history, preventive screenings, any current health conditions and the 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.

Care Advising Services

MEDSTAR HOSPITAL TRANSITION PROGRAM

Designed to enhance in-hospital patient education, care coordination, discharge observation or inpatient stay, the program provides you with a team of resources including a MedStar Transition Care Coordinator to better prepare you for discharge to home, coordinate follow-up care, support your adherence to care and treatment plans, and ultimately reduce readmissions to the hospital.

PATH (PERSONAL APPROACH TO HEALTH)

This program enhances the member experience through a collaborative, multi-disciplinary care advising approach to improve the quality of care. The MedStar Care Advising team consists of personnel including Medical Director leadership, along with RN Care Advisors, social workers, clinical nutritionists and pharmacists. The Care Advising 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 Care Advisor will reach out to you. If you would like to reach a Care Advisor proactively to discuss Care Advising, call **855-959-4033**.

Schedule of Benefits

The MedStar Select 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 copayments or coinsurance. 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.

ILLNESS OR INJURY	IN-NETWORK		OUT-OF-NETWORK	
Primary Care Copayments (Per visit copayment 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**		**40% coinsurance after deductible**	
Specialty Care (Per visit copayment applies to covered services by all other practitioners)	**$20 per visit**		**40% coinsurance after deductible**	
Emergency Care (includes non-maternity related Observation Stays)	**$100 per visit, waived if admitted as inpatient**		**$100 per visit, waived if admitted as inpatient**	
Urgent Care	**$10 per visit**		**40% coinsurance after deductible**	
Inpatient Hospitalization (Prior authorization required)	**$100 per admission**		**40% coinsurance after deductible**	
Outpatient Surgery	**$50 per surgery**		**40% coinsurance after deductible**	
DEDUCTIBLES				
Per Individual	**$0**		**$2,000**	
Per Family Family deductible (any type of coverage which is not individual is considered family)	**$0**		**$4,000**	
OUT-OF-POCKET MAXIMUM (In-network and out-of-network out-of-pocket maximums cross apply)				
Per Individual	**$1,000**		**$6,000**	
Per Family Family Out-of-Pocket Maximum information (any level of coverage which is not individual is considered family): ▪ The family out-of-pocket maximum is calculated in the aggregate. ▪ A family member may not contribute more than the individual out-of-pocket maximum to the family out-of-pocket maximum.	**$2,000**		**$12,000**	
The following amounts are included/excluded from the Out-of-Pocket Maximum:	Included	Excluded	Included	Excluded
Amounts in excess of the allowed amount	No	Yes	No	Yes
Inpatient copayments	Yes	No	N/A	N/A
Non-inpatient copayments	Yes	No	N/A	N/A
Coinsurance	Yes	No	Yes	No
Mental Health and Substance Abuse admission copayments	Yes	No	N/A	N/A
There is a $1000 annual out of pocket maximum, per individual, for pharmacy benefits				

PREVENTIVE SERVICES WILL BE COVERED IN COMPLIANCE WITH REQUIREMENTS UNDER ACA		
Pediatric Care and Immunizations ▪ Preventive/health screening examination ▪ Pediatric immunizations ▪ Well-baby visits	**Paid in full**	**40% coinsurance after deductible**
Adult Care and Immunizations ▪ Preventive/health screening examination ▪ Adult Immunizations required to be covered at no cost-sharing by ACA	**Paid in full**	**40% coinsurance after deductible**
Women's Care ▪ Screening gynecological exam ▪ Screening Pap test and screening mammogram ▪ Other preventive services	**Paid in full**	**40% coinsurance after deductible**
ALLERGY SERVICES		
Diagnostic testing	**Primary Care Physician, paid in full; Specialist, paid in full after $20 copay**	**40% coinsurance after deductible**
Treatment including injections and serum	**Primary Care Physician, paid in full; Specialist, paid in full after $20 copay**	**40% coinsurance after deductible**
DIAGNOSTIC SERVICES		
Advanced imaging (e.g., PET, MRI, CT, etc.)	**Paid in full after $30 copay per visit**	**40% coinsurance after deductible**
Other imaging (e.g., X-ray, sonogram, etc.)	**Paid in full after $15 copay per visit**	**40% coinsurance after deductible**
Lab and other services	**Paid in full**	**40% coinsurance after deductible**
CARE SERVICE & SETTINGS		
Home health care (60 visits per year)	**Paid in full**	**40% coinsurance after deductible**
Skilled nursing facility (30 days per year)	**Paid in full after $100 copay per admission**	**40% coinsurance after deductible**

HOSPITAL FACILITY/SURGICAL PROCEDURES		
Semi-private room, private room (if medically necessary), surgery, pre-admission testing		
Outpatient surgery	**Paid in full after $50 copay per surgery**	**40% coinsurance after deductible**
Inpatient hospitalization (Pre-authorization required)	**Paid in full after $100 copay per admission**	**40% coinsurance after deductible**
Anesthesia, assistant surgeon	**Paid in full**	**40% coinsurance after deductible**
Weight reduction surgery (pre-authorization required)	**Paid in full, only performed at MedStar Center of Excellence**	**Not Covered**
HOSPITAL PHYSICIAN SERVICES		

(Services performed by surgeons, surgical assistants, radiologists, pathologists, and anesthesiologists)		
Inpatient	**Paid in full**	**40% coinsurance after deductible**
Outpatient	**Paid in full**	**40% coinsurance after deductible**
IMMUNIZATIONS AND INOCULATIONS		
For tests, serum and medically necessary immunizations not covered under ACA	**Paid in full**	**40% coinsurance after deductible**
MEDICAL THERAPY SERVICES		
Chemotherapy, radiation therapy, dialysis treatment, infusion therapy	**Paid in full**	**40% coinsurance after deductible**
MENTAL HEALTH AND SUBSTANCE ABUSE		
Inpatient hospital/facility and professional services	**Paid in full after $100 copay per admission**	**40% coinsurance after deductible**
Partial hospitalization facility and physician services	**Paid in full**	**40% coinsurance after deductible**
Office visits for mental health and substance abuse	**Paid in full**	**40% coinsurance after deductible**
REPRODUCTIVE HEALTH		
Maternity care $100 is deposited into your Health Reimbursement Account if you participate in MedStar *My*Health Maternity program and deliver at a MedStar facility.	**Paid in full after $100 copay**	**40% coinsurance after deductible**
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.) ▪ Allows for the use of donor egg and sperm. However, the procurement of the donor egg and sperm are not covered.	**50% coinsurance**	**50% coinsurance after deductible**
THERAPY SERVICES		
Physical and occupational (Limited to 60 visits per year combined)	**Paid in full after $20 copay per visit**	**40% coinsurance after deductible**
Speech therapy (Limited to 60 visits per year)	**Paid in full after $20 copay per visit**	**40% coinsurance after deductible**
Cardiac rehabilitation coverage	**Paid in full**	**40% coinsurance after deductible**
Pulmonary rehabilitation coverage	**Paid in full**	**40% coinsurance after deductible**
Therapeutic manipulation (Chiropractic; limited to 30 visits per year)	**Paid in full after $20 copay per visit**	**40% coinsurance after deductible**
Acupuncture	**Paid in full after $20 copay**	**40% coinsurance after deductible**

	per visit	
OTHER MEDICAL SERVICES		
Ambulance services	**Paid in full**	**Paid in full**
Hospice care (pre-authorization required)	**Paid in full**	**40% coinsurance after deductible**
Dental services related to accidental injury	**Paid in full after 10% coinsurance**	**40% coinsurance after deductible**
Organ transplants (Pre-authorization required)	**Paid in full**	**40% coinsurance after deductible**
Nutritional counseling (12 visit maximum. Additional visits may be authorized if medically necessary.)	**Paid in full**	**40% coinsurance after deductible**
Diabetic equipment, and education	**Paid in full**	**40% coinsurance after deductible**
Diabetic Supplies including Glucometers, test strips, insulin and syringes	**Covered under pharmacy benefit**	**Covered under pharmacy benefit**
Durable Medical Equipment (DME)	**Paid in full**	**40% coinsurance after deductible**
Hospice (pre-authorization required)	**Paid in full**	**40% coinsurance after deductible**
Office visits	**Primary care physician, paid in full; Specialist, paid in full after $20 copay**	**40% coinsurance after deductible**
Private Duty Nursing	**Paid in full**	**40% coinsurance after deductible**

Pharmacy Coverage*

	MedStar Pharmacy		Participating Pharmacy	Mail Order Service
	(30-Day Supply)	(90-Day Supply)	(30-Day Supply)	(90-Day Supply)
Generic	**$5 copay**	**$10 copay**	**$10 copay**	**$20 copay**
Brand Preferred	**20% coinsurance up to $60 maximum**	**20% coinsurance up to $150 maximum**	**20% coinsurance up to $65 maximum**	**20% coinsurance up to $155 maximum**
Brand Non-preferred	**40% coinsurance up to $100 maximum**	**40% coinsurance up to $250 maximum**	**40% coinsurance up to $105 maximum**	**40% coinsurance up to $255 maximum**

* There is a $1000 annual out of pocket maximum, per individual, for Pharmacy benefits.

Notice of Nondiscrimination

MedStar Select Plan complies with applicable federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability or sex. MedStar Select Plan does not exclude people or treat them differently because of race, color, national origin, age, disability or sex.

MedStar Select Plan:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats or other formats)
- Provides free language services to people whose primary language is not English, such as
  - Qualified interpreters
  - Information written in other languages

If you need these services, contact Tracey McLaughlin, VP – Compensation, Benefits & HR Technology.

If you believe that MedStar Select Plan has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability or sex, you can file a grievance with Tracey McLaughlin, VP – Compensation, Benefits & HR Technology, 10980 Grantchester Way, Columbia, MD 21044, Tel: **410-772-6931**, Fax: 410.772.6922, **tracey.m.mclaughlin@medstar.net**. You can file a grievance in person or by mail, fax or email. If you need help filing a grievance, Tracey McLaughlin is available to help you. You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal available at **https://ocrportal.hhs.gov/ocr/portal/lobby.jsf**, or by mail or phone at U.S. Department of Health and Human Services, 200 Independence Avenue, SW, Room 509F, HHH Building, Washington, D.C., 20201, **1-800-368-1019**, **800-537-7697** (TDD).

Complaint forms are available at **http://www.hhs.gov/ocr/office/file/index.html**.

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-855-242-4872 (TTY: 1-855-250-5604).

注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-855-242-4872（TTY：1-855-250-5604）。

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-855-242-4872 (TTY: 1-855-250-5604)번으로 전화해 주십시오.

ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-855-242-4872 (ATS : 1-855-250-5604).

CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-855-242-4872 (TTY: 1-855-250-5604).

PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-855-242-4872 (TTY: 1-855-250-5604).

ማስታወሻ: የሚናገሩት ቋንቋ ኣማርኛ ከሆነ የትርጉም እርዳታ ድርጅቶች፣ በነጻ ሊያግዝዎት ተዘጋጀተዋል፡ ወደ ሚከተለው ቁጥር ይደውሉ 1-855-242-4872 (መስማት ለተሳናቸው: 1-855-250-5604).

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-855-242-4872 (телетайп: 1-855-250-5604).

Dè ɖɛ nià kɛ dyéɖé gbo: Ɔ jǔ ké m̀ [Bàsɔ́ɔ̀-wùɖù-po-nyɔ̀] jǔ ní, nìí, à wuɖu kà kò ɖò po-poɔ̀ ɓέìn m̀ gbo kpáa. Đá 1-855-242-4872 (TTY: 1-855-250-5604)

خبردار: اگر آپ اردو بولتے ہیں، تو آپ کو زبان کی مدد کی خدمات مفت میں دستیاب ہیں ۔ کال کریں 1-855-242-4872 (TTY: 1-855-250-5604).

توجه: اگر به زبان فارسی گفتگو می کنید، تسهیلات زبانی بصورت رایگان برای شما فراهم می باشد. با 1-855-242-4872 (TTY: 1-855-250-5604) تماس بگیرید.

ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou. Rele 1-855-242-4872 (TTY: 1-855-250-5604).

ATENÇÃO: Se fala português, encontram-se disponíveis serviços linguísticos, grátis. Ligue para 1-855-242-4872 (TTY: 1-855-250-5604).

ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1-855-242-4872 (رقم هاتف الصم والبكم: 1-855-250-5604-1).

સુચના: જો તમે ગુજરાતી બોલતા હો, તો નિ:શુલ્ક ભાષા સહાય સેવાઓ તમારા માટે ઉપલબ્ધ છે. ફોન કરો 1-855-242-4872 (TTY: 1-855-250-5604).

Notes

10980 Grantchester Way
Columbia, MD 21044

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