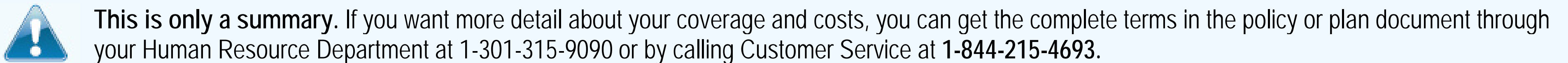

This is only a summary. If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document through your Human Resource Department at 1-301-315-9090 or by calling Customer Service at **1-844-215-4693.**

Important Questions	Answers	Why this Matters:
What is the overall deductible?	$200 single $400 family	You must pay all the costs up to the **deductible** amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the **deductible** starts over (usually, but not always, January 1st). See the chart starting on page 2 for how much you pay for covered services after you meet the **deductible**.
Are there other deductibles for specific services?	No.	You don't have to meet **deductibles** for specific services, but see the chart starting on page 2 for other costs for services this plan covers.
Is there an out–of–pocket limit on my expenses?	Yes, (separate out-of pocket limits) Medical - $200 single/$400 family Prescription drugs - $6,400 single/$12,800 family	The **out-of-pocket limit** is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses.
What is not included in the out–of–pocket limit?	Premiums, penalties, and charges not covered by the plan.	Even though you pay these expenses, they don't count toward the **out-of-pocket limit**.
Is there an overall annual limit on what the plan pays?	No.	The chart starting on page 2 describes any limits on what the plan will pay for specific covered services, such as office visits.
Does this plan use a network of providers?	Yes, Cigna at www.mycigna.com or call 1-844-215-4693.	If you use an in-network doctor or other health care **provider**, this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network **provider** for some services. Plans use the term in-network, **preferred**, or participating for **providers** in their **network**. See the chart starting on page 2 for how this plan pays different kinds of **providers**.
Do I need a referral to see a specialist?	No	You can see the **specialist** you choose without permission from this plan.
Are there services this plan doesn't cover?	Yes	Some of the services this plan doesn't cover are listed on page 6. See your policy or plan document for additional information about **excluded services**.

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

Common Medical Event	Services You May Need	Your Cost If You Use an In-network Provider	Your Cost If You Use an Out-of-network Provider	Limitations & Exceptions
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	Deductible/ 0% coinsurance	Deductible/ 20% coinsurance	-----------------------none----------------------
	Specialist visit	Deductible/ 0% coinsurance	Deductible/ 20% coinsurance	-----------------------none----------------------
	Other practitioner office visit	Deductible/ 0% coinsurance	Deductible/ 20% coinsurance	Coverage limited to $2,500 per calendar year for acupuncture/acupressure. Pre-certification required for pain management for chronic conditions, call HealthSmart at 1-877-202-6379.
	Preventive care/screening/immunization	No charge	Deductible/ 20% coinsurance	Coverage may be limited due to age or frequency of services. Precertification required for colonoscopy, call HealthSmart at 1-877-202-6379.
If you have a test	Diagnostic test (x-ray, blood work)	Deductible/ 0% coinsurance	Deductible/ 20% coinsurance	Deductible waived for pre-admission testing.
	Imaging (CT/PET scans, MRIs)	Deductible/ 0% coinsurance	Deductible/ 20% coinsurance	

Common Medical Event	Services You May Need	Your Cost If You Use an In-network Provider	Your Cost If You Use an Out-of-network Provider	Limitations & Exceptions
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at Express Scripts at 1-888-727-4787 www.express-scripts.com	Generic drugs	$5 copay retail/ $10 copay mail order per prescription.	If an Out-of-Network retail pharmacy is used the participant will pay the full cost of the prescription up front and file a paper claim to Express Scripts for reimbursement minus the applicable copay.	There is a separate out-of-pocket maximum for prescription drugs per calendar year of $6,400 single/$12,800 family. Retail and specialty drugs up to a 30 day supply/Mail order up to a 90 day supply per prescription. Specialty drugs are not covered through mail order. If a Generic is available and allowed by the Physician the individual will be required to pay the copay and the difference in cost between the Generic and Brand name if Brand is chosen (applies to both Retail and Mail Order prescriptions). Use of the specialty pharmacy vendor will be mandatory to receive certain injectable medications, which may also be subject to prior authorization.
	Preferred brand drugs	$25 copay retail/ $55 copay mail order per prescription.		
	Non-preferred brand drugs	$50 copay retail/ $125 copay mail order per prescription.		
	Specialty drugs	20% coinsurance up to a $100 maximum/ retail	Not covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	Deductible/ 0% coinsurance	Deductible/ 20% coinsurance	Pre-certification required call HealthSmart 1-877-202-6379. If pre-cert not obtained, the coinsurance rate will increase to 20% for network providers and 40% for out-of-network providers.
	Physician/surgeon fees	Deductible/ 0% coinsurance	Deductible/ 20% coinsurance	
If you need immediate medical attention	Emergency room services	Deductible/ 0% coinsurance	Deductible/ 20% coinsurance	------------------------none------------------------
	Emergency medical transportation	Deductible/ 0% coinsurance	Deductible/ 20% coinsurance	------------------------none------------------------
	Urgent care	Deductible/ 0% coinsurance	Deductible/ 20% coinsurance	------------------------none------------------------

Common Medical Event	Services You May Need	Your Cost If You Use an In-network Provider	Your Cost If You Use an Out-of-network Provider	Limitations & Exceptions
If you have a hospital stay	Facility fee (e.g., hospital room)	No charge	Deductible/ 20% coinsurance	Pre-certification required call HealthSmart 1-877-202-6379. If pre-cert not obtained, the coinsurance rate will increase to 20% for network providers and 40% for out of network providers.
	Physician/surgeon fee	Deductible/ 0% coinsurance	Deductible/ 20% coinsurance	
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	Deductible/ 0% coinsurance	Deductible/ 20% coinsurance	-----------------------none----------------------
	Mental/Behavioral health inpatient services	No charge	Deductible/ 20% coinsurance	Pre-certification required call HealthSmart 1-877-202-6379. If pre-cert not obtained, the coinsurance rate will increase to 20% for network providers and 40% for out of network providers.
	Substance use disorder outpatient services	Deductible/ 0% coinsurance	Deductible/ 20% coinsurance	-----------------------none----------------------
	Substance use disorder inpatient services	No charge	Deductible/ 20% coinsurance	Pre-certification required call HealthSmart 1-877-202-6379. If pre-cert not obtained, the coinsurance rate will increase to 20% for network providers and 40% for out of network providers.
If you are pregnant	Prenatal and postnatal care	Deductible/ 0% coinsurance	Deductible/ 20% coinsurance	-----------------------none----------------------
	Delivery and all inpatient services	No charge	Deductible/ 20% coinsurance	Pre-certification required call HealthSmart 1-877-202-6379. Delivery charges are subject to the deductible.

Common Medical Event	Services You May Need	Your Cost If You Use an In-network Provider	Your Cost If You Use an Out-of-network Provider	Limitations & Exceptions
If you need help recovering or have other special health needs	Home health care	Deductible/ 0% coinsurance	Deductible/ 20% coinsurance	Coverage limited to 90 visits per calendar year, and 8 hours maximum per day.
	Rehabilitation services	No charge	Deductible/ 20% coinsurance	Coverage limited to 100 days per period of disability and must follow within 24 hours of a hospital or extended care/skilled nursing facility stay. Pre-certification required, call HealthSmart 1-877-202-6379. If pre-cert not obtained, the coinsurance rate will increase to 20% for network providers and 40% for out of network providers.
	Habilitation services	Deductible/ 0% coinsurance	Deductible/ 20% coinsurance	Speech therapy is limited to 30 visits per calendar year. Inpatient cardiac rehabilitation therapy is limited to 100 days per condition.
	Skilled nursing care	No charge	Deductible/ 20% coinsurance	Coverage is limited to 100 days per period of disability.
	Durable medical equipment	Deductible/ 0% coinsurance	Deductible/ 20% coinsurance	-----------------------none----------------------
	Hospice service	No charge	Deductible/ 20% coinsurance	Coverage limited to 6 months per lifetime. Bereavement counseling limited to $500 per family.
If your child needs dental or eye care	Eye exam	Not covered	Not covered	-----------------------none----------------------
	Glasses	Not covered	Not covered	-----------------------none----------------------
	Dental check-up	Not covered	Not covered	-----------------------none----------------------

Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover (This isn't a complete list. Check your policy or plan document for other excluded services.)		
• Bariatric surgery • Cosmetic surgery • Dental care (Adult) • Hearing aids	• Infertility treatment • Long-term care • Non-emergency care when traveling outside the U.S.	• Routine eye care (Adult) • Routine foot care • Weight loss programs
Other Covered Services (This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)		
• Acupuncture – limited to $2,500 per calendar year for acupuncture/acupressure	• Chiropractic care	• Private-duty nursing

Your Rights to Continue Coverage: If you lose coverage under the plan, then, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a **premium**, which may be significantly higher than the premium you pay while covered under the plan. Other limitations on your rights to continue coverage may also apply. For more information on your rights to continue coverage, contact the plan at 1-301-315-9090. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or www.cciio.cms.gov

Your Grievance and Appeals Rights: If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to **appeal** or file a **grievance**. For questions about your rights, this notice, or assistance, you can contact the Claims Administrator at 1-844-215-4693. If there are any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Plan Administrator, you should contact the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform. Additionally, a consumer assistance program can help you file your appeal. Contact Maryland Office of the Attorney General Health Education and Advocacy Unit at 1-877-261-8807. A list of states with Consumer Assistance Programs is available at www.dol.gov/ebsa/healthreform and http://cciio.cms.gov/programs/consumer/capgrants/index.html.

Does this Coverage Provide Minimum Essential Coverage? The Affordable Care Act requires most people to have health care coverage that qualifies as "minimum essential coverage." **This plan or policy does provide minimum essential coverage.**

Does this Coverage Meet the Minimum Value Standard? The Affordable Care Act establishes a minimum value standard of benefits of a health plan. The minimum value standard is 60% (actuarial value). **This health coverage does meet the minimum value standard for the benefits it provides.**

Language Access Services: Spanish (Español): Para obtener asistencia en Español, llame al 1-844-215-4693 Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-844-215-4693 Chinese (中文): 如果需要中文的帮助， □□打□个号□1-844-215-4693 Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-844-215-4693.

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

About these Coverage Examples:

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

This is not a cost estimator.

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

See the next page for important information about these examples.

Having a baby
(normal delivery)

- **Amount owed to providers:** $7,540
- **Plan pays** $7,180
- **Patient pays** $360

Sample care costs:

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

Patient pays:

Deductibles	$200
Copays	$10
Coinsurance	$0
Limits or exclusions	$150
Total	$360

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

- **Amount owed to providers:** $5,400
- **Plan pays** $4,920
- **Patient pays** $480

Sample care costs:

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

Patient pays:

Deductibles	$200
Copays	$200
Coinsurance	$0
Limits or exclusions	$80
Total	$480

Questions and answers about the Coverage Examples:

What are some of the assumptions behind the Coverage Examples?

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

What does a Coverage Example show?

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

Does the Coverage Example predict my own care needs?

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

Does the Coverage Example predict my future expenses?

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

Can I use Coverage Examples to compare plans?

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

Are there other costs I should consider when comparing plans?

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