



The Summary of Benefits and Coverage (SBC) document will help you choose a health [plan](#). The SBC shows you how you and the [plan](#) would share the cost for covered health care services. **NOTE:** Information about the cost of this [plan](#) (called the [premium](#)) will be provided separately. This is only a summary. For more information about your coverage call 1-800-261-2393 or visit www.ehp.org. To get a copy of the Summary [Plan](#) Description, call 443-997-5400 or visit www.hopkinsmedicine.org/jhhr. For general definitions of common terms, such as [allowed amount](#), [balance billing](#), [coinsurance](#), [copayment](#), [deductible](#), [provider](#), or other underlined terms see the Glossary. You can view the Glossary at [Glossary of Health Coverage and Medical Terms \(dol.gov\)](https://www.dol.gov/glossary) or call 1-800-261-2393 for a copy.


| Important Questions | Answers | Why This Matters: |
|--|--|---|
| What is the overall deductible for the Lower Pay Tier? | \$150/person, \$300/family in-network; \$750/person, \$1,500/family out-of-network; excludes charges above allowed amount . | Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan , each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible . |
| Are there services covered before you meet your deductible ? | Yes. Preventive care and prescription drugs are covered before you meet your deductible . | This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost-sharing and before you meet your deductible . See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/ . |
| Are there other deductibles for specific services? | Yes. \$1,000 lifetime deductible for infertility treatment. | You must pay all of the costs for these services up to the specific deductible amount before this plan begins to pay for these services. |
| What is the out-of-pocket limit for the Lower Pay Tier? | Medical: \$1,500/person, \$3,000/family in-network; \$3,500/person, \$7,000/family out-of-network. Prescription drugs: \$3,600/person, \$7,200/family. | The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan , they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met. |
| What is not included in the out-of-pocket limit ? | Charges above plan maximums, premiums , balance-billing charges, health care this plan doesn't cover, penalties for failure to obtain preauthorization . | Even though you pay these expenses, they don't count toward the out-of-pocket limit . |
| Will you pay less if you use a network provider ? | Yes. See www.ehp.org or call 1-800-261-2393 for a list of in-network providers. | This plan uses a provider network . You usually pay the least if you use an EHP Preferred Network Provider . You usually pay more if you use an EHP Network Provider . You will always pay the most if you use an out-of-network provider , and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be |

aware your [network provider](#) might use an [out-of-network provider](#) for some services (such as lab work). Check with your [provider](#) before you get services.


Do you need a [referral](#) to see a [specialist](#)?

No.

You can see the [specialist](#) you choose without a [referral](#).

 All [copayment](#) and [coinsurance](#) costs shown in this chart are after your [deductible](#) has been met, if a [deductible](#) applies.

| Common Medical Event | Services You May Need | What You Will Pay | | | Limitations, Exceptions, & Other Important Information |
|--|--|--|--|---|--|
| | | EHP Preferred Provider (You pay the least) | EHP Network Provider (You pay more) | Out-of-Network Provider (You pay the most) | |
| If you visit a health care provider's office or clinic | Primary care visit to treat an injury or illness | \$10 copay ; Deductible does not apply | | 30% coinsurance | None |
| | Specialist visit | 10% coinsurance | 20% coinsurance | 30% coinsurance | None |
| | Preventive care/screening/immunization | No charge; Deductible does not apply | | 30% coinsurance | You may have to pay for services that aren't preventive . Ask your provider if the services you need are preventive. Then check what your plan will pay for. |
| If you have a test | Diagnostic test (x-ray, blood work) | 10% coinsurance | 20% coinsurance | 30% coinsurance | None |
| | Imaging (CT/PET scans, MRIs) | 10% coinsurance | 20% coinsurance | 30% coinsurance | None |


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|---|---|--|---|---|---|
| | | EHP Preferred Provider (You pay the least) | EHP Network Provider (You pay more) | Out-of-Network Provider (You pay the most) | |
| If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.ehp.org | Generic drugs | \$10 copay 30 day supply \$20 copay 90 day supply by mail \$30 copay 90 day supply at pharmacy | | Not covered | Preauthorization may be required for some drugs, or not covered. No charge for generic oral contraceptives. If you buy brand when generic available, must also pay cost difference. Specialty drugs limited to 30 day supply only Specialty drugs covered by PrudentRx Program only covered at Johns Hopkins Outpatient Pharmacies and CVS Specialty Pharmacy |
| | Preferred brand drugs | \$40 copay 30 day supply \$80 copay 90 day supply by mail \$120 copay 90 day supply at pharmacy | | Not covered | |
| | Non-preferred brand drugs | \$65 copay 30 day supply \$130 copay 90 day supply by mail \$195 copay 90 day supply at pharmacy | | Not covered | |
| | Specialty drugs not covered by PrudentRx Program | \$40 copay brand preferred \$65 copay brand non-preferred | | Not covered | |
| | Specialty drugs covered by PrudentRx Program | \$0 copay when obtained through PrudentRx Program 30% coinsurance if not obtained through PrudentRx Program | | Not covered | |
| If you have outpatient surgery | Facility fee (e.g., ambulatory surgery center) | 10% coinsurance | 20% coinsurance | 30% coinsurance | Preauthorization required, or not covered. |
| | Physician/surgeon fees | 10% coinsurance | 20% coinsurance | 30% coinsurance | |
| If you need immediate medical attention | Emergency room care | \$250 copay , waived if admitted | | | Not covered unless emergency medical situation |
| | Emergency medical transportation | No charge | | No charge (up to allowed amount) | Air transportation not covered unless medically necessary |
| | Urgent care | \$25 copay ; Deductible does not apply | | 30% coinsurance | None |
| If you have a hospital stay | Facility charges (e.g., hospital room) | \$150 copay and 10% coinsurance | \$150 copay and 20% coinsurance | \$500 copay and 30% coinsurance | Preauthorization required, or not covered. |
| | Physician/surgeon fees | 10% coinsurance | 20% coinsurance | 30% coinsurance | Preauthorization required for surgery, or not covered. |
| | | | | | |



All [copayment](#) and [coinsurance](#) costs shown in this chart are after your [deductible](#) has been met, if a [deductible](#) applies.

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|--|---|--|---|---|--|
| | | EHP Preferred Provider (You pay the least) | EHP Network Provider (You pay more) | Out-of-Network Provider (You pay the most) | |
| If you need mental health, behavioral health, or substance abuse services | Outpatient facility charges | \$10 copay /visit; Deductible does not apply | | 30% coinsurance | None |
| | Outpatient professional fees | \$10 copay /visit; Deductible does not apply | | 30% coinsurance | None |
| | Inpatient facility charges | \$150 copay and 10% coinsurance | \$150 copay and 20% coinsurance | \$500 copay and 30% coinsurance | Preauthorization required, or not covered. |
| | Inpatient professional fees | 10% coinsurance | 20% coinsurance | 30% coinsurance | None |
| If you are pregnant | Office visits | No charge for routine; Otherwise 10% coinsurance | No charge for routine; Otherwise 20% coinsurance | 30% coinsurance | None |
| | Childbirth/delivery professional fees | 10% coinsurance | 20% coinsurance | 30% coinsurance | None |
| | Childbirth/delivery facility charges | \$150 copay and 10% coinsurance | \$150 copay and 20% coinsurance | \$500 copay and 30% coinsurance | Preauthorization required for stays longer than 48 hours (normal delivery) or 96 hours (caesarean) or not covered. |
| If you need help recovering or have other special health needs | Home health care | 10% coinsurance | | 30% coinsurance | limit 40 visits per year |
| | Rehabilitation services | 10% coinsurance | 20% coinsurance | 30% coinsurance | PT/OT: limit 60 visits per year |
| | Habilitation services | 10% coinsurance | 20% coinsurance | 30% coinsurance | Speech therapy: limit 30 visits per year; preauthorization required or not covered. |
| | Skilled nursing care | 10% coinsurance | 10% coinsurance first 30 days, then 20% coinsurance | 30% coinsurance | Under age 19 only |
| | Durable medical equipment | 10% coinsurance | 20% coinsurance | 30% coinsurance | Preauthorization required or not covered. |
| | Hospice services | No charge, after Deductible | | 30% coinsurance | None |

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| Common Medical Event | Services You May Need | What You Will Pay | | | Limitations, Exceptions, & Other Important Information |
|--|----------------------------|--|--|--|--|
| | | EHP Preferred Provider (You pay the least) | EHP Network Provider (You pay more) | Out-of-Network Provider (You pay the most) | |
| If your child needs dental or eye care | Children's eye exam | No charge | | Benefit up to: \$52 optometrist \$60 ophthalmologist | Once every 12 months; must elect coverage for child. |
| | Children's glasses | \$175 allowance for frames after \$10 copay Lenses covered in full after \$10 copay | | Up to \$112 benefit for frames after \$10 copay Lenses covered per schedule | Once every 12 months; must elect coverage for child. |
| | Children's dental check-up | Not covered | | | Covered by Dental Plan. |

Excluded Services & Other Covered Services:

| Services Your Plan Generally Does NOT Cover (Check your Summary Plan Description for more information and a list of any other excluded services .) | | |
|---|---|--|
| <ul style="list-style-type: none"> • Cosmetic surgery • Dental care (Adult) | <ul style="list-style-type: none"> • Emergency room care for non-emergency medical situations • Long term care | <ul style="list-style-type: none"> • Private duty nursing • Routine foot care • Treatment that requires preauthorization, if not obtained |
| Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your Summary Plan Description.) | | |
| <ul style="list-style-type: none"> • Acupuncture, for anesthesia, pain control or therapeutic purposes (limit 20 visits per year) • Bariatric surgery, at Bayview Medical Center or Sibley Memorial Hospital only | <ul style="list-style-type: none"> • Chiropractic care, for initial exam, x-rays and spinal manipulation (limit 20 visits per year) • Infertility Treatment, at Johns Hopkins and Shady Grove Fertility Centers only; \$30,000 medical, \$30,000 prescription drug and three IVF attempts lifetime limit and six AI/IUI attempts per live birth | <ul style="list-style-type: none"> • Hearing aids, for children under 26 • Routine eye care (Adult) • Weight loss programs |

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is U.S. Department of Labor Employee Benefits Security Administration, 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform. For more information on your rights to continue coverage, contact the [plan](#) at 1-800-261-2393. Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit www.HealthCare.gov or call 1-800-318-2596.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your [plan](#) for a denial of a [claim](#). This complaint is called a [grievance](#) or [appeal](#). For more information about your rights, look at the explanation of benefits you will receive for that medical [claim](#). Your Summary [Plan](#) Description also provides complete information to submit a [claim](#), [appeal](#), or a [grievance](#) for any reason to your [plan](#). For more information about your rights, this

notice, or assistance, contact the [plan](#) at 1-800-261-2393. You may also contact the U.S. Department of Labor, 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 the Maryland Office of the Attorney General, Health Education and Advocacy Unit, 200 St. Paul Place, 16th Floor, Baltimore, MD 21202, 1-877-261-8807.

Does this plan provide Minimum Essential Coverage? Yes.

[Minimum Essential Coverage](#) generally includes [plans](#), [health insurance available](#) through the [Marketplace](#) or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of [Minimum Essential Coverage](#), you may not be eligible for the [premium tax credit](#).

Does this plan meet Minimum Value Standards? Yes.

If your [plan](#) doesn't meet the [Minimum Value Standards](#), you may be eligible for a [premium tax credit](#) to help you pay for a [plan](#) through the [Marketplace](#).

Language Access Services:

Spanish (Español): Para obtener asistencia en Español, llame al 1-800-261-2393.

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

About these Coverage Examples:



This is not a cost estimator. Treatments shown are just examples of how this [plan](#) might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your [providers](#) charge, and many other factors. Focus on the [cost sharing](#) amounts ([deductibles](#), [copayments](#) and [coinsurance](#)) and [excluded services](#) under the [plan](#). Use this information to compare the portion of costs you might pay under different health [plans](#). Please note these coverage examples are based on individual coverage.

Peg is Having a Baby

(9 months of in-network pre-natal care and a hospital delivery)

| | |
|---|-------|
| ■ The plan's overall deductible | \$150 |
| ■ Specialist coinsurance | 10% |
| ■ Hospital (facility) copayment | \$150 |
| ■ Other coinsurance | 10% |

This EXAMPLE event includes services like:

Specialist office visits (*prenatal care*)
 Childbirth/Delivery Professional Services
 Childbirth/Delivery Facility Services
 Diagnostic tests (*ultrasounds and blood work*)
 Specialist visit (*anesthesia*)

| | |
|---------------------------|-----------------|
| Total Example Cost | \$12,700 |
|---------------------------|-----------------|

In this example, Peg would pay:

| <i>Cost Sharing</i> | |
|-----------------------------------|----------------|
| Deductibles | \$150 |
| Copayments | \$200 |
| Coinsurance | \$1,200 |
| <i>What isn't covered</i> | |
| Limits or exclusions | \$60 |
| The total Peg would pay is | \$1,610 |

Managing Joe's type 2 Diabetes

(a year of routine in-network care of a well-controlled condition)

| | |
|---|-------|
| ■ The plan's overall deductible | \$150 |
| ■ Specialist coinsurance | 10% |
| ■ Hospital (facility) coinsurance | 10% |
| ■ Other coinsurance | 10% |

This EXAMPLE event includes services like:

Primary care physician office visits (*including disease education*)
 Diagnostic tests (*blood work*)
 Prescription drugs
 Durable medical equipment (*glucose meter*)

| | |
|---------------------------|----------------|
| Total Example Cost | \$5,600 |
|---------------------------|----------------|

In this example, Joe would pay:

| <i>Cost Sharing</i> | |
|-----------------------------------|----------------|
| Deductibles | \$150 |
| Copayments | \$800 |
| Coinsurance | \$30 |
| <i>What isn't covered</i> | |
| Limits or exclusions | \$20 |
| The total Joe would pay is | \$1,000 |

Mia's Simple Fracture

(in-network emergency room visit and follow up care)

| | |
|---|-------|
| ■ The plan's overall deductible | \$150 |
| ■ Specialist coinsurance | 10% |
| ■ Hospital (facility) copayment | \$250 |
| ■ Other coinsurance | 10% |

This EXAMPLE event includes services like:

Emergency room care (*including medical supplies*)
 Diagnostic test (*x-ray*)
 Durable medical equipment (*crutches*)
 Rehabilitation services (*physical therapy*)

| | |
|---------------------------|----------------|
| Total Example Cost | \$2,800 |
|---------------------------|----------------|

In this example, Mia would pay:

| <i>Cost Sharing</i> | |
|-----------------------------------|--------------|
| Deductibles | \$150 |
| Copayments | \$300 |
| Coinsurance | \$100 |
| <i>What isn't covered</i> | |
| Limits or exclusions | \$0 |
| The total Mia would pay is | \$550 |

The [plan](#) would be responsible for the other costs of these EXAMPLE covered services.