
 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, or to get a copy of the complete terms of coverage visit <http://benefits.jhu.edu/health-and-life/medical-plans.cfm>. 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 <http://benefits.jhu.edu/health-and-life/medical-plans.cfm> or call 410-516-2000.

Important Questions	Answers	Why This Matters:
<p><b>What is the overall <a href="#">deductible</a>?</b></p>	<p><b>\$250</b> person /  <b>\$750</b> family                      For non-participating providers  <b>\$500</b> person / <b>\$1,500</b> family                      Doesn't apply to preventive care</p>	<p>You must pay all the costs up to the <b><u>deductible</u></b> amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the <b><u>deductible</u></b> 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 <b><u>deductible</u></b>.</p>
<p><b>Are there services covered before you meet your <a href="#">deductible</a>?</b></p>	<p>Yes. Preventative care and prescription drugs are covered before you meet your deductible</p>	<p>The plan covers some items and services even if you haven't yet met the <b><u>deductible</u></b> amount, but <b><u>copayment</u></b> or <b><u>coinsurance</u></b> may apply.</p>
<p><b>Are there other <a href="#">deductibles</a> for specific services?</b></p>	<p><b>There are no other specific deductibles.</b></p>	<p>You must pay all of the costs for these services up to the specific <b><u>deductible</u></b> amount before this plan begins to pay for these services.</p>
<p><b>What is the <a href="#">out-of-pocket limit</a> for this <a href="#">plan</a>?</b></p>	<p><b>\$2,000</b> person / <b>\$6,000</b> family                      For non-participating providers  <b>\$4,000</b> person / <b>\$12,000</b> family</p>	<p>The <b><u>out-of-pocket limit</u></b> 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.</p>
<p><b>What is not included in the <a href="#">out-of-pocket limit</a>?</b></p>	<p>Premiums, balance-billed charges, and health care this plan doesn't cover.                      Prescription drug costs accumulate towards a separate out-of-pocket maximum.</p>	<p>Even though you pay these expenses, they don't count toward the <b><u>out-of-pocket limit</u></b>.</p>
<p><b>Will you pay less if you use a <a href="#">network provider</a>?</b></p>	<p>Yes. For medical, see <a href="http://www.EHP.org">www.EHP.org</a> or call 1-800-</p>	<p>If you use an in-network doctor or other health care <b><u>provider</u></b>, 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-</p>

	<p><b>261-2393</b> for a list of participating providers.</p> <p>For Prescription Drug, see <a href="http://www.Express-Scripts.com">www.Express- Scripts.com</a>.</p>	<p>network <b>provider</b> for some services. Plans use the term in-network, <b>preferred</b>, or participating for <b>providers</b> in their <b>network</b>. See the chart starting on page 2 for how this plan pays different kinds of <b>providers</b>.</p>
<p><b>Do you need a <a href="#">referral</a> to see a <a href="#">specialist</a>?</b></p>	<p>No. You don't need a referral to see a specialist.</p>	<p>You can see the <b>specialist</b> you choose without permission from this plan.</p>

- 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 providers by charging you lower deductibles, copayments and coinsurance amounts.

 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
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you visit a health care <a href="#">provider's</a> office or clinic	Primary care visit to treat an injury or illness	20% coinsurance	30% coinsurance of R&C after deductible	—————none—————
	<a href="#">Specialist</a> visit	20% coinsurance	30% coinsurance of R&C after deductible	—————none—————
	<a href="#">Preventive care/screening/immunization</a>	No charge	30% coinsurance of R&C after deductible	
If you have a test	<a href="#">Diagnostic test</a> (x-ray, blood work)	20% coinsurance	30% coinsurance of R&C after deductible	—————none—————
	Imaging (CT/PET scans, MRIs)	20% coinsurance	30% coinsurance of R&C after deductible	—————none—————
If you need drugs to treat your illness or condition More information about <a href="#">prescription drug coverage</a> is available at <a href="http://www.Express-Scripts.com">www.Express-Scripts.com</a>	Generic drugs	Retail: \$10 copay Mail Order: \$25 copay/prescription for mail-order		Prescription drug costs accumulate towards a separate out-of-pocket maximum.
	Preferred brand drugs	Retail: If no generic is available, 20% coinsurance (\$30 min/\$45 max) Mail Order: If no generic is available, 20% coinsurance (\$75 min/\$112.50 max)		For participating providers <b>\$2,000 person / \$6,000 family</b> For non-participating providers <b>\$4,000 person / \$12,000 family</b>
	Non-preferred brand drugs	Retail: If no generic or preferred brand is available, 25% coinsurance (\$60 min/\$100 max) Mail Order: If no generic or preferred brand is available, 25% coinsurance (\$150 min/\$250 max)		Covers up to a 30-day supply (retail prescription); 31-90 day supply (mail order prescription)
	<a href="#">Specialty drugs</a>	Same as non-specialty drug coverage reflected above their cost is dependent on tier of drug coverage (i.e. generic, preferred-brand, non-preferred brand, etc.)		
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	No charge	30% coinsurance of R&C after deductible	-Participating outpatient facility and outpatient surgery facility charges including freestanding surgical centered is covered at No charge -For Non-participating physician services failure to obtain pre-certification may result in a penalty
	Physician/surgeon fees	20% coinsurance	30% coinsurance of R&C after deductible	For Non-participating physician services failure to obtain pre-certification may result in a penalty or possible denial of benefits

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
<b>If you need immediate medical attention</b>	<a href="#">Emergency room care</a>	Facility: \$100 copay Physical: 20% coinsurance after deductible	Facility: \$100 copay Physical: 20% coinsurance of R&C after deductible	-Copay waived if admitted -For non-participating physician services failure to obtain pre-certification may result in a penalty or possible denial of benefits
	<a href="#">Emergency medical transportation</a>	30% coinsurance after deductible	30% coinsurance of R&C after deductible	—————none—————
	<a href="#">Urgent care</a>	\$50 copay (deductible waived)	\$50 co-ay (deductible waived)	—————none—————
<b>If you have a hospital stay</b>	Facility fee (e.g., hospital room)	\$250 copay per hospital admission then 20% coinsurance after deductible	\$250 copay per hospital admission then 30% of R&C coinsurance after deductible	-For non-participating providers, failure to obtain pre-certification may result in a penalty or possible denial of benefits -Unlimited hospital inpatient days allowed
	Physician/surgeon fees	20% coinsurance after deductible	30% of R&C coinsurance after deductible	—————none—————
<b>If you need mental health, behavioral health, or substance abuse services</b>	Outpatient services	20% coinsurance	30% coinsurance of R&C after deductible	—————none—————
	Inpatient services	\$250 copay per hospital admission then 20% coinsurance after deductible	\$250 copay per hospital admission then 30% of R&C coinsurance after deductible	For non-participating providers, failure to obtain pre-certification may result in a penalty or possible denial of benefits
<b>If you are pregnant</b>	Office visits	20% coinsurance after deductible	30% coinsurance of R&C after deductible	—————none—————
	Childbirth/delivery professional services	20% coinsurance after deductible	\$250 copay per hospital admission then 30% of R&C coinsurance after deductible	For non-participating providers failure to obtain pre-certification may result in a penalty or possible denial of benefits
	Childbirth/delivery facility services	\$250 copay per hospital admission then 20% coinsurance	\$250 copay per hospital admission then 20% coinsurance after deductible	For non-participating providers, failure to obtain pre-certification may result in a penalty or possible denial of benefits
<b>If you need help recovering or have other special health needs</b>	<a href="#">Home health care</a>	No charge	30% of R&C coinsurance after deductible	-Medically necessary services only coordinated by clinical case managers -90 visits per year maximum
	<a href="#">Rehabilitation services</a>	20% coinsurance	30% of R&C coinsurance	-Medically necessary services only

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
			after deductible	-For non-participating providers, failure to obtain pre-certification may result in a penalty or possible denial of benefits
	<a href="#">Habilitation services</a>	20% coinsurance	30% of R&C coinsurance after deductible	—————none—————
	<a href="#">Skilled nursing care</a>	20% coinsurance	30% of R&C coinsurance after deductible	-Medically necessary services only -For non-participating providers, failure to obtain pre-certification may result in a penalty or possible denial of benefits
	<a href="#">Durable medical equipment</a>	20% coinsurance	30% of R&C coinsurance after deductible	No limitations EXCEPT for medically necessary hearing aids for dependent covered children up to \$1,400 per aid
	<a href="#">Hospice services</a>	20% coinsurance	30% of R&C coinsurance after deductible	Must be pre-certified by Care Management; failure to obtain pre-certification may result in a penalty or possible denial of benefits
<b>If your child needs dental or eye care</b>	Children's eye exam	No charge	Not covered	Limited to one exam every two years
	Children's glasses	Not Covered	Not Covered	None
	Children's dental check-up	Not Covered	Not Covered	None

### Excluded Services & Other Covered Services:

#### Services Your [Plan](#) Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other [excluded services](#).)

- Cosmetic surgery
- Long-term care
- Routine foot care
- Dental care (Adult)
- Private-duty nursing
- Weight loss programs

#### Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your [plan](#) document.)

- Acupuncture (if prescribed for rehabilitation)
- Bariatric surgery must be pre-certified by Care Management; member must meet criteria and the procedure must be medically reviewed and approved prior to surgery
- Chiropractic care (restricted to initial exam, X-rays, & spinal manipulations)
- Hearing aids (medically necessary hearing for dependent minor children only): \$1,400 maximum per aid; services must be authorized by Care Management and prescribed, fitted and dispensed by licensed audiologist; replacement aids once every 36 months
- Most coverage provided outside the State of Maryland. See [www.Multiplan.com](http://www.Multiplan.com).
- Non-emergency care when traveling outside the U.S.
- Routine eye care (Adult; Limited to one exam every two years)
- Physical therapy (Limited to 45 visits per year)

- Infertility treatment including artificial insemination and intrauterine (maximum of 6 attempts per live birth), in vitro fertilization (maximum of 3 attempts per live birth); maximum lifetime benefit of \$100,000; pre-certification required for all services
- Speech therapy (Limited to 30 visits per year)

**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 at 1-866-444-3272 or [www.dol.gov/ebsa](http://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](http://www.cciio.cms.gov). 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](http://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 [plan](#) documents also provide 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:

Johns Hopkins University Benefits Service Center  
 Phone: 410-516-2000  
[Email:benefits@jhu.edu](mailto:benefits@jhu.edu)

Department of Labor's Employee Benefits Security Administration  
 1-866-444-EBSA (3272)  
[www.dol.gov/ebsa/healthreform](http://www.dol.gov/ebsa/healthreform)

**Does this plan provide Minimum Essential Coverage? YES**

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 plan meet the Minimum Value Standards? YES**

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 410-516-2000.  
 Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 410-516-2000.  
 Chinese (中文): 如果需要中文的帮助, 请拨打这个号码410-516-2000.  
 Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijigo holne' 410-516-2000.

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

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## 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 self-only coverage.

### Peg is Having a Baby

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

■ The <a href="#">plan's</a> overall <a href="#">deductible</a>	\$250
■ <a href="#">Specialist</a>	20%
■ Hospital (facility)	\$250
■ Other	20%

#### 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*)

<b>Total Example Cost</b>	<b>\$12,731</b>
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#### In this example, Peg would pay:

<i>Cost Sharing</i>	
Deductibles	\$250
Copayments	\$286
Coinsurance	\$1,500
<i>What isn't covered</i>	
Limits or exclusions	\$60
<b>The total Peg would pay is</b>	<b>\$2,096</b>

### Managing Joe's type 2 Diabetes

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

■ The <a href="#">plan's</a> overall <a href="#">deductible</a>	\$250
■ <a href="#">Specialist</a>	20%
■ Hospital (facility)	\$250
■ Other	20%

#### 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*)

<b>Total Example Cost</b>	<b>\$7,389</b>
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#### In this example, Joe would pay:

<i>Cost Sharing</i>	
Deductibles	\$250
Copayments	\$590
Coinsurance	\$363
<i>What isn't covered</i>	
Limits or exclusions	\$55
<b>The total Joe would pay is</b>	<b>\$1,258</b>

### Mia's Simple Fracture

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

■ The <a href="#">plan's</a> overall <a href="#">deductible</a>	\$250
■ <a href="#">Specialist</a>	20%
■ Hospital (facility)	\$100
■ Other	20%

#### This EXAMPLE event includes services like:

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

<b>Total Example Cost</b>	<b>\$1,925</b>
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#### In this example, Mia would pay:

<i>Cost Sharing</i>	
Deductibles	250\$
Copayments	100\$
Coinsurance	224\$
<i>What isn't covered</i>	
Limits or exclusions	0\$
<b>The total Mia would pay is</b>	<b>\$574</b>



## 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.