




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>What is the overall deductible?</p>	<p>\$250 person / \$750 family For non-participating providers \$500 person / \$1,500 family Doesn't apply to preventive care</p>	<p>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.</p>
<p>Are there services covered before you meet your deductible?</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 deductible amount, but copayment or coinsurance may apply.</p>
<p>Are there other deductibles for specific services?</p>	<p>There are no other specific deductibles.</p>	<p>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.</p>
<p>What is the out-of-pocket limit for this plan?</p>	<p>\$2,000 person / \$6,000 family For non-participating providers \$4,000 person / \$12,000 family</p>	<p>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.</p>
<p>What is not included in the out-of-pocket limit?</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 out-of-pocket limit.</p>
<p>Will you pay less if you use a network provider?</p>	<p>Yes. For medical, see www.EHP.org or call 1-800-</p>	<p>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-</p>

	<p>261-2393 for a list of participating providers.</p> <p>For Prescription Drug, see www.Express- Scripts.com.</p>	<p>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.</p>
<p>Do you need a referral to see a specialist?</p>	<p>No. You don't need a referral to see a specialist.</p>	<p>You can see the specialist 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 provider's office or clinic	Primary care visit to treat an injury or illness	20% coinsurance	30% coinsurance of allowed benefit after deductible	_____none_____
	Specialist visit	20% coinsurance	30% coinsurance of allowed benefit after deductible	_____none_____
	Preventive care/screening/immunization	No charge	30% coinsurance of allowed benefit deductible waived	
If you have a test	Diagnostic test (x-ray, blood work)	20% coinsurance	30% coinsurance of allowed benefit after deductible	_____none_____
	Imaging (CT/PET scans, MRIs)	20% coinsurance	30% coinsurance of allowed benefit after deductible	_____none_____
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.Express-Scripts.com	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 \$2,000 person / \$6,000 family For non-participating providers \$4,000 person / \$12,000 family
	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)
	Specialty drugs	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 allowed benefit 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 allowed benefit after	For Non-participating physician services failure to obtain pre-certification may result in a

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)	
			deductible	penalty or possible denial of benefits
If you need immediate medical attention	Emergency room care	Facility: \$100 copay Physician: 20% coinsurance after deductible	Facility: \$100 copay Physician: 20% coinsurance of allowed benefit after deductible	-Copay waived if admitted
	Emergency medical transportation	20% coinsurance after deductible	30% coinsurance of allowed benefit after deductible	—————none—————
	Urgent care	\$50 copay (deductible waived)	\$50 co-pay (deductible waived)	—————none—————
If you have a hospital stay	Facility fee (e.g., hospital room)	\$250 copay per hospital admission then 20% coinsurance after deductible	\$250 copay per hospital admission then 30% coinsurance of allowed benefit 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% coinsurance of allowed benefit after deductible	—————none—————
If you need mental health, behavioral health, or substance abuse services	Outpatient services	20% coinsurance	30% coinsurance of allowed benefit after deductible	—————none—————
	Inpatient services	\$250 copay per hospital admission then 20% coinsurance after deductible	\$250 copay per hospital admission then 30% coinsurance of allowed benefit after deductible	For non-participating providers, failure to obtain pre-certification may result in a penalty or possible denial of benefits
If you are pregnant	Office visits	No charge	30% coinsurance of allowed benefit after deductible	For routine pre/postnatal office visits only. For non-routine obstetrical care or complications of pregnancy, cost sharing may apply.
	Childbirth/delivery professional services	20% coinsurance after deductible	30% coinsurance of allowed benefit 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%	\$250 copay per hospital admission then 30%	For non-participating providers, failure to obtain pre-certification may result in a penalty

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)	
		coinsurance	coinsurance after deductible	or possible denial of benefits
If you need help recovering or have other special health needs	Home health care	No charge	30% coinsurance of allowed benefit after deductible	-Medically necessary services only -coordinated by clinical case managers -90 visits per year maximum
	Rehabilitation services	20% coinsurance	30% coinsurance of allowed benefit 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-
	Habilitation services	20% coinsurance	30% coinsurance of allowed benefit after deductible	-Pre-certification required
	Skilled nursing care	20% coinsurance	30% coinsurance of allowed benefit 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 120 visits per year maximum
	Durable medical equipment	20% coinsurance	30% coinsurance of allowed benefit after deductible	Pre-certification required; No limitations EXCEPT for medically necessary hearing aids for dependent covered children up to \$1,400 per aid
	Hospice services	20% coinsurance	30% coinsurance of allowed benefit after deductible	Must be pre-certified by Care Management; failure to obtain pre-certification may result in a penalty or possible denial of benefits
If your child needs dental or eye care	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.)

<ul style="list-style-type: none">• 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	<ul style="list-style-type: none">• 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• 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 for medical and Rx; pre-certification required for all services	<p>Coverage provided through the national and wrap network. See https://sarhpcdir.cigna.com/web/public/mcaPPOProviders</p> <ul style="list-style-type: none">• .• Non-emergency care when traveling outside the U.S.• Routine eye care (Adult; Limited to one exam every two years)• Physical therapy (Limited to combined 45 visits per year; pre-certification required)• Speech therapy (non-developmental; limited to 30 visits per year; pre-certification required)
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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, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or 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 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

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.

—————*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](#).

Peg is Having a Baby (9 months of in-network pre-natal care and a hospital delivery)		Managing Joe's type 2 Diabetes (a year of routine in-network care of a well-controlled condition)		Mia's Simple Fracture (in-network emergency room visit and follow up care)	
■ The plan's overall deductible	\$250	■ The plan's overall deductible	\$250	■ The plan's overall deductible	\$250
■ Specialist	20%	■ Specialist	20%	■ Specialist	20%
■ Hospital (facility)	\$250	■ Hospital (facility)	\$250	■ Hospital (facility)	\$100
■ Other	20%	■ Other	20%	■ Other	20%
<p>This EXAMPLE event includes services like: Specialist office visits (<i>prenatal care</i>) Childbirth/Delivery Professional Services Childbirth/Delivery Facility Services Diagnostic tests (<i>ultrasounds and blood work</i>) Specialist visit (<i>anesthesia</i>)</p>		<p>This EXAMPLE event includes services like: Primary care physician office visits (<i>including disease education</i>) Diagnostic tests (<i>blood work</i>) Prescription drugs Durable medical equipment (<i>glucose meter</i>)</p>		<p>This EXAMPLE event includes services like: Emergency room care (<i>including medical supplies</i>) Diagnostic test (<i>x-ray</i>) Durable medical equipment (<i>crutches</i>) Rehabilitation services (<i>physical therapy</i>)</p>	
Total Example Cost	\$12,731	Total Example Cost	\$7,389	Total Example Cost	\$1,925
In this example, Peg would pay:		In this example, Joe would pay:		In this example, Mia would pay:	
<i>Cost Sharing</i>		<i>Cost Sharing</i>		<i>Cost Sharing</i>	
Deductibles	\$250	Deductibles	\$250	Deductibles	\$250
Copayments	\$286	Copayments	\$590	Copayments	\$100
Coinsurance	\$1,500	Coinsurance	\$363	Coinsurance	\$224
<i>What isn't covered</i>		<i>What isn't covered</i>		<i>What isn't covered</i>	
Limits or exclusions	\$60	Limits or exclusions	\$55	Limits or exclusions	\$0
The total Peg would pay is	\$2,096	The total Joe would pay is	\$1,258	The total Mia would pay is	\$574

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

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.