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:
What is the overall deductible?	**$250** person / **$750** family For non-participating providers **$500** person / **$1,500** family Doesn't apply to preventive care	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 services covered before you meet your deductible?	Yes. Preventative care and prescription drugs are covered before you meet your deductible	The plan covers some items and services even if you haven't yet met the **deductible** amount, but **copayment** or **coinsurance** may apply.
Are there other deductibles for specific services?	**There are no other specific deductibles.**	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 this plan?	**$2,000** person / **$6,000** family For non-participating providers **$4,000** person / **$12,000** 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, balance-billed charges, and health care this plan doesn't cover. Prescription drug costs accumulate towards a separate out-of-pocket maximum.	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. For medical, see **www.EHP.org or call 1-800-261-2393** for a list of participating providers. For Prescription Drug, see **www.Express- Scripts.com**.	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 you need a referral to see a specialist?	No. You don't need a referral to see a specialist.	You can see the **specialist** you choose without permission from this plan.

- 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 after deductible	30% coinsurance of allowed benefit after deductible	——————none——————
	Specialist visit	20% coinsurance after deductible	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 after deductible	30% coinsurance of allowed benefit after deductible	——————none——————
	Imaging (CT/PET scans, MRIs)	20% coinsurance after deductible	30% coinsurance of allowed benefit after deductible	——————none——————

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 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. $2,000 per person, $6,000 per family Covers up to a 30-day supply (retail prescription); 31-90 day supply (mail order prescription)
	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)		
	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)		
	Specialty drugs	Same as non-specialty drug coverage reflected above. 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 after deductible	30% coinsurance of allowed benefit after deductible	For Non-participating physician services failure to obtain pre-certification may result in a 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	$250 copay per hospital admission then 30% coinsurance	-For non-participating providers, 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)	
		deductible	of allowed benefit after deductible	-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 after deductible	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% coinsurance after deuctible	$250 copay per hospital admission then 30% coinsurance after deductible	For non-participating providers, failure to obtain pre-certification may result in a penalty 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 after deductible	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 after deductible	30% coinsuranc of allowed benefit after deductible	-Pre-certification required
	Skilled nursing care	20% coinsurance after	30% 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)	
		deductible	of allowed benefit after deductible	-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 after deductible	30% coinsurance of allowed benefit after deductible	Pre-certification required; No limitations EXCEPT for medically necessary hearing aids up to $1,000 per aid every 36 months
	Hospice services	20% coinsurance after deductible	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
- Dental care (Adult)
- Long-term care
- Private-duty nursing
- Routine foot care
- 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
- Coverage provided through the national and wrap network. See https://sarhcpdir.cigna.com/web/public/mcaPPOProviders for details
- Chiropractic care (restricted to initial exam, X-rays, & spinal manipulations)
- Hearing aids: $1,000 maximum per aid for adults 18 years+; No maximum for dependents under age 18; 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
- 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)

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

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

The plan's overall deductible	$250
Specialist	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)*

Total Example Cost	**$10,990**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$250
Copayments	$300
Coinsurance	$1,100
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$1,710**

Managing Joe's type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

The plan's overall deductible	$250
Specialist	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)*

Total Example Cost	**$4,730**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$250
Copayments	$300
Coinsurance	$300
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$870**

Mia's Simple Fracture
(in-network emergency room visit and follow up care)

The plan's overall deductible	$250
Specialist	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)*

Total Example Cost	**$2,040**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$250
Copayments	$10
Coinsurance	$500
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$760**

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.

The **plan** would be responsible for the other costs of these EXAMPLE covered services.