




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](http://www.ehp.org). To get a copy of the Summary Plan Description, call 410-614-3301 or visit [https://www.hopkinsmedicine.org/som/offices/registrars/documents/shp\\_summary\\_plan\\_description.pdf](https://www.hopkinsmedicine.org/som/offices/registrars/documents/shp_summary_plan_description.pdf). 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 \(dol.gov\)](#) or call 1-800-261-2393 to request a copy.

Important Questions	Answers	Why This Matters:
<b>What is the overall <a href="#">deductible</a>?</b>	\$150 per person, \$450 per family	Generally, you must pay all of the costs from providers up to the <a href="#">deductible</a> amount before this <a href="#">plan</a> begins to pay. If you have other family members on the <a href="#">plan</a> , each family member must meet their own individual <a href="#">deductible</a> until the total amount of <a href="#">deductible</a> expenses paid by all family members meets the overall family <a href="#">deductible</a> .
<b>Are there services covered before you meet your <a href="#">deductible</a>?</b>	Yes. <a href="#">Preventive care</a> and prescription drugs are covered before you meet your <a href="#">deductible</a> .	This <a href="#">plan</a> covers some medical items and services even if you haven't yet met the <a href="#">deductible</a> amount. But a <a href="#">copayment</a> or <a href="#">coinsurance</a> may apply. For example, this <a href="#">plan</a> covers certain <a href="#">preventive services</a> without <a href="#">cost-sharing</a> and before you meet your <a href="#">deductible</a> . See a list of covered <a href="#">preventive services</a> at <a href="https://www.healthcare.gov/coverage/preventive-care-benefits/">https://www.healthcare.gov/coverage/preventive-care-benefits/</a> .
<b>Are there other <a href="#">deductibles</a> for specific services?</b>	Yes. \$1,500 lifetime for advanced reproductive techniques (ART) treatment	You must pay all of the costs for these services up to the specific <a href="#">deductible</a> amount before this <a href="#">plan</a> begins to pay for these services.
<b>What is the <a href="#">out-of-pocket limit</a> for this <a href="#">plan</a>?</b>	\$3,000 individual/\$9,000 family for expenses other than drug <a href="#">copayments</a> ; \$3,350 individual/\$3,700 family for drug <a href="#">copayments</a>	The <a href="#">out-of-pocket limit</a> is the most you could pay in a year for covered services. If you have other family members in this <a href="#">plan</a> , they have to meet their own <a href="#">out-of-pocket limits</a> until the overall family <a href="#">out-of-pocket limit</a> has been met.
<b>What is not included in the <a href="#">out-of-pocket limit</a>?</b>	Charges above <a href="#">plan</a> maximums, <a href="#">premiums</a> , <a href="#">balance-billing</a> charges, health care this <a href="#">plan</a> doesn't cover, penalties for failure to obtain <a href="#">preauthorization</a> , amounts paid for ART treatment	Even though you pay these expenses, they don't count toward the <a href="#">out-of-pocket limit</a> .
<b>Will you pay less if you use a <a href="#">network provider</a>?</b>	Yes. See <a href="http://www.ehp.org">www.ehp.org</a> or call 1-800-261-2393 for a list of in-network providers.	This <a href="#">plan</a> uses a <a href="#">provider network</a> . You will pay less if you use a <a href="#">provider</a> in this <a href="#">plan's network</a> . You will pay the most if you use an <a href="#">out-of-network provider</a> , and you might receive a bill from a <a href="#">provider</a> for the difference between the <a href="#">provider's</a> charge and what your <a href="#">plan</a> pays ( <a href="#">balance billing</a> ). Be aware your <a href="#">network provider</a> might use an <a href="#">out-of-network provider</a> for some services (such as lab work). Check with your <a href="#">provider</a> before you get services.

Do you need a <a href="#">referral</a> to see a <a href="#">specialist</a> ?	No.	You can see the <a href="#">specialist</a> you choose without a <a href="#">referral</a> .
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 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 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% <a href="#">coinsurance</a>	30% <a href="#">coinsurance</a>	None
	<a href="#">Specialist</a> visit	10% <a href="#">coinsurance</a>	30% <a href="#">coinsurance</a>	None
	<a href="#">Preventive care/screening/immunization</a>	No charge; <a href="#">deductible</a> does not apply	30% <a href="#">coinsurance</a> ; 10% <a href="#">coinsurance</a> for mammograms and well-child care	You may have to pay for services that aren't <a href="#">preventive</a> . Ask your <a href="#">provider</a> if the services needed are preventive. Then check what your <a href="#">plan</a> will pay for.
If you have a test	<a href="#">Diagnostic test</a> (x-ray, blood work)	10% <a href="#">coinsurance</a>	30% <a href="#">coinsurance</a>	None
	Imaging (CT/PET scans, MRIs)	10% <a href="#">coinsurance</a>	30% <a href="#">coinsurance</a>	
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.ehp.org">www.ehp.org</a>	Generic drugs	\$15 <a href="#">copayment</a> 30 days; \$30 <a href="#">copayment</a> 90 days by mail; \$45 <a href="#">copayment</a> 90 days at retail;	\$15 <a href="#">copayment</a> 30 days; \$45 <a href="#">copayment</a> 90 days, plus all charges above network pharmacy price	<a href="#">Deductible</a> does not apply. <a href="#">Preauthorization</a> may be required for some drugs, or not covered
	Preferred brand drugs	\$25 <a href="#">copayment</a> 30 days; \$50 <a href="#">copayment</a> 90 days by mail; \$75 <a href="#">copayment</a> 90 days at retail	\$25 <a href="#">copayment</a> 30 days; \$75 <a href="#">copayment</a> 90 days, plus all charges above network pharmacy price	
	Non-preferred brand drugs (including specialty drugs)	\$40 <a href="#">copayment</a> 30 days; \$80 <a href="#">copayment</a> 90 days by mail; \$120 <a href="#">copayment</a> 90 days at retail	\$40 <a href="#">copayment</a> 30 days; \$120 <a href="#">copayment</a> 90 days, plus all charges above network pharmacy price	

<b>If you have outpatient surgery</b>	Facility charges (e.g., ambulatory surgery center)	10% <a href="#">coinsurance</a>	10% <a href="#">coinsurance</a>	<a href="#">Preauthorization</a> required, or not covered.
	Physician/surgeon fees	20% <a href="#">coinsurance</a>	30% <a href="#">coinsurance</a>	
<b>If you need immediate medical attention</b>	<a href="#">Emergency room care</a>	\$50 <a href="#">copay</a>	\$50 <a href="#">copay</a>	Not covered unless emergency medical condition; <a href="#">copay</a> waived if admitted.
	<a href="#">Emergency medical transportation</a>	No charge	No charge (up to <a href="#">allowed amount</a> )	Air transportation not covered unless medically necessary.
	<a href="#">Urgent care</a>	No charge	No charge (up to <a href="#">allowed amount</a> )	None
<b>If you have a hospital stay</b>	Facility charges (e.g., hospital room)	10% <a href="#">coinsurance</a>	10% <a href="#">coinsurance</a>	<a href="#">Preauthorization</a> required, or not covered.
	Physician/surgeon fees	20% <a href="#">coinsurance</a>	30% <a href="#">coinsurance</a>	
<b>If you need mental health, behavioral health, or substance abuse services</b>	Outpatient services	10% <a href="#">coinsurance</a> , except no charge for professional fees for substance abuse services	10% <a href="#">coinsurance</a> , except 20% <a href="#">coinsurance</a> for professional fees for substance abuse services	None
	Inpatient services	Facility charges: no charge first 30 days, then 10% <a href="#">coinsurance</a> ; Professional fees: 20% <a href="#">coinsurance</a>	Facility charges: no charge (up to <a href="#">allowed amount</a> ) first 30 days, then 10% <a href="#">coinsurance</a> ; Professional fees: 20% <a href="#">coinsurance</a>	<a href="#">Preauthorization</a> required, or not covered.
<b>If you are pregnant</b>	Office visits	10% <a href="#">coinsurance</a> ; no charge for <a href="#">preventive services</a>	30% <a href="#">coinsurance</a>	Maternity care may include tests and services described elsewhere in the SBC.
	Childbirth/delivery professional fees	20% <a href="#">coinsurance</a>	30% <a href="#">coinsurance</a>	
	Childbirth/delivery facility charges	10% <a href="#">coinsurance</a>	10% <a href="#">coinsurance</a>	Stays longer than 48 hours (normal delivery) or 96 hours (caesarean) not covered unless preauthorized.

<b>If you need help recovering or have other special health needs</b>	<a href="#">Home health care</a>	No charge first 90 visits per year, then 20% <a href="#">coinsurance</a>	10% <a href="#">coinsurance</a> first 90 visits per year, then 20% <a href="#">coinsurance</a>	<a href="#">Preauthorization</a> required or not covered.
	<a href="#">Rehabilitation services</a>	20% <a href="#">coinsurance</a>	20% <a href="#">coinsurance</a>	<a href="#">Preauthorization</a> required for speech therapy or not covered.
	<a href="#">Habilitation services</a>	20% <a href="#">coinsurance</a>	20% <a href="#">coinsurance</a>	<a href="#">Preauthorization</a> required or not covered; under age 19 only.
	<a href="#">Skilled nursing care</a>	10% <a href="#">coinsurance</a>	10% <a href="#">coinsurance</a>	<a href="#">Preauthorization</a> required or not covered.
	<a href="#">Durable medical equipment</a>	20% <a href="#">coinsurance</a>	20% <a href="#">coinsurance</a>	<a href="#">Preauthorization</a> required for custom made equipment and supplies, or not covered.
	<a href="#">Hospice services</a>	No charge	No charge (up to <a href="#">allowed amount</a> )	<a href="#">Preauthorization</a> required or not covered.
<b>If your child needs dental or eye care</b>	Children's eye exam	No charge	Charges above \$30 not covered	Only covered once every 12 months
	Children's glasses	No charge	Charges above \$25 not covered	Only covered once every 12 months
	Children's dental check-up	Not Covered		Covered by Dental Plan

#### Excluded Services & Other Covered Services:

Services Your <a href="#">Plan</a> Generally Does NOT Cover (Check your Summary Plan Description for more information and a list of any other <a href="#">excluded services</a> .)		
<ul style="list-style-type: none"> <li>• Cosmetic Surgery</li> <li>• Dental Care (Adult)</li> <li>• Long Term Care</li> </ul>	<ul style="list-style-type: none"> <li>• Emergency room care for non-emergency medical conditions</li> <li>• Private Duty Nursing</li> <li>• Routine Eye Care (Adult)</li> </ul>	<ul style="list-style-type: none"> <li>• Routine Foot Care</li> <li>• Weight Loss Programs</li> </ul>
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"> <li>• Acupuncture, for anesthesia, pain control and therapeutic purposes only (\$300 <a href="#">plan</a> year maximum)</li> <li>• Bariatric Surgery</li> <li>• Chiropractic Care, for initial exam, x-rays and spinal manipulation only</li> </ul>	<ul style="list-style-type: none"> <li>• Hearing Aids (replacements only once every three years)</li> <li>• Infertility Treatment (In-Network only; separate <a href="#">coinsurance</a>; <a href="#">deductible</a> and lifetime maximum benefits apply)</li> <li>• Non-emergency care when travelling outside the U.S.</li> </ul>	

**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](http://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](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 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: Employer Health Programs, 1-800-261-2393 or [www.ehp.org](http://www.ehp.org). 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](http://www.dol.gov/ebsa/healthreform).

Additionally, a consumer assistance program can help you file your [appeal](#) or [grievance](#). Contact the Maryland Office of the Attorney General, Health Education and Advocacy Unit, 200 St. Paul Place, 16th Floor, Baltimore, MD 21202, 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) [coinsurance](#) 0%
- 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	\$40
Coinsurance	\$100
<i>What isn't covered</i>	
Limits or exclusions	\$60
<b>The total Peg would pay is</b>	<b>\$350</b>

**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](#) 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** \$5,600

In this example, Joe would pay:

<i>Cost Sharing</i>	
Deductibles	\$150
Copayments	\$500
Coinsurance	\$400
<i>What isn't covered</i>	
Limits or exclusions	\$60
<b>The total Joe would pay is</b>	<b>\$1,110</b>

**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](#) \$50
- Other [coinsurance](#) 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** \$2,800

In this example, Mia would pay:

<i>Cost Sharing</i>	
Deductibles	\$150
Copayments	\$50
Coinsurance	\$200
<i>What isn't covered</i>	
Limits or exclusions	\$0
<b>The total Mia would pay is</b>	<b>\$400</b>

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