



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 443-997-5400 or visit <https://mybenefitsjhhs.com>. 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:  |
|---|---|--|
| <p><b>What is the overall <a href="#">deductible</a> for the Higher Pay Tier?</b></p>     | <p>\$0 EHP Select Pediatric provider; \$300/person, \$600/family in-network; \$750/person, \$1,500/family out-of-network; excludes charges above <a href="#">allowed amount</a>.</p>  | <p>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>.</p>  |
| <p><b>Are there services covered before you meet your <a href="#">deductible</a>?</b></p> | <p>Yes. <a href="#">Preventive care</a> and prescription drugs are covered before you meet your <a href="#">deductible</a>.</p>   | <p>This <a href="#">plan</a> covers some 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>.</p> |
| <p><b>Are there other <a href="#">deductibles</a> for specific services?</b></p>          | <p>Yes. \$1,000 lifetime deductible for infertility treatment.</p>  | <p>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.</p>  |
| <p><b>What is the <a href="#">out-of-pocket limit</a> for the Higher Pay Tier?</b></p>    | <p><b>Medical:</b> \$3,000/person, \$6,000/family in-network; \$3,500/person, \$7,000/family out-of-network.<br/> <b>Prescription drugs:</b> \$3,600/person, \$7,200/family.</p>  | <p>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.</p>  |
| <p><b>What is not included in the <a href="#">out-of-pocket limit</a>?</b></p>            | <p>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>.</p> | <p>Even though you pay these expenses, they don't count toward the <a href="#">out-of-pocket limit</a>.</p>  |
| <p><b>Will you pay less if you use a <a href="#">network provider</a>?</b></p>            | <p>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.</p>   | <p>This <a href="#">plan</a> uses a <a href="#">provider network</a>. You usually pay the least if you use an EHP Select Pediatric or EHP Preferred <a href="#">Network Provider</a>. You usually pay more if you use an EHP <a href="#">Network Provider</a>. You will always 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 provider's charge and what your <a href="#">plan</a> pays</p>   |

([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. Except for [Emergency room care](#) and [Specialist](#) visits, no [copayment](#) or [coinsurance](#) applies for services by an EHP Select Pediatric provider.

| Common Medical Event   | Services You May Need                                   | What You Will Pay  |  |   | Limitations, Exceptions, & Other Important Information   |
|--|---|--|--|---|--|
|  |   | EHP Preferred Provider<br>(You pay the least)                          | EHP Network Provider<br>(You pay more) | Out-of-Network Provider<br>(You pay the most) |  |
| If you visit a health care <a href="#">provider's</a> office or clinic | Direct Primary Care visit to treat an injury or illness | No charge; <a href="#">Deductible</a> does not apply                   | Not covered                            | Not covered                                   | Dependents must designate Direct Primary Care as PCP, or not covered   |
|  | Other primary care visit to treat an injury or illness  | \$10 <a href="#">copay</a> ; <a href="#">Deductible</a> does not apply |  | 30% <a href="#">coinsurance</a>               | Covered for dependents only; Not covered if Direct Primary Care is designated PCP  |
|  | <a href="#">Specialist</a> visit                        | 10% <a href="#">coinsurance</a>  | 20% <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>               | You may have to pay for services that aren't <a href="#">preventive</a> . Ask your <a href="#">provider</a> if the services you need 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>  | 20% <a href="#">coinsurance</a>        | 30% <a href="#">coinsurance</a>               | None   |
|  | Imaging (CT/PET scans, MRIs)                            | 10% <a href="#">coinsurance</a>  | 20% <a href="#">coinsurance</a>        | 30% <a href="#">coinsurance</a>               | None   |



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| Common Medical Event  | Services You May Need                                   | What You Will Pay  |   |   | Limitations, Exceptions, & Other Important Information  |
|---|---|--|---|---|---|
|   |   | EHP Preferred Provider<br>(You pay the least)  | EHP Network Provider<br>(You pay more)                          | Out-of-Network Provider<br>(You pay the most)                   |   |
| <b>If you need drugs to treat your illness or condition</b><br>More information about prescription drug coverage is available at <a href="http://www.ehp.org">www.ehp.org</a> | Generic drugs   | Up to \$10 <a href="#">copay</a> 30 day supply<br>Up to \$20 <a href="#">copay</a> 90 day supply by mail<br>Up to \$30 <a href="#">copay</a> 90 day supply at pharmacy |   | Not covered   | <a href="#">Preauthorization</a> may be required for some drugs, or not covered.<br><br>No charge for generic oral contraceptives.<br><br>If you buy brand when generic available, must also pay cost difference.<br><br>Specialty drugs limited to 30 day supply only<br><br>Specialty drugs covered by PrudentRx Program only covered at Johns Hopkins Outpatient Pharmacies and CVS Specialty Pharmacy |
|   | Preferred brand drugs                                   | \$40 <a href="#">copay</a> 30 day supply<br>\$80 <a href="#">copay</a> 90 day supply by mail<br>\$120 <a href="#">copay</a> 90 day supply at pharmacy                  |   | Not covered   |   |
|   | Non-preferred brand drugs                               | \$65 <a href="#">copay</a> 30 day supply<br>\$130 <a href="#">copay</a> 90 day supply by mail<br>\$195 <a href="#">copay</a> 90 day supply at pharmacy                 |   | Not covered   |   |
|   | Specialty drugs <b>not</b> covered by PrudentRx Program | \$40 <a href="#">copay</a> brand preferred<br>\$65 <a href="#">copay</a> brand non-preferred   |   | Not covered   |   |
|   | Specialty drugs <b>covered</b> by PrudentRx Program     | \$0 <a href="#">copay</a> when obtained through PrudentRx Program<br>30% <a href="#">coinsurance</a> if not obtained through PrudentRx Program                         |   | Not covered   |   |
| <b>If you have outpatient surgery</b>   | Facility fee (e.g., ambulatory surgery center)          | 5% <a href="#">coinsurance</a>   | 15% <a href="#">coinsurance</a>                                 | 30% <a href="#">coinsurance</a>                                 | None  |
|   | Physician/surgeon fees                                  | 5% <a href="#">coinsurance</a>   | 15% <a href="#">coinsurance</a>                                 | 30% <a href="#">coinsurance</a>                                 |   |
| <b>If you need immediate medical attention</b>  | <a href="#">Emergency room care</a>                     | \$250 <a href="#">copay</a> , waived if admitted   |   |   | Not covered unless emergency medical situation  |
|   | <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>                             | \$25 <a href="#">copay</a> ; <a href="#">Deductible</a> does not apply   |   | 30% <a href="#">coinsurance</a>                                 | None  |
| <b>If you have a hospital stay</b>  | Facility charges (e.g., hospital room)                  | \$150 <a href="#">copay</a> and 10% <a href="#">coinsurance</a>  | \$150 <a href="#">copay</a> and 20% <a href="#">coinsurance</a> | \$500 <a href="#">copay</a> and 30% <a href="#">coinsurance</a> | <a href="#">Preauthorization</a> required, or not covered.  |
|   | Physician/surgeon fees                                  | 10% <a href="#">coinsurance</a>  | 20% <a href="#">coinsurance</a>                                 | 30% <a href="#">coinsurance</a>                                 | <a href="#">Preauthorization</a> required for surgery, or not covered.  |
| <b>If you need mental health, behavioral</b>  | Outpatient facility charges                             | \$10 <a href="#">copay</a> /visit; <a href="#">Deductible</a> does not apply   |   | 30% <a href="#">coinsurance</a>                                 | None  |



All [copayment](#) and [coinsurance](#) costs shown in this chart are after your [deductible](#) has been met, if a [deductible](#) applies. Except for [Emergency room care](#) and [Specialist](#) visits, no [copayment](#) or [coinsurance](#) applies for services by an EHP Select Pediatric provider.

| 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)   |  |
| health, or substance use disorder services                     | Outpatient professional fees              | \$10 <a href="#">copay</a> /visit; <a href="#">Deductible</a> does not apply   |   | 30% <a href="#">coinsurance</a>  | None   |
|  | Inpatient facility charges                | \$150 <a href="#">copay</a> and 10% <a href="#">coinsurance</a>  | \$150 <a href="#">copay</a> and 20% <a href="#">coinsurance</a>                     | \$500 <a href="#">copay</a> and 30% <a href="#">coinsurance</a>                                | <a href="#">Preauthorization</a> required, or not covered.   |
|  | Inpatient professional fees               | 10% <a href="#">coinsurance</a>  | 20% <a href="#">coinsurance</a>   | 30% <a href="#">coinsurance</a>  | None   |
| If you are pregnant  | Office visits                             | No charge for routine; Otherwise 10% <a href="#">coinsurance</a>   | No charge for routine; Otherwise 20% <a href="#">coinsurance</a>                    | 30% <a href="#">coinsurance</a>  | None   |
|  | Childbirth/delivery professional fees     | 10% <a href="#">coinsurance</a>  | 20% <a href="#">coinsurance</a>   | 30% <a href="#">coinsurance</a>  | None   |
|  | Childbirth/delivery facility charges      | \$150 <a href="#">copay</a> and 10% <a href="#">coinsurance</a>  | \$150 <a href="#">copay</a> and 20% <a href="#">coinsurance</a>                     | \$500 <a href="#">copay</a> and 30% <a href="#">coinsurance</a>                                | <a href="#">Preauthorization</a> 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 | <a href="#">Home health care</a>          | 10% <a href="#">coinsurance</a>  |   | 30% <a href="#">coinsurance</a>  | limit 180 visits per year  |
|  | <a href="#">Rehabilitation services</a>   | 10% <a href="#">coinsurance</a>  | 20% <a href="#">coinsurance</a>   | 30% <a href="#">coinsurance</a>  | None   |
|  | <a href="#">Habilitation services</a>     | 10% <a href="#">coinsurance</a>  | 20% <a href="#">coinsurance</a>   | 30% <a href="#">coinsurance</a>  | Under age 19 only  |
|  | <a href="#">Skilled nursing care</a>      | 10% <a href="#">coinsurance</a>  | 10% <a href="#">coinsurance</a> first 30 days, then 20% <a href="#">coinsurance</a> | 30% <a href="#">coinsurance</a>  | <a href="#">Preauthorization</a> required or not covered; limit 120 days per year.   |
|  | <a href="#">Durable medical equipment</a> | 10% <a href="#">coinsurance</a>  | 20% <a href="#">coinsurance</a>   | 30% <a href="#">coinsurance</a>  | <a href="#">Preauthorization</a> required for custom equipment or not covered.   |
|  | <a href="#">Hospice services</a>          | No charge, after <a href="#">Deductible</a>  |   | 30% <a href="#">coinsurance</a>  | None   |
| If your child needs dental or eye care                         | Children's eye exam                       | No charge  |   | Benefit up to: \$52 optometrist \$60 ophthalmologist   | Once every calendar year; must elect Vision Plan coverage for child.   |
|  | Children's glasses                        | \$175 allowance for frames after \$10 <a href="#">copay</a><br>Lenses covered in full after \$10 <a href="#">copay</a> |   | Up to \$112 benefit for frames after \$10 <a href="#">copay</a><br>Lenses covered per schedule | Once every calendar year; must elect Vision Plan coverage for child.   |



All [copayment](#) and [coinsurance](#) costs shown in this chart are after your [deductible](#) has been met, if a [deductible](#) applies. Except for [Emergency room care](#) and [Specialist](#) visits, no [copayment](#) or [coinsurance](#) applies for services by an EHP Select Pediatric provider.

| Common Medical Event | Services You May Need      | What You Will Pay                             |  |   | Limitations, Exceptions, & Other Important Information            |
|----------------------|----------------------------|---|--|---|---|
|                      |                            | EHP Preferred Provider<br>(You pay the least) | EHP Network Provider<br>(You pay more) | Out-of-Network Provider<br>(You pay the most) |   |
|                      | Children's dental check-up | No charge                                     |  | 20% <a href="#">coinsurance</a>               | Once every six months; must elect Dental Plan coverage for child. |

**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> </ul>   | <ul style="list-style-type: none"> <li>• Emergency room care for non-emergency medical situations</li> <li>• Long term care</li> </ul>  | <ul style="list-style-type: none"> <li>• Private duty nursing</li> <li>• Routine foot care</li> <li>• Treatment that requires preauthorization, if not obtained</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 or therapeutic purposes (limit 20 visits per year)</li> <li>• Bariatric surgery, at Bayview Medical Center, Sibley Memorial Hospital or Tampa General Hospital only</li> </ul> | <ul style="list-style-type: none"> <li>• Chiropractic care, for initial exam, x-rays and spinal manipulation (limit 20 visits per year)</li> <li>• Infertility Treatment, at specified fertility centers only; \$30,000 medical, \$30,000 prescription drug and three IVF attempts lifetime limit and six AI/IUI attempts per live birth</li> </ul> | <ul style="list-style-type: none"> <li>• Hearing aids, for children under 26</li> <li>• Routine eye care (Adult)</li> <li>• Weight loss programs</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 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](http://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](#) \$300
- [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*)

|                           |                 |
|---------------------------|-----------------|
| <b>Total Example Cost</b> | <b>\$12,700</b> |
|---------------------------|-----------------|

In this example, Peg would pay:

| <i>Cost Sharing</i>               |                |
|-----------------------------------|----------------|
| Deductibles                       | \$300          |
| Copayments                        | \$211          |
| Coinsurance                       | \$1,217        |
| <i>What isn't covered</i>         |                |
| Limits or exclusions              | \$0            |
| <b>The total Peg would pay is</b> | <b>\$1,728</b> |

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

- The [plan's](#) overall [deductible](#) \$300
- [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*)

|                           |                |
|---------------------------|----------------|
| <b>Total Example Cost</b> | <b>\$5,600</b> |
|---------------------------|----------------|

In this example, Joe would pay:

| <i>Cost Sharing</i>               |                |
|-----------------------------------|----------------|
| Deductibles                       | \$300          |
| Copayments                        | \$875          |
| Coinsurance                       | \$91           |
| <i>What isn't covered</i>         |                |
| Limits or exclusions              | \$0            |
| <b>The total Joe would pay is</b> | <b>\$1,266</b> |

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

- The [plan's](#) overall [deductible](#) \$300
- [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*)

|                           |                |
|---------------------------|----------------|
| <b>Total Example Cost</b> | <b>\$2,800</b> |
|---------------------------|----------------|

In this example, Mia would pay:

| <i>Cost Sharing</i>               |              |
|-----------------------------------|--------------|
| Deductibles                       | \$300        |
| Copayments                        | \$291        |
| Coinsurance                       | \$86         |
| <i>What isn't covered</i>         |              |
| Limits or exclusions              | \$0          |
| <b>The total Mia would pay is</b> | <b>\$677</b> |

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