This is only a summary. If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document 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?	For participating providers **$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 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.
Is there an out–of–pocket limit on my expenses?	Yes. For participating providers **$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**.
Is there an overall annual limit on what the plan pays?	No.	The chart starting on page 2 describes any limits on what the plan will pay for *specific* covered services, such as office visits.
Does this plan use a network of providers?	Yes. For medical see **www.EHP.org or call 1-800-261-2393** for a list of	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 providers. For Rx see www.Express-Scripts.com	participating for **providers** in their **network**. See the chart starting on page 2 for how this plan pays different kinds of **providers**.
Do I 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.
Are there services this plan doesn't cover?	Yes.	Some of the services this plan doesn't cover are listed on page 4. See your policy or plan document for additional information about **excluded services**.

- **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.

Common Medical Event	Services You May Need	Your Cost If You Use an In-network Provider	Your Cost If You Use an Out-of-network Provider	Limitations & Exceptions
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 R&C after deductible	——————none——————
	Specialist visit	20% coinsurance	30% coinsurance of R&C after deductible	——————none——————

Common Medical Event	Services You May Need	Your Cost If You Use an In-network Provider	Your Cost If You Use an Out-of-network Provider	Limitations & Exceptions
	Other practitioner office visit	20 % coinsurance for chiropractor and acupuncture	30% coinsurance of R&C for chiropractor and acupuncture	-Medically necessary acupuncture only -Acupuncture $1,000 annual max -Chiropractic care restricted to initial exam, X-rays, & spinal manipulations
	Preventive care/screening/immunization	No charge	30% coinsurance of R&C after deductible	
If you have a test	Diagnostic test (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 prescription are covered through Express Scripts (ESI) More information about **prescription drug coverage through ESI** is available at www.Express-Scripts.com	Generic drugs	$10 copay/ prescription at retail $25 copay/prescription for mail-order		Prescription drug costs accumulate towards a separate out-of-pocket maximum. For participating providers **$2,000 person / $6,000 family** For non-participating providers **$4,000 person / $12,000 family** Covers up to a 30-day supply (retail prescription); 31-90 day supply (mail order prescription)
	Preferred brand drugs	20% coinsurance with $30 min and $45 max/ prescription at retail $75 copay/prescription for mail-order		
	Non-preferred brand drugs	25% coinsurance with $60 min and $100 max/ prescription at retail $150 copay/ prescription for mail-order		
	Specialty drugs	Same as non-specialty drug coverage reflected above there cost is dependent on tier of drug coverage (i.e. generic, preferred-brand, non-preferred brand, etc.)		

Common Medical Event	Services You May Need	Your Cost If You Use an In-network Provider	Your Cost If You Use an Out-of-network Provider	Limitations & Exceptions
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance	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
If you need immediate medical attention	Emergency room services	Facility: $100 copay Physical: 20% coinsurance of R&C after deductible	Facility: $100 copay Physical: 20% coinsurance of R&C after deductible	-Co-pay waived if admitted -For non-participating physician services failure to obtain pre-certification may result in a penalty or possible denial of benefits
	Emergency medical transportation	30% coinsurance of R&C after deductible	30% coinsurance of R&C after deductible	——————none————
	Urgent care	$50 co-pay (deductible waived)	$50 co-pay (deductible waived)	——————none—————

Common Medical Event	Services You May Need	Your Cost If You Use an In-network Provider	Your Cost If You Use an Out-of-network Provider	Limitations & Exceptions
If you have a hospital stay	Facility fee (e.g., hospital room)	$250 co-pay per hospital admission then 20% coinsurance after deductible	$250 co-pay 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 fee	20% coinsurance after deductible	30% of R&C coinsurance after deductible	——————none——————
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	20% coinsurance	30% coinsurance of R&C after deductible	——————none——————
	Mental/Behavioral health inpatient services	$250 co-pay per hospital admission then 20% coinsurance after deductible	$250 co-pay 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
	Substance use disorder outpatient services	20% coinsurance	30% coinsurance of R&C after deductible	——————none——————
	Substance use disorder inpatient services	$250 co-pay per hospital admission then 20% coinsurance after deductible	$250 co-pay 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
If you are pregnant	Prenatal and postnatal care	20% coinsurance	30% coinsurance of R&C after deductible	——————none——————

Common Medical Event	Services You May Need	Your Cost If You Use an In-network Provider	Your Cost If You Use an Out-of-network Provider	Limitations & Exceptions
	Delivery and all inpatient services	$250 co-pay per hospital admission then 20% coinsurance after deductible	$250 co-pay 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
If you need help recovering or have other special health needs	Home health care	No charge	30% of R&C coinsurance after deductible	-Medically necessary services only coordinated by clinical case managers -90 visits per year maximum
	Rehabilitation services	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
	Habilitation services	20% coinsurance	30% of R&C coinsurance after deductible	——————none——————
	Skilled nursing care	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
	Durable medical equipment	20% coinsurance	30% of R&C coinsurance after deductible	No limitations EXCEPT for medically necessary hearing aids for dependent covered children up to $1400 per aid.
	Hospice service	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
If your child needs dental or eye care	Eye exam	No charge	Not covered	Limited to one exam every two years
	Glasses	Not Covered	Not Covered	None
	Dental check-up	Not Covered	Not Covered	None

Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover (This isn't a complete list. Check your policy or plan document for other excluded services.)

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

Other Covered Services (This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)

- Acupuncture (if prescribed for rehabilitation purposes; medically necessary acupuncture only with a $1,000 annual max)
- 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
- 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
- Most coverage provided outside the State of Maryland. See 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)
- Speech therapy (Limited to 30 visits per year)

Your Rights to Continue Coverage:

If you lose coverage under the plan, then, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a **premium**, which may be significantly higher than the premium you pay while covered under the plan. Other limitations on your rights to continue coverage may also apply.

For more information on your rights to continue coverage, contact the plan at [contact number]. You may also contact your state insurance department, the 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.

Your Grievance and Appeals Rights:

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to **appeal** or file a **grievance**. For questions about your rights, this notice, or assistance, you can 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

Does this Coverage Provide Minimum Essential Coverage?

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 Coverage Meet the Minimum Value Standard?

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 page.

About these Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.

This is not a cost estimator.

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care will also be different.

See the next page for important information about these examples.

Having a baby
(normal delivery)

- **Amount owed to providers:** $7,540
- **Plan pays** $5,520
- **Patient pays** $2,020

Sample care costs:

Hospital charges (mother)	$2,700
Routine obstetric care	$2,100
Hospital charges (baby)	$900
Anesthesia	$900
Laboratory tests	$500
Prescriptions	$200
Radiology	$200
Vaccines, other preventive	$40
Total	**$7,540**

Patient pays:

Deductibles	$500
Copays	$20
Coinsurance	$1,350
Limits or exclusions	$150
Total	**$2,020**

Managing type 2 diabetes
(routine maintenance of a well-controlled condition)

- **Amount owed to providers:** $5,400
- **Plan pays** $4,240
- **Patient pays** $1,160

Sample care costs:

Prescriptions	$2,900
Medical Equipment and Supplies	$1,300
Office Visits and Procedures	$700
Education	$300
Laboratory tests	$100
Vaccines, other preventive	$100
Total	**$5,400**

Patient pays:

Deductibles	$250
Copays	$400
Coinsurance	$430
Limits or exclusions	$80
Total	**$1,160**

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.