Johns Hopkins Student Health Program

Coverage Period: 07/01/2016 – 06/30/2017

Summary of Benefits and Coverage: What this Plan Covers & What it Costs **Coverage for: Individual and Family** | **Plan Type: PPO**

This is only a summary. If you want more detail about your coverage and costs, you can get the complete terms in the Summary Plan Description available at http://www.hopkinsmedicine.org/som/StudentInsurance/SHPSPD2014final.pdf or by calling 410-614-3301.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	$100 person/$300 family; not applicable to preventive care or prescription drugs; excludes charges above **allowed amount**	You must pay all the costs up to the **deductible** amount before this plan begins to pay for covered services you use. Check your Summary Plan Description 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?	Yes. $50 individual/$150 family for pediatric dental care. 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. $3,000 individual/$9,000 family for expenses other than drug copays; $3,350 individual/ $3,700 family for drug copays	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?	Penalties, charges above plan maximums, premiums, balance billed charges, and health care this plan doesn't cover	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. See www.ehp.org or call 1-800-261-2393 for a list of In-Network providers	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 I need a referral to see a specialist?	No	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 5. See your Summary Plan Description for additional information about **excluded services**.

Questions: Call 1-800-261-2393 or visit us at www.ehp.org. If you aren't clear about any of the bolded terms used in this form, see the Glossary. You can view the Glossary at www.dol.gov/ebsa/healthreform or call 1-800-261-2393 to request a copy.

- **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 In-Network **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	none
	Specialist visit	10% coinsurance	30% coinsurance	none
	Other practitioner office visit	20% coinsurance for acupuncture and chiropractor	30% coinsurance acupuncture 20% coinsurance chiropractor	Acupuncture: $300 plan year maximum, not covered unless preauthorized Chiropractor: 20 visits per condition per plan year maximum, limited to specific visit purposes
	Preventive care/screening/immunization	No charge	30% coinsurance; 10% coinsurance for mammograms and well-child care	No deductible In-Network
If you have a test	Diagnostic test (x-ray, blood work)	10% coinsurance	30% coinsurance	none
	Imaging (CT/PET scans, MRIs)	10% coinsurance	30% coinsurance	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 need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.ehp.org	Generic drugs	$10 co-pay 30 days $20 co-pay 90 days by mail $30 co-pay 90 days at retail	$10 co-pay 30 days, $30 co-pay 90 days, plus all charges above network pharmacy price	Preauthorization may be required for some drugs, generic and brand, or not covered.
	Preferred brand drugs	$20 co-pay 30 days $40 co-pay 90 days by mail $60 co-pay 90 days at retail	$20 co-pay 30 days, $60 co-pay 90 days, plus all charges above network pharmacy price	
	Non-preferred brand drugs	$35 co-pay 30 days $70 co-pay 90 days by mail $105 co-pay 90 days at retail	$35 co-pay 30 days, $105 co-pay 90 days, plus all charges above network pharmacy price	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	10% coinsurance	10% coinsurance	Not covered unless preauthorized
	Physician/surgeon fees	20% coinsurance	30% coinsurance	Not covered unless preauthorized
If you need immediate medical attention	Emergency room services	No charge within 72 hours of onset 20% coinsurance thereafter	No charge within 72 hours of onset 20% coinsurance thereafter	Not covered unless emergency medical situation
	Emergency medical transportation	20% coinsurance	20% coinsurance	none
	Urgent care	No charge (after deductible)	20% coinsurance	none
If you have a hospital stay	Facility fee (e.g., hospital room)	No charge (after deductible) first 30 days, then 20% coinsurance	No charge (after deductible) first 30 day, then 20% coinsurance	Not covered unless preauthorized
	Physician/surgeon fees	20% coinsurance	30% coinsurance	Not covered unless preauthorized

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 mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	10% coinsurance	10% coinsurance	none
	Mental/Behavioral health inpatient services	No charge (after deductible) first 30 days, then 20% coinsurance	No charge (after deductible) first 30 days, then 20% coinsurance	Not covered unless preauthorized
	Substance use disorder outpatient services	10% coinsurance for facility charges No charge for professional fees	10% coinsurance for facility charges 20% coinsurance for professional fees	none
	Substance use disorder inpatient services	No charge (after deductible) first 30 days, then 20% coinsurance	No charge (after deductible) first 30 days, then 20% coinsurance	Not covered unless preauthorized
If you are pregnant	Prenatal and postnatal care	10% coinsurance	30% coinsurance	none
	Delivery and all inpatient services	10% coinsurance	30% coinsurance	Stays longer than 48 hours (normal delivery) or 96 hours (caesarean) not covered unless preauthorized

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 need help recovering or have other special health needs	Home health care	No charge (after deductible) first 90 visits per year, then 20% coinsurance	10% coinsurance first 90 visits per year, then 20% coinsurance	Not covered unless preauthorized
	Rehabilitation services	20% coinsurance	20% coinsurance	Speech therapy not covered unless preauthorized
	Habilitation services	20% coinsurance	20% coinsurance	Not covered unless preauthorized
	Skilled nursing care	No charge (after deductible) first 30 days, then 20% coinsurance	No charge (after deductible) first 30 days, then 20% coinsurance	Not covered unless preauthorized
	Durable medical equipment	20% coinsurance	20% coinsurance	Not covered unless preauthorized
	Hospice service	No charge	No charge	Not covered unless preauthorized
If your child needs dental or eye care	Eye exam	No charge	Charges above $30	Only covered once every 12 months
	Glasses	No charge	Charges above $25	Only covered once every 12 months
	Dental check-up	20% coinsurance	20% coinsurance	Only covered once every 6 months

Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover (This isn't a complete list. Check your Summary Plan Description for other excluded services.)

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

Other Covered Services **(This isn't a complete list. Check your Summary Plan Description for other covered services and your costs for these services.)**

- Acupuncture, for anesthesia, pain control and therapeutic purposes only, $300 plan year maximum
- Bariatric surgery , at JHHSC institutions only
- Chiropractic care for initial exam, x-rays and spinal manipulation only, 20 visits per condition per plan year maximum
- Hearing aids, for children under 26; replacements only once every three years
- Infertility treatment, limited to artificial insemination and intrauterine insemination
- Non-emergency care when travelling outside the U.S.

Your Rights to Continue Coverage:

If you lose regular coverage under the plan, you may be eligible to elect to continue plan coverage under COBRA. You will be provided with a COBRA election package if you are eligible to elect continued coverage. You must make your COBRA continued coverage election within the time period shown in the election package. If you elect COBRA continued coverage, you must pay a **premium**, which may be significantly higher than the premium you pay for regular coverage under the plan. Other limitations on your rights to continue coverage under COBRA may also apply.

For more information on your rights to continue coverage, contact the plan at 1-800-261-2393. You may also contact the U.S. Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/health reform.

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: Employer Health Programs, 1-800-261-2393 or www.ehp.org, or the Department of Labor, Employee Benefits Security Administration, at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform.

Additionally, a consumer assistance program can help you file your appeal. Contact:
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 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.**

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** $6,580
- **Patient pays** $960

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	$200
Copays	$90
Coinsurance	$670
Limits or exclusions	$0
Total	**$960**

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

- **Amount owed to providers:** $5,400
- **Plan pays** $4,710
- **Patient pays** $690

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	$100
Copays	$240
Coinsurance	$350
Limits or exclusions	$0
Total	**$690**

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.