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

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 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
	Preventive care/screening/ immunization	No charge; deductible does not apply	30% coinsurance; 10% coinsurance for mammograms and well-child care	You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for.
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	
If you need drugs to treat your illness or condition **More information about prescription drug coverage is available at www.ehp.org**	Generic drugs	$15 copayment 30 days; $30 copayment 90 days by mail; $45 copayment 90 days at retail;	$15 copayment 30 days; $45 copayment 90 days, plus all charges above network pharmacy price	Deductible does not apply. Preauthorization may be required for some drugs, or not covered
	Preferred brand drugs	$25 copayment 30 days; $50 copayment 90 days by mail; $75 copayment 90 days at retail	$25 copayment 30 days; $75 copayment 90 days, plus all charges above network pharmacy price	
	Non-preferred brand drugs (including specialty drugs)	$40 copayment 30 days; $80 copayment 90 days by mail; $120 copayment 90 days at retail	$40 copayment 30 days; $120 copayment 90 days, plus all charges above network pharmacy price	

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

If you need help recovering or have other special health needs	Home health care	No charge first 90 visits per year, then 20% coinsurance	10% coinsurance first 90 visits per year, then 20% coinsurance	Preauthorization required or not covered.
	Rehabilitation services	20% coinsurance	20% coinsurance	Preauthorization required for speech therapy or not covered.
	Habilitation services	20% coinsurance	20% coinsurance	Preauthorization required or not covered; under age 19 only.
	Skilled nursing care	10% coinsurance	10% coinsurance	Preauthorization required or not covered.
	Durable medical equipment	20% coinsurance	20% coinsurance	Preauthorization required for custom made equipment and supplies, or not covered.
	Hospice services	No charge	No charge (up to allowed amount)	Preauthorization required or not covered.
If your child needs dental or eye care	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 Plan Generally Does NOT Cover (Check your Summary Plan Description for more information and a list of any other excluded services.)

- Cosmetic Surgery
- Dental Care (Adult)
- Long Term Care
- Emergency room care for non-emergency medical conditions
- Private Duty Nursing
- Routine Eye Care (Adult)
- Routine Foot Care
- Weight Loss Programs

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your Summary Plan Description.)

- Acupuncture, for anesthesia, pain control and therapeutic purposes only ($300 plan year maximum)
- Bariatric Surgery
- Chiropractic Care, for initial exam, x-rays and spinal manipulation only
- Hearing Aids (replacements only once every three years)
- Infertility Treatment (In-Network only; separate coinsurance; deductible and lifetime maximum benefits apply)
- Non-emergency care when travelling outside the U.S.

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. 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 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. 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.

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:

Cost Sharing	
Deductibles	$150
Copayments	$40
Coinsurance	$100
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$350**

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:

Cost Sharing	
Deductibles	$150
Copayments	$500
Coinsurance	$400
What isn't covered	
Limits or exclusions	$60
The total Joe would pay is	**$1,110**

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:

Cost Sharing	
Deductibles	$150
Copayments	$50
Coinsurance	$200
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$400**

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