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 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) or call 1-800-261-2393 for a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible for the Lower Pay Tier?	$0 EHP Select Pediatric provider; $150/person, $300/family in-network; $750/person, $1,500/ family out-of-network; excludes charges above allowed amount.	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 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. $1,000 lifetime deductible for infertility 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 the Lower Pay Tier?	**Medical:** $1,500/person, $3,000/family in-network; $3,500/person, $7,000/family out-of-network. **Prescription drugs:** $3,600/person, $7,200/family.	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.	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 usually pay the least if you use an EHP Select Pediatric or EHP Preferred Network Provider. You usually pay more if you use an EHP Network Provider. You will always 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. 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)	
If you visit a health care provider's office or clinic	Direct Primary Care visit to treat an injury or illness	No charge; Deductible 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 copay; Deductible does not apply		30% coinsurance	Covered for dependents only; Not covered if Direct Primary Care is designated PCP
	Specialist visit	10% coinsurance	20% coinsurance	30% coinsurance	None
	Preventive care/screening/ immunization	No charge; Deductible does not apply		30% coinsurance	You may have to pay for services that aren't preventive. Ask your provider if the services you need are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	10% coinsurance	20% coinsurance	30% coinsurance	None
	Imaging (CT/PET scans, MRIs)	10% coinsurance	20% coinsurance	30% coinsurance	None

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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)	
If you need drugs to treat your illness or condition **More information about prescription drug coverage is available at www.ehp.org**	Generic drugs	Up to $10 copay 30 day supply Up to $20 copay 90 day supply by mail Up to $30 copay 90 day supply at pharmacy		Not covered	Preauthorization may be required for some drugs, or not covered. No charge for generic oral contraceptives. If you buy brand when generic available, must also pay cost difference.
	Preferred brand drugs	$40 copay 30 day supply $80 copay 90 day supply by mail $120 copay 90 day supply at pharmacy		Not covered	
	Non-preferred brand drugs	$65 copay 30 day supply $130 copay 90 day supply by mail $195 copay 90 day supply at pharmacy		Not covered	
	Specialty drugs **not** covered by PrudentRx Program	$40 copay brand preferred $65 copay brand non-preferred		Not covered	Specialty drugs limited to 30 day supply only
	Specialty drugs **covered** by PrudentRx Program	$0 copay when obtained through PrudentRx Program 30% coinsurance if not obtained through PrudentRx Program		Not covered	Specialty drugs covered by PrudentRx Program only covered at Johns Hopkins Outpatient Pharmacies and CVS Specialty Pharmacy
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	5% coinsurance	15% coinsurance	30% coinsurance	None
	Physician/surgeon fees	5% coinsurance	15% coinsurance	30% coinsurance	
If you need immediate medical attention	Emergency room care	$250 copay, waived if admitted			Not covered unless emergency medical situation
	Emergency medical transportation	No charge		No charge (up to allowed amount)	Air transportation not covered unless medically necessary
	Urgent care	$25 copay; Deductible does not apply		30% coinsurance	None
If you have a hospital stay	Facility charges (e.g., hospital room)	$150 copay and 10% coinsurance	$150 copay and 20% coinsurance	$500 copay and 30% coinsurance	Preauthorization required, or not covered.
	Physician/surgeon fees	10% coinsurance	20% coinsurance	30% coinsurance	Preauthorization required for surgery, or not covered.
If you need mental health, behavioral	Outpatient facility charges	$10 copay/visit; Deductible does not apply		30% coinsurance	None

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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 copay/visit; Deductible does not apply		30% coinsurance	None
	Inpatient facility charges	$150 copay and 10% coinsurance	$150 copay and 20% coinsurance	$500 copay and 30% coinsurance	Preauthorization required, or not covered.
	Inpatient professional fees	10% coinsurance	20% coinsurance	30% coinsurance	None
If you are pregnant	Office visits	No charge for routine; Otherwise 10% coinsurance	No charge for routine; Otherwise 20% coinsurance	30% coinsurance	None
	Childbirth/delivery professional fees	10% coinsurance	20% coinsurance	30% coinsurance	None
	Childbirth/delivery facility charges	$150 copay and 10% coinsurance	$150 copay and 20% coinsurance	$500 copay and 30% coinsurance	Preauthorization 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	Home health care	10% coinsurance		30% coinsurance	limit 180 visits per year
	Rehabilitation services	10% coinsurance	20% coinsurance	30% coinsurance	None
	Habilitation services	10% coinsurance	20% coinsurance	30% coinsurance	Under age 19 only
	Skilled nursing care	10% coinsurance	10% coinsurance first 30 days, then 20% coinsurance	30% coinsurance	Preauthorization required or not covered; limit 120 days per year.
	Durable medical equipment	10% coinsurance	20% coinsurance	30% coinsurance	Preauthorization required for custom equipment or not covered.
	Hospice services	No charge, after Deductible		30% coinsurance	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 copay Lenses covered in full after $10 copay		Up to $112 benefit for frames after $10 copay 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 (You pay the least)	EHP Network Provider (You pay more)	Out-of-Network Provider (You pay the most)	
	Children's dental check-up	No charge		20% coinsurance	Once every six months; must elect Dental Plan coverage for child.

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)
- Emergency room care for non-emergency medical situations
- Long term care
- Private duty nursing
- Routine foot care
- Treatment that requires preauthorization, if not obtained

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 or therapeutic purposes (limit 20 visits per year)
- Bariatric surgery, at Bayview Medical Center, Sibley Memorial Hospital or Tampa General Hospital only
- Chiropractic care, for initial exam, x-rays and spinal manipulation (limit 20 visits per year)
- 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
- Hearing aids, for children under 26
- Routine eye care (Adult)
- Weight loss programs

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 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.

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*)

Total Example Cost	**$12,700**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$150
Copayments	$211
Coinsurance	$1,232
What isn't covered	
Limits or exclusions	$0
The total Peg would pay is	**$1,593**

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*)

Total Example Cost	**$5,600**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$150
Copayments	$875
Coinsurance	$86
What isn't covered	
Limits or exclusions	$0
The total Joe would pay is	**$1,111**

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*)

Total Example Cost	**$2,800**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$150
Copayments	$291
Coinsurance	$86
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$527**

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