

Medical Schedule of Benefits (Effective January 01, 2018)  
Sibley Memorial Hospital Employees and Eligible Dependents



		EHP Network Provider	Out of Network Provider	Hopkins Affiliated Facility Network (facility charges only)
Plan Year Deductible	Individual	\$100	\$750	\$0
	Family	\$200	\$1500	\$0
Out-of-Pocket Maximum	Individual	\$2000	\$3500	Included in EHP Network Provider Medical maximum
	Family	\$4000	\$7000	Included in EHP Network Provider Medical maximum
Lifetime Maximum			Unlimited	

Services & Supplies (In Alphabetical Order)		EHP Network Provider	Out of Network Provider	Hopkins Affiliated Facility Network (facility charges only)	
Acupuncture	Medically necessary services for anesthesia, pain control, and therapeutic purposes	\$40 co-pay, then 90% of allowed amount (20 visits per year maximum, all networks combined)	70% of allowed benefit; deductible applies (20 visits per year maximum, all networks combined)	Refer to EHP Network Provider Benefit	
Allergy Tests & Procedures	Allergy tests	80% of allowed amount; deductible applies	70% of allowed benefit; deductible applies	Not Available	
	Desensitization materials and serum	80% of allowed amount; deductible applies	70% of allowed benefit; deductible applies	Not Available	
Ambulance Transportation	Medically necessary transport	100% of allowed amount; deductible applies	100% of allowed benefit; deductible applies	Not Available	
Biofeedback	Biofeedback	80% of allowed amount; deductible applies (pre-authorization required)	70% of allowed benefit; deductible applies (pre-authorization required)	90% of allowed amount (pre-authorization required)	
Chemo & Radiation Therapy	Physician visit	\$40 co-pay for office visit, then 80% of allowed amount; deductible applies	70% of allowed benefit; deductible applies	Refer to EHP Network Provider Benefit	
	Materials and treatment	80% of allowed amount; deductible applies	70% of allowed benefit; deductible applies	90% of allowed amount	
Chiropractic Care	Chiropractor restricted to initial exam, x-rays, and spinal manipulations	\$40 co-pay, then 90% of allowed amount (20 visits per year maximum for all networks combined; must be 12 years of age)	70% of allowed benefit; deductible applies (20 visits per year maximum for all networks combined; must be 12 years of age)	Refer to EHP Network Provider Benefit	
	Chiropractor with PT privileges (physical therapy services)	Refer to Therapy section	Refer to Therapy section	Refer to Therapy Section	
Dialysis	Medically necessary services	80% of allowed amount; deductible applies	70% of allowed benefit; deductible applies	90% of allowed amount	
Durable Medical Equipment	Breast pumps (standard) and related supplies	100% of allowed amount; deductible waived	70% of allowed benefit; deductible applies (pre-authorization required)	100% of allowed amount for Johns Hopkins Home Care Group/Pharmaquip	
	Contraceptive devices	100% of allowed amount; deductible waived	70% of allowed benefit; deductible applies	Not Available	
	Custom DME, including custom wheelchairs	80% of allowed amount; deductible applies	70% of allowed benefit; deductible applies	Not Available	
	Custom-molded orthotics	80% of allowed amount; deductible applies (pre-authorization required)	70% of allowed benefit; deductible applies (pre-authorization required)	Not Available	
	Insulin pumps, Continuous Glucose Monitor and related supplies	80% of allowed amount; deductible applies	70% of allowed benefit; deductible applies	Not Available	
	Hearing aids	\$40 co-pay, then 90% of allowed amount (for dependent children up to age 26; pre-authorization required) replacement aids once every 36 months all networks combined	70% of allowed benefit; deductible applies (for dependent children up to age 26; pre-authorization required) replacement aids once every 36 months all networks combined	Not Available	Not Available
	Non-custom medical equipment and supplies	80% of allowed amount; deductible applies	70% of allowed benefit; deductible applies	90% of allowed amount for Johns Hopkins Home Care Group/Pharmaquip	
Prosthetic devices	80% of allowed amount; deductible applies (pre-authorization required)	70% of allowed benefit; deductible applies (pre-authorization required)	Not Available		

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Emergency Services	Emergency care (facility fees)	\$250 co-pay, then 100% of allowed amount; deductible waived (if admitted, ER co-pay waived); see Inpatient Facility Care for coverage	\$250 co-pay, then 100% of allowed benefit; deductible waived (if admitted, ER co-pay waived); see Inpatient Facility Care for coverage	\$250 co-pay, then 100% of allowed amount; deductible waived (if admitted, ER co-pay waived); see Inpatient Facility Care for coverage
	Emergency care (professional fees)	100% of allowed amount; deductible waived (if admitted, ER co-pay waived); see Inpatient Care for coverage	100% of allowed amount; deductible waived (if admitted, ER co-pay waived); see Inpatient Care for coverage	100% of allowed amount; (if admitted, ER co-pay waived); see Inpatient Care for coverage
Home Health Services	Medically necessary services	80% of allowed amount; deductible applies (40 visits per year maximum for all networks combined; pre-authorization required)	70% of allowed benefit; deductible applies (40 visits per year maximum for all networks combined; pre-authorization required)	Refer to EHP Network Provider Benefit
	Home infusion therapy	80% of allowed amount; deductible applies (pre-authorization required)	70% of allowed benefit; deductible applies (pre-authorization required)	90% of allowed amount for services through Johns Hopkins Home Care Group (pre-authorization required)
Hospice Care	Inpatient and home hospice	80% of allowed amount; deductible applies (pre-authorization required)	70% of allowed benefit; deductible applies (pre-authorization required)	Refer to EHP Network Provider Benefit
Hospital Care	Inpatient care including newborn nursery care; NICU (facility fees)	\$300 co-pay per admission, then 80% of allowed amount; deductible waived (pre-authorization required)	\$500 co-pay per admission, then 70% of allowed benefit; deductible applies (pre-authorization required)	\$300 co-pay per admission, then 90% of allowed amount (pre-authorization required)
	Inpatient care (professional fees)	80% of allowed amount; deductible applies	70% of allowed benefit; deductible applies	Refer to EHP Network Provider Benefit
	Skilled nursing/rehabilitation facility	80% of allowed amount; deductible applies (120 days per year maximum for all networks combined; pre-authorization required)	70% of allowed benefit; deductible applies (120 days per year maximum for all networks combined; pre-authorization required)	90% of allowed amount (120 days per year maximum for all networks combined; pre-authorization required)
	Short-term acute rehabilitation	80% of allowed amount; deductible applies (120 days per year maximum for all networks combined; pre-authorization required)	70% of allowed benefit; deductible applies (120 days per year maximum for all networks combined; pre-authorization required)	90% of allowed amount (120 days per year maximum for all networks combined; pre-authorization required)
	Observation care (facility fees)	\$250 co-pay, then 100% of allowed amount; deductible waived (if admitted, co-pay waived; see Inpatient Facility Care for coverage)	\$250 co-pay, then 100% of allowed benefit; deductible waived (if admitted, co-pay waived; see Inpatient Facility Care for coverage)	\$250 co-pay, then 100% of allowed amount; deductible waived (if admitted, co-pay waived; see Inpatient Facility Care for coverage)
	Observation care (professional fees)	100% of allowed amount; deductible waived (if admitted, co-pay waived; see Inpatient Care for coverage)	100% of allowed benefit; deductible waived (if admitted, co-pay waived; see Inpatient Care for coverage)	100% of allowed amount (if admitted, co-pay waived; see Inpatient Care for coverage)
	Outpatient surgery & ambulatory surgical center (facility fees)	\$200 co-pay, then 90% of allowed amount; deductible applies	70% of allowed benefit; deductible applies	\$50 co-pay, then 90% of allowed amount
	Outpatient surgery & ambulatory surgical center (professional fees)	80% of allowed amount; deductible applies	70% of allowed benefit; deductible applies	Refer to EHP Network Provider Benefit
Hyperbaric Oxygen Therapy	Medically necessary services	\$40 co-pay, then 90% of allowed amount (pre-authorization required)	70% of allowed benefit; deductible applies (pre-authorization required)	90% of allowed amount (pre-authorization required)
Immunizations	Preventive immunizations for communicable diseases	100% of allowed amount; deductible waived	70% of allowed benefit; deductible applies	100% of allowed amount
	Travel immunizations	100% of allowed amount; deductible waived	70% of allowed benefit; deductible applies	100% of allowed amount
Infusion Therapy	Home infusion therapy	80% of allowed amount; deductible applies (pre-authorization required)	70% of allowed benefit; deductible applies (pre-authorization required)	90% of allowed amount for Johns Hopkins Home Care Group/Pharmaquip (pre-authorization required)
	Outpatient infusion therapy	80% of allowed amount; deductible applies (pre-authorization required)	70% of allowed benefit; deductible applies (pre-authorization required)	90% of allowed amount (pre-authorization required)

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Injections	Injections	80% of allowed amount; deductible applies	70% of allowed benefit; deductible applies	Refer to EHP Network Provider Benefit
	Materials and serum	80% of allowed amount; deductible applies	70% of allowed benefit; deductible applies	Refer to EHP Network Provider Benefit
Laboratory	Laboratory tests including pathology	80% of allowed amount; deductible applies	70% of allowed benefit; deductible applies	90% of allowed amount
Mental Health & Substance Abuse Services	Outpatient mental health care (facility fees)	\$15 co-pay, then 100% of allowed amount	70% of allowed benefit; deductible applies	\$15 co-pay, then 100% of allowed amount
	Outpatient mental health care (professional fees)	\$15 co-pay, then 100% of allowed amount	70% of allowed benefit; deductible applies	\$15 co-pay, then 100% of allowed amount
	Inpatient mental health care (facility fees)	\$300 co-pay per admission, then 80% of allowed amount; deductible waived (pre-authorization required)	\$500 co-pay per hospital admission, then 70% of allowed benefit; deductible applies (pre-authorization required)	\$300 co-pay per admission, then 90% of allowed amount (pre-authorization required)
	Inpatient mental health care (professional fees)	80% of allowed amount; deductible waived	70% of allowed benefit; deductible applies	90% of allowed amount
	Outpatient substance abuse care (facility fees)	\$15 co-pay, then 100% of allowed amount	70% of allowed benefit; deductible applies	\$15 co-pay, then 100% of allowed amount;
	Outpatient substance abuse care (professional fees)	\$15 co-pay, then 100% of allowed amount	70% of allowed benefit; deductible applies	\$15 co-pay, then 100% of allowed amount
	Inpatient substance abuse care (facility fees)	\$300 co-pay per admission, then 80% of allowed amount; deductible waived (pre-authorization required)	\$500 co-pay per admission, then 70% of allowed benefit; deductible applies (pre-authorization required)	\$300 co-pay per admission, then 90% of allowed amount (pre-authorization required)
	Inpatient substance abuse care (professional fees)	80% of allowed amount; deductible waived	70% of allowed benefit; deductible applies	90% of allowed amount
	Intensive outpatient program	\$15 co-pay, then 100% of allowed amount (pre-authorization required)	70% of allowed benefit; deductible applies (pre-authorization required)	\$15 co-pay, then 100% of allowed amount (pre-authorization required)
	Partial hospital facility services	\$15 co-pay, then 100% of allowed amount (pre-authorization required)	70% of allowed benefit; deductible applies (pre-authorization required)	\$15 co-pay, then 100% of allowed amount (pre-authorization required)
	Medication management	\$15 co-pay, then 100% of allowed amount	70% of allowed benefit; deductible applies	\$15 co-pay, then 100% of allowed amount
	Mental health testing and procedures	\$15 co-pay, then 100% of allowed amount (pre-authorization required)	70% of allowed benefit; deductible applies (pre-authorization required)	\$15 co-pay, then 100% of allowed amount (pre-authorization required)
Methodone Treatment	Medically necessary outpatient care	\$15 co-pay, then 100% of allowed amount (pre-authorization required)	70% of allowed benefit; deductible applies (pre-authorization required)	\$15 copay, then 100% of allowed amount. (pre-authorization required)
Nutritional Counseling	Medically necessary services	80% of allowed amount; deductible applies (limited to 3 visits per year for all networks combined)	70% of allowed benefit; deductible applies (limited to 3 visits per year for all networks combined)	\$15 co-pay, then 90% of allowed amount (limited to 3 visits per year for all networks combined)

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Office Visits for Treatment of Illness or Injury	Primary care office visit only (Adult)	\$15 co-pay, then 100% of allowed amount	70% of allowed benefit; deductible applies	Not Available
	Primary care office visit (Pediatric: age 19 and under)	\$15 co-pay, then 100% of allowed amount	70% of allowed benefit; deductible applies	Not Available
	Primary care office visit only (GYN)	\$15 co-pay, then 100% of allowed amount	70% of allowed benefit; deductible applies	Not Available
	Specialty care office visit only (Adult & Pediatric)	\$40 co-pay, then 100% of allowed amount	70% of allowed benefit; deductible applies	Not Available
	Treatment and diagnostic services in the office	100% of allowed amount; deductible applies	70% of R&C; deductible applies	90% of allowed amount
Preventive Services	Preventive exam (PCP, GYN and Well Child care)	100% of allowed amount; deductible waived	70% of allowed benefit; deductible applies	Not Available
	Diagnostic services for preventive exam	100% of allowed amount; deductible waived	70% of allowed benefit; deductible applies	100% of allowed amount
	Routine preventive screenings: mammogram, colonoscopy, PAP test, etc.	100% of allowed amount; deductible waived	70% of allowed benefit; deductible applies	100% of allowed amount
	Routine hearing exams	100% of allowed amount; deductible waived	70% of allowed benefit; deductible applies	100% of allowed amount
Private Duty Nursing	Private Duty Nursing	Not Covered	Not Covered	Not Covered
Radiology Procedures	Advance imaging including MRI, CT and PET scans	90% of allowed amount; deductible applies	70% of allowed benefit; deductible applies	90% of allowed amount
	All other imaging studies; including X-Ray and Ultrasound	90% of allowed amount; deductible applies	70% of allowed benefit; deductible applies	90% of allowed amount

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Reproductive Health	Physician office visits (prenatal care only)	\$40 co-pay, then 90% of allowed amount	70% of allowed benefit; deductible applies	Refer to EHP Network Provider Benefit
	Infertility treatment	Invitro Fertilization not covered. Artificial Insemination covered at 50% of allowed amount up to annual maximum; deductible applies (pre-authorization required for all services and prescriptions; all criteria must be met; \$10,000 ANNUAL MAXIMUM COMBINED INCLUDING PRESCRIPTION DRUGS, LAB WORK AND X-RAYS;	Not Covered	Invitro Fertilization not covered. Artificial Insemination covered at 50% of allowed amount up to annual maximum; deductible applies (pre-authorization required for all services and prescriptions; all criteria must be met; \$10,000 ANNUAL MAXIMUM COMBINED INCLUDING PRESCRIPTION DRUGS, LAB WORK AND X-RAYS;
	Birthing centers (facility fees)	\$150 co-pay, then 90% of allowed amount	70% of R&C; deductible applies	Not Available
	Birthing centers (professional fees)	80% of allowed amount; deductible applies	70% of allowed benefit; deductible applies	Not Available
	Inpatient maternity care and delivery; newborn nursery care; NICU (facility fees)	\$300 co-pay per admission, then 90% of allowed amount; deductible waived (pre-authorization required)	\$500 co-pay per admission, then 70% of allowed benefit; deductible applies (pre-authorization required)	\$300 co-pay per admission, then 90% of allowed amount (pre-authorization required)
	Inpatient maternity care and delivery; newborn nursery care; NICU (professional fees)	80% of allowed amount ; deductible applies	70% of allowed benefit; deductible applies	Refer to EHP Network Provider Benefit
	Interruption of pregnancy	\$150 co-pay, then 90% of allowed amount	70% of allowed benefit; deductible applies	90% of allowed amount
	Female sterilization (professional services for surgery, anesthesia and related pathology)	100% of allowed amount; deductible waived	70% of allowed benefit; deductible applies	100% of allowed amount
Surgical Procedures	Male sterilization (professional services for surgery, anesthesia and related pathology)	100% of allowed amount; deductible waived	70% of allowed benefit; deductible applies	100% of allowed amount
	Surgical treatment for morbid obesity	Covered at Sibley Memorial Hospital & Johns Hopkins Bayview Medical Center only (pre-authorization required)	Covered at Sibley Memorial Hospital & Johns Hopkins Bayview Medical Center only (pre-authorization required)	Covered at Sibley Memorial Hospital & Johns Hopkins Bayview Medical Center only (pre-authorization required) 100% after \$150 copay
	Primary care office surgical procedures	90% of allowed amount; deductible applies	70% of allowed benefit; deductible applies	Refer to EHP Network Provider Benefit
	Specialist care office surgical procedures	90% of allowed amount; deductible applies	70% of allowed benefit; deductible applies	Refer to EHP Network Provider Benefit
	Outpatient surgery (including freestanding surgical centers) (facility fees)	\$200 co-pay, then 90% of allowed amount; deductible applies	70% of allowed benefit; deductible applies	\$50 co-pay, then 90% of allowed amount
	Outpatient surgery (including freestanding surgical centers) (professional fees)	80% of allowed amount; deductible applies	70% of allowed benefit; deductible applies	Refer to EHP Network Provider Benefit
	Inpatient surgery (facility fees)	\$300 co-pay per admission, then 80% of allowed amount (pre-authorization required)	\$500 co-pay per admission, then 70% of allowed benefit; deductible applies (pre-authorization required)	\$300 co-pay per admission, then 90% of allowed amount (pre-authorization required)
Inpatient surgery (professional fees)	80% of allowed amount; deductible applies	70% of allowed benefit; deductible applies	Refer to EHP Network Provider Benefit	

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Therapy	Habilitative services for children under the age of 19	80% of allowed amount; deductible applies (pre-authorization required)	70% of allowed benefit; deductible applies (pre-authorization required)	\$10 co-pay, then 90% of allowed amount (pre-authorization required)
	Physical therapy/occupational therapy medically necessary services	80% of allowed amount; deductible applies (60 visits per year maximum for all networks combined; PT/OT pre-authorization required for visits 13-60)	70% of allowed benefit; deductible applies (60 visits per year maximum for all networks combined; PT/OT pre-authorization required for visits 13-60)	\$10 co-pay, then 90% of allowed amount (60 visits per year maximum for all networks combined; PT/OT pre-authorization required for visits 13-60)
	Speech therapy (non-developmental medically necessary services)	80% of allowed amount; deductible applies (30 visits per year maximum for all networks combined; pre-authorization required)	70% of allowed benefit; deductible applies (30 visits per year maximum for all networks combined; pre-authorization required)	\$10 co-pay, then 90% of allowed amount (30 visits per year maximum for all networks combined; pre-authorization required)
	Pulmonary rehabilitation	80% of allowed amount; deductible applies	70% of allowed benefit; deductible applies	90% of allowed amount
	Cardiac rehabilitation	80% of allowed amount; deductible applies (90 visits per year maximum for all networks combined; pre-authorization required)	70% of allowed benefit; deductible applies (90 visits per year maximum for all networks combined; pre-authorization required)	\$10 co-pay, then 90% of allowed amount (90 visits per year maximum for all networks combined; pre-authorization required)
	Vision therapy	80% of allowed amount; deductible applies (30 visits per year maximum for all networks combined; pre-authorization required)	70% of allowed benefit; deductible applies (30 visits per year maximum for all networks combined; pre-authorization required)	Not Available
Urgent Care Center	Physician visit	\$40 co-pay, then 100% of allowed amount; deductible waived	70% of allowed benefit; deductible applies	Not Available
	Diagnostic services and treatment	100% of allowed amount; deductible waived	70% of allowed benefit; deductible applies	90% of Allowed amount