

Medical PPO Schedule of Benefits (Effective January 01, 2019)  
Suburban Hospital Employees and Eligible Dependents



		EHP Network Provider	Out of Network Provider	Hopkins Preferred Network Facilities (facility charges only)
Plan Year Deductible	Individual	\$400	\$750	\$0
	Family	\$800	\$1500	\$0
Out-of-Pocket Maximum	Individual	\$2500	\$2500	Included in EHP Network Provider Medical maximum
	Family	\$5000	\$5000	Included in EHP Network Provider Medical maximum
Lifetime Maximum	Unlimited			

Services & Supplies (In Alphabetical Order)		EHP Network Provider	Out of Network Provider	Hopkins Preferred Network Facilities (facility charges only)
Acupuncture	Medically necessary services for anesthesia, pain control, and therapeutic purposes	80%; deductible applies (15 visit annual maximum for all networks combined)	70% of allowed benefit; deductible applies (15 visit annual maximum for all networks combined)	Not Available
Allergy Tests & Procedures	Allergy tests	100%, deductible waived	70% of allowed benefit; deductible applies	Not Available
	Desensitization materials and serum	100%, deductible waived	70% of allowed benefit; deductible applies	Not Available
Ambulance Transportation	Medically necessary transport	80%, deductible applies	70% of allowed benefit; deductible applies	Not Available
Biofeedback	Biofeedback	\$20 co-pay, then 100%, deductible waived	70% of allowed benefit; deductible applies	90%
Chemo & Radiation Therapy	Physician visit	80%; deductible applies	70% of allowed benefit; deductible applies	90% (facility charge only); deductible waived
	Materials and treatment	80%; deductible applies	70% of allowed benefit; deductible applies	90% (facility charge only); deductible waived
Chiropractic Care	Chiropractor restricted to initial exam, x-rays, and spinal manipulations	80%; deductible applies (15 visit annual maximum for all networks combined)	70% of allowed benefit; deductible applies (15 visit annual maximum for all networks combined)	Not Available
	Chiropractor with PT privileges (physical therapy services)	Refer to Therapy section	Refer to Therapy section	Refer to Therapy section
Dialysis	Medically necessary services	80%; deductible applies (pre-authorization required)	70% of allowed benefit; deductible applies (pre-authorization required)	Not Available
Durable Medical Equipment	Breast pumps (standard) and related supplies	100%; deductible waived	70% of allowed benefit; deductible applies	Not Available
	Contraceptive devices	100%; deductible waived	70% of allowed benefit; deductible applies	Not Available
	Custom DME, including custom wheelchairs	80%; deductible applies	70% of allowed benefit; deductible applies	Not Available
	Custom-molded orthotics	80%; deductible applies (pre-authorization required; \$250 lifetime maximum)	70% of allowed benefit; deductible applies (pre-authorization required; \$250 lifetime maximum)	Not Available
	Insulin pumps, Continuous Glucose Monitor and related supplies	80%; deductible applies	70% of allowed benefit; deductible applies	Not Available
	Hearing aids	90%; deductible applies (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
	Non-custom medical equipment and supplies	80%; deductible applies	70% of allowed benefit; deductible applies	90%; deductible waived
Prosthetic devices	80%; deductible applies	70% of allowed benefit; deductible applies	Not Available	

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Emergency Services	Emergency care (facility fees)	\$125 co-pay, then 90%; deductible waived (co-pay waived if admitted)	\$125 co-pay, then 90% of allowed benefit; deductible waived (co-pay waived if admitted)	\$125 co-pay, then 90%; deductible waived (co-pay waived if admitted)
	Emergency care (professional fees)	90%; deductible waived	90% of allowed benefit; deductible waived	90%; deductible waived
Home Health Services	Medically necessary services	\$20 co-pay; deductible waived (120 visit annual maximum; pre-authorization required)	70% of allowed benefit; deductible applies (120 visit annual maximum; pre-authorization required)	Not Available
	Home infusion therapy	\$20 co-pay, then 100%; deductible waived	70% of allowed benefit; deductible applies	Not Available
Hospice Care	Inpatient and home hospice	80%; deductible applies	70% of allowed benefit; deductible applies	Not Available
Hospital Care	Inpatient care including newborn nursery care; NICU (facility fees)	\$100 co-pay per admission, then 80%; deductible applies (for a service that Suburban does not provide: \$100 co-pay per admission, then 90%; deductible waived)	\$300 co-pay per admission, then 70% of allowed benefit; deductible applies	\$100 co-pay per admission, then 90%; deductible waived
	Inpatient care (professional fees)	80%; deductible applies	70% of allowed benefit; deductible applies	90%; deductible waived
	Skilled nursing/rehabilitation facility	80%; deductible applies (90 day annual maximum)	70% of allowed benefit; deductible applies (90 day annual maximum)	Not Available
	Short-term acute rehabilitation	80%; deductible applies (60 day annual maximum)	70% of allowed benefit; deductible applies (60 day annual maximum)	Not Available
	Observation care (facility fees)	\$125 co-pay, then 90%; deductible waived (co-pay waived if admitted)	\$125 co-pay, then 90% of allowed benefit; deductible waived (co-pay waived if admitted)	\$125 co-pay, then 90%; deductible waived (co-pay waived if admitted)
	Observation care (professional fees)	90%; deductible waived	90% of allowed benefit; deductible waived	90%; deductible waived
	Outpatient surgery & ambulatory surgical center (facility fees)	80%; deductible applies	70% of allowed benefit; deductible applies	90%; deductible waived
	Outpatient surgery & ambulatory surgical center (professional fees)	80%; deductible applies	70% of allowed benefit; deductible applies	90%; deductible waived
Hyperbaric Oxygen Therapy	Medically necessary services	80%; deductible applies (pre-authorization required)	70% of allowed benefit; deductible applies (pre-authorization required)	Not Available
Immunizations	Preventive immunizations for communicable diseases	100%; deductible waived	70% of allowed benefit; deductible applies	Not Available
	Travel immunizations	100%; deductible waived	70% of allowed benefit; deductible applies	Not Available
Infusion Therapy	Home infusion therapy	\$20 co-pay, then 100%; deductible waived	70% of allowed benefit; deductible applies	Not Available
	Outpatient infusion therapy	\$20 co-pay, then 100% of; deductible waived	70% of allowed benefit; deductible applies	100%; deductible waived

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Injections	Injections	80%; deductible applies	70% of allowed benefit; deductible applies	Not Available
	Materials and serum	80%; deductible applies	70% of allowed benefit; deductible applies	Not Available
Laboratory	Laboratory tests including pathology	80%; deductible applies	70% of allowed benefit; deductible applies	90%; deductible waived
Mental Health & Substance Abuse Services	Outpatient mental health care (facility fees)	\$20 co-pay, then 100%; deductible waived	70% of allowed benefit; deductible applies	100%; deductible waived
	Outpatient mental health care (professional fees)	\$20 co-pay, then 100%; deductible waived	70% of allowed benefit; deductible applies	100%; deductible waived
	Inpatient mental health care (facility fees)	\$100 co-pay per admission, then 100%; deductible waived	\$300 co-pay per admission, then 70% of allowed benefit; deductible applies	\$100 co-pay per admission, then 100%; deductible waived
	Inpatient mental health care (professional fees)	100%; deductible waived	70% allowed benefit; deductible applies	100%; deductible waived
	Outpatient substance abuse care (facility fees)	\$20 co-pay, then 100%; deductible waived	70% of allowed benefit; deductible applies	100%; deductible waived
	Outpatient substance abuse care (professional fees)	\$20 co-pay, then 100%; deductible waived	70% of allowed benefit; deductible applies	100%; deductible waived
	Inpatient substance abuse care (facility fees)	\$100 co-pay per admission, then 100%; deductible waived	\$300 co-pay per admission, then 70% of allowed benefit; deductible applies	\$100 co-pay per admission, then 100%; deductible waived
	Inpatient substance abuse care (professional fees)	100%; deductible waived	70% of allowed benefit; deductible applies	100%; deductible waived
	Intensive outpatient program	\$20 co-pay, then 100%; deductible waived	70% of allowed benefit; deductible applies	100%; deductible waived
	Partial hospital facility services	\$20 co-pay, then 100%; deductible waived	70% of allowed benefit; deductible applies	\$20 co-pay, then 100%; deductible waived
	Medication management	\$20 co-pay, then 100%; deductible waived	70% of allowed benefit; deductible applies	\$20 co-pay, then 100%; deductible waived
	Mental health testing and procedures	\$20 co-pay, then 100%; deductible waived	70% of allowed benefit; deductible applies	\$20 co-pay, then 100%; deductible waived
Methodone Treatment	Medically necessary outpatient care	\$20 co-pay, then 100%; deductible waived	70% of allowed benefit; deductible applies	Not Available
Nutritional Counseling	Medically necessary services	80%; deductible applies (limited to 6 visits per plan year for all networks combined; additional visits must be pre-authorized)	70% of allowed benefit; deductible applies (limited to 6 visits per plan year for all networks combined; additional visits must be pre-authorized)	Not available

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Office Visits for Treatment of Illness or Injury	Primary care office visit only (Adult)	\$20 co-pay; deductible waived	70% of allowed benefit; deductible applies	Not Available
	Primary care office visit (Pediatric: age 19 and under)	\$20 co-pay; deductible waived	70% of allowed benefit; deductible applies	Not Available
	Primary care office visit only (GYN)	\$20 co-pay; deductible waived	70% of allowed benefit; deductible applies	Not Available
	Specialty care office visit only (Adult & Pediatric)	\$25 co-pay; deductible waived	70% of allowed benefit; deductible applies	Not Available
	Treatment and diagnostic services in the office	80%; deductible applies	70% of allowed benefit ; deductible applies	90%; deductible waived
Preventive Services	Preventive exam (PCP, GYN and Well Child care)	100%; deductible waived (limit one per plan year; birth to age one: 6 visit limit; age one to age two: 2 visit limit; age two to age six: 1 visit per plan year limit)	70% of allowed benefit; deductible applies (limit one per plan year; birth to age one: 6 visit limit; age one to age two: 2 visit limit; age two to age six: 1 visit per plan year limit)	Not Available
	Diagnostic services for preventive exam	100%; deductible waived	70% of allowed benefit; deductible applies	100%; deductible waived
	Routine preventive screenings: mammogram, colonoscopy, PAP test, etc.	100%; deductible waived (mammogram limited to one baseline exam between ages 35 to 39; one per plan year age 40 and up)	70% of allowed benefit; deductible applies (mammogram limited to one baseline exam between ages 35 to 39; one per plan year age 40 and up)	Not Available
	Routine hearing exams	\$20 co-pay; deductible waived (limit one every 24 months)	70% of allowed benefit; deductible applies (limit one every 24 months)	Not Available
Private Duty Nursing	Private Duty Nursing	Not Available	Not Available	Not Available
Radiology Procedures	Advance imaging including MRI, CT and PET scans	80%; deductible applies	70% of allowed benefit; deductible applies	90%; deductible waived
	All other imaging studies; including X-Ray and Ultrasound	80%; deductible applies	70% of allowed benefit; deductible applies	90%; deductible waived

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Reproductive Health	Physician office visits (prenatal care only)	\$25 co-pay; deductible waived	70% of allowed benefit; deductible applies	Not Available
	Infertility treatment	50%; deductible applies (preauthorization required for all services and prescriptions; all criteria must be met; \$30,000 lifetime maximum combined including prescription drugs, lab work and x-rays; in vitro fertilization attempts limited to a maximum of three per lifetime within the \$30,000 lifetime maximum, member must be enrolled in the EHP Plan for one year before beginning infertility treatment)	Not Covered	50%; deductible applies (preauthorization required for all services and prescriptions; all criteria must be met; \$30,000 lifetime maximum combined including prescription drugs, lab work and x-rays; in vitro fertilization attempts limited to a maximum of three per lifetime within the \$30,000 lifetime maximum, member must be enrolled in the EHP Plan for one year before beginning infertility treatment)
	Birth centers (facility fees)	100%; deductible waived	70% of allowed benefit; deductible applies	Not Available
	Birth centers (professional fees)	100%; deductible waived	70% of allowed benefit; deductible applies	Not Available
	Inpatient maternity care and delivery; newborn nursery care; NICU (facility fees)	\$100 co-pay per admission, then 80%; deductible waived (for a service that Suburban does not provide: \$100 co-pay per admission, then 90%; deductible waived)	\$300 co-pay per admission, then 70% of allowed benefit; deductible applies	\$100 co-pay per admission, then 90%; deductible waived
	Inpatient maternity care and delivery; newborn nursery care; NICU (professional fees)	100%; deductible waived	70% of allowed benefit; deductible applies	Not Available
	Interruption of pregnancy	80%; deductible applies	70% of allowed benefit; deductible applies	90%; deductible waived
	Female sterilization (professional services for surgery, anesthesia and related pathology)	100%; deductible waived	70% of allowed benefit; deductible applies	100%; deductible waived
Male sterilization (professional services for surgery, anesthesia and related pathology)	100%; deductible waived	70% of allowed benefit; deductible applies	100%; deductible waived	
Surgical Procedures	Surgical treatment for morbid obesity	Covered at Johns Hopkins Bayview Medical Center and Sibley Memorial Hospital only. \$300 co-pay per admission, then 80%; deductible applies, pre-authorization required (Services paid as stated regardless of no availability at Suburban Hospital)	Not Covered	Not Available
	Primary care office surgical procedures	\$20 co-pay; deductible waived	70% of allowed benefit; deductible applies	Not Available
	Specialist care office surgical procedures	\$25 co-pay; deductible waived	70% of allowed benefit; deductible applies	Not Available
	Outpatient surgery (including freestanding surgical centers) (facility fees)	80%; deductible applies	70% of allowed benefit; deductible applies	90%; deductible waived
	Outpatient surgery (including freestanding surgical centers) (professional fees)	80%; deductible applies	70% of allowed benefit; deductible applies	90%; deductible waived
	Inpatient surgery (facility fees)	80%; deductible applies	70% of allowed benefit; deductible applies	90%; deductible waived
	Inpatient surgery (professional fees)	80%; deductible applies	70% of allowed benefit; deductible applies	90%; deductible waived

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Therapy	Habilitative services for children under the age of 19	80%; deductible applies (pre-authorization required)	70% of allowed benefit; deductible applies (pre-authorization required)	Not Available
	Physical therapy/occupational therapy medically necessary services	80%; 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)	90%; (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%; deductible applies	70% of allowed benefit; deductible applies	90%
	Pulmonary rehabilitation	80%; deductible applies (pre-authorization required)	70% of allowed benefit; deductible applies (pre-authorization required)	90%
	Cardiac rehabilitation	80%; deductible applies (pre-authorization required)	70% of allowed benefit; deductible applies (pre-authorization required)	90%
	Vision therapy	Not Covered	Not Covered	Not Covered
Urgent Care Center	Physician visit	\$20 co-pay; deductible waived	70% of allowed benefit; deductible applies	Not Available
	Diagnostic services and treatment	100%	70% of allowed benefit; deductible applies	Not Available