STUDENT HEALTH PROGRAM
MEDICAL BENEFITS AT-A-GLANCE FOR ELIGIBLE MEMBERS
Effective Date: July 1, 2010

Services and Supplies		Option 1 In Network Providers All Services Subject to Deductible	Option 2 Out of Network Providers All Services Subject to Deductible
Calendar Year Deductible (All Options Combined)	Individual	$100	$100
	Family	$300	$300
Coinsurance Out Of Pocket Maximum Per Calendar Year (All Options Combined)	Individual	$3000	$3000
	Family	$9000	$9000
Maximum Lifetime Benefit (All Options Combined)		$1,000,000	
Treatment Of Illness Or Injury	Primary Care Office Visit (over 19 years of age)	80%	70% of R&C
	Adult Specialty Care Office Visit	90%	70% of R&C
	Pediatric Care Office Visit (under 19 years of age)	100%	90% of R&C
	Pediatric Specialty Care Office Visit (under 19 years of age)	90%	70% of R&C
	Podiatry Care Office Visit	90%	70% of R&C
Laboratory And X-Ray Procedures	Laboratory Tests, Imaging Exams, X-rays and Ultrasound	90%	70% of R&C
Surgical Procedures	Professional Services for Inpatient and Outpatient Surgery	80% (1)	70% of R&C (1)
	Reconstructive and/or Surgically Implanted Prosthetics	80% (1)	70% of R&C (1)
	Gastric Bypass Surgery (must be coordinated by Clinical Case Management)	80% (2) at JHH institutions only	Available under Option 1 only
Preventive Services	Adult General Physical Exam	80%	70% of R&C
	Well-Child Care: Office Visits, Immunizations and PKU, Flu Vaccine, Urinalysis and Lead Testing	100%	90% of R&C

Services and Supplies		Option 1 In Network Providers All Services Subject to Deductible	Option 2 Out of Network Providers All Services Subject to Deductible
Preventive Services	Mammograms (screening) (once per 12 month period)	100%	90% of R&C
	Annual Pap (pathology) (once per 12 month period)	90%	70% of R&C
	Colonoscopy (screening)	80%	70% of R&C
	Annual GYN Exam (once per 12 month period)	80%	70% of R&C
	Adult Immunizations and Inoculations Gardasil covered for the FDA approved age range of 9-26 years of age	80%	70% of R&C
Allergy Tests and Procedures	Allergy Tests	90%	90% of R&C
	Desensitization Materials and Serum	80%	80% of R&C
Physical/Occupational Therapy	Excludes Maintenance Therapy	80%	80% of R&C
Chiropractic Care	Restricted to Initial Evaluation, X-Rays and Spinal Manipulations (limited to $1,000 maximum per calendar year)	80%	80% of R&C
Reproductive Health	Physician Office Visits (prenatal care only)	90%	70% of R&C
	Charges for Delivery and Related Anesthesia	90% (1)	70% of R&C (1)
	Newborn Care (initial and discharge visits only)	90% (1)	90% of R&C (1)
	Newborn Care (all other inpatient visits)	80% (1)	80% of R&C (1)
	Birthing Center (licensed facility only)	90% (1)	90% of R&C (1)
	Voluntary Sterilization	80% (1)	80% of R&C (1)
Urgent Care Center	Physician Visit	100%	80% of R&C
Emergency Services	Emergency Care (facility and professional fees) (i.e., the onset of a sudden and serious condition requiring immediate care)	100% for services within 72 hours after onset of emergency, then 80%	100% of R&C for services within 72 hours after onset of emergency, then 80% of R&C

Services and Supplies		Option 1 In Network Providers All Services Subject to Deductible	Option 2 Out of Network Providers All Services Subject to Deductible
Chemotherapy/ Radiation Therapy	Physician Visit	100%	80% of R&C
	Physician Materials	80%	80% of R&C
Acupuncture	$300 Maximum per Calendar Year Must be coordinated by Clinical Case Managers	80%	70% of R&C
Ambulance Transportation	To and/or from a Hospital Only	80%	80% of R&C
Home Health Care	Must be provided by a Licensed Health Care Organization Medically necessary services coordinated by Clinical Case Managers	100% for 1st 90 visits per calendar year, then 80% (1)	90% of R&C for 1st 90 visits per calendar year, then 80% of R&C (1)
Hospice Care	Inpatient and Home	100% (1)	100% of R&C (1)
Speech Therapy	Restorative, Non-Developmental Therapy Only Must be coordinated by Clinical Case Managers	80% (1)(3)	80% of R&C (1)(3)
Durable Medical Equipment	Equipment, Prosthetic Appliances, and Medical Supplies	80%	80% of R&C (1)
Nutrition Counseling	Limited to 1 initial consultation and 1 follow-up visit (Additional visits must be medically necessary and coordinated by Clinical Case Managers)	90%	70% of R&C
Hospital Care	Inpatient Care (semi-private, unless private room is medically necessary)	100% for 1st 30 days, then 80% (1)	100% of R&C for 1st 30 days, then 80% of R&C (1)
	Intensive Care	100% for 1st 30 days, then 80% (1)	100% of R&C for 1st 30 days, then 80% of R&C (1)
	Other Inpatient Services	100% for 1st 30 days, then 80% (1)	100% of R&C for 1st 30 days, then 80% of R&C (1)
	Inpatient Physician Services (excluding surgical services)	80% (1)	80% of R&C (1)
	Skilled Nursing Rehabilitation Facility	100% for 1st 30 days, then 80% (1)	100% of R&C for 1st 30 days, then 80% of R&C (1)
	Outpatient Services (including outpatient testing prior to outpatient surgery)	90%	90% of R&C
	Outpatient Surgery Facility Charges (including freestanding surgical centers)	90% (1)	90% of R&C (1)

Mental Health and Substance Abuse Services	Option 1 In Network Providers All Services Subject to Deductible	Option 2 Out of Network Providers All Services Subject to Deductible
Professional Fees for Outpatient Mental Health Care	90%	70% of R&C
Professional Fees for Inpatient Mental Health Care	80%	80% of R&C
Facility Charges for Inpatient Mental Health Care	100% for 1st 30 days, then 80% (1)	100% of R&C for 1st 30 days, then 80% of R&C (1)
Facility Charges for Alcohol and Substance Abuse Care	100% for 30 days per calendar year, then 80% (1)	100% of R&C for 30 days per calendar year, then 80% of R&C (1)
Professional Fees for Inpatient Alcohol and Substance Abuse Care	80%	80% of R&C
Professional Fees for Outpatient Alcohol & Substance Abuse Care	100%	80% of R&C

Prescription Drugs	In Network Retail Pharmacy (30 day supply)	In-Network Retail Pharmacy (90-day supply for maintenance drugs)	Mail Order (90 day supply)
Generic	$10 Copay	$30 Copay	$20 Copay
Preferred Brand	$20 Copay	$60 Copay	$40 Copay
Non Preferred Brand	$35 Copay	$105 Copay	$70 Copay

(1) Failure to obtain pre-certification may result in a penalty or possible denial of benefits.
(2) Pre-Certification is required. The member must meet criteria and the procedure must be medically reviewed and approved prior to surgery. All services must be provided at a Johns Hopkins institution.
(3) Covered benefits only include therapy aimed at restoring the level of speech the individual had attained before the onset of a condition (i.e., before an illness or injury). Speech therapy for developmental disorders, such as stuttering, articulation disorders, tongue thrust, lisping, etc. is Not Covered.

"R&C" (Reasonable and Customary Charge) is explained under the heading "Payment Terms You Should Know" in your Summary Plan Description (SPD). You are responsible for any charges above R&C.
All benefits are subject to medical necessity.
This is not a complete description of benefits. For more information, please refer to the SPD.