



JOHNS HOPKINS
M E D I C I N E

JOHNS HOPKINS HEALTH SYSTEM CORPORATION
THE JOHNS HOPKINS HOSPITAL

Summary Plan Description

Non-Represented Employees

**EHP Medical/Dental
Flexible Spending Accounts**

January 2007

Important Telephone Numbers

Claims or Coverage Questions	Johns Hopkins EHP HR Service Center	(410) 424-4450 or (410) 955-6208
Care Management Program (Pre-certification of services)	Johns Hopkins EHP	(410) 424-4450
COBRA Questions	Johns Hopkins EHP	(410) 424-4450
Flexible Spending Accounts	EHP Ceridian Benefit Services	(410) 424-4450 (800) 992-2437
Claim Forms	HR Service Center, Phipps 455	(410) 955-6208
Confidential Help With Personal Problems	Faculty and Staff Assistance Program	(410) 955-1220
Credit Union Services	Credit Union	(410) 955-6116

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GENERAL INFORMATION

General Information About Your Benefits

Benefits For You And Your Family

Health care benefits are probably the benefits employees believe are the most important, and with good reason. The cost of health care can take a major bite out of a household budget. The Johns Hopkins Health System Corporation/The Johns Hopkins Hospital (JHHSC/JHH) offers you and your family health care benefits under the EHP Medical and Dental Plans to help you pay for medical, vision and dental care when you need it. Health Care and Dependent Care Flexible Spending Accounts (FSAs) are available to help you save on your out-of-pocket health care and dependent day care expenses.

Short Term and Mid Term Disability benefits also offer necessary income protection should you become ill or injured and are unable to work for an extended length of time.

These benefits are provided under the Johns Hopkins Health System Corporation/The Johns Hopkins Hospital Employee Benefits Plan for Non-Represented Employees and are described in this Summary Plan Description (SPD). Please read it carefully.

The benefits described in this SPD are for eligible non-represented employees of the Johns Hopkins Health System Corporation and the Johns Hopkins Hospital. (Benefits for employees of the members of the Johns Hopkins Home Care Group are set forth in a separate SPD).

Benefits are administered through Johns Hopkins Employer Health Programs, Inc.

Long Term Disability, Life and Accidental Death and Dismemberment insurance benefits are described in a separate summary plan description.

This January 2007 version of the SPD replaces the prior version of the SPD which was dated January 2004. This January 2007 version applies to all claims incurred on or after January 1, 2007.

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Who Is Eligible

Employee Coverage

Employees are generally eligible for the benefits described in this SPD as follows:

Benefit Plan:	Full-Time Employee (30+ Hours/Week)	Part-Time Employee (20-29 Hours/Week)	Weekend Option Nurse
EHP Medical Plans (includes vision and prescription drugs)	Yes	Yes	Yes
EHP Dental Plans	Yes	Yes	Yes
Salary Protection			
• Short Term Disability (11 Weeks)	Yes	Yes	No
• Optional Mid Term Disability	Yes	Yes	No
• Optional Long Term Disability	Yes	Yes	Yes
Flexible Spending Accounts			
• Health Care Account	Yes	Yes	Yes
• Dependent Care Account	Yes	Yes	Yes
Benefit Credits	Yes	No	Yes

Dependent Coverage

Eligible dependents may also be covered under the EHP Medical and Dental Plans. Eligible dependents are:

- ◆ Your legal spouse. You must submit proof that you are married (such as a copy of your marriage license/certificate or income tax return) the first time you enroll your spouse. You may not cover your former spouse after the divorce has become final.
- ◆ Your unmarried children who depend primarily on you for financial support, through the end of the calendar year in which they turn age 19. You must submit a copy of your child's birth certificate the first time you enroll your child;
- ◆ Your unmarried children from the end of the calendar year in which they turn age 19 until the end of the calendar year in which they turn age 25, but only while they are earning the required minimum number of credits per semester at an accredited college or university and they depend primarily on you for financial support. If there is any question, you must provide proof of a

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school's accreditation. Dependent children must take 12 credits or more per semester to be covered while in undergraduate school. However, dependent children in nursing school who take less than 12 credits can be covered if the school provides a letter stating that the child's schedule is considered "full time" under the school's rules. Dependent children in graduate school must take 9 credits or more per semester to be covered. You must provide proof of eligible student status every semester as explained below.

- ◆ Same sex domestic partners and their dependent children, if they meet the requirements set forth below under ***Domestic Partner Coverage***; and
- ◆ Your physically or mentally disabled dependent child(ren) of any age, provided the physical or mental disability began while they were eligible as described above.

To be considered disabled, a child must be entitled to Supplemental Security Income (SSI) benefits on account of disability. However, if the child has not applied for SSI, you can instead demonstrate to the Plan Administrator's satisfaction that the child meets the SSI disability criteria for adults -- the inability to engage in any substantial gainful activity as a result of any medically determinable physical or mental impairment(s) which can be expected to result in death, or has already lasted, or can be expected to last, for a continuous period of not less than 12 months.

Children whom you may enroll must be your natural children, stepchildren who reside with you, foster children, children legally adopted or placed for adoption, children covered by a Qualified Medical Child Support Order (QMCSO), and any other children for whom you are the legal guardian.

Please note: You may not cover a stepchild if the stepchild does not reside with you. Also, you may not cover your former spouse after the divorce has become final.

A dependent in active military service is not eligible for coverage.

If your spouse also works for JHHSC/JHH, you cannot be covered as both an employee and a dependent. Likewise, if your eligible child also works for JHHSC/JHH, he or she cannot be covered as both an employee and a dependent. Please note that your eligible dependents may only be covered by one parent's plan.

If you have any questions about this coverage, please contact the HR Service Center, Phipps 455, at 410-955-6208.

Proof of Student Status

You must provide proof of eligible student status. Fall semester verification letters will be mailed each September to employees with coverage for children who turn age 19 in that calendar year. The letter will specify a deadline (usually October 31) by which the required proof of student status must be returned. If the required proof is returned by the deadline, student status will be considered verified

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through December 31st and the child will be included in the spring semester verification process described next. If the required proof is not returned by the deadline, the child's coverage will terminate December 31.

Spring semester verification letters will be mailed in January to employees with coverage for children who turn ages 20 thru 25 in that calendar year. The letter will specify a deadline (usually February 28) by which the required proof of student status must be returned. If the required proof is returned by the deadline, student status will be considered verified through the following December 31. If the required proof is not returned by the deadline, the child's coverage will terminate retroactively to the preceding December 31.

Domestic Partner Coverage

Coverage under the EHP Medical and Dental Plans is also available under certain circumstances for same sex domestic partners and their dependent children, in accordance with the JHHSC/JHH Policy Regarding Employee Benefits for Domestic Partners (Same Sex). A same sex domestic partner is eligible for coverage only while he or she satisfies the requirements for benefits under the Domestic Partner Policy. A dependent child of a same sex domestic partner is only eligible for coverage while the domestic partner is actually covered under the EHP Medical or Dental Plans and only if the child would be eligible for coverage as explained above if he or she were your child.

The Internal Revenue Code has different tax rules for domestic partner coverage. Because of that, contributions for domestic partner coverage must be made with after tax dollars. Also, an employee with domestic partner coverage will have additional taxable income on Form W-2 equal to the fair market value of the domestic partner coverage minus the required contribution for the coverage.

Expenses of a domestic partner or the partner's children cannot be reimbursed under the Health Care or Dependent Care Flexible Spending Accounts.

Coverage for a domestic partner or the partner's children can only be added or dropped during annual open enrollment. The Special Enrollment and family status change rules do not apply to domestic partners and their children. Of course, coverage will automatically end immediately if a domestic partner or the partner's children are no longer eligible for coverage under the Plans or the Domestic Partner Policy.

Finally, domestic partners and their children are not eligible for COBRA coverage.

Qualified Medical Child Support Order (QMCSO)

You may enroll children who are not otherwise eligible as dependents (as described above) in the EHP Medical or Dental Plans if called for by a Qualified Medical Child Support Order (QMCSO). A

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QMCSO is a court order setting responsibility for health care expenses for non-custodial children. If you are served with a QMCSO, please send the court order to the HR Service Center as soon as possible. Coverage will only be provided if the Plan Administrator determines that the QMCSO meets certain requirements imposed by law.

When Coverage Begins

Coverage under the EHP Medical and Dental Plans and Short Term Disability begins the first day of the month following your date of hire, if you are eligible and you complete and submit all required enrollment forms within seven days from your first day of work. To be eligible, you must be a full-time employee who is regularly scheduled to work at least 30 hours per week, or a part-time employee who is regularly scheduled to work at least 20 hours per week. You are also eligible if you are classified by your employer as a weekend option nurse. You are not eligible if you are classified by your employer as temporary employee or if you are included in a unit of employees covered by a collective bargaining agreement that does not expressly provide for participation in the Plans. If you do not complete and submit all required enrollment forms within seven days from your first day of work, you will not have coverage until the next annual open enrollment unless you have a family status change or qualify for ***Special Enrollment*** as explained below.

In order for coverage to be effective, you must be actively at work on the first day of coverage performing your usual duties during your usual working hours. If you are absent from work due to a Paid Time Off (PTO) day, vacation day, holiday, jury duty or other similar reasons, you will still be considered actively at work and coverage will be effective.

Coverage for your dependents will begin at the same time as your own if you have enrolled them in accordance with your Guide to Benefits booklet. If you have a new baby, adopt a child, or have a child placed with you for adoption, and you enroll this dependent within 30 days, your child's coverage becomes effective on the date of the birth or adoption. If you marry and you enroll your spouse within 30 days after your marriage, your spouse's coverage becomes effective on the date of your marriage.

Changing Your Coverage

During the annual open enrollment period, you may change your EHP Medical or Dental Plans coverage, or change your contributions to a Health Care or Dependent Care Flexible Spending Account. Outside of the annual open enrollment period, you may obtain or cancel coverage, add new dependents, or drop a dependent from your coverage *only* if you have a qualifying family status change or a ***Special Enrollment*** situation (see **Special Enrollment Rights** discussed below). In the case of a Flexible Spending Account, you may also increase or decrease your contributions if you have a qualifying family status change, subject to the minimum and maximum limitations described later in this SPD under **Flexible Spending Accounts**.

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Examples of IRS-qualified changes in family status include:

- ◆ Marriage, legal separation, annulment or divorce;
- ◆ Birth, death or adoption of a dependent;
- ◆ Placement for adoption of a dependent;
- ◆ A change in employment status (for example: you or your dependent terminate employment or start a new job);
- ◆ A change from full-time to part-time employment (or vice versa) by you or your dependent;
- ◆ A change in your or your dependent's employment status due to an unpaid leave of absence;
- ◆ Your dependent becomes eligible or is no longer eligible for coverage under the Plan;
- ◆ Your spouse elects to add or drop coverage during open enrollment under your spouse's plan;
- ◆ You are required to cover your child due to a QMCSO;
- ◆ You or your dependent gain or lose eligibility for Medicare or Medicaid (you may change the current election for the affected person only); and
- ◆ Any other event that the Plan Administrator determines to qualify as a family status change under the Internal Revenue Code.

Any employee, spouse or dependent child whose coverage under any other group health plan suddenly or unexpectedly ends may possibly be permitted coverage under the EHP Medical or Dental Plans provided appropriate contributions are made. Please notify the HR Service Center about your situation to see if coverage is available.

Any change in your benefit enrollment must correspond directly to the change in family status. If you submit your enrollment form and a copy of proof of the family status change (such as a marriage or birth certificate or adoption papers) within 30 days after the change, coverage becomes effective on the date of the change. If you delay past 30 days, you must wait until the next open enrollment before coverage can become effective. Please keep the HR Service Center informed of any changes in family status by contacting us in Phipps Room 455.

Special Enrollment Rights For EHP Medical and Dental Coverage

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Losing other coverage

If you did not enroll for coverage under the EHP Medical or Dental Plans because you had coverage through another source (such as a spouse's employer or COBRA), and you subsequently lost that other coverage, you may enroll for EHP Medical or Dental coverage under this Plan. You must request this special enrollment within 30 days of losing your other coverage. Coverage under the EHP Medical or Dental Plans will become effective on the first of the month following the date your enrollment materials are received in the HR Service Center.

The special enrollment provision does not apply if you lost coverage under the other plan because you did not make required contributions or if you lost coverage for cause (such as submitting a fraudulent claim).

New Dependents

Dependents whom you acquire through marriage, birth, adoption, or placement for adoption may be granted special enrollment, as long as you enroll them for coverage within 30 days following the date you acquired the dependent. If enrolled on time, coverage will become effective on the date of the marriage, birth, adoption or placement for adoption. If you do not have coverage for yourself or your spouse, you may also enroll yourself or your spouse when you enroll your new dependent.

Certificates Of Coverage

If you or a covered dependent lose coverage under the EHP Medical Plans (including COBRA coverage), be sure to notify the HR Service Center and request a certificate of coverage. This certificate of coverage is available at no cost to you. This certificate will state the length of time you (or your covered dependent) had uninterrupted coverage under the EHP Medical Plans. It will also show the date coverage ended. The certificate of coverage may allow you to reduce any pre-existing condition limits that apply to future medical coverage.

Please note that certificates are not automatically provided for dependents until the HR Service Center is aware that the dependent has lost coverage (for example, when a dependent no longer qualifies for coverage because of age). You may request a certificate of coverage for up to 24 months from the date your coverage ended.

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Coverage Costs

JHHSC/JHH pays the majority of the cost of your coverage under the EHP Medical and Dental Plans and provides you with flexible benefit credits to help pay for your benefit options. Each *full-time* employee and *weekend option nurse* will receive up to \$520 (\$20 bi-weekly) in benefit credits per year. This amount helps you to cover the costs of those benefits that require employee contributions, including the EHP Medical and Dental Plans.

Starting in 2008, the \$20 bi-weekly benefit credit is only provided to full-time employees and weekend option nurses who have completed a Health Risk Assessment. The opportunity to complete a Health Risk Assessment is offered during open enrollment each year. If the Health Risk Assessment is not completed, the bi-weekly benefit credit is reduced to \$10.

You will probably need to supplement your benefit credits with contributions deducted from your paycheck on a pre-tax basis. Because your contributions are deducted before taxes, you reduce your taxable income and save on federal and state income taxes, and Social Security taxes. Special rules may apply for state taxes if you live in Pennsylvania or New Jersey.

For the exact contributions required by the EHP Medical and Dental Plans, please refer to your Guide to Benefits booklet or contact the HR Service Center. JHHSC/JHH pays the full cost of your Short Term Disability benefits.

If you have benefit credits left over after making your contributions to the EHP Medical and Dental Plans (or if you waive EHP Medical and Dental coverage), the left over credits will be paid to you in cash. However, if you contribute to a Health Care Flexible Spending Account or a Dependent Care Flexible Spending Account (see the discussion about **Flexible Spending Accounts** later in this SPD), any left over credits will be used to make your contributions to those Accounts instead.

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The Johns Hopkins EHP Medical Plans

There are two Johns Hopkins EHP Medical Plans for you to choose from: the Basic Plan and the Premium Plan. You choose which of the EHP Medical Plans you want – Basic or Premium – each year during open enrollment.

The EHP Medical Plans described in this SPD are administered by Johns Hopkins Employer Health Programs. The EHP Medical Plans are designed to provide you and your family with quality health care services in the most cost-effective settings. The EHP Medical Plans offer you the security of a wide range of health care benefits, including coverage for inpatient and outpatient hospital care, medical and surgical services, prescription drugs, vision care and mental health and substance abuse services. The EHP Medical Plans also offer vital preventive care benefits usually not provided under traditional health care options. These include coverage for routine physicals; well-woman care, including Pap tests and mammograms; and well-child care, including immunizations and check-ups.

The Basic Plan and Premium Plan differ in several respects as explained in this SPD. Both Plans give you access to The Johns Hopkins Hospital, Johns Hopkins Bayview Medical Center, and a network of local and regional community hospitals. For a complete listing, please see the provider directory.

Basic Plan -- Access Care Through Your PCP

The Basic Plan incorporates the cost-efficiencies that result from using a network of highly qualified health care professionals and facilities. The Basic Plan offers you the reassurance of being treated by a participating doctor you choose, in a location convenient to you.

Basic Plan benefits are only provided when you receive care through your Primary Care Physician (PCP). Your PCP is responsible for helping to keep you well, providing routine treatment, or referring you to an EHP Network specialist when necessary. Most importantly, when you receive care coordinated by your PCP, most services are covered at 100% (there is a \$10 co-pay for certain services, \$20 co-pay for specialty care). Plus, there are no claims to file — the EHP Network provider receives payment directly from the Plan.

Primary Care Physicians

If you have Basic Plan coverage, you must select a PCP for yourself and a PCP for each of your covered dependents. Females covered by the Basic Plan who are age 14 years or older may choose an OB/GYN as their PCP for obstetrical or gynecological care in addition to their regular PCP (their internist, family physician, or pediatrician) for all other care.

To receive care under the Basic Plan, simply call your PCP's office to make an appointment. We

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encourage you to establish a relationship with your PCP so that you feel comfortable with him or her. You can change your PCP by calling an EHP Customer Service Representative at 1-800-261-2393 or 410-424-4450. Your PCP change will become effective the first day of the month following the date you request the change. If you do not select a PCP, you will not receive any benefits under the Basic Plan.

Check the Johns Hopkins EHP provider directory for PCPs accepting new patients, available in the HR Service Center, Phipps 455, or on the EHP Web site at www.ehp.org.

Premium Plan – Direct Access To Care

The Premium Plan offers *two* ways to receive care. Like the Basic Plan, the Premium Plan incorporates the cost-efficiencies that result from using the EHP Network of highly qualified health care professionals and facilities. However, you can also use Out-of-Network providers, although lower benefits are provided. The Premium Plan offers you the reassurance of being treated by any doctor you choose, in a location convenient to you.

Direct Access To Network Providers

You may go to any provider in the Johns Hopkins EHP Network and the Premium Plan will pay benefits. Most services are covered at 100% (there is a \$15 co-pay for certain services, \$30 co-pay for specialty care). You do not have to select a Primary Care Physician and you never need a referral (certain services require pre-certification, as explained later in this SPD). Plus, there are no claims to file — the EHP Network provider receives payment directly from the Plan. Some services are only available thru EHP Network providers, as described later in this SPD under **Covered Services and Supplies**.

Out-of-Network Care

The Premium Plan will also pay benefits if you go to a provider outside of the Johns Hopkins EHP Network. You must first pay an annual deductible of \$500 per person (\$1,000 per family). After the deductible, the Premium Plan will pay 70% of the Reasonable and Customary Charge (see **Payment Terms You Should Know** discussed below), and you pay the remaining 30%, until you reach an annual out-of-pocket maximum of \$3,200 per person (\$6,400 per family). After you reach the out-of-pocket maximum, your benefits for covered services are paid at 100% of the Reasonable and Customary Charge for the remainder of that calendar year. You are responsible for any amounts over the Reasonable and Customary Charge, and those amounts do not count towards the annual out-of-pocket maximum.

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Pre-existing Conditions

Your coverage under the EHP Medical Plans is affected by any pre-existing condition you may have before becoming eligible for coverage. A pre-existing condition is any physical or mental condition for which you or your eligible dependents have been diagnosed or received treatment, including any medical services or medication, during the 90 days before your date of hire. However, if you do not enroll for Medical Plan coverage when you are first eligible, or if you transfer from an ineligible to an eligible status after your date of hire, it is the 90 days before the effective date of your coverage. If you add a dependent after you are first eligible, it is the 90 days ending on the dependent's effective date of coverage.

If you or a dependent have one or more pre-existing conditions, any charges incurred during the first six months after your date of hire to treat this condition(s) will be subject to a \$5,000 maximum. If you or a dependent do not enroll for coverage under one of the EHP Medical Plans when you are first eligible, the \$5,000 maximum applies instead to any charges incurred during the first six months of coverage. In either case, the \$5,000 maximum does not include any Short Term or Mid Term Disability benefits relating to the pre-existing condition.

Please note: If you (or your dependent) were previously covered by another health plan, the period of time for which you (or your dependent) were covered may be credited against the six-month limited coverage period under the EHP Medical Plans. You will need to submit a certificate of coverage from the prior plan to the HR Service Center. Contact the HR Service Center if you have any questions or if you need help in obtaining a certificate of coverage from the prior plan. Prior plan coverage is only recognized if there is no more than a 62-day gap between coverage under the prior plan and coverage under the EHP Medical Plans. In addition, the six-month limited coverage period does not apply to newborn or newly adopted children if they are enrolled for health plan coverage within 31 days after birth or adoption, and that coverage is either under the EHP Medical Plans or is prior plan coverage that is recognized under this paragraph.

Payment Terms You Should Know

To understand how your benefits are processed and paid, please refer to the following terms.

- ◆ **Deductible and deductible carryover feature** — If you use an Out-of-Network provider under the Premium Plan, the deductible is the amount you must pay each calendar year before the Premium Plan begins to pay benefits. (Out-of-Network providers are not covered under the Basic Plan.) Expenses incurred and applied to your deductible in October, November and December of a calendar year are also carried over and applied to the next calendar year's deductible. Expenses incurred by two or more individuals can meet the family deductible. However, no one individual

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will be required to satisfy more than the individual deductible.

- ◆ Reasonable and Customary Charge (R&C) — This is the usual fee charged by similar providers for the same services or supplies in the same geographic area. Johns Hopkins Employer Health Programs determines what is a Reasonable and Customary Charge. EHP Network providers will not charge more than the Reasonable and Customary Charge, but Out-of-Network providers (covered by Premium Plan only) can charge more.
- ◆ Cost Sharing Provision — The terms *co-pay* and *coinsurance* describe ways that you share in the cost of your medical expenses.
 - ***Co-pay (Network providers):*** The amount you pay for doctor's office visits and prescription drugs. Under the Basic Plan, for most services, the co-pay is \$10 (\$20 for specialty care). Under the Premium Plan, for most services, the co-pay is \$15 (\$30 for specialty care). Please refer to the **Medical Benefits At-A-Glance** chart later in this SPD for specific co-pay amounts. The co-pay does not apply toward the out-of-pocket maximum. You pay the co-pay directly to the provider (your doctor or pharmacy) at the time of service.
 - ***Coinsurance (Out-of-Network providers, Premium Plan only):*** The coinsurance is your share for certain medical expenses. If you receive care from an Out-of-Network provider (covered by Premium Plan only), the Plan generally pays 70% of the Reasonable and Customary (R&C) charge, after the deductible, and you pay the remaining 30%, plus any amounts over R&C.
 - ***Out-of-Pocket Maximum (Out-of-Network providers, Premium Plan only):*** Since you are responsible for a portion of the cost of your medical expenses charged by an Out-of-Network provider under the Premium Plan, the Plan includes an annual out-of-pocket maximum calculated on a calendar year basis to protect you in the event of high medical bills. After you have paid the annual out-of-pocket limit (\$3,200 per person, \$6,400 per family), the Premium Plan pays any additional covered expenses at 100% for the remainder of that calendar year. If you receive care from an Out-of-Network provider under the Premium Plan, you are still responsible for any amounts over the Reasonable and Customary charge.

The out-of-pocket maximum includes the deductible and coinsurance, but does not include co-pays; penalties; prescription drug co-pays and expenses; amounts in excess of the Reasonable and Customary (R&C) charge; amounts in excess of Plan maximums; any charges for services which are not covered, or mental health and substance abuses charges, including for treatment of alcoholism.

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- ◆ **Maximum Lifetime Benefit** — This is the maximum amount the EHP Medical Plans will pay for a covered individual during his or her lifetime. The lifetime benefit maximum for the EHP Medical Plans is \$3,000,000. There is a separate lifetime maximum benefit of \$100,000 for treatment of substance abuse. Benefits provided under both the Basic Plan and the Premium Plan are combined for purposes of the lifetime benefit. Benefits paid by the EHP Medical Plan before the separate Basic and Premium Plans became available in 2004 are also counted and combined when applying the lifetime benefit limit.
- ◆ **Providers** — a provider is any hospital, skilled nursing facility, individual, organization, or agency licensed to provide professional services and acting within the scope of that license. Benefits will only be paid for covered services from providers who meet this definition. Benefits will not be provided under the EHP Medical Plans for any services and related charges provided by a close relative of the patient (spouse, child, grandchild, brother, sister, brother-in-law, sister-in-law, parent or grandparent).

Care Management Program

The Johns Hopkins EHP Medical Plans have several features designed to help both you and the Plans manage health care costs, while still providing you with quality care. While part of increasing health care costs results from new technology and important medical advances, another significant cause is the way health care services are used.

Some studies indicate that a high percentage of the cost for health care services may be unnecessary. For example, hospital stays can be longer than necessary. Some hospitalization may be entirely avoidable, such as when surgery could be performed at an outpatient facility with equal quality and safety. Also, surgery is sometimes performed when other treatment could be more effective. All of these instances increase costs for JHHSC/JHH and you. To help control these costs, the EHP Medical Plans feature a Care Management Program.

Before you can receive benefits for certain medical services and supplies under the EHP Medical Plans, you must have these services and supplies pre-certified and coordinated through the Johns Hopkins EHP Care Management Program. Your EHP Network doctor will initiate this pre-certification process if you receive Network care under the Basic or Premium Plan. You or your Out-of-Network doctor are required to initiate this pre-certification process if you receive Out-of-Network care under the Premium Plan. If you do not obtain pre-certification, coverage for benefits may be limited or denied entirely. The following services and supplies require pre-certification and coordination through the Care Management Program:

- ◆ Durable medical equipment and medical supplies;

EHP MEDICAL PLANS

- ◆ Hearing aids for dependent children;
- ◆ Home health care;
- ◆ Hospice care;
- ◆ Hospital stays;
- ◆ Hypnosis or biofeedback training for treatment of voiding dysfunction
- ◆ Prosthetic devices and orthotics;
- ◆ Rehabilitation;
- ◆ Skilled nursing facility stays;
- ◆ Speech therapy;
- ◆ Surgical procedures (Certain procedures only, as described on a list maintained by Johns Hopkins Employer Health Programs.);
- ◆ Transplant services; and
- ◆ Use of certain drugs and medications (Certain drugs and medications only, as described on a list maintained by Johns Hopkins Employer Health Programs.).

The purpose of the Care Management Program is to assure you receive quality care that is medically necessary and appropriate. The Program also strives to protect you from significant, and sometimes unnecessary, health care expenses. *The Care Management Program is not intended to diagnose or treat your medical conditions or guarantee benefits.* Rather, the Care Management Program will coordinate the medical care services you receive across the continuum of care.

There are dedicated care managers available to help you in coordinating medical care for both acute and chronic illnesses. They will work closely with you, your Primary Care Physician and your other medical providers to ensure that you have access to appropriate services. Your care manager may also suggest alternative care options and coordinate with providers to improve standards for the medical care you receive. Additionally, your care manager can help you identify non-medical resources, such as social workers or community groups, that can help you.

EHP MEDICAL PLANS

Chronic Care Management Program

The Johns Hopkins EHP Medical Plans are committed to supporting you in managing your health. If you have asthma, diabetes or cardiovascular problems and meet certain criteria, the EHP Medical Plans provide an innovative Chronic Care Management Program to help you.

Some features of the Chronic Care Management Program, depending on your health status, include:

- ◆ Regular monitoring to review your diet, medications and other related health information;
- ◆ Access to disease specialists and your personal nurse case manager;
- ◆ Access to the EHP TeleWatch monitoring system;
- ◆ Educational materials about your condition, tips on managing your symptoms, healthy eating, exercise and stress management.

The Chronic Care Management Program is free and completely voluntary. Your eligibility for benefits under the EHP Medical Plans will not be affected if you participate in the Program or if you withdraw from the Program after you have started.

Becoming more involved in your own health can positively impact many aspects of your life. Johns Hopkins EHP encourages you to consider participating in the Chronic Care Management Program.

Your EHP Medical Plan Identification Card

A Johns Hopkins EHP Medical Plan identification card will be issued to you and each of your covered dependents. Carry your identification card with you at all times and show it to your health care provider whenever you receive medical care.

Only you and your covered dependents are permitted to use the identification card. It is illegal to loan your card to persons who are not covered under the EHP Medical Plans. If you lose your identification card, call a Johns Hopkins EHP Customer Service Representative immediately to request a new card.

Your identification card includes important information and phone numbers about the procedures to follow to receive benefits.

EHP MEDICAL PLANS

EHP Customer Service

An important feature of your EHP Medical Plans is the Customer Service Representatives available to assist you by answering any questions you may have about covered benefits, using your plan, filing a claim, resolving complaints, etc.

If you have a question, EHP Customer Service Representatives are available Monday through Friday, from 8 a.m. to 5 p.m., at 1-800-261-2393 or 410-424-4450.

COVERED SERVICES AND SUPPLIES

What's Covered by the Johns Hopkins EHP Medical Plans

Medical Benefits At-A-Glance

The following chart summarizes most of the benefits and services available under the Johns Hopkins EHP Medical Plans. Except as noted on the chart, EHP Network benefits are the same for the Basic and Premium Plans. Out-of-Network benefits are only provided by the Premium Plan. This chart is not a complete description of benefits. For more information, please refer to the rest of this SPD.

SERVICES PROVIDED	EHP NETWORK PROVIDERS	OUT-OF-NETWORK PROVIDERS
	Basic and Premium Plans	Premium Plan Only
CALENDAR YEAR DEDUCTIBLE		
Per individual	None	\$500
Per family	None	\$1,000
COINSURANCE OUT-OF-POCKET MAXIMUM (INCLUDING DEDUCTIBLE)		
Per individual	N/A	\$3,200
Per family	N/A	\$6,400
PENALTY FOR FAILURE TO OBTAIN PRE-CERTIFICATION		
	N/A	\$500 or possible denial of benefits
MAXIMUM LIFETIME BENEFIT PER PERSON		
Both Plans combined	\$3,000,000	
MAXIMUM LIFETIME BENEFIT PER PERSON FOR SUBSTANCE ABUSE TREATMENT		
Both Plans combined	\$100,000	
1. TREATMENT OF ILLNESS OR INJURY		
Primary care office visit	100% after: \$10 co-pay – Basic \$15 co-pay – Premium	70% of R&C, after deductible
Specialty care office visit	100% after: \$20 co-pay – Basic \$30 co-pay – Premium	70% of R&C, after deductible
Diagnostic services and treatment	100%	70% of R&C, after deductible

BASIC PLAN ONLY COVERS EHP NETWORK CARE COORDINATED BY YOUR PCP

EHP Network Providers have agreed to accept the EHP fee schedule as full payment and will not balance bill the Plan Member above the EHP fee schedule, other than required co-pays, coinsurance, and deductibles. Out-of-Network providers can bill for charges in addition to deductibles and coinsurance. All benefits are subject to medical necessity. This chart is not a complete description of benefits. For more information, please refer to the rest of this SPD.

NOTE: "R&C" is explained under **Payment Terms You Should Know**, earlier in this SPD.

COVERED SERVICES AND SUPPLIES

SERVICES PROVIDED	EHP NETWORK PROVIDERS	OUT-OF-NETWORK PROVIDERS
	Basic and Premium Plans	Premium Plan Only
2. PREVENTIVE SERVICES		
General physical exam (no co-pay for first visit each year) ⁽¹⁾	100% after: \$10 co-pay – Basic \$15 co-pay – Premium	70% of R&C, after deductible
Diagnostic services	100%	70% of R&C, after deductible
Well child care	100% after: \$10 co-pay – Basic \$15 co-pay – Premium	70% of R&C, after deductible
Mammogram	100%	70% of R&C, after deductible
GYN exam (no co-pay for first visit each year) ⁽¹⁾	100% after: \$10 co-pay – Basic \$15 co-pay – Premium	70% of R&C, after deductible
3. IMMUNIZATIONS AND INOCULATIONS		
For common communicable diseases (as approved by Care Management Program)	100%	70% of R&C, after deductible
4. PRESCRIPTION DRUGS		
In-network pharmacy only 34-day supply, includes oral contraceptives and limited smoking cessation products No co-pay for prescribed Prilosec OTC, Claritin OTC and Claritin D OTC	\$10 co-pay – generic \$15 co-pay – brand preferred \$30 co-pay – brand non-preferred	
90-day supply for maintenance drugs	<u>Mail order:</u> \$20 co-pay – generic \$30 co-pay – brand preferred \$60 co-pay – brand non-preferred <u>In-Network pharmacy:</u> \$30 co-pay – generic \$45 co-pay – brand preferred \$90 co-pay – brand non-preferred	
5. ALLERGY TESTS AND PROCEDURES		
Allergy tests	100%	70% of R&C, after deductible
Desensitization materials and serum	100%	70% of R&C, after deductible

BASIC PLAN ONLY COVERS EHP NETWORK CARE COORDINATED BY YOUR PCP

EHP Network Providers have agreed to accept the EHP fee schedule as full payment and will not balance bill the Plan Member above the EHP fee schedule, other than required co-pays, coinsurance, and deductibles. Out-of-Network providers can bill for charges in addition to deductibles and coinsurance. All benefits are subject to medical necessity. This chart is not a complete description of benefits. For more information, please refer to the rest of this SPD.

NOTE: "R&C" is explained under **Payment Terms You Should Know**, earlier in this SPD.

COVERED SERVICES AND SUPPLIES

(1) There is no co-pay for one general physical or one GYN exam per year. If you get both a general physical and a GYN exam in the same year, the co-pay applies to the second visit (and any additional visits).

COVERED SERVICES AND SUPPLIES

SERVICES PROVIDED	EHP NETWORK PROVIDERS	OUT-OF-NETWORK PROVIDERS
	Basic and Premium Plans	Premium Plan Only
6. LABORATORY AND X-RAY PROCEDURES		
Laboratory tests, imaging exams, X-ray exams and Ultrasound	100%	70% of R&C, after deductible
7. SURGICAL PROCEDURES		
Professional services for inpatient and outpatient surgery; Care Management Program coordination may be required	100%	70% of R&C, after deductible ⁽¹⁾
Medically necessary reconstructive and/or surgically implanted prosthetic devices	100%	70% of R&C, after deductible ⁽¹⁾
8. MEDICAL SUPPLIES		
Disposable supplies (e.g., ostomy bags, diabetic supplies, syringes)	100%	70% of R&C, after deductible
9. REPRODUCTIVE HEALTH		
Physician office visits (for prenatal care only)	100%	70% of R&C, after deductible
Full care for the mother during pregnancy including physician, hospitalization, laboratory, and X-ray services	100%	70% of R&C, after deductible ⁽¹⁾
Birthing centers (licensed facility)	100%	70% of R&C, after deductible ⁽¹⁾
Voluntary sterilization	100%	70% of R&C, after deductible ⁽¹⁾
Interruption of pregnancy	100%	70% of R&C, after deductible ⁽¹⁾
Invitro fertilization and artificial insemination; must be coordinated through Care Management Program	Not covered under Basic 100% under Premium after separate \$1,000 deductible ⁽²⁾	Not covered
10. URGENT CARE CENTER		
Physician visit	100%	70% of R&C, after deductible
Diagnostic services and treatment	100%	70% of R&C, after deductible

BASIC PLAN ONLY COVERS EHP NETWORK CARE COORDINATED BY YOUR PCP

EHP Network Providers have agreed to accept the EHP fee schedule as full payment and will not balance bill the Plan Member above the EHP fee schedule, other than required co-pays, coinsurance, and deductibles. Out-of-Network providers can bill for charges in addition to deductibles and coinsurance. All benefits are subject to medical necessity. This chart is not a complete description of benefits. For more information, please refer to the rest of this SPD.

NOTE: "R&C" is explained under **Payment Terms You Should Know**, earlier in this SPD.

- (1) Failure to obtain pre-certification for hospitalization will result in a \$500 penalty or possible denial of benefits.
- (2) \$30,000 lifetime maximum combined including prescription drugs, lab work and X-rays, in-vitro fertilization attempts (any implantation of oocyte) limited to a maximum of three per lifetime within the \$30,000 lifetime maximum, all services provided at Johns Hopkins Institutions only.

COVERED SERVICES AND SUPPLIES

SERVICES PROVIDED	EHP NETWORK PROVIDERS	OUT-OF-NETWORK PROVIDERS
	Basic and Premium Plans	Premium Plan Only
11. EMERGENCY SERVICES		
Emergency care (medical emergencies only, i.e., the onset of a sudden and serious condition requiring immediate care)	\$100 co-pay (waived if admitted)	
12. AMBULANCE TRANSPORTATION		
Ground transportation, or air transportation when medically necessary	100%	100% of R&C
13. HOSPITAL CARE ⁽¹⁾		
Inpatient care (semi-private unless private accommodations are medically necessary); must be coordinated through Care Management Program	100%	\$500 co-pay per hospital admission; then 70% of R&C, after deductible ⁽¹⁾
Intensive care	100%	70% of R&C, after deductible ⁽¹⁾
Other inpatient services including preadmission testing	100%	70% of R&C, after deductible
Hospital inpatient days limitation	None	None
Skilled nursing/rehabilitation facility (120 days per calendar year combined maximum; must be coordinated through Care Management Program)	100%	70% of R&C, after deductible ⁽¹⁾
Outpatient services including outpatient testing prior to outpatient surgery	100%	70% of R&C, after deductible
Outpatient surgery facility charges including freestanding surgical centers	100%	70% of R&C, after deductible
14. CHEMOTHERAPY/RADIATION THERAPY		
Includes physician services and materials	100%	70% of R&C, after deductible

BASIC PLAN ONLY COVERS EHP NETWORK CARE COORDINATED BY YOUR PCP

EHP Network Providers have agreed to accept the EHP fee schedule as full payment and will not balance bill the Plan Member above the EHP fee schedule, other than required co-pays, coinsurance, and deductibles. Out-of-Network providers can bill for charges in addition to deductibles and coinsurance. All benefits are subject to medical necessity. This chart is not a complete description of benefits. For more information, please refer to the rest of this SPD.

NOTE: "R&C" is explained under **Payment Terms You Should Know**, earlier in this SPD.

(1) Failure to obtain pre-certification for hospitalization will result in a \$500 penalty or possible denial of benefits.

COVERED SERVICES AND SUPPLIES

SERVICES PROVIDED	EHP NETWORK PROVIDERS	OUT-OF-NETWORK PROVIDERS
	Basic and Premium Plans	Premium Plan Only
15. ACUPUNCTURE		
For anesthesia, pain control and therapeutic purposes (\$1,500 calendar year combined maximum)	100% after: \$10 co-pay – Basic \$15 co-pay – Premium	70% of R&C, after deductible
16. HOME HEALTH CARE		
Must be coordinated through Care Management Program (40 visits per calendar year combined maximum)	100%	70% of R&C, after deductible
17. HOSPICE CARE		
Inpatient and home; must be coordinated through Care Management Program	100%	70% of R&C, after deductible ⁽¹⁾
18. SPEECH THERAPY		
Non-developmental care; must be coordinated through Care Management Program (30 visits per calendar year combined maximum)	100%	70% of R&C, after deductible
19. PHYSICAL/OCCUPATIONAL THERAPY		
60 visits per calendar year combined maximum by licensed physical or occupational therapist only	100%	70% of R&C, after deductible
20. CHIROPRACTIC CARE		
Restricted to initial exam, X-rays and spinal manipulations (\$1,500 calendar year combined maximum)	100% after: \$10 co-pay – Basic \$15 co-pay – Premium	70% of R&C, after deductible
21. DURABLE MEDICAL EQUIPMENT AND SUPPLIES		
Equipment, prosthetic appliances and medical supplies; must be coordinated through Care Management Program	100%	70% of R&C, after deductible

BASIC PLAN ONLY COVERS EHP NETWORK CARE COORDINATED BY YOUR PCP

EHP Network Providers have agreed to accept the EHP fee schedule as full payment and will not balance bill the Plan Member above the EHP fee schedule, other than required co-pays, coinsurance, and deductibles. Out-of-Network providers can bill for charges in addition to deductibles and coinsurance. All benefits are subject to medical necessity. This chart is not a complete description of benefits. For more information, please refer to the rest of this SPD.

NOTE: "R&C" is explained under **Payment Terms You Should Know**, earlier in this SPD.

(1) Failure to obtain pre-certification for hospitalization will result in a \$500 penalty or possible denial of benefits.

COVERED SERVICES AND SUPPLIES

MENTAL HEALTH AND SUBSTANCE ABUSE SERVICES	Care Coordinated by Clinical Case Manager Basic and Premium Plans*	Care Not Coordinated by Clinical Case Manager Premium Plan Only*
Inpatient care for mental health (30 days per calendar year combined maximum)	100% ⁽¹⁾	\$500 co-pay per hospital admission, then 80% of R&C after deductible ⁽¹⁾ ₍₃₎
Outpatient treatment for mental health (52 visits per calendar year combined maximum)	100% for first 30 visits per year after: \$10 co-pay – Basic \$15 co-pay – Premium Then, 50% for next 22 visits:	50% of R&C after deductible ⁽³⁾ ⁽⁴⁾
Inpatient care for substance abuse (30 days per calendar year combined maximum) Inpatient care for alcohol abuse (7 days per calendar year combined maximum for alcohol detoxification only)	100% ⁽¹⁾	\$500 co-pay per hospital admission, then 80% of R&C after deductible (\$20,000 calendar year maximum benefit) ⁽¹⁾ ⁽³⁾
Outpatient treatment for substance abuse and alcohol detoxification (30 visits per calendar year combined maximum)	100% after: \$10 co-pay – Basic \$15 co-pay – Premium	50% of R&C after deductible (\$2,500 calendar year maximum benefit) ⁽³⁾ ⁽⁴⁾

BASIC PLAN ONLY COVERS CARE COORDINATED BY A CLINICAL CASE MANAGER

EHP Network providers have agreed to accept the EHP fee schedule as full payment and will not balance bill the Plan Member above the EHP fee schedule, other than required co-pays, coinsurance, and deductibles. Out-of-Network providers can bill for charges in addition to deductibles and coinsurance. All benefits are subject to medical necessity. This chart is not a complete description of benefits. For more information, please refer to the rest of this SPD.

NOTE: “R&C” is explained under **Payment Terms You Should Know**, earlier in this SPD.

- (1) Failure to obtain pre-certification for hospitalization can result in a denial of benefits.
- (3) This coinsurance does not apply to the coinsurance out-of-pocket maximum.
- (4) Services for outpatient Mental Health and Substance Abuse visits that are initially applied to the calendar year deductible will not count towards the 52 visits per year maximum.

*A Clinical Case Manager must coordinate your care or the Basic Plan will not pay benefits. Under the Premium Plan, all day and visit limits are combined for care coordinated or not coordinated by a Clinical Case Manager. To receive a higher level of benefits under the Premium Plan, a Clinical Case Manager must coordinate your care. A Clinical Case Manager is a mental health professional who will help you determine the best course of treatment for you. Your Clinical Case Manager will refer you to a Johns Hopkins EHP Network provider. If you have Premium Plan coverage, you may refer yourself to any provider in or out of the EHP Network. However, if you refer yourself to a mental health professional or facility without the help of a Clinical Case Manager, there will be a substantial reduction in your benefits. You can contact a Clinical Case Manager at (410) 424-4476 or (800) 261-2429.

Please note: There is a separate lifetime maximum benefit of \$100,000 for treatment of substance abuse.

COVERED SERVICES AND SUPPLIES

Covered Services and Supplies

The Johns Hopkins EHP Medical Plans provide benefits for the services and supplies listed in this section. Only services and supplies that are *medically necessary* are covered.

A medically necessary service or supply is one that the Plan Administrator determines:

- Diagnoses, prevents or treats a covered medical condition;
- Is appropriate for the symptoms, diagnosis or treatment of the covered medical condition;
- Is supplied or performed in accordance with current standards of medical practice within the United States of America;
- Is not primarily for the convenience of the covered person, facility or provider;
- Is the most appropriate supply or level of service that can safely be provided; and
- Is recommended or approved by the attending professional provider.

In the case of an inpatient admission, medically necessary also means treatment that could not adequately be provided on an outpatient basis.

Benefit limits, coinsurance and co-pay amounts are described in the **Medical Benefits At-A-Glance** chart. The chart highlights the major benefits that are payable.

In General

Covered services and supplies include the following (when medically necessary and subject to any conditions or limitations as described elsewhere in this SPD):

- ◆ Abortion (elective);
- ◆ Acupuncture for anesthesia, pain control and therapeutic purposes provided by a licensed acupuncturist;
- ◆ Adult preventive services;
- ◆ Ambulance services;
- ◆ Ambulatory surgical center;
- ◆ Anesthetics and oxygen, and their administration;

COVERED SERVICES AND SUPPLIES

- ◆ Artificial limbs and eyes;
- ◆ Birthing facilities;
- ◆ Blood products, if not replaced;
- ◆ Casts, splints;
- ◆ Chiropractic care for misalignment or partial dislocation of or in the vertebral column and correction by manual or mechanical means of nerve interference;
- ◆ Consultation services by a specialist in the medical field for which the consultation relates. Staff consultation required by the facility is not covered;
- ◆ Contraceptive devices, limited to IUDs and diaphragms only;
- ◆ Convalescent facility care and home health care;
- ◆ Cosmetic/reconstructive surgery when due to:
 - Accidental injury or illness (unless the Plans would exclude coverage for the injury or illness for a reason other than it occurred before coverage began);
 - Correction of a congenital malformation of a child, or
 - Treatment for morbid obesity, as described below under “Obesity treatment”;
- ◆ Dental services if rendered as initial treatment as a result of an accident causing injury to sound natural teeth and treatment is provided within 48 hours of the accident;
- ◆ Depo provera;
- ◆ Diabetic supplies (must be coordinated by EHP Care Management Program);
- ◆ Diagnostic X-rays and laboratory services;
- ◆ Doctors’ (including surgeons’) fees for treatment of illness or injury;
- ◆ Doctors’ fees and hospital charges for maternity care;
- ◆ Doctors’ fees for office visits;

COVERED SERVICES AND SUPPLIES

- ◆ Durable medical and surgical equipment (rental), including wheelchairs. Durable medical equipment is medical equipment which:
 - Can withstand repeated use;
 - Is primarily and customarily used to serve a medical purpose;
 - Is generally not useful to a person in the absence of illness or injury;
 - Is appropriate for use in the home; and
 - Is not primarily for the convenience of the patient;
- ◆ Emergency services;
- ◆ Foot care for incision and drainage of infected tissues of the foot, removal of lesions, treatment of fractures and dislocations of bone in the foot;
- ◆ Foot orthotics that are:
 - custom-molded and related to a specific medical diagnosis; or
 - an integral part of a leg brace and the cost is included in the orthotist's charge.
- ◆ Freestanding dialysis facility;
- ◆ Gastric bypass surgery – see “Obesity treatment” below.
- ◆ Hearing aids for dependent children under age 18 up to \$1400 per aid. The aids must be prescribed, fitted, and dispensed by a licensed audiologist. Replacement aids are available only once every three years and must be pre-certified thru the Care Management Program.
- ◆ Home health care;
- ◆ Hospice care;
- ◆ Hospital charges for covered semi-private room and board and other hospital-provided services and supplies;
- ◆ Hypnosis or biofeedback training, but only for treatment of voiding dysfunction and must be pre-certified thru the Care Management Program;
- ◆ Infertility services (covered under Premium Plan only), provided that:
 - You have one continuous year of coverage by the Premium Plan;
 - Care Management Program pre-certifies treatment;

COVERED SERVICES AND SUPPLIES

- You and your spouse have a history of continuous infertility as a married couple for at least *two* consecutive years immediately before receiving infertility treatment, or have a specific, medically documented infertility diagnosis;
 - Treatment is provided by JHH institutions. This requirement is waived for IVF services if JHH institutions will not provide the IVF services. However, this requirement is **not** waived if the reason why JHH institutions will not provide the IVF services is because (1) the IVF services are not medically necessary, or (2) other infertility treatment (such as artificial insemination) should be tried first. Treatment received at non-JHH institutions is covered as treatment received from an Out-of-Network provider, regardless of whether or not the provider is In-Network;
 - The husband's sperm and the wife's egg are used for IVF services (three IVF implantation limit);
 - The order of infertility treatment options has followed a logical succession of medically appropriate and cost-effective care;
 - Infertility is not related to a previous sterilization by you or your spouse;
 - Treatment is provided for married couples only, and not in domestic partnership situations; and
 - The mother must be covered by the Premium Plan.
-
- ◆ Laboratory tests;
 - ◆ Lyme disease vaccinations, provided the patient's PCP (Basic Plan) or Network doctor (Premium Plan) classifies the patient as "high risk" for developing Lyme disease;
 - ◆ Mental health and substance abuse benefits;
 - ◆ Midwifery services;
 - ◆ Newborn care;
 - ◆ Nursing services (professional) by a registered nurse or licensed practical nurse who is not a close relative (spouse, child, grandchild, brother, sister, brother-in-law, sister-in-law, parent, or grandparent) of the patient;
 - ◆ Obesity treatment – non-surgical treatment for employees only, as part of the Johns Hopkins Weight Management Program. Your employer pays 50% of the charges for your participation in the Program. The other 50% is charged to you and covered by this Plan as follows. You must first pay a \$300 annual deductible, regardless of whether you have Basic or Premium Plan coverage. After that, both the Basic and Premium Plan cover 70% of the amount charged to you and you pay the remaining 30%. The maximum benefit payment by the Plan per calendar year is \$1,000.

COVERED SERVICES AND SUPPLIES

- ◆ Obesity treatment – surgical treatment for morbid obesity when Body Mass Index (BMI) (weight in kilograms/height in meters squared) is greater than 40, or equal to or greater than 35 with a co-morbid medical condition, including hypertension, a cardiopulmonary condition, sleep apnea, or diabetes. Surgery must be pre-certified by the Care Management Program and all services must be provided at Johns Hopkins institutions. You must first pay a \$1,000 deductible per surgery. Surgery is covered under the Premium Plan only.
- ◆ Obesity treatment – surgical treatment for overhanging, stretching or laxity of skin, but only if medically necessary as a result of surgical or non-surgical treatment for morbid obesity. Limited to a lifetime benefit maximum of \$5,000. Surgery must be pre-certified by the Care Management Program and is covered under the Premium Plan only.
- ◆ Prosthetic devices and orthotics that are integral to the device;
- ◆ Rehabilitation services;
- ◆ Second surgical opinions;
- ◆ Skilled nursing facility services;
- ◆ Surgical dressings and medical supplies;
- ◆ Surgical procedures;
- ◆ Temporomandibular Joint Syndrome (TMJ) treatment and/or orthognathic surgery, limited to physical therapy, surgery and ortho devices such as mouthguards and intraoral devices (excludes orthodontics and prosthetics);
- ◆ Therapies, including:
 - Chemotherapy;
 - Dialysis treatment;
 - Nutrition counseling (annual visit exclusive of procedures and testing);
 - Occupational, physical and speech therapy provided by a licensed occupational, physical, or speech therapist, that is required because of an illness or accidental injury. Speech therapy is limited to therapy aimed at restoring the level of speech the individual had attained before the onset of a condition. Stuttering, articulation disorders, tongue thrust and lispng, and maintenance therapy are not covered;
 - Radiotherapy;
- ◆ Transplants;

COVERED SERVICES AND SUPPLIES

- ◆ Vasectomies and tubal ligations;
- ◆ Well-child care; and
- ◆ X-ray, radium, and radioisotope treatment.

Following are descriptions of other services and supplies covered by the EHP Medical Plans.

Prescription Drug Benefits

Benefits are paid for prescription drugs designated as such under federal law, as well as injectable insulin, diabetic supplies (needles and syringes when prescribed with insulin only), and other medicines and supplies designated by Johns Hopkins Employer Health Programs. The EHP Medical Plans prescription drug benefits also cover birth control pills. You can receive a supply equal to 34 days. Prescription drug benefits also cover Viagra, provided:

- The member is male;
- There is a documented organic cause of erectile dysfunction;
- The treating provider is an EHP Network provider; and
- The maximum monthly number of doses is limited to six with refills limited to three months per prescription.

EHP Network Pharmacies

You ***must*** obtain prescription drugs from an EHP Network pharmacy to receive benefits under both the Basic and Premium Plans. Your Johns Hopkins EHP provider directory has a complete list of Network pharmacies. *No benefits are provided if drugs are purchased from an Out-of-Network pharmacy.*

An EHP Network pharmacy has an arrangement to provide prescription drugs to you at an agreed upon price. When you buy covered drugs from an EHP Network pharmacy, present your Johns Hopkins EHP Medical Plan identification card to the pharmacist. You should request and retain a paid receipt for your co-pay amount if you need it for income tax purposes or to submit a claim to your Health Care Flexible Spending Account.

Please note: Your pharmacist may need to obtain pre-certification before dispensing certain prescription drugs, which may delay filling your prescription.

COVERED SERVICES AND SUPPLIES

Co-pay

The co-pays are the same for the Basic and Premium Plans. You pay a \$10 co-pay for each separate prescription or refill for a generic drug. The co-pay is \$15 for a brand name preferred drug and \$30 for a brand name non-preferred drug, regardless of whether a generic version is available. For maintenance drugs, you may receive a 90-day supply at three times the normal monthly co-pay for that prescription. Or, you may use the EHP Medical Plans' Mail Order program, presently offered through Advance Rx. Through this program, you can receive a 90-day supply of maintenance drugs each time you order. Your co-pay through the Mail Order program is \$20 for each separate prescription or refill of a generic drug. The Mail Order co-pay is \$30 for brand name preferred drugs and \$60 for brand name non-preferred drugs. If you have any questions about the Mail Order program, call EHP.

Medication Co-pay Waiver Program

Starting January 1, 2008, as part of the "Healthy@Hopkins" program, if you receive treatment for asthma or diabetes that is covered by the EHP Medical Plan, you may be eligible to have the co-pay waived for certain medications you take for treatment of your condition.

Contact the Care Management Program by phone at 410-762-5213 or 800-261-2396 (extension 5213), or by email at healthyhopkins@jhhc.com. Ask for a copy of the Medication Copay Waiver Agreement and the Frequently Asked Questions piece. They will provide you with details about the program and what you must do to have your co-pay waived. You may be required to report routine test results and/or discuss your progress with a personal care nurse assigned to you. If you are already enrolled in the Chronic Care Management Program, you should automatically receive a copy of the Medication Copay Waiver Agreement from your care manager.

Not all medications for treatment of asthma and diabetes are eligible for co-pay waiver, but many of the most widely prescribed medications are. The Frequently Asked Questions piece contains a list of the medications that are currently eligible. JHHSC/JHH may add or remove medications from the list in the future.

What's Not Covered

No prescription drug benefits will be paid for the following:

- ◆ Any amounts you are required to pay directly to the pharmacy for each prescription or refill;
- ◆ Drugs or medications that are not approved for treatment of a condition by the FDA;
- ◆ With regard to the Mail Order program, any drug which requires refrigeration, except insulin;
- ◆ Any charge for administration of drugs or insulin;
- ◆ Smoking cessation medications, except as described below under *Smoking Cessation*;

COVERED SERVICES AND SUPPLIES

- ◆ Drugs that are not prescribed for the treatment of an illness or injury. For example, the Plans do not cover vitamins, Psoralens, Tretonin, anorexants or diet pills, or Minoxidil;
- ◆ Methadone;
- ◆ Schedule V-exempt narcotics; and
- ◆ Hypodermic needles and syringes (other than for diabetic use).

Over-the-Counter Drugs

Prescription drug benefits are normally not provided for a drug or medication that is available “over-the-counter” (“OTC”) A drug or medication is considered to be OTC if it can be obtained without a prescription, regardless of whether or not your doctor gives you a prescription for it. However, prescription drug benefits are provided for Prilosec OTC, Claritin OTC and Claritin D OTC, but only if your doctor prescribes these drugs and you show the pharmacist your prescription at time of purchase. No co-pay applies when you obtain prescribed Prilosec OTC, Claritin OTC and Claritin D OTC.

COVERED SERVICES AND SUPPLIES

Smoking Cessation

The Johns Hopkins EHP Medical Plans cover a 90 day supply per calendar year of smoking cessation products. The benefit is provided for employees and spouses/domestic partners only. The benefit covers a 90 day supply of either Zyban or nicotine patches or nicotine gum – the choice is up to you.

The smoking cessation benefit also covers a 90 day supply per calendar year of Chantix. An additional 90 day supply of Chantix per calendar year will be covered if prescribed by your physician.

Emergency Services

It is not easy to think clearly in a medical emergency. Knowing what to do before you are faced with an emergency can help you get appropriate care at the higher benefit level.

Emergency Medical Situation

In an emergency medical situation, you should go to the nearest medical facility for immediate care. An emergency medical situation is one in which a prudent layperson determines that:

- ◆ Immediate care is needed as the result of a sudden and serious illness or injury; and
- ◆ Care is required to prevent:
 - permanently placing your health in danger;
 - causing other serious medical consequences;
 - causing serious impairment to bodily functions; or
 - causing serious permanent dysfunction of any bodily organ or part.

For treatment of an emergency medical situation under the EHP Medical Plans -- Basic and Premium - - your care will be covered under the EHP Network benefit regardless of whether or not the emergency room facility participates in the EHP Network. Emergency room care is covered in full, after a \$100 co-pay. This co-pay will be waived if you are admitted. If you go to an Out-of-Network emergency room facility, the EHP Medical Plans will not pay more than the Reasonable and Customary charge for the treatment you receive.

If your emergency medical situation is such that you are able to be moved to an EHP Network facility and you choose not to be transferred, then after you are able to be moved:

- benefits will no longer be paid by the Basic Plan; and
- benefits will be paid by the Premium Plan at 70% of the R&C charges, after the Out-of-Network deductible.

COVERED SERVICES AND SUPPLIES

You (or someone on your behalf) must notify Johns Hopkins Employer Health Programs within 48 hours after receiving emergency room care outside the State of Maryland or it will not be covered by the EHP Medical Plans. If you receive treatment in an emergency room for a condition that is not an emergency medical situation, the EHP Medical Plans will not pay benefits.

If you have Basic Plan coverage, if at all possible, contact your PCP to coordinate your care before proceeding to an emergency room. You or your emergency room doctor can call your PCP directly from the emergency room, if necessary. He or she may be able to tell you the best way to handle your present situation to avoid a long, unnecessary wait in the emergency room.

Urgent Care Centers

An urgent care center is a facility licensed to provide medical services for unexpected illnesses or injuries that require prompt medical attention, but are not life- or limb-threatening. If you have Basic Plan coverage, your PCP is unable to see you, and you need prompt medical attention for a condition that is not an emergency medical situation, you may go to an urgent care center. If you have Premium Plan coverage and you need prompt medical attention for a condition that is not an emergency medical situation, you may also go to an urgent care center.

If you go to a Johns Hopkins EHP Network urgent care center, your care will be covered at 100% under the EHP Network benefit. Remember, if you have Basic Plan coverage you must go to an EHP Network urgent care center or the Basic Plan will not pay benefits. If you go to an Out-of-Network urgent care center, only the Premium Plan will pay benefits. Your care will be covered at 70% of the R&C charges, after the Out-of-Network deductible. You pay the remaining amounts, plus any amounts over R&C.

Out-Of-Area Care

Basic Plan

If you have Basic Plan coverage, unforeseeable medical care received while out of the Johns Hopkins EHP Network service area, including out-of-area emergency room care, will be covered as follows:

- For any unforeseeable medical treatment (including unforeseeable prescription drugs) required while traveling outside the EHP Network service area, claims will be paid at 100% of the Reasonable and Customary charge for covered services and drugs, after the appropriate co-pay, as long as you have selected a PCP and your PCP authorizes the care or prescription drugs. This provision only applies to treatment or prescription drugs that are received before it is safe to return to the EHP Network service area and does not include treatment or drugs that could have reasonably been anticipated before leaving the area. You (or someone on your behalf)

COVERED SERVICES AND SUPPLIES

must notify Johns Hopkins Employer Health Programs within 48 hours after the treatment or prescription drugs are received or they will not be covered.

- If you have not selected a PCP or if your PCP does not authorize care, no benefits will be provided for out-of-area treatment or prescription drugs.

Premium Plan

If you have Premium Plan coverage, claims for medical care received while traveling outside the EHP Network service area will be paid by the Premium Plan at 70% of the R&C charges, after the Out-of-Network deductible for covered services. For any unforeseeable prescription drugs required while traveling outside the Johns Hopkins EHP Network service area, claims will be paid at 100% of the Reasonable and Customary charge for the drugs, after the appropriate co-pay. This provision does not include prescription drugs that could have reasonably been anticipated before leaving the EHP Network service area.

Coverage for Students

If your dependent child goes to school outside the EHP Network service area, care received for unforeseeable medical treatment and emergency situations is covered by the EHP Medical Plans at 100% of the Reasonable and Customary charge, provided Johns Hopkins Employer Health Programs is notified within 48 hours after the care is received.

Routine or foreseeable care provided outside the EHP Network service area is not covered by the Basic Plan. Routine or foreseeable care provided outside the EHP Network service is covered by the Premium Plan at 70% of the R&C charges, after the Out-of-Network deductible for covered services.

You (or someone on your behalf) must notify Johns Hopkins Employer Health Programs of any out-of-area care (including emergency room care) within 48 hours. If notice is not given on time, no coverage will be provided by the Basic Plan, and Premium Plan coverage will be provided under the Out-of-Network benefit.

Ambulance Services

The EHP Medical Plans cover both air and ground ambulance transportation services when the following criteria are met:

- ◆ Because of an accident or emergency medical situation, it is medically necessary to transport you to the hospital; or
- ◆ It is medically necessary to transport you from a hospital as an inpatient to another hospital, because:
 - The first hospital lacks the equipment or expertise necessary to care for you;

COVERED SERVICES AND SUPPLIES

- You are transported directly from a hospital to a skilled nursing facility or rehabilitation facility;
- As determined medically appropriate through the Care Management Program.

Air ambulance services are covered only if it is medically necessary to be transported by air and not by ground.

Vision Benefits

The EHP Medical Plans cover a full range of optometry and ophthalmology vision care services through the Johns Hopkins Routine Vision Care Network. The Premium Plan also covers vision care services from Out-of-Network providers. You can receive Johns Hopkins Routine Vision Care Network services at any of these provider sites: Wilmer Comprehensive Eye Care Services (located at The Wilmer Eye Institute at The Johns Hopkins Hospital), Green Spring Station, Severna Park, and the Bayview Medical Center. You can also receive Network optometry services at Pearle Vision Centers, Penn Optical, and other locations throughout the Baltimore Metropolitan area. For a complete listing of Network provider sites, refer to the Johns Hopkins Routine Vision Care Network section of the EHP provider directory, available from Johns Hopkins EHP or the HR Service Center or go to www.ehp.org.

Vision benefits are paid as follows, depending upon whether you use a Johns Hopkins Routine Vision Care Network provider (Basic or Premium Plan) or an Out-of-Network provider (Premium Plan only):

<i>Covered Vision Services</i>	<i>Johns Hopkins Routine Vision Care Network (Basic and Premium)</i>	<i>Out-of-Network (Premium only)</i>
Routine exam (once every 12 months, includes contact lens fitting fee)	100%, after \$10 co-pay – Basic and Premium	Up to \$35
Materials (once every 12 months):	\$10 co-pay – Basic and Premium, then:	
Single Vision	Up to \$37.50	Up to \$35
Bifocal	Up to \$46	Up to \$40
Trifocal	Up to \$58.50	Up to \$55
Lenticular	Up to \$88	Up to \$80

COVERED SERVICES AND SUPPLIES

<i>Covered Vision Services</i>	<i>Johns Hopkins Routine Vision Care Network (Basic and Premium)</i>	<i>Out-of-Network (Premium only)</i>
Frames	Up to \$35	Up to \$35
Contact Lenses		
Medically Necessary	Up to \$165	Up to \$165
Elective	Up to \$95	Up to \$95

Please Note: Benefits are provided for necessary or elective contact lenses in lieu of lenses and frames. This means that you can get either eyeglasses or contact lenses in a 12-month period, but not both. Network providers offer a group of selected frames at prices that do not exceed the maximum frame benefit set forth in the chart above. You are responsible for charges above the maximum benefit.

Charges for the following will not be covered under the EHP Medical Plans:

- ◆ Any eye examination or any corrective eye wear required as a condition of employment;
- ◆ Blended lenses;
- ◆ Charges for lost or broken lenses and frames, except at the normal intervals when services are otherwise covered;
- ◆ Coating the lens or lenses;
- ◆ Cosmetic lenses and optional cosmetic processes;
- ◆ Laminating the lens or lenses;
- ◆ Material costs which exceed the maximum benefits as shown in the previous chart;
- ◆ Oversize lenses;
- ◆ Photochromic lenses; tinted lenses except Pink #1 and Pink #2;
- ◆ Progressive multifocal lenses;
- ◆ Services or supplies not provided by a licensed physician, optometrist, or ophthalmologist;
- ◆ Special procedure services and supplies such as orthoptics and vision training, or in connection with medical or surgical treatment of the eye;
- ◆ Two pair of glasses in lieu of bifocals; and
- ◆ Ultraviolet (UV) protected lenses.

Maternity Benefits

Even if you were not enrolled in the EHP Medical Plans before your first pre-natal visit, you may still receive benefits during your pregnancy and delivery.

COVERED SERVICES AND SUPPLIES

Basic Plan

If you have Basic Plan coverage, the Plan covers 100% of your prenatal care, routine tests, and delivery when you receive care that is coordinated by your designated EHP Network OB/GYN PCP, or that is provided by an EHP Network OB/GYN with a referral from your regular PCP. If you receive care that is not coordinated by your designated EHP Network OB/GYN PCP and that was not referred from your regular PCP, the Basic Plan does not pay benefits. Hospital or birthing center expenses are treated just like any other covered hospital stay. Midwife delivery services provided by a licensed midwife are also eligible for coverage.

Premium Plan

If you have Premium Plan coverage, the Plan covers 100% of your prenatal care, routine tests, and delivery when you receive care from an EHP Network OB/GYN. Care received from an Out-of-Network OB/GYN is covered at 70% of the R&C charges, after the deductible, and you are responsible for any remaining charges. Hospital or birthing center expenses are treated just like any other covered hospital stay. Midwife delivery services provided by a licensed midwife are also eligible for coverage.

The EHP Medical Plans will provide maternity benefits for a mother and eligible newborn child for hospital stays up to:

- ◆ 48 hours following a vaginal delivery; or
- ◆ 96 hours, if the delivery is performed by cesarean section.

If the doctor and new mother agree that the stay does not need to be 48 (or 96) hours, the new mother and baby may leave the hospital as soon as it is medically approved. If the stay is to be longer than 48 hours (or 96 hours), Johns Hopkins Employer Health Programs must authorize the additional time.

Women's Health and Cancer Rights Act of 1998

The EHP Medical Plans provide benefits for participants electing breast reconstruction in connection with a mastectomy. These include:

- ◆ Reconstruction of the breast on which the mastectomy has been performed,
- ◆ Surgery and reconstruction of the other breast to provide a symmetrical appearance, and
- ◆ Prosthesis and physical complications for all stages of a mastectomy, including lymphedemas (swelling associated with the removal of lymph nodes).

The manner of coverage is determined in consultation with the attending physician and patient. Normal plan co-pays and lifetime maximums will apply.

COVERED SERVICES AND SUPPLIES

Alternative Care

Sometimes, following a serious illness or major surgery, you may need follow-up care. Generally, this care does not need to be provided in a hospital. Alternative care includes home health care and/or skilled nursing care. In the case of a terminal illness, hospice care is often a viable alternative to a hospital setting. The EHP Medical Plans pay benefits toward a variety of these alternative care services.

Home Health Care Benefits

*Please note: All home health care services must be pre-certified under the **Care Management Program** described earlier in this SPD.*

Home health care is often recommended when you are able to handle tasks like feeding and bathing yourself, but still require medical attention. It also offers the comfort of receiving care in familiar surroundings, rather than a hospital room.

Home health care services and supplies must be provided by a licensed health care organization to be covered. No benefits are paid for services performed by a close relative or anyone living in your household. Each home health care visit is limited to four hours.

Basic Plan

If you have Basic Plan coverage, the Plan pays 100% of the charges for covered home health care services referred by your PCP. No benefits are provided by the Basic Plan without a PCP referral.

Premium Plan

If you have Premium Plan coverage, the Plan pays 100% of the charges for covered home health care services received from EHP Network providers. The Premium Plan pays 70% of the R&C charges, after the deductible, for covered services received from Out-of-Network providers and you are responsible for any remaining charges.

For both the Basic and Premium Plans, covered home health care services include:

- ◆ Part-time or intermittent skilled nursing care by a nurse;
- ◆ Part-time or intermittent home health aide services for a patient who is receiving covered nursing or therapy services;
- ◆ Physical, respiratory, occupational and speech therapy when provided by a home health care agency;

COVERED SERVICES AND SUPPLIES

- ◆ Medical and surgical supplies when provided by a home health care agency (excluding non-injectable prescription drugs);
- ◆ Injectable prescription drugs (after a \$30 co-pay per 30 day supply);
- ◆ Oxygen and its administration; and
- ◆ Medical and social service consultations.

Covered home health care services ***do not*** include the following:

- ◆ Domestic or housekeeping services;
- ◆ Rental or purchase of equipment or supplies;
- ◆ Meals-on-wheels or other similar food arrangements;
- ◆ Care provided in a nursing home or skilled nursing facility (see ***Skilled Nursing Facility Benefits*** discussed below);
- ◆ More than 40 visits per calendar year;
- ◆ Home care for mental health conditions; and
- ◆ Custodial care.

Skilled Nursing Facility Benefits

Please note: Your stay in a skilled nursing facility must be pre-certified under the Care Management Program described earlier in this SPD.

A skilled nursing facility is a special facility that offers 24-hour nursing care outside of a traditional hospital setting.

Basic Plan

If you have Basic Plan coverage, the Plan pays 100% of the charges for covered skilled nursing facility services referred by your PCP. No benefits are provided by the Basic Plan without a PCP referral.

Premium Plan

If you have Premium Plan coverage, the Plan pays 100% of the charges for covered skilled nursing facility services received from EHP Network providers. The Premium Plan pays 70% of the R&C charges, after the deductible, for covered services received from Out-of-Network providers and you are responsible for any remaining charges.

COVERED SERVICES AND SUPPLIES

For both the Basic and Premium Plans, covered skilled nursing facility services include:

- ◆ Room and board;
- ◆ Use of special treatment rooms;
- ◆ X-ray and laboratory examinations;
- ◆ Physical, occupational or speech therapy;
- ◆ Oxygen and other gas therapy; and
- ◆ Drugs, biological solutions, dressings and casts.

The patient's PCP (Basic Plan) or physician (Premium Plan) must prescribe care in a skilled nursing facility and the patient must be under a physician's supervision throughout the stay. Benefits will not be provided for more than 120 days per calendar year. However, once in an employee's lifetime up to an additional 75 days of benefits may be provided during one calendar year, subject to the following:

- ◆ the stay in the skilled nursing facility must be required in connection with a surgical procedure that is covered under the EHP Medical Plans;
- ◆ only employees are eligible for additional days, not spouses or dependents;
- ◆ home care must have been attempted but determined to be medically unsatisfactory;
- ◆ the employee must have at least 30 years of service with JHHSC/JHH.

In order to be covered by the EHP Medical Plans, a skilled nursing facility may not:

- ◆ Be used mainly as a place for rest or a place for the aged;
- ◆ Provide treatment primarily for such mental disorders as drug addiction, alcoholism, chronic brain syndrome, mental retardation or senile deterioration; or
- ◆ Provide custodial, hospice or educational care of any kind.

Hospice Care Benefits

*Please note: Hospice care must be pre-certified under the **Care Management Program** described earlier in this SPD.*

Hospice care is often recommended for terminally ill patients. Hospice care helps keep the patient as comfortable as possible and provides supportive services to the patient and his or her family. Patients who can no longer be helped by a hospital, but require acute medical care, can be moved to a hospice facility, if available. The patient is cared for by a team of professionals and volunteer workers, which generally includes a doctor and a registered nurse, and may include a dietary counselor, home health aide, medical social worker and others.

COVERED SERVICES AND SUPPLIES

The goals of the hospice are to provide an alert and pain-free existence for the patient and to keep the family actively involved in the care.

Basic Plan

If you have Basic Plan coverage, the Plan pays 100% of the charges for covered hospice care services referred by your PCP. No benefits are provided by the Basic Plan without a PCP referral.

Premium Plan

If you have Premium Plan coverage, the Plan pays 100% of the charges for covered hospice care services received from Network providers. The Premium Plan pays 70% of the R&C charges, after the deductible, for covered hospice care services received Out-of-Network and you are responsible for any remaining charges.

For both the Basic and Premium Plans, covered hospice care services include:

- ◆ Inpatient care;
- ◆ Nutritional counseling and special meals;
- ◆ Part-time nursing;
- ◆ Homemaker services;
- ◆ Durable medical equipment;
- ◆ Doctor home visits; and
- ◆ Bereavement and counseling services.

Certain benefits may be paid for outpatient (in-home) hospice care. For details, please call EHP Customer Service.

Hospice care services ***do not*** include the following:

- ◆ Any curative or life prolonging procedures;
- ◆ Services of a close relative or an individual who normally resides in the patient's home; and
- ◆ Any period when the individual receiving care is not under a physician's care.

Transplants

Please note: All transplants must be pre-approved and pre-certified under the Care Management Program described earlier in this SPD. Procurement of the organ and performance of the transplant must take place at a Johns Hopkins Employer Health Programs designated transplant center in the United States.

COVERED SERVICES AND SUPPLIES

The EHP Medical Plans will pay benefits for non-experimental and non-investigational transplants of the human heart, kidney, lung, heart/lung, bone marrow, liver, pancreas and cornea. No benefits are paid for transplants that are experimental (as defined later in this SPD under **What's Not Covered by the EHP Medical Plans**). Coverage is contingent upon continuing to meet the criteria for Employer Health Programs transplant approval until the date of the transplant. Covered services include:

- ◆ Inpatient or outpatient hospital charges for treatment and surgery by a Johns Hopkins Employer Health Programs designated transplant center;
- ◆ Tissue typing;
- ◆ Removal of the organ;
- ◆ Obtaining, storing, and transporting the organ; and
- ◆ Travel expenses for the recipient, if medically necessary, to and from the transplant center.

No benefits will be paid for the following:

- ◆ Organ transplant charges incurred without prior approval by the Care Management Program, or at a transplant center which was not designated by Johns Hopkins Employer Health Programs;
- ◆ The transplant of an organ which is synthetic, artificial, or obtained from other than a human body;
- ◆ An organ transplant or organ procurement performed outside the United States;
- ◆ An organ transplant which the Plan Administrator determines to be experimental; and
- ◆ Expenses of an organ donor, except when the recipient is a participant in this Plan who receives the organ in a covered organ transplant. When coordinating with the donor's health plan, the EHP Medical Plans will be secondary. If an organ is sold (i.e., not donated), no benefits are paid for the donor's expenses.

Mental Health and Substance Abuse Services

The Johns Hopkins EHP Medical Plans provides inpatient mental health and substance abuse care, including alcohol detoxification. Outpatient treatment includes psychotherapy and counseling for substance abuse. There is a total lifetime combined inpatient and outpatient maximum benefit of \$100,000 for substance abuse treatment.

Basic Plan

If you have Basic Plan coverage, a Clinical Case Manager must coordinate your care or the Basic Plan will not pay benefits. A Clinical Case Manager is a mental health professional who will help you determine the best course of treatment and refer you to a Johns Hopkins EHP Network provider.

Premium Plan

COVERED SERVICES AND SUPPLIES

If you have Premium Plan coverage, you will receive a higher level of benefits if a Clinical Case Manager coordinates your care. You also have the option to obtain care without using a Clinical Case Manager, but the Premium Plan will pay lower benefits if you do. You may refer yourself to any provider in or out of the Johns Hopkins EHP Network. The choice is yours. However, if you refer yourself to a provider without the help of a Clinical Case Manager, there will be a substantial reduction in your benefits.

You can contact a Clinical Case Manager at 410-424-4476 or 1-800-261-2429. Or, you may contact the Faculty and Staff Assistance Program at 410-955-1220.

EHP Network Providers

The Johns Hopkins EHP Network includes a variety of specialists to meet your needs, including psychiatrists, psychologists and licensed certified social workers. All EHP Network providers are experienced professionals, licensed in the state where they practice. They share the EHP Network's philosophy of quality care provided in the least restrictive manner. Mental health and substance abuse Network providers offer a full range of counseling services, including individual therapy, family counseling, group therapy, addiction recovery programs and special therapy sessions.

Care Coordinated By A Clinical Case Manager – Basic or Premium Plan

Outpatient mental health care: If you obtain outpatient mental health care that ***is coordinated*** by a Clinical Case Manager, covered services are paid in full by either Plan after a \$10 co-pay (Basic) or \$15 co-pay (Premium) for up to 30 visits per calendar year. Up to an additional 22 visits per year are covered at 50%, and you pay the remaining 50%. If you have Premium Plan coverage, these limits are in combination with any care you receive that is ***not coordinated*** by a Clinical Case Manager.

Outpatient substance abuse care: If you obtain outpatient substance abuse care that ***is coordinated*** by a Clinical Case Manager, covered services are paid in full by either Plan after a \$10 co-pay (Basic) or \$15 co-pay (Premium) for up to 30 visits per calendar year. If you have Premium Plan coverage, these limits are in combination with any care you receive that is ***not coordinated*** by a Clinical Case Manager.

Inpatient mental health care: If you obtain inpatient mental health care that ***is coordinated*** by a Clinical Case Manager, covered services are paid in full by either Plan for up to 30 days of treatment per calendar year. You pay no co-pay. If you have Premium Plan coverage, this limit is in combination with any care you receive that is ***not coordinated*** by a Clinical Case Manager.

Inpatient substance abuse care: If you obtain inpatient substance abuse care that ***is coordinated*** by a Clinical Case Manager, covered services are paid in full by either Plan for up to 30 days of treatment

COVERED SERVICES AND SUPPLIES

per calendar year. You pay no co-pay. Treatment for alcohol detoxification is limited to seven days per calendar year. You may not receive benefits for more than 30 days of inpatient substance abuse treatment per calendar year (including treatment for alcohol detoxification). If you have Premium Plan coverage, this limit is in combination with any care you receive that is ***not coordinated*** by a Clinical Case Manager.

Care Not Coordinated By A Clinical Case Manager – Premium Plan Only

If you have Premium Plan coverage, you may choose to access care directly by contacting a licensed psychiatrist, psychologist, or certified social worker who is practicing within the scope of his or her license. When you obtain care directly you pay the required amounts before the Premium Plan will pay benefits, as described in the **Medical Benefits At-A-Glance** chart earlier in this SPD. However, you must still call a Clinical Case Manager at one of the confidential numbers (410-424-4476 or 800-261-2429) to request pre-certification before being admitted as an inpatient.

Note: *You must receive pre-certification from a Clinical Case Manager before being admitted for all inpatient, inpatient residential, and outpatient facility treatment programs for mental health and substance abuse services. The confidential number to call is (410) 424-4476 or (800) 261-2429. Failure to obtain pre-certification can result in a denial of coverage.*

Outpatient mental health care: If you choose to refer yourself for outpatient mental health care that is ***not coordinated*** by a Clinical Case Manager, Premium Plan benefits will be paid at 50% of the R&C charges, after the deductible. You pay the remaining 50%, plus any amounts in excess of the R&C charges. Covered services are paid for up to 52 visits per calendar year. Please note the limits on days covered are in combination with any care you receive that ***is coordinated*** by a Clinical Case Manager.

Outpatient substance abuse care: If you choose to refer yourself for outpatient substance abuse care that is ***not coordinated*** by a Clinical Case Manager, Premium Plan benefits will be paid at 50% of the R&C charges, after the deductible, up to a maximum of \$2,500 in any calendar year. You pay the remaining 50%, plus any amounts in excess of the R&C charges and any amounts over \$2,500 in any calendar year. Covered services are paid for up to 30 visits per calendar year. Please note the limits on days covered are in combination with any care you receive that ***is coordinated*** by a Clinical Case Manager.

Inpatient mental health care: If you choose to refer yourself for inpatient mental health care that is ***not coordinated*** by a Clinical Case Manager, Premium Plan benefits will be paid at 80% of the R&C charges, after the deductible and after a separate \$500 co-pay for the admission. You pay the remaining 20%, plus any amounts in excess of R&C charges. In addition, a complete denial of benefits can apply if you do not obtain pre-certification for the admission. You may receive up to 30 days of treatment per calendar year in combination with any care you receive that ***is coordinated*** by a Clinical Case Manager.

COVERED SERVICES AND SUPPLIES

Inpatient substance abuse care: If you choose to refer yourself for inpatient substance abuse care that is ***not coordinated*** by a Clinical Case Manager, Premium Plan benefits will be paid at 80% of the R&C charges, after the deductible and after a separate \$500 co-pay for the admission. You pay the remaining 20%, plus any amounts in excess of the R&C charges. In addition, a complete denial of benefits can apply if you do not obtain pre-certification for the admission. The annual maximum benefit for alcohol detoxification is seven days per calendar year. You may receive up to 30 days of inpatient substance abuse treatment per calendar year (including days of treatment for alcohol detoxification) in combination with any care you receive that ***is coordinated*** by a Clinical Case Manager. In addition, there is a benefit maximum of \$20,000 per calendar year for inpatient substance abuse care.

Please note: Coinsurance and co-pays for mental health and substance abuse care do not count toward your annual out-of-pocket maximum.

WHAT'S NOT COVERED

What's Not Covered by The EHP Medical Plans

The Johns Hopkins EHP Medical Plans do not cover the following:

- ◆ Charges excluded under the **Coordination of Benefits** provisions set forth later in this SPD;
- ◆ Charges that would not be made if no coverage by the Plans existed;
- ◆ Charges for which you are not legally required to pay;
- ◆ Charges in excess of the Reasonable and Customary charge or above the allowable lifetime or annual maximums;
- ◆ Claims filed more than 12 months after the expenses were incurred;
- ◆ Confinement, treatment, services, or supplies received before your (or your dependent's) effective date of coverage under the Plans or after the termination date of coverage;
- ◆ Contraceptive devices, including Norplant or the removal of Norplant (IUDs and diaphragms are not excluded);
- ◆ Controlled substances, hallucinogens or narcotics not administered on the advice of a doctor;
- ◆ Convenience items, such as telephone and television rental, slippers, meals for family members, or first aid kits and supplies;
- ◆ Cosmetic/reconstructive surgery. However, cosmetic/reconstructive surgery is covered if needed:
 - because of an accidental injury or illness that is covered by the Plans (or that would be covered by the Plans but for the fact that the injury or illness occurred before eligibility began);
 - because of a congenital malformation of a child, or
 - following treatment for morbid obesity, as described earlier in this SPD under **Covered Services and Supplies**;
- ◆ Coverages refused by another plan as a penalty for non-compliance with that plan's requirements;
- ◆ Custodial care, residential care or rest cures;
- ◆ Dental treatment except in connection with an accidental injury to sound natural teeth that is part of the initial emergency treatment within 48 hours after the accident;

WHAT'S NOT COVERED

- ◆ Drugs that are non-prescription, non-legend or over-the-counter;
- ◆ Drugs or devices not approved by the FDA for marketing and/or for the prescribed treatment of a specific diagnosis unless approved by the Johns Hopkins EHP Care Management Program;
- ◆ Emergency room services or treatments in other than emergency situations;
- ◆ Equipment that does not meet the definition of Durable Medical Equipment provided earlier in this SPD under **Covered Services and Supplies**, including air conditioners, humidifiers, dehumidifiers, purifiers or physical fitness equipment, whether or not recommended by a doctor;
- ◆ Experimental treatment, defined as the use of any treatment, procedure, equipment, device, drug or drug usage which the Plan Administrator determines, in its sole and absolute discretion, is being studied for safety, efficiency and effectiveness and/or which has not received or is awaiting endorsement for general use within the medical community by government oversight agencies, or other appropriate medical specialty societies at the time services are rendered.

The Plan Administrator will make a determination on a case by case basis, using the following principles as generally establishing that something is experimental:

- If the drug or device cannot be lawfully marketed without approval of the U.S. Food and Drug Administration and approval for marketing has not been given at the time the drug or device is furnished;
- If the drug, device, equipment, treatment or procedure, or the patient informed consent document utilized with the drug, device, equipment, treatment or procedure, was reviewed and approved by the treating facility's Institutional Review Board or other body serving a similar function, or if Federal law requires such review or approval;
- If Reliable Evidence shows that the drug, device, equipment, treatment or procedure is the subject of ongoing phase II clinical trials; is the subject of research, experimental study or the investigational arm of ongoing phase III clinical trials; or is otherwise under study to determine its maximum tolerated dose, its toxicity, its safety, its efficacy or its efficacy as compared with a standard means of treatment or diagnosis;
- If Reliable Evidence shows that the prevailing opinion among experts regarding the drug, device, equipment, treatment or procedure is that further studies or clinical trials are necessary to determine its maximum tolerated dose, its toxicity, its safety, its efficacy or its efficacy as compared with a standard means of treatment or diagnosis.

“Reliable Evidence” means only published reports and articles in the authoritative medical and scientific literature; the written protocols used by the treating facility or the protocol(s) of another facility studying substantially the same drug, device, equipment, treatment or procedure; or the written

WHAT'S NOT COVERED

informed consent used by the treating facility or by another facility studying substantially the same drug, device, equipment, treatment or procedure;

- ◆ Foot devices, unless (1) they are an integral part of a leg brace and the cost is included in the orthotist's charge; or (2) they are custom-molded and related to a specific medical diagnosis. Orthopedic shoes (not integral to a brace), diabetic shoes, supportive devices for the feet and orthotics used for sport and leisure activities are not covered;
- ◆ Glasses, contact lenses, eye refractions, or the examinations for their fitting or prescription, except when medically necessary after cataract surgery or as described under ***Vision Benefits***, earlier in this SPD;
- ◆ Hearing aids, or the examination for their fitting or prescription (except for dependent children as described under **Covered Services and Supplies** earlier in this SPD);
- ◆ Hypnosis or biofeedback training, except for treatment of voiding dysfunction as explained under **Covered Services and Supplies** earlier in this SPD;
- ◆ Immunizations related to travel unless approved by the Center for Disease Control guidelines for the countries to be visited;
- ◆ Injury sustained or an illness contracted while committing a crime;
- ◆ Injury sustained or an illness resulting from war, act of war, act of terrorism, riot, rebellion, civil disobedience, or from military service in any country;
- ◆ Injury sustained while riding on a motorcycle, unless the covered person was wearing a helmet approved by state law;
- ◆ Marital counseling;
- ◆ Myopia or hyperopia correction by means of corneal microsurgery, such as keratomileusis, keratophakia, radial keratotomy or laser surgery and all related services;
- ◆ Nicotine addiction treatment or smoking cessation programs, except as described under ***Smoking Cessation*** earlier in this SPD;
- ◆ Obesity treatment, including surgical procedures for weight reduction or for treatment of conditions resulting from being overweight, except as described under **Covered Services and Supplies** earlier in this SPD;

WHAT'S NOT COVERED

- ◆ Pre-existing conditions, except as described under **Pre-Existing Conditions** earlier in this SPD;
- ◆ Private room charges beyond the amount normally charged for a semi-private room, unless a private room is medically necessary;
- ◆ Replacement of braces or prosthetic devices, unless there is sufficient change in the patient's physical condition to make the original brace or device no longer functional;
- ◆ Reversals of sterilization procedures, such as vasectomies and tubal ligations;
- ◆ Routine foot care (including any service or supply related to corns, calluses, flat feet, fallen arches, non-surgical care of toenails, and other symptomatic complaints of the feet);
- ◆ Self-inflicted injury or illness, unless the self-infliction was the result of a mental illness such that application of this exclusion would violate ERISA Section 702;
- ◆ Services and supplies paid in full or in part under any other plan of benefits provided by JHHSC/JHH, a school, or a government, or for services you are not required to pay for;
- ◆ Services and supplies not recommended or approved by a doctor;
- ◆ Services and supplies required as a condition of employment;
- ◆ Services and supplies not specifically listed as covered in this SPD;
- ◆ Services performed by a doctor or other professional provider enrolled in an education, research, or training program when such services are primarily provided for the purposes of education, research, or training program;
- ◆ Sexual dysfunction treatment not related to organic disease;
- ◆ Support garments;
- ◆ Surgical treatment for overhanging, stretching or laxity of skin, except in connection with obesity treatment as described under **Covered Services and Supplies** earlier in this SPD;
- ◆ Surrogate motherhood treatment, including any charges related to giving birth or for treatment of the newborn child resulting from the surrogate motherhood;

WHAT'S NOT COVERED

- ◆ Telephone consultation charges, missed appointment charges or charges for the completion of claim forms;
- ◆ Transsexualism, gender dysphoria, or sexual reassignment or change, including medication, implants, hormone therapy, surgery, medical or psychiatric treatment;
- ◆ Treatment which is not medically necessary, as described under **Covered Services and Supplies** earlier in this SPD;
- ◆ Treatment which is not performed by an appropriate licensed professional provider acting within the scope of the provider's license;
- ◆ Treatment for:
 - an injury arising out of, or in the course of, any employment for wage or profit; or
 - a disease covered with respect to your employment, by any Workers' Compensation law, occupational disease law, or similar legislation;
- ◆ Treatment covered by no-fault auto insurance, or any other federal or state-mandated law;
- ◆ Treatment for which a third party may be liable, unless otherwise payable as described under **When the EHP Medical Plans And Short Term Disability Plan May Recover Payment**, later in this SPD;
- ◆ Treatment by a provider who is a close relative of the patient (spouse, child, grandchild, brother, sister, brother in law, sister in law, parent or grandparent) or who resides in the patient's home;
- ◆ Vision training or eye exercises to increase or enhance visual activity or coordination; and
- ◆ Wigs and artificial hair pieces (except in cases of baldness resulting from chemotherapy, radiation therapy or surgery, in which case benefits are limited to one wig once every 24 months, not to exceed \$400, as coordinated through the Care Management Program).

Please note: The above list cannot address all possible medical situations. If you are not sure if a service or supply is covered after reviewing this list, please call Johns Hopkins EHP Customer Service at (410) 424-4450 or (800) 261-2393.

JOHNS HOPKINS EHP DENTAL PLANS

Johns Hopkins EHP Dental Plans

The Johns Hopkins EHP Dental Plans benefits described in this section are administered by Johns Hopkins Employer Health Programs.

There are two Johns Hopkins EHP Dental Plans for you to choose from: the Comprehensive Plan and the High Option Plan. You choose the Plan that you want each year during open enrollment. Both offer a broad range of dental care services for you and your family. The Dental Plans differ in the services they provide and how much you pay out of your pocket. Both Plans offer you basic and preventive care services, such as cleanings, X-rays, annual check-ups, and fillings. You can save money under either Plan when you use dentists who are in the Johns Hopkins EHP Dental Network.

If you have any questions about your benefits under the EHP Dental Plans, call EHP Dental Customer Service at 1-800-516-0646.

Out-of-pocket Expenses

When you receive services from EHP Network dentists, there is no annual deductible to meet under either Plan. However, you will have to pay an annual (calendar year) deductible under both Plans before benefits will be paid for services received from Out-of-Network dentists. The annual deductible amounts under both Plans are \$50 per person and \$150 per family. Expenses incurred by two or more individuals can meet the family deductible. However, no one individual will be required to satisfy more than the individual deductible.

Maximum Benefits

Under the Comprehensive Plan, there is a \$1,500 combined annual (calendar year) benefit maximum per person for all preventive, basic and major dental services. Under the High Option Plan, the combined annual (calendar year) benefit maximum is \$3,000 per person. In addition, there is a separate lifetime maximum benefit of \$1,500 per person for orthodontic services (available under the High Option Plan only).

JOHNS HOPKINS EHP DENTAL PLANS

Dental Benefits At-A-Glance

The following chart provides a summary side-by-side comparison of the EHP Dental Plans. This chart is not a complete description of benefits. Refer to the description of the covered services which follows the chart for more detail.

Covered Services	Comprehensive Plan		High Option Plan	
	<i>In-network</i>	<i>Out-of-network</i>	<i>In-network</i>	<i>Out-of-network</i>
Calendar year deductible	None	\$50 per person \$150 per family	None	\$50 per person \$150 per family
Calendar year benefit maximum	\$1,500 combined per person per year		\$3,000 combined per person per year	
Preventive services				
Exams (two per calendar year)	100%	80% of R&C, after deductible	100%	80% of R&C, after deductible
X-rays (once every 36 months)	100%	80% of R&C, after deductible	100%	80% of R&C, after deductible
Bitewing X-rays (once per calendar year)	100%	80% of R&C, after deductible	100%	80% of R&C, after deductible
Sealants for children under age 15	100%	80% of R&C, after deductible	100%	80% of R&C, after deductible
Topical fluoride treatment for children under age 18	100%	80% of R&C, after deductible	100%	80% of R&C, after deductible

NOTE: “R&C” (“Reasonable and Customary”) is the usual fee charged by similar providers for the same services or supplies in the same geographic area. Johns Hopkins Employer Health Programs determines what is a Reasonable and Customary Charge. An Out-of-Network provider can charge more than the Reasonable and Customary Charge and you will be responsible for the difference.

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Covered Services	Comprehensive Plan		High Option Plan	
	<i>In-network</i>	<i>Out-of-network</i>	<i>In-network</i>	<i>Out-of-network</i>
Basic services				
Fillings	80%	60% of R&C, after deductible	80%	60% of R&C, after deductible
Endodontics	80%	60% of R&C, after deductible	80%	60% of R&C, after deductible
Oral surgery	80%	60% of R&C, after deductible	80%	60% of R&C, after deductible
Treatment of gum disease (Periodontics)	80%	60% of R&C, after deductible	80%	60% of R&C, after deductible
General anesthesia	80%	60% of R&C, after deductible	80%	60% of R&C, after deductible
Major services*				
Crowns, Inlays and Onlays	50%	30% of R&C, after deductible	60%	40% of R&C, after deductible
Bridges	50%	30% of R&C, after deductible	60%	40% of R&C, after deductible
Dentures (full or partial)	50%	30% of R&C, after deductible	60%	40% of R&C, after deductible
Orthodontia	Not covered	Not covered	50%, up to lifetime max of \$1,500	Not covered

NOTE: "R&C" ("Reasonable and Customary") is the usual fee charged by similar providers for the same services or supplies in the same geographic area. Johns Hopkins Employer Health Programs determines what is a Reasonable and Customary Charge. An Out-of-Network provider can charge more than the Reasonable and Customary Charge and you will be responsible for the difference.

**Pre-treatment review is recommended for all major services.*

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What the EHP Dental Plans Cover

Both the Comprehensive Plan and High Option Plan cover the following services at the levels shown on the **Dental Benefits At-A-Glance** chart:

Preventive and Diagnostic Services

- ◆ Fluoride treatments for children under age 18, up to two applications per calendar year;
- ◆ Palliative emergency treatment;
- ◆ Routine oral exams and cleanings, not more than twice per calendar year;
- ◆ Sealant on permanent teeth for children under age 15, once per tooth every 36 months; and
- ◆ X-rays:
 - A full mouth series, once every 36 months; and
 - One set of bite-wing X-rays every calendar year.

Basic Services

- ◆ Endodontic treatment, including root canal therapy;
- ◆ Extractions;
- ◆ Fillings;
- ◆ General anesthetics given in connection with oral surgery when medically necessary;
- ◆ Injection of antibiotic drugs;
- ◆ Oral pathology biopsy;
- ◆ Oral surgery;
- ◆ Periodontal treatment and treatment of other diseases of the gums and tissues of the mouth, once every 24 months; and
- ◆ Pulpotomy.

Major Services

- ◆ Inlays, onlays, gold fillings, crowns and installation of fixed bridges for the first time. Gold fillings are covered only if no other restoration method is possible;
- ◆ Installation of partial or full dentures for the first time, including adjustments for six months following installation (dentures are not covered until you have been covered under an EHP Dental Plan for 12 consecutive months);
- ◆ Repair or recementing of crowns, inlays, or bridges;
- ◆ Repair or relining of dentures (not more than once every 24 months); and

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- ◆ Replacement of an existing partial or full denture, crown, or fixed bridge by a new denture, crown, or fixed bridge, or the addition of teeth to an existing denture or bridge to replace extracted natural teeth (subject to the Prosthesis Replacement Rule, described below).

Orthodontia

Orthodontia benefits are provided for adults and children under the High Option Plan only. The patient must be covered under the High Option Plan for 12 consecutive months before orthodontia services are covered. Only services provided by an EHP dental network orthodontist are covered. The Plan pays 25% of the orthodontist's covered cost when treatment begins or is first covered by the Plan. The balance of the covered cost is paid out over the treatment period, up to a maximum period of 24 months. Services are covered at 50% with no deductible, up to a lifetime maximum of \$1,500 per person. Please note that benefits will not be paid to repair or replace an orthodontic appliance. Also, if treatment stops before it is completed, only those services and supplies that are received before treatment stops will be covered.

Prosthesis Replacement Rule

To receive benefits for certain replacements or additions to existing dentures, crowns or bridgework, you must provide satisfactory proof that:

- ◆ The replacement or addition of teeth is required to replace one or more teeth extracted after the existing crown, denture or bridgework was installed; or
- ◆ The present denture, crown or bridgework cannot be made serviceable, and it is at least five years old; or
- ◆ The present denture is an immediate temporary one that cannot be made permanent. Replacement by a permanent denture must be necessary and must take place within six months from the date the immediate temporary one was first installed.

In all cases, the patient must have been covered under an EHP Dental Plan for 12 consecutive months before prosthesis replacement services are covered.

Pre-Treatment Review

Pre-treatment review is designed to give you and your dentist a better understanding of the benefits payable under the EHP Dental Plans before services are provided. A pre-treatment review is recommended if dental services are expected to cost \$500 or more, or for certain treatments including bone surgery, bridges, crowns, inlays (post and core) and onlays, periodontic procedures and veneers.

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For any of these treatments, we recommend that your dentist provide a proposed course of treatment and a pre-treatment estimate.

Most dentists are familiar with pre-treatment review. Here's how it works:

1. Before beginning a course of treatment that is expected to cost \$500 or more, ask your dentist to submit to Johns Hopkins Employer Health Programs a pre-treatment review form describing the treatment plan and indicating the itemized services and charges.
2. Based upon the treatment plan, Johns Hopkins Employer Health Programs will determine what expenses are covered by the Plan and notify you and your dentist.
3. Ask your dentist to submit a revised treatment plan to Johns Hopkins Employer Health Programs if there is a major change in your course of treatment.

Please note: Emergency treatments and oral exams (including cleanings and X-rays) are considered part of a treatment plan. However, these services may be performed before the pre-treatment review is made.

Use Network Dentists and Save

Your Johns Hopkins EHP Dental Plans offer you the choice to receive dental services from Network or Out-of-Network dentists. However, you can save money on your dental bills by using Network dentists. That's because the dentists who participate in the EHP Dental Network have agreed to charge reduced fees for their services, and both Plans pay a higher level of benefits for services received from Network dentists. The Johns Hopkins EHP Dental Network currently includes approximately 300 participating dentists.

Alternate Treatment

There is often more than one solution to a dental problem. In dentistry, new technology and procedures give dentists many treatment choices – and the costs for each can vary greatly. When an alternate treatment can be performed without compromising the quality of care, the EHP Dental Plans will pay benefits only for the lower cost treatment. The purpose of this rule is to assure that your dentist is using cost-efficient alternatives.

For example, let's suppose your tooth can be restored with an amalgam filling, and you and your dentist select another type of restoration (gold, for example). The EHP Dental Plans will limit payment to the covered charge for the amalgam or other similar material. You and your dentist may decide to use gold fillings, but the Plans will only cover the cost of amalgam and you will be responsible for the difference.

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For this reason, it is important to obtain a pre-treatment estimate before you receive dental work. This way, you'll know up front what the Plans will pay and what will not be covered.

What The EHP Dental Plans Do Not Cover

The EHP Dental Plans do not cover the following:

- ◆ Bleaching techniques;
- ◆ Crowns of porcelain or acrylic veneer or pontics on or replacing upper and lower first, second and third molars;
- ◆ Devices or appliances that are lost, missing or stolen;
- ◆ Extra sets of dentures or other appliances;
- ◆ General anesthesia unless medically necessary and given in connection with oral surgery;
- ◆ Implants (crowns for implants are covered);
- ◆ Mouthguards, except for bruxism (clenching);
- ◆ Procedures started before you became covered under the Plans (not applicable to orthodontia benefits);
- ◆ Services or supplies for which coverage would be excluded for one of the reasons set forth under **What's Not Covered Under the EHP Medical Plans**;
- ◆ Services or supplies which are not dental services or supplies;
- ◆ Services or supplies provided by a JHHSC/JHH medical department, clinic or similar facility;
- ◆ Services or supplies ordered while you are covered under the Plans, but not delivered or installed within 30 days after your coverage ends;
- ◆ Services or supplies that do not meet the standards of dental practice;
- ◆ Services or supplies that are cosmetic in nature, including personalization of dentures, unless required as a result of an accident or illness that occurred while covered by the Plans;

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- ◆ Services or supplies to correct vertical dimension, periodontal splinting or implantology;
- ◆ Temporomandibular joint dysfunction (TMJ) syndrome, disorders of the disc, muscles, and/or inflammation of the joints, Costen-Syndrome or similar disorder (these may be covered under your medical plan);
- ◆ Training or supplies used for dietary counseling, oral hygiene or plaque control; and
- ◆ Treatment by someone other than a dentist. However, the Plans do cover certain services when provided by a dental hygienist acting within the scope of his or her license.

Election of No Dental Benefits

The EHP Dental Plans are optional benefits and are not included as part of EHP Medical Plans coverage. No coverage by the Dental Plans is provided unless you elect coverage in accordance with your Guide to Benefits booklet.

FLEXIBLE SPENDING ACCOUNTS

Flexible Spending Accounts

Your JHHSC/JHH Employee Benefits Plan for Non-Represented Employees offers you two tax-saving Flexible Spending Accounts (FSAs):

- ◆ The Health Care Flexible Spending Account; and
- ◆ The Dependent Care Flexible Spending Account.

You can contribute part of your paycheck each pay period to one or both of these Accounts. Contributions are deducted from your paycheck on a pre-tax basis. Reimbursements of eligible expenses are non-taxable.

You can contribute to an FSA regardless of whether you elect coverage under the EHP Medical Plans or you waive coverage.

Health Care FSA

When you contribute to the Health Care FSA, you can be reimbursed for eligible health care expenses with pre-tax dollars. Eligible expenses are those that meet IRS guidelines and are not otherwise covered by any other health care plan.

Dependent Care FSA

When you contribute to the Dependent Care FSA, you can be reimbursed for eligible dependent day care expenses with pre-tax dollars. Eligible expenses are day care charges for eligible dependent(s) during the time that you are at work.

When You Can Contribute to an FSA

You must sign up each year during open enrollment if you wish to contribute to an FSA. Your contributions will begin on January 1, or after your election to begin contributing following an eligible family status change (described earlier in this SPD under **Changing Your Coverage**). If you are a new employee, you can begin contributing on the first of the month following your date of hire, provided you have completed and returned your enrollment form within seven days after your date of hire.

How Much You Can Contribute to an FSA

Health Care FSA: you can contribute up to \$5,000 per calendar year (minimum of \$5.00 per bi-weekly pay, maximum of \$192.30 per bi-weekly pay).

FLEXIBLE SPENDING ACCOUNTS

Dependent Care FSA: you can contribute up to \$5,000 per calendar year (\$2,500 if you are married and file a separate tax return) (minimum of \$10 per bi-weekly pay, maximum of \$192.30 per bi-weekly pay).

The maximum contribution amounts include any unused flexible benefit credits that are applied to make your FSA contributions. It is better to contribute a little less than you think you will need, rather than more. As explained later in this section, if you do not use it, you will lose it.

Each FSA is separate. Money contributed to a Health Care FSA can only be used to reimburse you for eligible health care expenses. Likewise, money contributed to a Dependent Care FSA can only be used to reimburse you for eligible dependent day care expenses. You may not move money from one FSA to the other.

How to Use the FSAs

To best take advantage of the tax savings offered by the FSAs, follow these steps.

Step One -- Estimate Your Expenses

Estimate the amount you spend on health care expenses that are not covered by your or your spouse's health care plan, and/or the amount you spend on dependent day care expenses each year. To do this, you should review your expenses from previous years and think about predictable expenses in the upcoming year. Eligible expenses are described later in this Section.

Please note: If you are a new hire or otherwise start contributing mid-year, estimate your expenses only from the date you start contributing to the end of the calendar year.

Step Two -- Calculate Your Payroll Deductions

Next, determine the amount that you will contribute to your FSA(s) each bi-weekly pay period. To do so, divide your annual expected eligible health care expenses and/or dependent care expenses by 26 pay periods. (The *Health Care and Dependent Care FSA Worksheets* set forth below can help you figure your expected eligible expenses.) This gives the amount you should elect to contribute to your FSA(s) each bi-weekly pay period (subject to the minimum and maximum contribution amounts set forth above).

For example, suppose you expect to have \$1,200 in uncovered health care expenses next calendar year. To be reimbursed for these expenses from your Health Care FSA, you could contribute \$46.15 of your paycheck each pay period. Your taxable income would be reduced by \$1,200 for the year and you would pay taxes on the reduced amount.

FLEXIBLE SPENDING ACCOUNTS

Once you elect how much to contribute for a calendar year, you cannot change that election until the next year, unless you have a qualified family status change (see **Changing Your Coverage**, earlier in this SPD). Any change in the amount you contribute must be consistent with your family status change.

If you enroll for part of the calendar year, because you are a new hire or had a qualified family status change, your annual contribution would be divided by the number of remaining pay periods in that year. That amount would then be deducted from your paycheck each pay period and contributed to your FSA for the remainder of that calendar year.

For example, if you contribute to an FSA for 13 pay periods during a year and chose to contribute \$260 for the year, you would contribute \$20 per pay.

Step Three -- Submit a Claim for Reimbursement

When you have an eligible expense, you will need to submit a claim form to receive reimbursement from your FSA. Specific information about submitting claim forms to each of the FSAs is described later in this section.

Use It or Lose It

Be sure to estimate your health and dependent care expenses carefully. According to federal law, you lose any money left in your FSAs at the end of the calendar year. However, you do have until March 31 of the next calendar year to submit any expenses incurred during the previous year. After that time, any remaining money is lost.

Eligible Health Care Expenses

Some examples of eligible health care expenses that can be reimbursed from your Health Care FSA include:

- ◆ Out-of-pocket medical, vision and dental care expenses, such as deductibles, co-pays, coinsurance amounts and amounts over annual maximums;
- ◆ Out-of-pocket preventive care expenses;
- ◆ Non-prescription drugs that are used to treat an injury or illness (such as antacids, allergy medications, pain relievers and cold medicines);
- ◆ Laser eye surgery;
- ◆ Vision care, including out-of-pocket expenses for eyeglasses, contact lenses and contact lens solution;
- ◆ Retin-A for acne treatment;
- ◆ Nicotine patches for smoking cessation; and
- ◆ Out-of-pocket hearing care expenses.

FLEXIBLE SPENDING ACCOUNTS

Some examples of expenses that may not be reimbursed from the Health Care FSA include:

- ◆ Cosmetic surgery (unless to correct a deformity resulting from a congenital abnormality, an accidental injury, or a disfiguring disease);
- ◆ Health club dues;
- ◆ Non-prescription drugs that are merely beneficial to your health (such as vitamins or dietary supplements);
- ◆ Cosmetics and toiletries;
- ◆ Weight loss programs (unless directed to participate by your physician to treat a specific disease);
- ◆ Non-prescription sunglasses; and
- ◆ Other health care insurance premiums.

For a complete list of eligible expenses, please see IRS Publication 502, available from the HR Service Center or go to www.irs.gov. Items shown in the list of “What Medical Expenses Are Deductible” in Publication 502 (other than health insurance or HMO premiums) are generally eligible for reimbursement from the Health Care FSA. Non-prescription drugs (which are not deductible) can also be reimbursed if they qualify as explained above.

Health Care FSA Worksheets

You may use the following worksheets to help you estimate your eligible health care expenses and calculate how much to contribute to your Health Care FSA.

Take a look at your health care expenses that are not covered by any plan during the year, and try to predict your expenses for the following year. You should review your medical, dental and vision benefits carefully before trying to predict your expenses.

FLEXIBLE SPENDING ACCOUNTS

Health Care FSA Worksheet # 1

Use this worksheet to help estimate your eligible health care expenses:

Eligible Expenses	Your estimated out-of-pocket costs
Medical, dental and vision deductibles	\$ _____
Medical, dental and vision co-pays	\$ _____
Medical, dental and vision expenses over the amount covered by your benefit plans	\$ _____
Hearing expenses not covered by your medical plan	\$ _____
Special education or communication equipment for covered blind or deaf persons	\$ _____
Other non-covered health care expenses	\$ _____
Annual Total	\$ _____
Divided by the number of pay periods (26 for a full calendar year)	\$ _____

Remember, the maximum amount you may contribute to a Health Care FSA is \$5,000, or \$192.30 per bi-weekly pay period (minimum of \$5.00 per bi-weekly pay period).

FLEXIBLE SPENDING ACCOUNTS

Health Care FSA Worksheet # 2

If you itemize uninsured health care expenses and deduct them on your income tax return, you may not be reimbursed for the same expenses from your Health Care FSA. You may use this worksheet to help you decide which method will work best for you: deducting health care expenses on your tax return or using the Health Care FSA.

1. Calculate your adjusted gross income \$ _____
2. Multiply this amount by 7.5% X 7.5% _____
3. The minimum amount of health care expenses you must have to be eligible to deduct health care expenses on your tax return \$ _____

If your total uninsured health care expenses are ***less than*** the amount on Line 3, you cannot deduct any expenses on your tax return. However, you can be reimbursed for these expenses from your Health Care FSA on a pre-tax basis and thus save on your taxes.

If your total uninsured expenses are ***more than*** the amount on Line 3, you have the choice of deducting the ***excess*** expenses on your tax return, or being reimbursed for all your expenses (up to the amount you contribute) from the Health Care FSA. Keep in mind, you may only deduct those expenses that are more than 7.5% of your adjusted gross income. Because of that, generally it is more advantageous to use the Health Care FSA.

Filing a Claim for Reimbursement From the Health Care FSA

To receive reimbursement from your Health Care FSA, you must submit a claim form, available from the HR Service Center. Please provide your medical plan's description of what was paid (if the expenses were covered under your or your spouse's health care plan), as well as bills, receipts, and any other documentation of your expenses.

If you submit a claim for more than the balance in your FSA, you will be reimbursed up to the full amount you elect to contribute over the entire year minus any reimbursements you have already received for the year. Your future contributions will cover the amount of your claim. You will receive an Explanation of Payment with your reimbursement check. Reimbursement checks are processed bi-weekly.

FLEXIBLE SPENDING ACCOUNTS

You may fax your claim to 1-888-342-5333 or mail it to:

Ceridian Benefit Services
P.O. Box 9101
Clearwater, FL 33758-9101

Using the Dependent Care FSA

You may be reimbursed from the Dependent Care Flexible Spending Account for day care expenses incurred for dependents who live with you and require care either inside or outside of your home. Reimbursements are tax free. To qualify, your dependents must be:

- ◆ Children under age 13 for whom you can claim an income tax exemption; or
- ◆ Your spouse, children (age 13 and older) or parents, who are physically or mentally unable to care for themselves and who live in your home for at least half of the calendar year. In addition, children and parents cannot have annual taxable income (from pensions, interest, dividends, rents, trusts, etc.) greater than the personal exemption amount for tax purposes (\$3,300 for 2006.) Social Security benefits are not counted as taxable income for this test.

Eligible Dependent Care Expenses

Following are examples of eligible dependent care expenses that may be reimbursed from the Dependent Care FSA:

- ◆ Day care centers for children or the elderly;
- ◆ Day camp;
- ◆ Nursery school (not kindergarten);
- ◆ Day care in a nursing home; and
- ◆ In-home day care.

You may not use the Dependent Care FSA for dependent health care expenses.

Eligible Day Care Providers

You may be reimbursed for dependent care expenses only if the person or organization providing the care is not your own child under age 19 or a dependent you are claiming on your income tax return. If the day care provider is an individual, you must show that person's Social Security Number when you submit your claim for reimbursement. If the day care provider is an organization, you must provide their tax identification number to receive reimbursement.

FLEXIBLE SPENDING ACCOUNTS

When You May Use the Dependent Care FSA

You are eligible for reimbursements from a Dependent Care FSA if you are a single parent, or if you are married and your spouse:

- ◆ Works;
- ◆ Is looking for work;
- ◆ Goes to school full-time; or
- ◆ Is mentally or physically incapable of caring for themselves.

When Both Spouses Participate in Dependent Care FSAs

You and your spouse may both contribute to the Dependent Care FSA if you both work for JHHSC/JHH. In addition, if you contribute to the FSA and your spouse's employer also offers a dependent care FSA, you and your spouse may both contribute to these separate FSAs. If you do, the amount that you may contribute depends upon the amount your spouse contributes.

The combined maximum amount that you and your spouse can contribute to dependent care FSAs in a calendar year is \$5,000. You may divide the contributions however you like between your FSA and your spouse's FSA. For example, you may both wish to contribute \$2,500, or you may wish to contribute \$1,000 and your spouse \$4,000. It is up to you.

The Dependent Care Tax Credit

You may be eligible for a dependent care tax credit on your income taxes. You can claim a tax credit on eligible expenses up to \$3,000 per calendar year for one dependent, or \$6,000 per year for two or more dependents. But you can't use your Dependent Care FSA and the tax credit for the same expenses. If you use a combination of tax credits and FSA, the tax credit will be reduced, dollar for dollar, by the amount you are reimbursed from your Dependent Care FSA.

Generally, if your family's annual income is approximately \$25,000 or more, the FSA will save you more in taxes. On the other hand, if your total household income is less than approximately \$25,000, it is probably better to take the tax credit. Use the following worksheet to help determine which method will work best in your situation.

FLEXIBLE SPENDING ACCOUNTS

Dependent Care FSA Worksheet

Use this worksheet to help estimate your eligible dependent care expenses for the next calendar year:

Step 1. Estimate your total eligible expenses:

\$ _____ times _____ = \$ _____
(cost per week) (weeks of care) (annual dependent care expenses)

Step 2. Calculate the FSA tax savings and the Federal Tax Credit:

FSA tax savings

1. Enter your expenses up to \$5,000 if you are single or married and filing jointly, or \$2,500 if married and filing separately: \$ _____
2. Enter your marginal tax rate from Chart 1 (on the next page): _____%
3. **Item 1 X Item 2 = \$ _____ (Your Dependent Care FSA Tax Savings)**

Federal tax credit

1. Enter your expenses up to \$2,400 if care is for one dependent, \$4,800 if for two dependents: \$ _____
2. Enter your tax credit percentage from Chart 2 (on the next page): _____%
3. **Item 1 X Item 2 = \$ _____ (Your Federal Tax Credit Tax Savings)**

Step 3. Compare the tax savings using an FSA vs. the Tax Credit. Which is larger?

FLEXIBLE SPENDING ACCOUNTS

Chart 1: Marginal Federal Tax Rate

This chart approximates the rate at which a reduction in your taxable income affects your income and Social Security taxes, based on 2006 tax tables. Find the range and filing status that fits your family's total income. Then, look in the right-hand column for the marginal tax rate that applies to your income.

Single:

<u>Taxable Income</u>	<u>Marginal Tax Rate***</u>
\$0 – 7,550	10%
\$7,551 – 30,650	15%
\$30,651 – 74,200	25%
\$74,201 – 154,800	28%
\$154,801 – 336,550	33%
\$336,551 and up	35%

Married Filing Jointly:

<u>Taxable Income</u>	<u>Marginal Tax Rate***</u>
\$0 – 15,100	10%
\$15,101 – 61,300	15%
\$61,301 – 123,700	25%
\$123,701 – 188,450	28%
\$188,451 – 336,550	33%
\$336,551 and up	35%

Head of Household:

<u>Taxable Income</u>	<u>Marginal Tax Rate***</u>
\$0 – 10,750	10%
\$10,751 – 41,050	15%
\$41,051 – 106,000	25%
\$106,001 – 171,650	28%
\$171,651 – 336,550	33%
\$336,551 and up	35%

*****Add 7.65% to the percentages above for Social Security taxes for earnings up to \$97,500 in 2007, and add 1.45% for all earnings above that amount.**

Chart 2 Federal Tax Credit Percentage

FLEXIBLE SPENDING ACCOUNTS

<u>Taxable Income</u>	<u>Tax Credit</u>
Up to \$15,000	35%
\$ 15,001 - 17,000	34%
\$ 17,001 - 19,000	33%
\$ 19,001 - 21,000	32%
\$ 21,001 - 23,000	31%
\$ 23,001 - 25,000	30%
\$ 25,001 - 27,000	29%
\$ 27,001 - 29,000	28%
\$ 29,001 - 31,000	27%
\$ 31,001 - 33,000	26%
\$ 33,001 - 35,000	25%
\$ 35,001 - 37,000	24%
\$ 37,001 - 39,000	23%
\$ 39,001 - 41,000	22%
\$ 41,001 - 43,000	21%
\$ 43,001 and up	20%

Filing a Claim for the Dependent Care FSA

To receive reimbursement from your Dependent Care FSA, you must submit a claim form, available from the HR Service Center. You must include the following information with your claim:

- ◆ The name of the person receiving the care;
- ◆ The type of service provided (such as day care) and the date the service was provided;
- ◆ The amount paid for the service; and
- ◆ The name and Social Security number or tax identification number of the person or organization providing the care.

If you submit a claim for more than the balance in your FSA, you will be reimbursed only up to your balance at that time. You will be reimbursed for the remaining amount once you contribute additional money to your FSA. You will receive an Explanation of Payment with your reimbursement check. Reimbursement checks are processed bi-weekly.

You may fax your claim to 1-888-342-5333 or mail it to:

Ceridian Benefit Services
P.O. Box 9101
Clearwater, FL 33758-9101

SHORT TERM DISABILITY BENEFITS

Short Term Disability Benefits

Your Short Term Disability benefits are designed to provide you with a continuing source of income during short periods of illness or injury. Coverage is provided by JHHSC/JHH at no cost to you; you do not pay anything for this coverage. You are eligible for benefits if you are regularly scheduled to work 20 or more hours per week, effective the first day of the month following your date of hire and completion of any employment probationary period that may apply to you. ***However, your coverage will not begin unless and until you turn in your enrollment form.*** Weekend option nurses are not eligible for Short Term Disability benefits.

If you are injured in an accident for which you might recover from a third party or from your own insurance (such as personal injury protection), please refer to the reimbursement and subrogation provisions explained below at **When the EHP Medical Plans and Short Term Disability Plan May Recover Payment.**

Payment of Benefits

Short Term Disability pays benefits when you cannot perform your regular job duties due to an illness or injury. You will receive benefits equal to 60% of your regular bi-weekly base pay (including regular shift differential and excluding overtime and commissions). This benefit amount is payable to you for up to 11 weeks of disability. Benefits begin after you have been unable to work for 14 consecutive calendar days. You must be under a doctor's care to be considered disabled. Your Short Term Disability benefits will be supplemented by any time you may have available in your Sick Bank or PTO Bank up to 100% of your regular bi-weekly base pay. Please note that you must submit your claim for Short Term Disability benefits within 90 days from the date of the illness or injury that caused your disability to occur.

Short Term Disability benefits are not provided for an illness or injury that is work-related. These kinds of claims should be submitted to Workers' Compensation.

Short Term Disability benefits are not provided for an illness or injury that occurs or begins while you are on a leave of absence.

Benefits From Other Sources

You may be eligible to receive benefits from other disability plans, such as other group insurance plans or government disability programs. If that happens, your JHHSC/JHH Short Term Disability benefits will be reduced by any amounts payable under these other plans.

SHORT TERM DISABILITY BENEFITS

Return to Work

When your Short Term Disability benefits begin, you will usually be approved for a specified number of weeks of benefits based on your doctor's certification of how long you are expected to be unable to work. If you return to work before the approved number of weeks is up, please notify the Short Term Disability coordinator at 410-762-5312.

Recurring Disabilities

If you recover and return to work but then suffer a relapse, you may be eligible for additional disability benefits. The amount of your disability benefits depends on the nature of the disability and how long you have been back to work.

If you have been back to work for less than two weeks and become disabled again from the same or a related cause, the second period of disability will be considered a continuation of the first one.

If you have been back to work for less than two weeks and become disabled from a different and unrelated cause, a new disability benefit period would begin after you have been unable to work for 14 consecutive calendar days.

Any disability that occurs after you have been back to work for two weeks or more, whether it is a relapse or a new condition, will be considered a new disability period. Benefits would begin after you have been unable to work for 14 consecutive calendar days.

Partial Disability

If you are able to continue or return to work at JHHSC/JHH on a part time basis after an illness or injury, you may qualify for Partial Short Term Disability benefits. You will be considered partially disabled and entitled to partial Short Term Disability benefits if the number of hours you are regularly scheduled to work is reduced by at least 20% due to a disabling condition. If you are partially disabled, your Short Term Disability benefits will be reduced by 50% of your JHHSC/JHH reduced schedule pay. The combination of your Short Term Disability benefits and reduced schedule pay may not exceed 100% of your regular bi-weekly base pay.

SHORT TERM DISABILITY BENEFITS

The following example explains how partial disability benefits are calculated:

1. Regular bi-weekly base pay	\$2,000
2. Multiplied by the regular percentage for STD benefit	x 60%
3. Regular weekly STD benefit (<i>one half of Line 1 x Line 2</i>)	\$600 per Week
4. Pay received for reduced schedule employment	\$500 per Week
5. Multiplied by Partial Disability Offset percentage	x 50%
6. Partial Disability Offset	\$250 per Week
7. Regular weekly STD Benefit minus Partial Disability Offset (<i>Line 3 - Line 6</i>)	\$350 per Week
8. Plus pay received for reduced schedule employment	\$500 per Week
9. Total pay and STD Benefits (<i>Line 7 + Line 8</i>)	\$850 per Week

Days of partial disability count the same as days of total disability for determining your entitlement to disability benefits. Thus, partial disability days count as full days to determine if you have been unable to work for the required 14 days before benefits begin. Similarly, days for which partial disability benefits are paid count as full days towards the maximum 11 weeks of benefits.

Pre-Existing Conditions

Your Short Term Disability benefits are affected by any pre-existing condition you may have before becoming eligible for coverage. A pre-existing condition is any physical or mental condition for which you have been diagnosed or treated during the 90 days before your date of hire. The pre-existing condition rules do not apply to a timely return from an approved leave of absence, temporary layoff, or absence approved under the Family and Medical Leave Act (FMLA).

If you have one or more pre-existing conditions, then Short Term Disability benefits payable during the first six months of coverage on account of a disability related to the pre-existing condition(s) will be subject to a \$5,000 maximum. This \$5,000 maximum does not include medical benefits related to the pre-existing condition(s).

SHORT TERM DISABILITY BENEFITS

What's Not Covered By Short Term Disability Benefits

Short Term Disability benefits are not paid for any of the following:

- ◆ Any disability arising from an injury or illness for which coverage is excluded as described under **What's Not Covered by the EHP Medical Plans** earlier in this SPD, regardless of whether you have coverage under the Medical Plans;
- ◆ Any disability for which you are eligible to receive benefits under Workers' Compensation, or which results from an injury or illness you incur in the course of any employment;
- ◆ Any disability for which you are eligible to receive payment under motorcycle insurance or any disability resulting from an injury while riding a motorcycle without a helmet approved by law;
- ◆ Any period of disability beginning prior to your effective date of coverage under this Plan; and
- ◆ Any period of disability during which you are not under the regular care of a physician.

When Short Term Disability Benefits End

Your Short Term Disability benefits will end on the earliest of when you:

- ◆ Are no longer under the regular care of a physician;
- ◆ Are no longer disabled;
- ◆ Fail to supply proof of your illness or injury;
- ◆ End your employment; or
- ◆ Receive the maximum amount of benefits, as described earlier in this section.

Mid Term Disability Benefits

You may extend your Short Term Disability benefits with Mid Term Disability benefits, but only if you have enrolled for Long Term Disability insurance coverage (as explained in your Guide to Benefits booklet). Mid Term Disability benefits extend your Short Term Disability benefits for up to an additional 13 weeks of disability after Short Term benefits run out. The Mid Term Disability benefit is calculated the same way and operates under the same rules as your Short Term Disability benefits.

ADMINISTRATIVE INFORMATION

Administrative Information About Your Johns Hopkins EHP Benefits

Filing A Claim With Employer Health Programs

You do not have to file a claim form with Employer Health Programs if you receive services from an EHP Network provider under the EHP Medical Plans or under the EHP Dental Plans. EHP Network providers will file claims on your behalf.

However, there are certain times when you do need to file a claim form with Employer Health Programs. These include:

- ◆ If you receive medical services from an Out-of-Network provider (covered under Premium Plan only), or Out-of-Network care that is covered as explained under *Emergency Services* and *Out-of-Area Care* earlier in this SPD, unless the Out-of-Network provider files the claim for you. It is your responsibility to determine if the Out-of-Network provider files a claim for you;
- ◆ If you use the Mail Order Drug program (or receive emergency prescription drugs from an out-of-area non-Network pharmacy);
- ◆ If you receive dental services from an Out-of-Network provider; or
- ◆ If you are applying for Short Term Disability benefits.

To submit your claim, complete a claim form, attach your itemized bills to it, and send it to the address shown on the form. Claims should be reported promptly, and no claims will be accepted after one year from the date services or supplies were provided.

Itemized bills must include the following information:

- ◆ The date(s) that services or supplies were received;
- ◆ A description and diagnosis of the services or supplies rendered;
- ◆ The charge for each service or supply;
- ◆ The name, address and professional status of the provider; and
- ◆ The full name of the individual who received the care.

More information about your claims and appeals rights is set forth below under **Claims for Benefits** in the **Administrative Information** section.

ADMINISTRATIVE INFORMATION

What Happens When You Have Duplicate Coverage

You and members of your family could be covered under more than one group health plan or health insurance coverage. These other plans may include health care insurance available through your spouse's employer. You may also qualify for benefits from state no-fault automobile laws.

The Johns Hopkins EHP Medical Plans and the Dental Plans, like most plans, include a Coordination of Benefits (COB) provision. The purpose of this provision is to limit the total amount you may receive from all medical or dental plans to no more than 100% of the covered charges. The COB rules apply to both the Medical Plans and the Dental Plans.

The plan that pays first is the Primary Plan. The Secondary Plan makes up the difference between the benefit paid (or deemed paid) by the Primary Plan and the maximum amount that would be paid under the Secondary Plan if there were no Primary Plan.

If the EHP Medical Plans are your Secondary Plan, only covered expenses up to the Plans' fee schedule may be covered. Any applicable co-pays, coinsurance or deductibles under the two plans still apply.

The plan of the patient's employer is the Primary Plan. To determine benefits for covered dependent children, the plan of the parent whose birthday falls earlier in the year is the Primary Plan for children. However, if the other health care plan does not include this "birthday rule" on children's coverage, or if both parents have the same birthday, the plan of the parent that has covered the dependent for a longer period of time is the Primary Plan and pays first. The other parent's plan will be Secondary.

The Coordination of Benefits rules usually do not apply in cases where parents are divorced or legally separated. The plan of the parent with a court order setting responsibility for health care expenses will usually be the only plan that covers a child. The Coordination of Benefits rules only apply when a child is actually covered under the separate plans of both parents.

When both plans have a COB provision, the following chart shows you how the Primary Plan is determined for your husband or wife.

If you are:	And the other plan is sponsored by:	And expenses are for:	Then your plan is:
Husband	Your wife's employer	Yourself Your wife	Primary Secondary
Wife	Your husband's employer	Your husband Yourself	Secondary Primary

ADMINISTRATIVE INFORMATION

If you have enrolled your spouse in one of the EHP Medical Plans and your spouse loses coverage under his or her other plan, the EHP Medical Plans become primary for both of you and any covered dependent children.

Please note that the EHP Medical Plans are the Secondary Plan to any other plan covering a qualified beneficiary who has elected COBRA.

The EHP Medical Plans are the Primary Plan if you are covered under one of the Plans as an active employee and you are also covered by Medicare. Similarly, the EHP Medical Plans are the Primary Plan for your covered spouse if your spouse is covered by Medicare and if you are an active employee.

When the EHP Medical Plans are the Secondary Plan, they will deem the Primary Plan to have made all benefit payments that would have been made had you complied with all the rules of the Primary Plan. For example, if you fail to submit a claim on time to the Primary Plan or if you do not get the required pre-certification for treatment, the EHP Medical Plans will make their Secondary Plan payment based on the payment the Primary Plan would have made if you submitted the claim on time or if you obtained the required pre-certification.

Coverage by Affiliated EHP Plans and the EHP Medical Plans

Inter-Affiliate Transfer Policy

Special annual deductible and out-of-pocket limit rules apply to an employee and his or her dependents who have been covered by an EHP Medical or Dental plan sponsored by an employer that has adopted the Johns Hopkins Health System Corporation Inter-Affiliate Transfer Policy. We refer to such an employer's plan as an "Affiliated EHP Plan." Currently, Johns Hopkins Health System Corporation/The Johns Hopkins Hospital, Bayview Medical Center, Johns Hopkins Medical Management, Howard County General Hospital and Howard County Health Services have adopted the Inter-Affiliate Transfer Policy.

The special rules apply whenever an employee transfers coverage from an Affiliated EHP Plan to the Plans described in this SPD during a plan year. Any expenses incurred by an employee and his or her dependents which count against an annual deductible or out-of-pocket limit under the prior Affiliated EHP Plan will also be counted against the applicable annual deductible or out of pocket limit under these Plans.

ADMINISTRATIVE INFORMATION

EHP Medical Plans – Switching Between Basic and Premium Plans

If you are covered under the Basic Plan and switch to the Premium Plan, or vice versa, the following rule applies. When applying limits on the dollar amount of expenses covered or the number of days or visits allowed for any medical benefit provided by either the Basic or Premium Plans, any expenses covered or days or visits allowed for that benefit by the Basic Plan will also be counted as if they were covered or allowed by the Premium Plan and vice versa. In addition, benefits provided by the EHP Medical Plan (the predecessor to the separate Basic and Premium Plans) are treated as benefits provided by the separate Plans when applying lifetime limits.

Employees Whose Worksite Is Outside The United States

If your worksite is outside the United States and you are covered by the EHP Medical or Dental Plans, the terms of your coverage will differ somewhat from the terms set forth in this Summary Plan Description. The differences are explained in the “Addendum to Summary Plan Description for Employees Whose Worksite is Outside the United States”. A copy of the Addendum will ordinarily be supplied to you when you are provided with information about moving to your worksite outside of the United States. If you need another copy, please contact The Johns Hopkins Hospital HR Service Center.

Starting in 2008, employees whose worksite is outside the United States will no longer have coverage under the EHP Medical or Dental Plans. Instead, a policy offered by CIGNA will provide the health and dental insurance coverages. Employees whose worksite is outside the United States will still be eligible for Short Term and Mid Term Disability benefits and the Health Care and Dependent Care Flexible Spending Accounts as described in this Summary Plan Description.

When the EHP Medical Plans and Short Term Disability Plan May Recover Payment

If you or your dependents have an injury, illness or other condition that is covered by the EHP Medical Plans and for which a third party might be liable, you must notify Johns Hopkins Employer Health Programs as soon as possible. You must comply with the EHP Medical Plans’ Reimbursement and Subrogation rights set forth below.

Reimbursement

The EHP Medical Plans’ reimbursement provisions apply when you or your dependents receive, or in the future may receive, any amounts by settlement, verdict or otherwise, including from an insurance carrier, for an injury, illness or other condition. We call these amounts a “Recovery”. These reimbursement provisions also apply to your Short Term and Mid Term Disability benefits. If you or

ADMINISTRATIVE INFORMATION

your dependents have received a Recovery, the Plans will subtract the amount of the Recovery from the benefits they would otherwise pay for treatment of the injury, illness or other condition or for Short or Mid Term Disability. If there is a possible future Recovery, the Plans may delay paying benefits until the Recovery is received, and then subtract the amount of the Recovery.

If the Plans have already paid benefits to or on behalf of you or your dependents for treatment of an injury, illness or other condition or for Short or Mid Term Disability, you or your dependents (or the legal representatives, estate or heirs of you or your dependents) must promptly reimburse the Plans from any Recovery received for the amount of benefits paid by the Plans. Reimbursement must be made regardless of whether you or your dependents are fully compensated (“made whole”) by the Recovery.

In order to secure the Plans’ reimbursement rights, by participating in the Plans you and your dependents, to the full extent of the Plans’ claim for reimbursement, (1) grant the Plans a first priority lien against the proceeds of any Recovery received; (2) assign to the Plans any benefits you or your dependents may have under any insurance policy or other coverage and (3) agree to hold in trust for the Plans the proceeds of any Recovery received.

You and your dependents are obligated to cooperate with the Plans and their agents in order to protect the Plans’ reimbursement rights. Cooperation means providing the Plans or their agents with any relevant information requested, signing and delivering any documents as the Plans or their agents reasonably request, obtaining the written consent of the Plans or their agents before releasing any party from liability, taking actions as the Plans or their agents reasonably request to assist the Plans in making a full recovery, and taking no action that may prejudice the Plans’ rights.

The Plans are only responsible for those legal costs to which they agree in writing, and will not otherwise bear the legal costs of you and your dependents. If you take any action to prevent the Plans from enforcing their reimbursement rights, you will also be liable to reimburse the Plans for any legal expenses that the Plans or their agents incur in enforcing the Plans’ reimbursement rights.

Subrogation

The EHP Medical Plans’ subrogation provisions apply when another party (including an insurance carrier) is or may be liable for your or your dependents’ injury, illness or other condition, and the EHP Medical Plans have already paid benefits for treatment of the injury, illness or other condition. These subrogation provisions also apply to your Short Term and Mid Term Disability benefits.

The Plans are subrogated to all of your and your dependents’ rights against any party (including an insurance carrier) that is or may be liable for your and your dependents’ injury, illness or other condition or for paying for treatment of the injury, illness or other condition. The Plans are subrogated to the extent of the amount of the medical and/or Short or Mid Term Disability benefits they pay to or

ADMINISTRATIVE INFORMATION

on behalf of you or your dependents. The Plans may assert their subrogation right independently of you and your dependents.

You and your dependents are obligated to cooperate with the Plans and their agents in order to protect the Plans' subrogation rights. Cooperation means providing the Plans or their agents with any relevant information requested, signing and delivering any documents as the Plans or their agents reasonably request, obtaining the written consent of the Plans or their agents before releasing any party from liability, taking actions as the Plans or their agents reasonably request to assist the Plans in making a full recovery, and taking no action that may prejudice the Plans' rights.

If you or your dependents enter into litigation or settlement negotiations regarding the obligations of other parties, you and your dependents must not prejudice the Plans' subrogation rights in any way.

The Plans' legal costs in subrogation matters will be borne by the Plans. However, if you take any action to prevent the Plans from enforcing their subrogation rights, you will be liable to reimburse the Plans for any legal expenses that the Plans or their agents incur in enforcing the Plans' subrogation rights. Your and your dependents' legal costs will be borne by you and your dependents.

When Benefit Plan Coverage Ends

Your coverage under the benefit plans described in this SPD will end on the earliest of the following dates:

- ◆ The end of the month in which you end your employment or are no longer an eligible employee;
- ◆ The effective date of your election to waive coverage under the plan;
- ◆ The date on which you stop making the required contributions for coverage;
- ◆ The date the plan is discontinued;
- ◆ The date on which you report for active duty as a full-time member of the armed forces of any country.

Coverage for a dependent will end on the earliest of the following dates:

- ◆ The date your coverage ends;
- ◆ The end of the month in which he/she no longer qualifies as an eligible dependent under the plan;
- ◆ The effective date of your election to drop dependent coverage;
- ◆ The date on which you stop making contributions for your dependents; or
- ◆ The date on which your dependent enters military service.

ADMINISTRATIVE INFORMATION

For certain of the above events, you or your dependents may be able to continue coverage by self-payment under COBRA, as explained below. If you take an unpaid leave of absence from your employment (including a leave covered by the Family and Medical Leave Act (FMLA)), you must continue making your required contributions for benefit plan coverage to remain in effect. If you do not make your required contributions, your benefit plan coverage will end. If your leave is covered under FMLA, you may be allowed to resume coverage upon your return from leave.

COBRA Continuation Coverage

COBRA allows you, your spouse or former spouse and your dependents to continue your coverage under the EHP Medical and/or Dental Plans for a specified period of time after certain qualifying events take place. Except as explained below for newborn or adopted children, only persons who are actually covered under a Plan on the date of the qualifying event may continue coverage by that Plan under COBRA. You, your spouse, and your adult dependents have separate election rights. To continue coverage under COBRA, the covered person must pay the full premium rates, plus a 2% administrative charge.

If your employment ends during the plan year in which you contribute to a Health Care FSA, COBRA also allows you to continue making after-tax contributions to the FSA. You may continue these contributions until the close of the plan year. You may not continue contributions to your Dependent Care FSA.

Length of COBRA Coverage

Coverage under your EHP Medical and Dental Plans may be continued under COBRA for up to 18 months for you, your spouse, and your eligible dependents, if coverage is lost due to one of the following qualifying events:

- ◆ Your employment ends for reasons other than gross misconduct; or
- ◆ Your work hours are reduced so that you are no longer eligible.

Coverage may be continued for up to 24 months if your employment ends because you are called up for military duty that is covered by the Uniformed Services Employment and Reemployment Rights Act (commonly known as “USERRA”).

Dependent children include children born to you, adopted by you, or placed with you for adoption while you are covered under COBRA. For such a child to qualify for COBRA, you must notify the HR Service Center in writing and elect COBRA coverage for the new child as soon as possible, but in no case later than 30 days after the event. If notice is given and the election is made on a timely basis, the newborn or adopted child will be covered as of the date of the birth, adoption, or placement for adoption.

ADMINISTRATIVE INFORMATION

If you are at least age 62 and have at least 25 “Years of Vesting Service” under the Johns Hopkins Health System Corporation Retirement Plan when you lose coverage due to one of the above qualifying events, you may continue coverage under COBRA until the end of the month in which you reach age 65. This allows you to continue coverage under COBRA until you are eligible for Medicare.

You may also cover your spouse while you are receiving this extended COBRA coverage. If you cover your spouse until you reach age 65 (when your COBRA coverage ends), your spouse may thereafter continue COBRA coverage until the end of the month in which he or she reaches age 65 or has been on COBRA for 36 months in total, whichever occurs first. This extended COBRA coverage for you and your spouse is subject to all the rules that otherwise apply to COBRA coverage as explained in this SPD.

If you, your spouse or any of your dependents is Social Security disabled at any time during the first 60 days of COBRA coverage, coverage for the disabled individual and each of the individual’s family members may be extended for an additional 11 months, for a total of 29 months. Premiums for the additional 11 months will increase from 102% to 150% of the full cost. The HR Service Center must be notified in writing of the Social Security disability within 60 days after the date of the determination and before the 18 months of regular COBRA coverage ends, or the 11 additional months of COBRA coverage will not be provided.

However, in the case of a disabled employee (but not a family member) whose application for Social Security disability benefits is pending at the end of the 18 months of regular COBRA coverage, written notice of the disability determination may be given to the HR Service Center after 18 months of regular COBRA coverage ends if:

- the employee applied for Social Security disability benefits no later than 60 days after regular COBRA coverage began;
- the Social Security Administration’s failure to make a determination before the 18 months of regular COBRA ends is not the employee’s fault;
- the employee is found to be disabled under the long term disability plan of the employee’s employer;
- the employee requests the additional 11 months of COBRA before the 18 months of regular COBRA ends;
- the Social Security Administration makes its determination no later than 210 days after the 18 months of regular COBRA ends, which determination finds that the disability began before the start of COBRA coverage, and
- the employee gives written notice to the HR Service Center of the Social Security determination within 30 days after the employee receives the determination.

ADMINISTRATIVE INFORMATION

If notice of an employee's Social Security disability determination is given after the 18 months of regular COBRA ends as provided above, only the employee (and not any family member) is entitled to the additional 11 months of COBRA coverage.

If the Social Security Administration notifies you or any of your dependents that he or she is no longer disabled, then the additional 11 months of COBRA coverage no longer applies and you must notify the HR Service Center in writing within 30 days of the Social Security notice.

Please contact the HR Service Center if you have any questions about your eligibility.

Your spouse and dependent children may individually elect COBRA continuation coverage for up to 36 months if coverage ends because of:

- ◆ Your divorce;
- ◆ Your legal separation;
- ◆ Your entitlement to Medicare; or
- ◆ Your death.

Please note: You may not elect coverage on behalf of a divorced spouse, but he or she may personally elect to continue coverage.

Your dependent children may individually elect continuation coverage for up to 36 months if they stop being eligible for dependent coverage as explained in **General Information About Your Benefits**, under **Who Is Eligible**.

In the case of divorce, separation, or a dependent child no longer being eligible for dependent coverage, you, your spouse, or your child must notify the HR Service Center in writing within 60 days after that event occurs. If that notice is given on time, your spouse or child will be notified of the right to continue coverage under COBRA. If written notice of the event is not given on time, then your spouse and child will have no rights to continue coverage under COBRA.

You, your spouse or dependents will be notified of the right to continue coverage under COBRA if:

- ◆ Your employment ends for reasons other than gross misconduct;
- ◆ Your work hours are reduced so that you are no longer eligible; or
- ◆ You die.

If one of the above events that allow COBRA coverage to be continued for 36 months occurs after an event that allows COBRA coverage to be continued for 18 months but before the 18 months has expired, then COBRA coverage (if initially elected) may be continued for up to 36 months, measured from the first event. If another event occurs, you, your spouse or dependent child must notify the HR

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Service Center in writing within 60 days after the second event. If the HR Service Center is not notified in time, COBRA may not be continued past 18 months.

You must notify the HR Service Center in writing if you, your spouse or dependent child change addresses. The HR Service Center will only send communications to a recipient's last known address.

Electing COBRA Coverage

You, your spouse or dependent children have 60 days from the date coverage would otherwise end or from the time notice of COBRA rights is given (whichever is later) to elect to continue coverage under the EHP Medical Plans or Dental Plans under COBRA. If COBRA is not elected, coverage under the Medical Plans and Dental Plans will end.

If COBRA coverage is elected on a timely basis, you, your spouse or your dependent children will have an additional 45-day period to pay the first premium, starting on the date the election was made.

All premium payments must be made directly to the address shown on your COBRA election notice.

Each individual who elects to continue coverage under COBRA must pay the full premium cost, plus 2% for administrative expenses. You will be advised of the monthly cost of COBRA coverage per person at the appropriate time. After you, your spouse or dependent children have elected to continue coverage under COBRA and have paid the required premiums, coverage will be reinstated back to the date regular coverage was lost. The EHP Medical and Dental Plans will not pay any claims made in the interim. Upon reinstatement of coverage, invoices may be submitted or re-submitted to the Plans for payment.

If the benefits or coverage costs under the EHP Medical or Dental Plans change for active employees, the COBRA coverage benefits and costs will change as well. Covered persons will be notified of any changes.

When COBRA Coverage Ends

The right to COBRA continuation coverage will end before the conclusion of the 18, 24, 29 or 36 month period, whichever applies, if:

- ◆ A covered individual becomes covered under another group medical plan after COBRA coverage is elected (unless a pre-existing condition limitation would prevent the individual from receiving benefits from the new plan for a particular illness or injury);
- ◆ A covered individual becomes covered by Medicare after COBRA coverage is elected;

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- ◆ The premium is not received on a timely basis; or
- ◆ JHHSC/JHH stops providing group medical coverage for all active employees.

Benefit Coverage And FMLA

Under the Family and Medical Leave Act (FMLA), you may be eligible to take up to 12 weeks of time off, as determined by the HR Service Center. If you are approved for FMLA leave, there are certain rules that apply for you to continue coverage under your benefit plans.

Required Employee Contributions for Regular Coverage

While you are on FMLA leave, you will be billed for your required employee contributions for the benefit plan coverage you have elected. If you pay the required contributions on time, you (and your spouse and dependent children, if you elected coverage for them) will remain covered under the elected benefit plans. If you do not pay the required contributions on time, benefit plan coverage for you (and your spouse and dependent children) will end.

Eligibility For COBRA

If you do not return to employment with JHHSC/JHH at the end of your FMLA leave, you (and your spouse and dependent children) may elect COBRA coverage under the EHP Medical and/or Dental Plans that you (or your spouse or dependent children) were covered under on the day before the FMLA leave began (or become covered under during the FMLA leave). You may elect COBRA even if your regular coverage under the EHP Medical and/or Dental Plans ends during your leave for failure to make required employee contributions.

If properly elected, COBRA continuation coverage will begin at the end of your FMLA leave. For example, if you take all your FMLA leave and do not to return to work, your COBRA continuation coverage (if properly elected) would begin on your *last* day of FMLA leave. If you notify the HR Service Center before your FMLA leave is over that you do not plan to return to work, your COBRA continuation coverage (if properly elected) will begin on the day after you notify the HR Service Center.

For more information about the Family and Medical Leave Act, please contact the HR Service Center.

When You Become Covered By Medicare

When you reach age 65, you will be eligible for Medicare benefits. You may become eligible for Medicare benefits at an earlier date if you become permanently disabled. If you are still an active employee when you reach age 65 and become covered by Medicare, your EHP Medical Plans

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coverage (Basic or Premium) will continue as your primary medical plan unless you elect to waive EHP Medical Plans coverage.

Before your 65th birthday, you should obtain an explanation of Medicare benefits from the Social Security Administration. Make sure that you are actually enrolled for Medicare when you turn age 65. Enrollment does not happen automatically – you must go to the Social Security Administration and apply for Social Security benefits in order to have Medicare coverage.

If you do not enroll in Medicare Part A when first eligible, you may incur penalties and delays in obtaining Medicare coverage later. You may delay enrolling in Medicare Part B without penalty as long as you remain actively employed with JHHSC/JHH.

The EHP Medical Plans prescription drug benefit is, on average for all plan participants, expected to pay as much in benefits as the standard Medicare Part D prescription drug coverage would be expected to pay. That means the EHP prescription drug benefit constitutes “creditable coverage” for Medicare Part D purposes. You should receive a Creditable Coverage Notice shortly before you become eligible for Medicare that has more information about electing Medicare Part D coverage. If you do not receive that Notice, contact the HR Service Center.

Plan Information

Following is information regarding the administration and funding of your benefit Plan.

Plan Sponsor

The Johns Hopkins Hospital sponsors the Johns Hopkins Health System Corporation/The Johns Hopkins Hospital Employee Benefits Plan for Non-Represented Employees, which contains the benefit plans described in this SPD. The Employee Benefits Plan covers eligible non-represented employees of the Johns Hopkins Hospital and the Johns Hopkins Health System Corporation.

The Johns Hopkins Hospital’s Employer Identification Number (EIN) is 52-0591656.

Plan Administrator

The Plan Administrator manages the Employee Benefits Plan on a day-to-day basis and resolves questions about Plan details and entitlement to benefits. The Plan Administrator is the Vice President, Human Resources of JHHSC/JHH.

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If you have questions about your benefits and how they are administered, you should contact:

Benefits Office
Attention: Director of Benefits
The Johns Hopkins Hospital
600 North Wolfe Street, Phipps 455
Baltimore, MD 21287-1454
Telephone: 410-955-6208

Plan Year

The Plan Year for ERISA purposes is July 1 – June 30. However, annual benefit limits under the Employee Benefits Plan are determined on a calendar year (January 1 - December 31) basis.

Plan Funding

Except for Long Term Disability, Life and Accidental Death and Dismemberment insurance benefits, the benefits provided by the Employee Benefits Plan are not financed or administered by an insurance company. Benefits are paid from the general assets of JHHSC/JHH through a contract with Johns Hopkins Employer Health Programs. You can contact Johns Hopkins Employer Health Programs at:

Johns Hopkins Employer Health Programs
6704 Curtis Court
Glen Burnie, Maryland 21060
410-424-4450 or 800-261-2393

Information about the funding of the Long Term Disability, Life and Accidental Death and Dismemberment insurance benefits is contained in their separate summary plan description.

Plan Number

The plan number is 506.

Legal Action

The agent for service of legal process is:

JHHSC/JHH General Counsel
600 N. Wolfe Street
Administration Building
Baltimore, Maryland 21287

You may also serve legal process on the Plan Administrator.

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Claims And Appeals

In order for you to receive Medical, Dental or Short Term and Mid Term Disability benefits under the Employee Benefits Plan, you or your provider must file a claim. Claims are filed for you by EHP Network providers under the EHP Medical and Dental Plans. An Out-of-Network medical provider can file your claim for you under the Premium Plan, but if your provider doesn't file the claim you must file it yourself. You must file claims for Out-of-Network care that is covered as explained under ***Emergency Services*** and ***Out-of-Area Care*** earlier in this SPD, for dental services rendered by Out-of-Network dental providers, and for Short Term and Mid Term Disability benefits.

All claims for benefits under an insured plan (Long Term Disability, Life and Accidental Death and Dismemberment) must be made to the insurance company that issues the policy for the plan in accordance with the policy's rules.

Claims for the Health Care and Dependent Care Flexible Spending Accounts must be made as explained earlier in this SPD under **Flexible Spending Accounts**.

Following are the Plan's procedures for filing claims and appealing claim denials involving Medical, Dental, Vision and Short Term and Mid Term Disability benefits.

The Plan's procedures do not apply until a claim is filed with Employer Health Programs. A "claim" is a request to Employer Health Programs for coverage of treatment you already received or a request for recertification of coverage by Employer Health Programs for treatment you want to receive. A decision by your doctor or other provider that you do not need a certain treatment is not a claim covered by the procedures.

The filing requirements, and other procedures related to claims and appeals, differ depending on whether you have an "Urgent Care Claim," a "Pre-Service Claim" or a "Post-Service Claim". There are special rules if a pre-approved course of treatment is reduced or terminated, or if you want to extend a pre-approved course of treatment. Medical benefits claims can be any of the foregoing types of claims. On the other hand, claims for Dental or Short Term and Mid Term Disability benefits are always handled under the Post-Service Claims rules.

Urgent Care Claims, Pre-Service Claims and Post-Service Claims

Certain services and supplies must be "pre-certified" through the Care Management Program in order to be covered or to avoid a penalty. See the earlier discussion in this SPD about the **Care Management Program** and the **Medical Benefits At-A-Glance** chart. If a service or supply must be pre-certified, a request for pre-certification is a "**Pre-Service Claim**". (Pre-treatment review for major Dental services is recommended so you and your provider will know in advance what benefits will be

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paid. However, pre-treatment review is not required in order for the services to be covered and there is no penalty for failing to request review.)

If service or supply must be pre-certified and it is needed for urgent care, it is an “**Urgent Care Claim**”. A service or supply is for Urgent Care if following the time limits (set forth below) for Pre-Service Claims:

- ◆ could seriously jeopardize the life or health of the patient or the ability of the patient to regain maximum function, or
- ◆ in the opinion of a physician with knowledge of the patient’s medical condition, would subject the patient to severe pain that cannot be adequately managed without the service or supply.

In general, whether a service or supply is for Urgent Care is determined by Employer Health Programs based on the standards of a prudent layperson with average knowledge of health and medicine. However, if a physician with knowledge of the patient’s medical condition determines that the service or supply is for Urgent Care, it will be treated as such.

If a service or supply does not need to be pre-certified, a claim for payment is a “**Post-Service Claim**”. (All Dental and Short Term and Mid Term Disability benefit claims are Post-Service Claims.)

Filing a Claim

See the **Care Management Program** discussion earlier in this SPD for how to request pre-certification (for either a Pre-Service or Urgent Care Claim).

To file a Post-Service Claim, you or your provider must complete and submit a claim form and attach itemized bills with the information described below. (Remember, an EHP Network provider will file claims for you.) Claims should be reported promptly, and no claims will be accepted more than 12 months after the treatment was provided. Unless a different address is shown on the top of the form, send all Post-Service Claims to:

JHHSC/JHH
EHP Medical Plans
c/o Johns Hopkins Employer Health Programs
6704 Curtis Court
Glen Burnie, Maryland 21060

Itemized bills must include the following information:

- ◆ the date(s) the services, drugs or supplies were received;

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- ◆ the diagnosis;
- ◆ a description of the treatment received;
- ◆ the charge for each service, drug or supply;
- ◆ the name, address and professional status of the provider; and
- ◆ the full name of the patient.

Claim forms are available at the Johns Hopkins Hospital HR Service Center and from Johns Hopkins Employer Health Programs. To avoid delay in handling your claim, answer all questions completely and accurately. *Claims cannot be processed without your signature where required on the form.*

Reducing or Terminating an Approved Course of Treatment

If the Care Management Program pre-certifies a specific period or number of treatments, it may in rare cases later determine that the pre-certified period or number of treatments should be reduced or terminated. If that happens, Care Management will notify you in advance and give you time to file an appeal and receive a determination before the reduction or termination takes effect. *Special time limits apply -- see "Claims and Appeals Procedures" below.*

Extending an Approved Course of Treatment

If Care Management pre-certifies a specific period or number of treatments, and you or your provider want the period or number to be extended, you or your provider must file a request to extend the approved course of treatment. A request that is filed before the additional treatment is provided is a Pre-Service Claim. A request that is filed after the additional treatment is provided is a Post-Service Claim. *Special time limits apply – see "Claims and Appeals Procedures" below.*

Authorized Representative

An authorized representative may file a claim or appeal a denial of benefits for you. To name an authorized representative, you must use a Designation of Authorized Representative form which you can get from Employer Health Programs or by calling an EHP Customer Service Representative.

Note: You do not need to file a Designation of Authorized Representative form for your *provider* to file your initial claim. You also do not need to file a Designation of Authorized Representative form for your *provider* to file your First Level Appeal of a Pre-Service Claim or to file your First Level Appeal or Final Appeal of an Urgent Care Claim. However, you must file a Designation of Authorized Representative form for your *provider* to file your First Level Appeal of a Post-Service Claim and to file any other Final Appeal for you.

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Claims and Appeals Procedures

If your claim for benefits (Urgent Care, Pre- or Post-Service) is denied in whole or in part, you must follow the procedures in this section and exhaust your appeal rights before you may file suit in court. Once your claim has been filed and Employer Health Programs has all of the necessary information, your claim will be processed as set forth below and you will be notified of the decision.

Urgent Care Claims

If an Urgent Care Claim is improperly filed, Employer Health Programs will notify you within 24 hours. The notice may be oral, unless you request that it be written.

Unless additional information is needed, you will be notified of an Urgent Care Claim decision within 72 hours after the claim is properly filed. However, if your Urgent Care Claim involves a request to extend an approved course of treatment, and your request is received at least 24 hours before the end of the approved course of treatment, you will be notified of the decision within 24 hours.

Pre-Service Claims

If a Pre-Service Claim is improperly filed, Employer Health Programs will notify you within five days. The notice may be oral, unless you request that it be written.

Unless additional information is needed, you will be notified of a Pre-Service Claim decision within 15 days after the claim is properly filed. If there are matters beyond Employer Health Programs' control, this period may be extended up to 15 more days. If an extension is needed, you will be told before the initial 15 day period ends why an extension is needed and when a decision is expected.

Post-Service Claims

Unless additional information is needed, if a Post-Service Claim for medical or dental benefits is denied, you will be notified within 30 days after the claim is properly filed. You will be notified within 45 days for a denial of a Short Term or Mid Term Disability benefit claim. If there are matters beyond Employer Health Programs' control, this period may be extended up to 15 more days (up to two 30 day extensions for Disability benefits). If an extension is needed, you will be told before the initial 30 day (or 45 day) period ends why an extension is needed and when a decision is expected.

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If Additional Information is Needed

Pre-Service and Post-Service Claims

If Employer Health Programs needs more information to decide a Pre-Service or Post Service Claim, you will be told what additional information is needed and you will have 45 days to supply it. The time limit for Employer Health Programs to decide your claim is suspended until you supply the additional information. If you do not supply the information within 45 days, your claim will be processed without the additional information, and Employer Health Programs may draw reasonable presumptions from your failure to supply the additional information.

Urgent Care Claims

If Employer Health Programs needs more information to decide an Urgent Care Claim, you will be told within 24 hours what additional information is needed and you will have 48 hours to supply it. The time limit for Employer Health Programs to decide your Urgent Care Claim is suspended until you supply the additional information.

You will be notified of Employer Health Programs' decision on your Urgent Care Claim within 48 hours after the earlier of when (1) you supply the additional information or (2) the time for you to supply the additional information expires. If you do not supply the information within 48 hours, your claim will be processed without the additional information, and Employer Health Programs may draw reasonable presumptions from your failure to supply the additional information.

If Your Claim is Denied

You will be notified in writing if your claim (Urgent, Pre- or Post-Service) is denied in whole or in part. The notice will tell you why the claim was denied and the specific Plan provisions on which the denial is based. It will also describe any additional information that could change the decision. The notice will tell you how and when you can appeal the denial.

The notice will tell you if an internal rule or guideline was relied on to deny your claim, and how to request a free copy of the rule or guideline. The notice will tell you if your claim was denied because the treatment is not medically necessary or is experimental, and how to request a free explanation of the scientific or clinical judgment relied upon.

For an Urgent Care Claim, the notice will explain the expedited review process.

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First Level Appeal

If you think Employer Health Programs made a mistake in denying your claim, or in reducing, terminating or refusing to extend an approved course of treatment, or if you are otherwise dissatisfied with a claim decision, you may file a First Level Appeal.

Your First Level Appeal must be filed within 180 days after you are notified that your claim has been denied. However, if you are notified of a proposed reduction or termination of an approved course of treatment and you wish to appeal the proposed action and have a decision on your appeal before the proposed action takes effect, your First Level Appeal must be filed within 10 days after you are notified. If you file a First Level Appeal more than 10 days after you are notified of a proposed reduction or termination, the reduction or termination will probably take effect before you have a decision on your Appeal.

If you do not file a First Level Appeal within the time allowed, you lose all rights to appeal.

Except for an appeal of a denial of an Urgent Care Claim, your First Level Appeal must be in writing. You may hand deliver it to Employer Health Programs or file by mail. If you file by mail, a notice of receipt will be sent to you. The address for First Level Appeals is:

JHHSC/JHH
EHP Medical Plans
c/o Johns Hopkins Employer Health Programs
6704 Curtis Court
Glen Burnie, MD 21060

A First Level Appeal of a denial of an Urgent Care Claim may be made orally or in writing. You should supply all information for an Urgent Care Claim appeal by telephone, fax, hand delivery or other similar method. You may appeal a denial of an Urgent Care Claim by hand delivery to the address above, or by telephone or fax to:

Telephone: 410-424-4400
FAX: 410-424-4806
Attention: Urgent Care Claims Appeals

Please note that this fax number is for Urgent Care Claims Appeals only and should not be used for any other claims.

All First Level Appeals will be submitted to the Complaint and Grievance Committee. You may submit written comments, documents, records and other information relating to your claim. The Complaint and Grievance Committee will consider everything you submit, regardless of whether it

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was submitted or considered in the initial claim determination. Upon written request and free of charge, you will be provided with reasonable access to and copies of all Plan documents, records and other information relevant to your claim.

If the denial of your claim involved a medical judgment (such as whether a treatment is experimental or medically necessary), the Complaint and Grievance Committee will consult with a health care professional with training and experience in the field of medicine involved.

If medical or vocational experts were consulted when your claim was denied, they will be identified upon your request.

When Your First Level Appeal Will Be Decided

The time in which your First Level Appeal will be decided depends on whether it involves an Urgent Care Claim, a Pre-Service Claim, a Post-Service Claim, or a reduction, termination or denial of a request to extend an approved course of treatment.

Urgent Care Claim—You will be notified of the decision within 36 hours after your appeal is filed.

Pre-Service Claim -- You will be notified of the decision within 15 days after your appeal is filed.

Post-Service Claim -- You will be notified of the decision on a medical or dental benefit claim within 30 days after your appeal is filed. You will be notified within 45 days for a Short Term or Mid Term Disability benefit claim. (If more time is needed to decide a Disability claim, this period may be extended up to another 45 days. If an extension is needed, you will be told before the initial 45 day period ends why an extension is needed and when a decision is expected.)

Reduction or termination of an approved course of treatment -- You will be notified of the decision within 30 days after your appeal is filed. However, if you filed your appeal within 10 days after being notified of the proposed action, the course of treatment will not be reduced or terminated before your appeal is decided. (See below for additional Final Appeal rights you may have before treatment is reduced or terminated.)

Request to extend an approved course of treatment -- If your appeal is filed before the additional treatment has been provided, the Pre-Service Claim time applies. If your appeal is filed after the additional treatment has been provided, the Post-Service Claim time applies.

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You will be sent a written notice of the Complaint and Grievance Committee's decision. If your appeal is denied, the notice will tell you why and the specific Plan provisions on which the denial is based. The notice will tell you if an internal rule or guideline was relied on to deny your appeal, and how to request a free copy of the rule or guideline. The notice will tell you if your appeal was denied because the treatment is not medically necessary or is experimental, and how to request a free explanation of the scientific or clinical judgment relied upon. The notice will also tell you how and when you can file a Final Appeal. If your claim is an Urgent Care Claim, the notice will explain the expedited Final Appeal process.

Final Appeal

If your First Level Appeal is denied, you may make a Final Appeal to the Plan Administrator. Except for an appeal of a denial of an Urgent Care claim, your Final Appeal must be in writing and must include details about your claim and why you think it should not be denied. You must submit your Final Appeal to the Plan Administrator in care of Johns Hopkins Employer Health Programs at the address shown above.

A Final Appeal of a denial of an Urgent Care Claim may be made orally or in writing. You should supply all information for an Urgent Care Claim appeal by telephone, fax, hand delivery or other similar method. You may make a Final Appeal of a denial of an Urgent Care Claim by hand delivery to the address above, or by telephone or fax to:

Telephone: 410-424-4400
FAX: 410-424-4806
Attention: Urgent Care Claims Appeals

Please note that this fax number is for Urgent Care Claims Appeals only and should not be used for any other claims.

Except for an appeal of a reduction or termination of an approved course of treatment, a Final Appeal to the Plan Administrator must be filed within the later of (1) 90 days after you are notified of the Complaint and Grievance Committee's denial of your First Level Appeal or (2) 180 days after you were initially notified that your claim was denied.

If the Complaint and Grievance Committee denied your First Level Appeal of a proposed reduction or termination of an approved course of treatment and you wish to file a Final Appeal and have a decision on your appeal before the proposed action takes effect, your Final Appeal must be filed within five days after you are notified of the Committee's decision. If you file a Final Appeal more than five days after you are notified of the Committee's decision, the reduction or termination will probably take effect before you have a decision on your Final Appeal.

If you don't file a Final Appeal within the time allowed, you lose all rights to appeal.

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Your Final Appeal will be submitted to the Plan Administrator. You may submit written comments, documents, records and other information relating to your claim. The Plan Administrator will consider everything you submit, regardless of whether it was submitted or considered in the initial benefit determination or your First Level Appeal. Upon written request and free of charge, you will be provided with reasonable access to and copies of all Plan documents, records and other information relevant to your claim.

If the denial of your claim or the First Level Appeal decision involved a medical judgment (such as whether a treatment is experimental or medically necessary), the Plan Administrator will consult with a health care professional with training and experience in the field of medicine involved.

If medical or vocational experts were consulted when your First Level Appeal was decided, they will be identified upon your request.

The time limit for deciding your Final Appeal depends on whether it involves an Urgent Care Claim, a Pre-Service Claim, a Post-Service Claim, or a reduction, termination or denial of a request to extend an approved course of treatment.

Urgent Care claim -- You will be notified of the decision within 36 hours after your Final Appeal is filed.

Pre-Service Claim -- You will be notified of the decision within 15 days after your Final Appeal is filed.

Post-Service Claim -- You will be notified of the decision on a medical or dental benefit claim within 30 days after your Final Appeal is filed. You will be notified within 45 days for a Short Term or Mid Term Disability benefit claim.

Reduction or termination of an approved course of treatment -- You will be notified of the decision within 30 days after your Final Appeal is filed. However, if you filed your final appeal within five days after being notified of the Complaint and Grievance Committee's decision on your First Level Appeal, the approved course of treatment will not be reduced or terminated before your Final Appeal is decided.

Request to extend an approved course of treatment -- If your Final Appeal is filed before the additional treatment has been provided, the Pre-Service Claim time applies. If your Final Appeal is filed after the additional treatment has been provided, the Post-Service Claim time applies.

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You will be sent a written notice of the Plan Administrator's decision. If your Final Appeal is denied, the notice will contain the same type of information as the notice from the Complaint and Grievance Committee. If you disagree with the Plan Administrator's decision, you may bring a civil action against the Plan under ERISA Section 502.

Voluntary Independent Review

If your Final Appeal involved a clinical determination as to whether a treatment is experimental or medically necessary and you are dissatisfied with the decision, and if your claim exceeds \$500, then you may submit your claim to independent review. You are not required to submit your claim to independent review, and doing so will not affect your right to bring a civil action against the Plan under ERISA Section 502. Whether or not you submit your claim to independent review will have no effect on your rights to any other benefits under the Plan. There is no charge for you to submit your claim to independent review. Your authorized representative (as described above) may represent you in the independent review process, at your cost.

Independent review is provided by an independent medical review service under a contract for Johns Hopkins Employer Health Plans. Upon your request to EHP, you will be provided additional information about the medical review service and how it performs the independent review. The medical review service is referred to below as the IRO ("Independent Review Officer").

You cannot submit your claim to independent review unless you first make a timely Final Appeal to the Plan Administrator and the Plan Administrator has issued the Final Appeal decision. If you want to submit your claim to independent review, you must request independent review in writing within 60 days after you receive the Plan Administrator's Final Appeal decision. If you do not request independent review in writing within 60 days, you cannot submit your claim to independent review. Send your request for independent review to Johns Hopkins Employer Health Plans at the address shown above for making a First Level Appeal. Upon receipt of your request, EHP will submit your claim and related information to the IRO for independent review. Note that information submitted to the IRO will include your "Protected Health Information" (described in this SPD).

The IRO will access and rely on appropriate clinical expertise in making the review determination. The IRO does not have any direct financial interest in Johns Hopkins Employer Health Plans, the Plan sponsor or your employer, nor will the IRO have any financial interest in the outcome of the review determination.

If the independent review involves an Urgent Care claim, the IRO will issue the review determination within 72 hours after you initiate the independent review process. For all other claims, the IRO will issue the review determination within 30 days after you initiate the independent review process. The IRO review determination will be in writing and a copy will be sent to you by EHP.

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The IRO's independent review determination is not binding on the Plan or the Plan Administrator. However, after the IRO's determination is made, the Plan Administrator will consider the determination and decide if there should be any change in the Plan Administrator's decision on your Final Appeal. You will be advised in writing of the Plan Administrator's decision. If you submit your claim to independent review, the statute of limitations deadline by which you would have to bring a civil action against the Plan (and any other defense based on timeliness) is "tolled" (i.e., suspended) from the time you submit until you are advised in writing of the Plan Administrator's decision.

Protected Health Information

The Employee Benefits Plan may create or obtain information, which relates to your physical or mental health condition, treatment or payment for your health care. When this information is individually identifiable to you, it is called "Protected Health Information (PHI)". The Plan may disclose PHI to the Plan Sponsor, and the Plan Sponsor may use or disclose PHI obtained from the Plan, only for Plan administration purposes, as set forth in the Employee Benefits Plan document.

The Plan has a Notice of Privacy Practices which describes how your PHI may be used and disclosed and how you can get access to your PHI. You may request a copy of the Notice from the Plan Administrator at any time.

The Plan has implemented safeguards that protect the confidentiality, integrity and availability of PHI which is transmitted or maintained by electronic media.

Your Rights Under ERISA

As a Plan participant, you are entitled to the following rights and protections under the Employee Retirement Income Security Act of 1974 -- commonly called ERISA:

- ◆ You can examine, free of charge, all of the official documents related to the plans (such as plan documents, insurance contracts, annual reports, SPDs, any other plan agreements, or any other documents filed with the U.S. Department of Labor). You can examine copies of these documents in the Plan Administrator's office.
- ◆ If you wish, you can get your own copies of the Plan documents by writing to the Plan Administrator. You may have to pay a reasonable charge to cover the cost of photocopying.

Additional ERISA Rights

In addition to creating rights for plan participants, ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plans. These people are called fiduciaries.

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ERISA requires that fiduciaries act prudently and solely in the interest of you and other plan participants and beneficiaries.

Moreover, no one, including your employer or any other person, may fire you or otherwise discriminate against you in any way for the purpose of preventing you from obtaining a benefit under these plans or exercising your rights under ERISA.

If your claim for a benefit is denied in whole or in part, you must receive a written explanation of the reason for the denial. You have the right to have the Plan Administrator review and reconsider your claim.

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request certain materials from the plan and do not receive them within 31 days, you may file suit in a federal court to enforce your rights. In such a case, the court may require the Plan Administrator to pay you up to \$110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Plan Administrator. If you have a claim for benefits which is denied or ignored in whole or in part, you may file suit in a state or federal court. If it should happen that plan fiduciaries misuse the plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a federal court.

The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example if it finds your claim is frivolous.

If you have any questions about this plan, you should contact the Plan Administrator. If you have any questions about this statement or your rights under ERISA, you should contact the nearest Area Office of the Employee Benefits Security Administration, U.S. Department of Labor, as listed in the telephone directory, or contact the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Ave., N.W., Washington, D.C., 20210.

JHHSC/JHH's Rights

The benefit plans described in this SPD are for non-bargaining unit employees only. The Johns Hopkins Health System Corporation/The Johns Hopkins Hospital expects to continue these plans indefinitely, but reserves the right to modify, amend, suspend, or terminate any plan at any time, and for any reason without prior notification. You will be notified of any changes to these plans and how they affect your benefits, if at all. The plans described in this SPD are governed by contracts and plan documents, which are available for examination in the HR Service Center. We have attempted to make the explanations of the plans in this SPD as accurate as possible. However, should there be a discrepancy between this SPD and the provisions of the contracts or other plan documents, the

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provisions of the contracts or other plan documents will govern. In addition, you should not rely on any oral descriptions of the plans, since the written descriptions in the contracts or plan documents will always govern. To the extent any benefit under a plan is provided by an insurance policy, no benefits are provided by the plan except for those benefits, if any, which are paid by the insurance company which issues the policy.

Not A Contract Of Employment

This SPD and the plans described in this SPD do not constitute a contract of employment. You have the right to terminate your employment at any time. JHHSC/JHH retains the same right regardless of any other documents or oral or written statements issued by the employer or its representatives.

Plan Administrator's Authority

The Plan Administrator has discretionary authority to interpret the terms of the benefit plans described in this SPD and to decide any questions of fact which relate to entitlement to benefits under the plans.

For More Information

If you have questions, you can speak with an EHP Customer Service Representative by calling (800) 261-2393 or (410) 424-4450. Or, contact the HR Service Center.