

Special Treatment (and Incentive) for Chronic Conditions

Perhaps you have already been diagnosed with a chronic condition, such as asthma or diabetes. Healthy@Hopkins can teach you how to better manage your chronic condition. While you're being treated, your condition-related medication can be purchased with \$0 co-pay.

To qualify, you must first complete the PWP. Then, you may contact EHP Care Management at 410-762-5213 to enroll in a care management program for diabetes or asthma. If your medical claims show that you are currently being treated for diabetes or asthma, EHP Care Management may contact you directly. In any case, if you agree to participate in the care management program for one of these conditions, you must sign an agreement. This agreement covers the actions you need to take to complete the program, and it will describe the rules around having your co-pay(s) waived for condition-related prescription drug medication for a period of time.

While you're enrolled in EHP's Care Management program, you will be paired up with a registered nurse who will:

- Work with you to set and achieve personalized health goals
- Provide you with individualized education and resources for managing your symptoms
- Regularly review with you your medications, vital signs and other appropriate health information
- Help you work with your primary care and other specialist physicians to coordinate care

To find out more about the program, please call 410-762-5213 or (toll-free) 800-261-2396. You can also send an e-mail to healthyhopkins@jhhc.com.

If your spouse/same-sex domestic partner also works for JHHCG, you cannot be covered as both an employee and dependent. In addition, your eligible dependents may only be covered by one parent's plan.

Paying for Your Benefit Plans

JHHCG pays for the majority of your benefits. For most benefits, your contributions are made on a pre-taxed basis. Because your contributions are deducted before taxes, you reduce your taxable income and save on federal and state income taxes, as well as Social Security taxes.

For Dependent Life Insurance and Long-Term Disability (LTD) coverage, your contributions are made on an after-tax basis. The advantage of paying for these particular benefits with after-tax contributions is that when Life or LTD benefits are paid, they will not be subject to income taxes, since you will have already paid taxes on your contributions.

Medical Benefit Plans

When you enroll in a medical plan, you can elect coverage for:

- Yourself
- Yourself and your child(ren)
- Yourself and your spouse
- Yourself and your same-sex domestic partner
- Family coverage, including spouse and child(ren)
- Family coverage, including same-sex domestic partner and child(ren)

Eligible dependents include your legal spouse (with submission of marriage certificate), your same-sex domestic partner (with completion of an Affidavit of Domestic Partnership form), and your dependent child(ren) (with submission of a birth certificate) up to age 25 with submission of proof of dependency.

Coverage for new employees is effective on the first of the month following date of hire, provided a completed enrollment form has been received by the HR Department within 30 days of the employment date. Eligible dependent children are covered through the end of the year in which they turn 25 and provided they are still financially dependent on you.

For a list of network hospitals and PCPs who are accepting new patients, check the EHP Provider Directory available at the Holabird Site. You also may visit EHP's Web site at <http://www.ehp.org>.

Johns Hopkins EHP

Johns Hopkins EHP (Employer Health Programs) offers a choice of health care plans:

EHP BASIC PLAN

In-Network Benefits Only:

- You must choose a Primary Care Physician (PCP)
- Females ages 14+ must choose an OB/GYN PCP
- Referrals are mandatory
- 1 Annual preventative PCP and OB/GYN co-pay waived
- \$10 PCP co-pay; \$20 specialty co-pay
- No out-of-network benefits except for life-threatening emergencies
- Prescription co-pays \$10/\$20/\$40 (generic/preferred/non-preferred); prescription mail order \$20/\$30/\$60 (generic/preferred/non-preferred)
- Prescription co-pays for a 90-day supply (at participating pharmacy for maintenance drugs) \$30/\$45/\$90 (generic/preferred/non-preferred)
- No infertility or gastric by-pass benefits

EHP PREMIUM PLAN

In-Network Benefits:

- Visit any network doctor — NO REFERRALS REQUIRED
- No need to select a Primary Care Physician (PCP)
- 100% coverage for most services
- 1 Annual preventative PCP and OB/GYN co-pay waived
- No deductible
- \$15 PCP co-pay, \$30 specialty co-pay
- Infertility and gastric by-pass benefits after \$1,000 deductible and pre-authorization (does not apply to dependent children)
- Prescription co-pays \$10/\$20/\$40 (generic/preferred/non-preferred); prescription mail order \$20/\$30/\$60 (generic/preferred/non-preferred)
- Prescription co-pays for a 90-day supply (at participating pharmacy for maintenance drugs) \$30/\$45/\$90 (generic/preferred/non-preferred)

Out-Of-Network Benefits:

- 70% coverage for most services after a \$500 deductible (\$1,000 family)

Pre-Existing Conditions

Your EHP coverage is affected by conditions you may have before becoming eligible. A pre-existing condition is any physical or mental condition for which you or your eligible dependents have been diagnosed with or treated for during the 90 days before your date of hire. However, if you do not elect coverage when you are first eligible, the 90-day pre-existing condition period ends on the effective date of your coverage. If you have one or more pre-existing conditions, any charges incurred during the first six months of coverage to treat this condition(s) will be subject to a \$5,000 maximum benefit.

Tier Pharmacy Benefit Structure

- **Tier One: All Generic Drugs (lowest co-pay)** Generic drugs contain the same active ingredients and are chemically and therapeutically equivalent to brand-name medications, but are less expensive.
- **Tier Two: Preferred Brand Drugs (middle co-pay)** These brand-name drugs offer the most therapeutically safe and effective treatment for most medical conditions.
- **Tier Three: Non-Preferred Brand (highest co-pay)** These drugs often have either a generic equivalent or a preferred-brand alternative. You should talk to your PCP if you have any questions regarding which tier is best for you.

Over-the-counter (OTC) Medications

Prilosec OTC, Claritin OTC, and Claritin-D-OTC may be purchased without any co-pay or cost to you. Coverage of these drugs are subject to the same criteria as the prescription benefit i.e., written or verbal prescription from a provider is required.

Vision Benefits through The Johns Hopkins Routine Vision Care Network

Johns Hopkins EHP includes a full range of vision care services through The Johns Hopkins Routine Vision Care Network. You can receive care at any of these provider sites:

- The Wilmer Eye Institute at The Johns Hopkins Hospital
- Green Spring Pavilion I
- Severna Park
- White Marsh
- Bayview Medical Offices

You can also receive optometry services at Pearle Vision Centers at Johns Hopkins, Penn Optical and other locations throughout the Baltimore metropolitan area. For a listing of provider sites, refer to the list of Johns Hopkins Routine Vision Care providers, available from EHP, HR Department, or online at www.ehp.org.

If you use a Johns Hopkins Routine Vision Care Network provider, you can receive these benefits*:

- Eye exams covered at 100% after a \$10 co-pay, once every 12 months;
- Lenses and selected frames, covered at 100% after a \$10 co-pay, once every 12 months, or
- Elective contact lenses, covered after a \$10 co-pay.

Contact lens fitting fee may be covered in lieu of an eye exam once every 12 months.

If you choose to receive vision care from a non-Johns Hopkins Routine Vision Care Network provider, benefits are limited. The plan will pay up to the amounts shown in the chart above for the featured products and services.

Cost of Coverage

JHHCG and you share in the cost of your health care coverage. For 2010, please refer to the chart showing your bi-weekly contributions for either EHP Basic Plan or EHP Premium Plan Medical Coverage.

Same Sex Domestic Partner (SSDP) Post-tax note

If you are including a Same Sex Domestic Partner (SSDP) and/or your same sex domestic partner's child(ren), you will be billed an imputed income as shown in the Bi-Weekly Rates table under the Post Tax column.

The calculations for imputed income provided above illustrate the computation for adding back non-cash taxable income. The actual amount added back to your income may vary slightly from these calculations due to rounding.

* The plan makes an allowance equal to the cost of a standard exam, lenses and frames once every 12 months.

SERVICE	IN-NETWORK ANNUAL BENEFIT AMOUNT (ONCE EVERY 12 MONTHS)	OUT-OF-NETWORK ANNUAL BENEFIT AMOUNT (ONCE EVERY 12 MONTHS)
One routine eye exam or contact lens fitting fee every 12 months*	100%, after \$10 co-pay	Up to \$35
Materials:	\$10 co-pay	
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
Frames	Up to \$35	Up to \$35
Contact Lenses	\$10 co-pay	
Medically necessary	Up to \$165	Up to \$165
Elective	Up to \$95	Up to \$95

2009 Biweekly Rates at JHHCG		
EHP Basic	Pre tax	Post tax
Employee only	\$36.22	
Employee and Child(ren) / Employee and SSDP's Child(ren) Only	\$104.94	\$159.42
Employee & Spouse / Domestic Partner	\$130.65	\$245.49
Family / Family with SSDP and Employee's Child(ren)	\$141.15	\$131.71
Family / Family with SSDP and SSDP Child(ren)	\$141.15	\$280.63

EHP Premium	Pre tax	Post tax
Employee only	\$39.22	
Employee and Child(ren) / Employee and SSDP's Child(ren) Only	\$114.15	\$173.21
Employee & Spouse / Domestic Partner	\$142.10	\$226.83
Family / Family with SSDP and Employee's Child(ren)	\$153.52	\$143.26
Family / Family with SSDP and SSDP Child(ren)	\$153.52	\$305.05

EHP Dental - Comprehensive	Pre tax	Post tax
Employee only	\$7.36	
Employee and Child(ren) / Employee and SSDP's Child(ren) Only	\$14.73	\$2.59
Employee & Spouse / Domestic Partner	\$20.25	\$4.53
Family / Family with SSDP and Employee's Child(ren)	\$22.09	\$5.18
Family / Family with SSDP and SSDP Child(ren)	\$22.09	\$4.43

EHP Dental - High Option	Pre tax	Post tax
Employee only	\$9.83	
Employee and Child(ren) / Employee and SSDP's Child(ren) Only	\$19.67	\$3.63
Employee & Spouse / Domestic Partner	\$27.04	\$6.37
Family / Family with SSDP and Employee's Child(ren)	\$29.50	\$6.10
Family / Family with SSDP and SSDP Child(ren)	\$29.50	\$7.27

Comparison Chart

The following chart provides a side-by-side comparison of the two Johns Hopkins EHP medical plans:

NOTE: "R&C" is the reasonable & customary allowance for an expense.

JOHNS HOPKINS EHP COVERED SERVICES	Basic Plan REFERRALS REQUIRED	Premium Plan NO REFERRALS REQUIRED	
	In-Network Care Only, Coordinated by your PCP	(Access Care In-Network)	(Access Care Out-of-Network)
Calendar year annual deductible	None	None	\$500/person \$1,000/family
Calendar year annual out-of-pocket maximum	None	None	\$3,200/person \$6,400/family
Maximum lifetime benefit	All options: 3,000,000 combined, \$100,000 for substance abuse	All options: 3,000,000 combined, \$100,000 for substance abuse	
Office visits One (1) annual preventative visit*	\$10 co-pay primary care office visit \$20 co-pay specialty care office visit \$0 co-pay	\$15 co-pay primary care \$30 co-pay specialty \$0 co-pay	70% of R&C, after deductible 70% of R&C, after deductible
Annual physical exam (by PCP)	\$10 co-pay	\$15 co-pay	70% of R&C, after deductible
Urgent Care, etc	\$15 co-pay	\$15 co-pay	70% of R&C, after deductible
Lab test and X-rays	100%	100%	70% of R&C, after deductible
Well-child care	\$10 co-pay	\$15 co-pay	70% of R&C, after deductible
Mammograms	100%	100%	70% of R&C, after deductible
Annual GYN exam	\$0 co-pay	\$0 co-pay	70% of R&C, after deductible
Immunizations and inoculations	100%	100%	70% of R&C, after deductible
Allergy tests and serum	100%	100%	70% of R&C, after deductible
Professional services for inpatient and outpatient surgery (must obtain pre-authorization for inpatient services)	100%	100%	70% of R&C, after deductible (a)
Inpatient hospitalization (semi-private room unless private accommodations are approved for medical reasons)	100%	100%	\$500 co-pay per hospital admission, then 70% of R&C, after deductible (a)
Medically necessary intensive care	100%	100%	70% of R&C, after deductible (a)
Other inpatient services including pre-admission testing (must obtain pre-authorization)	100%	100%	70% of R&C, after deductible (a)

(a) \$500 penalty applies for failure to obtain pre-authorization for hospitalization.

*Subject to either one annual PCP or GYN/OB visit.

JOHNS HOPKINS EHP	Basic Plan	Premium Plan	
	REFERRALS REQUIRED	NO REFERRALS REQUIRED	
COVERED SERVICES	In-Network Care Only, Coordinated by your PCP	(Access Care In-Network)	(Access Care Out-of-Network)
Medically necessary reconstructive surgery and/or surgically implanted prosthetics	100%	100%	70% of R&C, after deductible
Maternity care	100%	100%	70% of R&C, after deductible (a)
Infertility services: In-vitro fertilization and artificial insemination (pre-certification required for all services and Rx; contact EHP for eligibility provisions)	No infertility services available	100% at JHH institutions only after \$1,000 deductible (maximum of \$30,000 per lifetime, including prescription drugs, with no more than 3 attempts)	Available at JHH institutions only
Gastric by-pass surgery (pre-certification required)	No gastric by-pass surgery available	100% at JHH institutions only after \$1,000 deductible	Available at JHH institutions only
Emergency treatment	\$125 co-pay	\$125 co-pay	\$125 co-pay (b)
Prescription drugs (30-day supply includes oral contraceptives; limited smoking cessation products also included)	\$10 co-pay (generic) \$20 co-pay (preferred) \$40 co-pay (non-preferred)	\$10 co-pay (generic) \$20 co-pay (preferred) \$40 co-pay (non-preferred)	
Over the Counter (OTE)* (Prilosec, Claritin OTC, Claritin-D-OTC)	\$0 co-pay	\$0 co-pay	
Prescription drugs (90-day supply at a participating pharmacy for maintenance drugs)	\$30 co-pay (generic) \$45 co-pay (preferred) \$90 co-pay (non-preferred)	\$30 co-pay (generic) \$45 co-pay (preferred) \$90 co-pay (non-preferred)	
Mail-order program (90-day supply for maintenance drugs)	\$20 co-pay (generic) \$30 co-pay (preferred) \$60 co-pay (non-preferred)	\$20 co-pay (generic) \$30 co-pay (preferred) \$60 co-pay (non-preferred)	
Home health care (40 visits per year combined maximum under Johns Hopkins EHP Options)	100%	100%	70% of R&C, after deductible
Physical and occupational therapists (subject to visit limitations)	100%	100%	70% of R&C, after deductible
Speech therapy (non-developmental services only), must be pre-authorized	100% (c)	100% (c)	70% of R&C, after deductible (c)
Durable medical equipment, including diabetic supplies through JH Pharmaquip	100%	100%	70% of R&C, after deductible
Chiropractic care	\$10 co-pay up to \$1,500 per year (d)	\$15 co-pay up to \$1,500 per year (d)	70% of R&C up to \$1,500 per year (d)
Acupuncture	\$10 co-pay; \$1,500 maximum per year	\$15 co-pay; \$1,500 maximum per year	70% of R&C up to \$1,500 per year

- (a) \$500 penalty applies for failure to obtain pre-authorization for hospitalization.
- (b) Does not include deductible.
- (c) All speech therapy services must be pre-authorized by Care Management.
- (d) Restricted to initial exam and X-rays, and spinal manipulation; up to \$1,500 per year.

NOTE: "R&C" is the reasonable and customary allowance for an expense.

JOHNS HOPKINS EHP	Basic Plan REFERRALS REQUIRED	Premium Plan NO REFERRALS REQUIRED	
COVERED SERVICES	In-Network Care Only, Coordinated by Clinical Case Manager	(Access Care In-Network)	(Access Care Out-of-Network)
Inpatient care for mental health (must obtain pre-authorization)	100% (a) (b)	100% (a)	\$500 co-pay per hospital admission, then 70% of R&C, after deductible (a)
Outpatient treatments for mental health	\$20 co-pay (a) (b)	\$20 co-pay	70% of R&C, after deductible
Inpatient care for substance abuse (subject to medical necessity)	100% (a) (b)	100% (a)	\$500 co-pay per hospital admission, then 70% of R&C, after deductible (a)
Inpatient care for alcohol abuse (subject to medical necessity)	100% (a) (b)	100% (a)	\$500 co-pay per hospital admission, then 70% of R&C, after deductible (a)
Outpatient treatment for substance abuse and detoxification	\$20 co-pay (a) (b)	\$20 co-pay	70% of R&C, after deductible

(a) \$500 penalty or a possible denial of benefits for failure to obtain pre-authorization for hospitalization.
(b) All mental health and substance abuse must be pre-authorized by Care Management.

Dental Benefit Plans

If you are an employee regularly scheduled to work 30 or more hours per you can choose dental coverage under:

- Johns Hopkins EHP Comprehensive Plan, or
- Johns Hopkins EHP High Option.

If you have elected the Johns Hopkins EHP medical plan or opted out of medical coverage, you may also elect no dental coverage.

Under either of the two Johns Hopkins EHP dental benefit options, you can elect coverage for:

- Yourself
- Yourself and your child(ren)
- Yourself and your spouse
- Yourself and your same-sex domestic partner
- Family coverage, including spouse and child(ren)
- Family coverage, including same-sex domestic partner and child(ren)

Eligible dependents include your legal spouse (with submission of marriage certificate), your same-sex domestic partner (with completion of an Affidavit of Domestic Partnership form), and your dependent child(ren) (with submission of birth certificate) up to age 25 with submission of proof of dependency. Coverage for new employees is effective on the first of the month following date of hire, with a completed enrollment form. Eligible dependent children are covered through the end of the year in which they turn age 25 and they are still financially dependent on you.

Please note: Benefits will not be provided under the plan if services are provided by an immediate family member.

If your spouse/same-sex domestic partner also works for JHHCG, you cannot be covered as both an employee and dependent. In addition, your eligible dependent(s) may only be covered by one parent's plan.