WAIVER OF SCHOOL OF MEDICINE STUDENT HEALTH PROGRAM (medical insurance)

Johns Hopkins School of Medicine requires all students and their spouses and children to have adequate health insurance. If you elect to waive enrollment in the Student Health Program for yourself (if permitted) or your eligible family members, we require that the alternative health coverage meet the following minimum criteria. Foreign insurance, non-Maryland HMO's, and travel insurance plans are <u>not</u> acceptable as alternative coverage as they do not meet the minimum requirements.

Criteria	JHUSOM Student Health Program	Requirements for Alternative Coverage
Annual plan year deductible	$150 per person capped at $350 combined total for family	Deductible cannot be more than $750 per person per plan year.
Inpatient Hospitalization	Most services covered 100% for the first 30 days then covered at 80% in network.	Must cover at least 70%
Outpatient Services	70% - 100% based on service and if provider is in or out of network	Must cover at least 70%
Prescription Drugs Covered	Yes, has a three-tiered prescription co-payment plan.	Must provide coverage for prescription drugs
Mental Health & Substance Abuse Treatment	Inpatient: Most services covered 100% for the first 30 days, and then covered at 80% in network. Outpatient: 70% - 100% based on service and if provider is in or out of network.	Must provide at least 70% coverage for mental health care, inpatient psychiatric care, and treatment for chemical dependence. Must cover inpatient hospitalization for both mental health and substance abuse for a minimum of 30 days and outpatient coverage for mental health and substance abuse of at least 15 visits per year.
Pre-existing Conditions	No exclusions or limitations for pre-existing conditions.	Must provide coverage for pre-existing conditions equivalent or better than SHP
Claims processing unit must be based in the U.S.	Yes, is based in the U.S.	Must be U.S. based
U.S. phone number	Yes, has a U.S. phone number	Must be U.S. based
Coverage for services provided in Maryland	Yes	Must provide coverage for all medically necessary care while you are within 50 miles of the Baltimore metropolitan area.
Coverage for services provided outside of Maryland and outside of the U.S.	Yes, member of Multiplan 1-866-980-7427	Must provide coverage outside of Maryland, including travel study or research abroad
Coverage Period	Coverage is provided during the period of your appointment in the School of Medicine.	Must provide coverage for the entire academic year, including the summer months and remain in force as long as you are a registered student, postdoctoral fellow or trainee at Johns Hopkins School of Medicine.

<u>OVER</u>

WAIVER OF SCHOOL OF MEDICINE STUDENT HEALTH PROGRAM (medical insurance)

DEMOGRAPHIC INFORMATION OF STUDENT, TRAINEE OR POSTDOCTORAL FELLOW *(Please print)*

LAST NAME: _____ FIRST NAME: _____ MIDDLE INITIAL: _____

DATE OF BIRTH (mm/dd/yyyy): ____/_____/_____

EFFECTIVE DATE FOR THIS WAIVER (mm/dd/yyyy):_____ (Note: School of Medicine policy determines the effective date of the waiver. If the completed form is received by the 10th of the month, the waiver can be effective retroactive to the 1st; if the completed form is received after the 10th of the month, the waiver will be effective the 1st of the following month)

STATUS (CHECK ONE)

____ I am a **Medical Student or degree candidate in Medical & Biological Illustration or degree candidate in Health Sciences Informatics**
I understand that I must pay the University Health Services fee regardless of enrollment or waiver of the Student Health Program medical insurance. I am requesting to opt out of the Student Health Program (SHP) insurance plan:

_____ for myself only; I do not have a spouse or dependent children, or
_____ for myself and my eligible family members (spouse and/or dependent children), or
_____ for my eligible family members only (I want coverage in the SHP insurance plan for myself and have/will complete the required enrollment form.)

____I am a **Ph.D. candidate in the School of Medicine** requesting a waiver for my spouse and/or dependent children. I understand that I must enroll in the Student Health Program and am covered by University Health Services and that my department/preceptor will pay the individual premium/fee for that coverage.

____I am a **Postdoctoral Fellow** (full-time) in School of Medicine requesting a waiver for my spouse and/or dependent children. I understand that I must enroll in the Student Health Program and am covered by University Health Services and that my department/preceptor will pay the individual premium/fee for that coverage.

____I am a **Trainee** in School of Medicine and am requesting a health insurance waiver for myself and all eligible family members.

____I am a **Visiting Medical Student** in the School of Medicine and am requesting a health insurance waiver for myself and all eligible family members.

____OTHER: I am a _____ in the School of Medicine and am requesting a health insurance waiver for myself and all eligible family members. I understand that this request requires prior approval by the Office of the Registrar or the Office of Postdoctoral Fellows.

ALTERNATIVE HEALTH COVERAGE INFORMATION (this section MUST be completed): A copy of the current health insurance card MUST be submitted with this Waiver form for each person covered by this Waiver form.

The person(s) waiving coverage in the Student Health Program are covered by other health insurance which meets the minimum requirements as stated on the reverse side of this form. The insurance plan in which I/they are enrolled is:

Insurance Company Name: _____

Name of primary subscriber: _____

Policy/Member Number: _____ Effective date: _____

FINANCIAL RESPONSIBILITY STATEMENT

- **I have read and understand the required coverage information for alternative insurance on the reverse side of this form.**
- **I understand that I may only enroll myself and/or my eligible family members in the Johns Hopkins University School of Medicine Student Health Program (SHP) insurance plan during the announced open enrollment period or, outside of open enrollment, only should a qualified life event occur that would permit enrollment. I understand that documentation is required for all Qualified Life Events. Qualified life events in your family or enrollment status can include:**
  - **Involuntary loss of other coverage through parent or spouse**
  - **Marriage**
  - **Birth or adoption of a child**
  - **Start or loss of your spouse/same-sex domestic partner's employment**
  - **Divorce or termination of same-sex domestic partnership**
  - **Death of your spouse/same-sex domestic partner or child**
- **I understand that, by waiving the Student Health Program sponsored by The Johns Hopkins University, I am accepting full financial responsibility for hospital, laboratory, physician, diagnostic testing and other medical costs not covered by my insurance.**
- **I acknowledge the risk of inadequate health insurance coverage could affect my finances and my credit standing.**

_____ _____

Signature of Student, Trainee, Postdoctoral Fellow **Date**