

Table Of Contents

Benefits for You and Your Family	1
Who is Eligible.....	1
Qualified Medical Child Support Order (QMCSO).....	1
When Coverage Begins	1
Changing Your Coverage.....	2
Special Enrollment Rights for Medical Coverage.....	3
<i>Losing other coverage</i>	3
<i>New Children</i>	3
<i>Medicaid and Children’s Health Insurance Program</i>	3
Certificates of Coverage.....	4
About Your Student Health Program.....	5
Providers.....	5
Options for Coverage	5
<i>About Referrals</i>	6
Pre-Existing Conditions	6
Payment Terms You Should Know	7
Care Management Program.....	8
Your Student Health Program Identification Card.....	9
Customer Service	10
Medical Benefits At-A-Glance	11
Student Health Program Covered Services and Supplies.....	16
In General	16
<i>Emergency Services</i>	21
<i>Maternity Benefits</i>	22
<i>Women’s Health and Cancer Rights Act</i>	23
<i>Alternative Care</i>	23
<i>Home Health Care Benefits</i>	23
<i>Skilled Nursing Facility Benefits</i>	24
<i>Hospice Care Benefits</i>	25
<i>Surgery</i>	26
<i>Transplants</i>	26
Mental Health and Substance Abuse Services	27
Prescription Drug Benefits	28
<i>EHP Network Pharmacies</i>	29
<i>Co-pay</i>	29
<i>What’s Not Covered</i>	30
<i>Over-the-Counter Drugs</i>	30

What’s Not Covered by the Student Health Program.....	32
Other Information About Your Benefits.....	37
Filing A Claim.....	37
What Happens When You Have Duplicate Coverage.....	37
When the Student Health Program May Recover Payment.....	39
<i>Reimbursement</i>	39
<i>Subrogation</i>	40
When Medical Coverage Ends	40
COBRA Continuation Coverage	41
<i>Electing COBRA Coverage</i>	43
<i>When COBRA Coverage Ends</i>	43
When You Become Covered By Medicare	44
<i>Benefits You Will Receive From Medicare</i>	44
Basic Administrative Information about Your Benefits.....	44
<i>Name of Program/Plan</i>	44
<i>Source of Program Benefit Payments</i>	45
Claims for Benefits.....	45
<i>Urgent Care Claims, Pre-Service Claims and Post-Service Claims</i>	46
<i>Filing a Claim</i>	46
<i>Reducing or Terminating an Approved Course of Treatment</i>	47
<i>Extending an Approved Course of Treatment</i>	47
<i>Authorized Representative</i>	47
<i>Claims and Appeals Procedures</i>	48
Voluntary Independent Review	53
Protected Health Information	54
<i>Permitted Use and Disclosure</i>	54
<i>Plan Sponsor's Certification</i>	55
<i>Separation Between Program and Plan Sponsor</i>	56
<i>Security of Electronic PHI</i>	56
Your Rights Under ERISA.....	57
<i>Additional ERISA Rights</i>	57
Student Health Program’s Rights	58
Plan Administrator’s Authority	58
For More Information.....	58

Benefits for You and Your Family

The Student Health Program offers 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, and mental health and substance abuse services. The Program offers you the flexibility to receive care from the physicians of your choice.

These benefits are provided under the Student Health Program and are described in this Summary Plan Description. Please read it carefully.

This Summary Plan Description sets forth the benefits provided to pre and post doctoral fellows and students and for persons who are hired to work as House Staff. All Student Health Program members have the same plan of benefits.

The medical benefits described in this SPD are administered by the Johns Hopkins Employer Health Programs (EHP).

This SPD is effective for expenses incurred on and after July 1, 2011. For expenses incurred before that date, please refer to the prior version of this SPD.

Who is Eligible

- Any individual holding pre- or postdoctoral student status (including Leave of Absence status and persons hired to work as House Staff) in the JHU School of Medicine, Bloomberg School of Public Health, JHU School of Nursing or JHH Schools of Medical Imaging;
- Any student who has registered and/or who has reached the effective date of appointment at any of the above schools (including persons hired to work as House Staff).

Eligible dependents may also be covered under the Student Health Program.

Eligible dependents are:

- Your legal spouse;
- Your same-sex domestic partner, as defined by the Johns Hopkins University, who is listed on your affidavit of domestic partnership;
- Your or your spouse/same-sex domestic partner's children, until they turn age 26.
- Your or your spouse/same-sex domestic partner's physically or mentally disabled dependent child of any age provided the physical or mental disability began prior to age 26. 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, and foster children, children legally adopted or placed for adoption, children covered by a Qualified Medical Child Support Order (QMCSO), and any 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 is also eligible for enrollment in the Student Health Program, he or she may choose to be covered as a participant rather than as a dependent, but not as both. Please note that your eligible children may only be covered by one parent's plan.

If you have any questions about this coverage:

- if you are enrolled through the School of Medicine, please contact the Registrar's Office at (410) 614-3301.
- if you are enrolled through the Bloomberg School of Public Health, please contact the Student Accounts Office at (410) 955-5725.
- if you are enrolled through the JHH Schools of Medical Imaging, please call (410) 528-8208.
- if you are enrolled through the JHU School of Nursing, please call (410) 955-7547.

Qualified Medical Child Support Order (QMCSO)

You may enroll children who are not otherwise eligible as described above in the Student Health Program if called for by a Qualified Medical Child Support Order (QMCSO). A 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 Registrar's Office, if you are enrolled through the School of Medicine, or to the Student Accounts Offices of the Bloomberg School of Public Health, the JHH Schools of Medical Imaging and the School of Nursing, 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

Students are eligible to participate in the Student Health Program upon registration and/or the effective date of appointment with no waiting period. There is no coverage until you submit a properly completed application. If your completed application is received by the 10th of the month, your coverage will be effective on the first day of that month, with no waiting period. If the application is

received on the 11th of the month or later, your coverage will become effective on the first day of the following month.

Medical coverage for your dependents will begin at the same time as your own if you have properly enrolled them. 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 or you have the option to begin your coverage no later than the first of the month following the date of marriage.

Changing Your Coverage

During the annual enrollment period, you may change your Student Health Program coverage. Outside of the annual enrollment period, you may change coverage *only* if you have a qualifying family status change or a special enrollment situation (see heading **Special Enrollment Rights**). Appropriate documentation of the life event may be required.

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;
- Your dependent becomes eligible or is no longer eligible for coverage under the Student Health Program;
- You are required to cover your child due to a QMCSO;
- You or your dependent become eligible for Medicare or Medicaid (you may change the current election for the eligible person only); and
- Any other event that qualifies as a family status change under the Internal Revenue Code (with the approval of the Plan Administrator) to be consistent with your family status change.

Further, any student, their spouse, or dependent child whose coverage under any other group health plan ends is permitted to enroll in coverage under the Program within 30 days of the date of the loss of other coverage as explained below under Special Enrollment Rights. Please notify the Registrar's Office, School of Medicine, or the Student Accounts Offices of the Bloomberg School of Public Health, the JHH Schools of Medical Imaging and the JHU School of Nursing 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 a new enrollment form or a change of information form 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 Johns Hopkins University School of Medicine, Bloomberg School of Public Health, the JHH Schools of Medical

Imaging and the JHU School of Nursing informed of any changes in family status by contacting the appropriate school.

Special Enrollment Rights for Medical Coverage

Losing other coverage

If you did not enroll in the Student Health Program because you had coverage through another source (such as a spouse's employer or COBRA), and you subsequently lose that coverage, you may enroll for medical coverage under the Student Health Program. You must request this ***special enrollment*** by submitting a properly completed enrollment form within 30 days of losing your other coverage. Student Health Program medical coverage will become effective on the date after you lost the other coverage, provided you enroll within 30 days.

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 Children

Children whom you acquire through marriage, birth, adoption, or placement for adoption, may be granted a ***special enrollment***, as long as you have requested coverage by submitting a properly completed enrollment form within 30 days following the date you acquired the child. You must go to the Registrar's Office, School of Medicine, or the Student Accounts Offices of the Bloomberg School of Public Health, the JHH Schools of Medical Imaging or the JHU School of Nursing to request special enrollment. In the case of marriage, medical coverage will become effective on the date of your marriage, or you have the option to begin your coverage no later than the first of the month following the date of marriage. In the case of birth, adoption, or placement for adoption, coverage will become effective on the date of the event. In either case, you must enroll within 30 days after the event. If you do not have coverage for yourself or your spouse, you may also enroll yourself or your spouse when you enroll your new child.

Medicaid and Children's Health Insurance Program

If you or your child have health insurance coverage under Medicaid or a Children's Health Insurance Program ("CHIP") and you or your child lose eligibility for that coverage, you may enroll for medical coverage under the Student Health Program. You must request this special enrollment within 60 days of losing your Medicaid or CHIP coverage. If enrolled on time, coverage will become effective on the date of loss of eligibility for the Medicaid or CHIP coverage.

If you or your child becomes eligible to receive assistance from Medicaid or CHIP to pay your required contributions for coverage under the Student Health Program, you may enroll for Student Health Program coverage. You must request this special enrollment within 60 days of becoming eligible for the assistance. Coverage under the Student Health Program will become effective on the first day of the month following the date your enrollment materials are received.

You must go to the Registrar's Office, School of Medicine, or the Student Accounts Offices of the

Bloomberg School of Public Health, the JHH Schools of Medical Imaging or the JHU School of Nursing to request any of the above special enrollments.

Certificates of Coverage

If you or a covered dependent lose your Student Health Program coverage (including COBRA coverage), be sure to notify the School of Medicine, the Bloomberg School of Public Health, the JHH Schools of Medical Imaging or the JHU School of Nursing and request a certificate of coverage. This certificate of coverage is available at no cost to you. At a minimum, this certificate will state the length of time you (or your covered dependent) had uninterrupted medical coverage. 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 appropriate school is aware that the dependent has lost coverage (for example, when a child 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.

About Your Student Health Program

The Student Health Program benefits described in this SPD are administered by Johns Hopkins Employer Health Programs.

Providers

For the purposes of this Program, a provider is any hospital, skilled nursing facility, individual, organization, or agency licensed or certified to provide professional services and acting within the scope of that license or certification. Benefits will only be paid for covered services from providers who meet this definition.

The University Health Services Health Center (UHSHC) is also a covered provider for those persons who pay the student health fee, and their dependents.

The Student Health Program allows you to go to any provider in the Program's networks, or you may go to a provider that is not in the networks. The choice is yours, but the Program often pays higher benefits if you go to an in-network provider.

The Student Health Program offers two networks:

- You can go to providers that participate in the Johns Hopkins Employer Health Programs (EHP) Network.
- For services received *outside* the State of Maryland, you can go to providers that participate in the MultiPlan PHCS Healthy Directions Network. For services received *inside* the State of Maryland, MultiPlan Network providers are only considered to be in-Network providers if they also participate in the Johns Hopkins EHP Network.
- Any reference to Network providers in this SPD also means MultiPlan PHCS Healthy Directions Network providers, but only for services received *outside* the State of Maryland.

You should ask your provider if they are in the EHP Network before you receive services in Maryland, or if they are in the MultiPlan PHCS Healthy Directions Network before you receive services outside of Maryland. For a complete listing of EHP Network providers, please see the provider directory available at www.ehp.org, or call 410-424-4450 or 800-261-2393. For a complete listing of MultiPlan PHCS Healthy Directions Network providers, please see the provider directory available at www.multiplan.com or call 866-980-7427.

Options for Coverage

There are two different Options for how you obtain medical care. The level of coverage and the deductible you must meet depend on which Option you use:

- Option 1 – access care through EHP Network providers.

- Option 2 – access care through non-Network providers.

The various coverage levels and deductibles for each Option are shown on the Medical Benefits At-A-Glance chart starting at page 14 of this SPD.

As you will see on the chart, sometimes the 100% coverage only applies if you access care through Option 1. Other times, the 100% coverage applies for care accessed through Option 2 as well. However, the Program only covers charges up to the Reasonable and Customary (“R&C”) charge (explained below under **Payment Terms You Should Know**). Providers under Option 1 will never charge more than the Reasonable and Customary charge, but non-Network providers under Option 2 can charge more than the Reasonable and Customary charge, and you must pay the difference.

About Referrals

You are not required by the Student Health Program to get a referral in order to access care that is covered by either Option. However, many specialists will not see you unless you have been referred by a primary care physician.

Please note: Benefits will not be provided under the Student Health Program for any services and related charges provided by an immediate relative of the patient (spouse, same-sex domestic partner, child, grandchild, brother, sister, in-law, grandparent, or parent).

Pre-Existing Conditions

Your coverage under the Student Health Program 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 the effective date of your coverage.

If you have one or more pre-existing conditions, any charges incurred during the first 365 days of coverage to treat this condition(s) will be subject to a \$10,000 maximum.

Please note: The exclusion will apply for a period of 365 consecutive days beginning on the covered person’s enrollment date. However, if you were previously covered by another health plan, the period of time for which you were covered may be credited against the 365-day exclusion period. You will need to submit a certificate of creditable coverage from your prior health plan to the Registrar’s Office, School of Medicine, or the Student Accounts Offices of the Bloomberg School of Public Health, the JHH Schools of Medical Imaging and the JHU School of Nursing. Contact your respective school if you have any questions or if you need help in obtaining a certificate of creditable coverage from your prior plan. Prior health plan coverage is only recognized if there is no more than a 62-day gap between your coverage under the prior plan and your Student Health Program coverage.

The \$10,000 maximum does not apply to (1) charges related to pregnancy or (2) expenses incurred after June 30, 2011 by a person under age 19.

Payment Terms You Should Know

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

- **Deductible and deductible carryover feature** — The deductible is the amount you must pay each plan year (July 1 – June 30) before the Student Health Program begins to pay benefits. The deductible is waived for certain preventive care services as shown on the Medical Benefits At-A-Glance chart. Expenses incurred and applied to your deductible in April, May and June of a plan year are also carried over and applied to the next plan year's deductible. Expenses incurred by three or more individuals can meet the family deductible. However, no one individual will be required to satisfy more than the individual deductible. If you transfer from one student status to a different status that is still eligible for coverage under the Program, and you do not have any lapse of coverage, any amounts you paid towards a year's deductible will still be counted and the deductible carryover feature will continue to apply. Please note that your coinsurance payments (i.e., your percentage or share of expenses) and any amounts over the Reasonable and Customary Charge do not apply toward the deductible.

If two or more family members receive injuries in the same accident, and as a result of those injuries incur covered expenses, only one deductible amount will be deducted from the total covered expenses incurred as a result of those injuries. If you acquire two or more children as a result of a multiple birth and if you incur covered expenses for those children as a result of premature birth, abnormal congenital condition, or sickness commencing or injury received not more than 30 days after their birth, only one deductible amount will be deducted from the total covered expenses incurred for those children as a result of the multiple birth.

- **Cost Sharing Provision** — The term *coinsurance* describes the way that you share in the cost of your medical expenses.
 - **Coinsurance:** *The coinsurance is your share for certain medical expenses. After the deductible is satisfied, the Program generally pays from 70% up to 100% of the Reasonable and Customary Charge for most services. For services covered at less than 100% you must pay the remaining non-covered percentage. For non-Network providers, you must also pay any amounts over the Reasonable and Customary Charge.*
 - **Out-of-Pocket Maximum:** Since you are responsible for a portion of the cost of your medical expenses, the Program includes a plan year out-of-pocket maximum to protect you in the event of high medical bills. After you have paid the plan year out-of-pocket maximum (\$3,000 per person or \$9,000 per family), the Program covers any additional medical expenses incurred in the same plan year at 100% of the Reasonable and Customary Charge. The out-of-pocket maximum applies on a per person basis, regardless of your level of coverage (individual, husband and wife, family, etc.). For example, if you have individual coverage, your maximum is \$3,000. If you have family coverage, your maximum and the separate maximum for each member of your family is still \$3,000. Plus, once you have paid \$9,000 during a plan year for all members of your family in total, then all members of your family have met the maximum.

The out-of-pocket maximum includes the deductible and coinsurance but does not include: penalties; prescription drug coinsurance and expenses; Program maximums; any charges for services which are not covered, or any charges above the Reasonable and Customary Charge.

- **Maximum Lifetime Benefit** — The Student Health Program previously had a maximum lifetime benefit dollar limit of \$1,000,000. Except as otherwise provided in this SPD, no maximum lifetime benefit dollar limit applies to expenses incurred on and after July 1, 2011. Any individual who reached the maximum lifetime benefit dollar limit before July 1, 2011, and who dropped coverage under the Student Health Program may reenroll for coverage as provided in this SPD.
- **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. The Student Health Program only covers charges up to the Reasonable and Customary Charge. EHP network providers (Option 1) will never charge you more than the Reasonable and Customary Charge. However, a non-network provider (Option 2) can charge you more than the Reasonable and Customary Charge, and you must pay the difference.

Care Management Program

The Student Health Program has several features designed to help both you and the Program 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 the Student Health Program and you. To help control these costs, the Program features a Care Management Program.

Before you can receive benefits for certain medical services or supplies under the Program, you must have them pre-certified and coordinated through the Care Management Program. You must initiate the pre-certification process by contacting your Student Health Program Customer Service representative at (888) 400-0091 or (410) 424-4485. If you do not obtain pre-certification, coverage for the services or supplies may be limited or denied.

The following services and supplies require pre-certification through the Care Management Program:

- Acupuncture;
- Durable medical equipment and medical supplies;
- Home health care;

- Hospice care;
- Hospital stays;
- Inpatient rehabilitation services;
- Outpatient surgical center facility charges;
- Prosthetic devices and orthotics;
- Skilled nursing facility stays;
- Speech therapy;
- Surgical procedures (certain procedures only, as described on a list maintained by Johns Hopkins EHP on behalf of the Student Health Program). You are required to contact Student Health Program Customer Service to see if a procedure is on the list. If it is, it is your responsibility to obtain pre-certification;
- Transplant services; and
- Use of certain drugs, supplies, and medications (certain drugs and medications only, as described on a list maintained by Johns Hopkins EHP on behalf of the Student Health Program). You are required to contact Student Health Program Customer Service to see if a drug, supply, or medication is on the list. If it is, it is your responsibility to obtain pre-certification.

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 and your 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.

You must initiate the pre-certification process by contacting your Student Health Program Customer Service representative at (888) 400-0091 or (410) 424-4485.

Your Student Health Program Identification Card

A Student Health Program 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 any 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 Program. If you lose your identification card, call the enrollment office in your respective school immediately to request a new card.

Your identification card includes important information and phone numbers.

Customer Service

An important feature of your Student Health Program is the Customer Service Representatives available to serve you. Trained Customer Service Representatives are available to assist you by answering any questions you may have about covered benefits, using your program, filing a claim, resolving complaints, etc.

If you have a question, Customer Service Representatives are available Monday through Friday, from 8 a.m. to 5 p.m., at (888) 400-0091 or (410) 424-4485.

Medical Benefits At-A-Glance

The following chart summarizes most of the benefits and services available under the Student Health Program.

<i>Services and Supplies</i>	<i>Option 1 Access Care through EHP Network Providers All Coverage Subject to Deductible</i>	<i>Option 2 Access Care through Out of Network Providers All Coverage Subject to Deductible</i>
PLAN YEAR DEDUCTIBLE (BOTH OPTIONS COMBINED)		
Individual		\$100
Family		\$300
COINSURANCE OUT OF POCKET MAXIMUM PER PLAN YEAR (BOTH OPTIONS COMBINED)		
Individual		\$3,000
Family		\$9,000
TREATMENT OF ILLNESS OR INJURY		
Primary care office visit (age 19 and older)	80%	70% of R&C
Adult specialty care office visit	90%	70% of R&C
Pediatric care office visit (under age 19)	100%	90% of R&C
Pediatric specialty care office visit	90%	70% of R&C
Podiatry care office visit	90%	70% of R&C
Diagnostic services and treatment	90%	70% of R&C
PREVENTIVE SERVICES		
General physical exam	100% (deductible waived)	70% of R&C
Diagnostic services for physical exam	100% (deductible waived)	70% of R&C
Well-child care: office visits, immunizations and PKU, flu vaccine, urinalysis and lead testing	100% (deductible waived)	90% of R&C
Mammograms (screening) Once per 12 month period	100% (deductible waived)	90% of R&C
Colonoscopy screening	100% (deductible waived)	70% of R&C

“R&C” (Reasonable and Customary Charge) is explained under the heading “Payment Terms You Should Know”, earlier in this SPD. You are responsible for any charges above R&C.

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.

<i>Services and Supplies</i>	<i>Option 1 Access Care through EHP Network Providers All Coverage Subject to Deductible</i>	<i>Option 2 Access Care through Out of Network Providers All Coverage Subject to Deductible</i>
Annual GYN exam Once per 12 month period	100% (deductible waived)	70% of R&C
Annual PAP test (pathology) Once per 12 month period	100% (deductible waived)	70% of R&C
Adult immunizations and inoculations; Gardasil is covered only for FDA approved age range 9 – 26	100% (deductible waived)	70% of R&C
SURGICAL PROCEDURES		
Professional services for inpatient and outpatient surgery	80% ⁽¹⁾	70% of R&C ⁽¹⁾
Reconstructive and/or surgically implanted prosthetics	80% ⁽¹⁾	70% of R&C ⁽¹⁾
LABORATORY AND X-RAY PROCEDURES		
Laboratory tests, imaging exams, X-rays and ultrasound	90%	70% of R&C
NUTRITIONAL COUNSELING		
One initial consultation and one follow-up; additional visits must be coordinated through Care Management Program	90%	70% of R&C
REPRODUCTIVE HEALTH		
Physician office visits (for prenatal care only)	90%	70% of R&C
Charges for delivery and related anesthesia	90% ⁽¹⁾	70% of R&C ⁽¹⁾
Newborn care Initial and discharge visits only	90% ⁽¹⁾	90% of R&C ⁽¹⁾
Newborn care All other inpatient visits	80% ⁽¹⁾	80% of R&C ⁽¹⁾
Birthing center (licensed facility only)	90% ⁽¹⁾	90% of R&C ⁽¹⁾
Voluntary sterilization	80% ⁽¹⁾	80% of R&C ⁽¹⁾
ALLERGY TESTS AND PROCEDURES		
Allergy tests	90%	90% of R&C
Desensitization materials and serum	80%	80% of R&C

(1) Failure to obtain pre-certification may result in a penalty or possible denial of benefits.

“R&C” (Reasonable and Customary Charge) is explained under the heading “Payment Terms You Should Know”, earlier in this SPD. You are responsible for any charges above R&C.

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.

<i>Services and Supplies</i>	<i>Option 1 Access Care through EHP Network Providers All Coverage Subject to Deductible</i>	<i>Option 2 Access Care through Out of Network Providers All Coverage Subject to Deductible</i>
URGENT CARE CENTER		
Physician visit	100%	80% of R&C
Diagnostic services and treatment	90%	70% of R&C
EMERGENCY SERVICES		
Care in hospital emergency room for emergency medical situations only Facility and professional fees	100% for services within 72 hours after onset of emergency, then 80%	100% of R&C for services within 72 hours after onset of emergency, then 80% of R&C
HOSPITAL CARE		
Inpatient care (semi-private, unless private room is medically necessary)	100% for 1 st 30 days per admission then 80% ⁽¹⁾	100% of R&C for 1 st 30 days per admission then 80% of R&C ⁽¹⁾
Intensive care	100% for 1 st 30 days per admission then 80% ⁽¹⁾	100% of R&C for 1 st 30 days per admission then 80% of R&C ⁽¹⁾
Other inpatient services	100% for 1 st 30 days per admission then 80% ⁽¹⁾	100% of R&C for 1 st 30 days per admission then 80% of R&C ⁽¹⁾
Inpatient physician services (excluding surgical services)	80% ⁽¹⁾	80% of R&C ⁽¹⁾
Skilled nursing facility	100% for 1 st 30 days per admission then 80% ⁽¹⁾	100% of R&C for 1 st 30 days per admission Then 80% of R&C ⁽¹⁾
Outpatient exams and testing prior to outpatient surgery	90%	90% of R&C
Outpatient surgery facility charges, including freestanding surgical centers	90% ⁽¹⁾	90% of R&C ⁽¹⁾

(1) Failure to obtain pre-certification may result in a penalty or possible denial of benefits.

“R&C” (Reasonable and Customary Charge) is explained under the heading “Payment Terms You Should Know”, earlier in this SPD. You are responsible for any charges above R&C.

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.

<i>Services and Supplies</i>	<i>Option 1 Access Care through EHP Network Providers All Coverage Subject to Deductible</i>	<i>Option 2 Access Care through Out of Network Providers All Coverage Subject to Deductible</i>
CHEMOTHERAPY/RADIATION THERAPY		
Physician visit	100%	80% of R&C
Physician Materials	80%	80% of R&C
ACUPUNCTURE		
\$300 maximum per plan year	80% ⁽¹⁾	70% of R&C ⁽¹⁾
HOME HEALTH CARE		
Must be provided by a licensed health care Organization	100% for 1 st 90 visits per plan year, then 80% ⁽¹⁾	90% of R&C for 1 st 90 visits per plan year, then 80% of R&C ⁽¹⁾
HOSPICE CARE		
Inpatient and home	100% ⁽¹⁾	100% of R&C ⁽¹⁾
AMBULANCE TRANSPORTATION		
To and/or from a hospital only	80%	80% of R&C
SPEECH THERAPY		
Restorative, non-developmental therapy only	80% ⁽¹⁾⁽³⁾	80% of R&C ⁽¹⁾⁽³⁾
PHYSICAL/OCCUPATIONAL THERAPY		
Excludes maintenance therapy	80%	80% of R&C
CHIROPRACTIC CARE		
Restricted to initial evaluation, X-Rays and spinal manipulations; \$1,000 plan year maximum	80%	80% of R&C
DURABLE MEDICAL EQUIPMENT		
Equipment, prosthetic appliances and medical supplies	80% ⁽¹⁾	80% of R&C ⁽¹⁾

(1) Failure to obtain pre-certification may result in a penalty or possible denial of benefits.

(3) Covered benefits only include therapy aimed at restoring the level of speech the individual had attained before the onset of a condition (i.e., before an illness or injury). Speech therapy for developmental disorders such as stuttering, articulation disorders, tongue thrust, lisping, etc. is Not Covered.

“R&C” (Reasonable and Customary Charge) is explained under the heading “Payment Terms You Should Know”, earlier in this SPD. You are responsible for any charges above R&C.

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.

<i>Services and Supplies</i>	<i>Option 1 Access Care through EHP Network Providers All Coverage Subject to Deductible</i>	<i>Option 2 Access Care through Out of Network Providers All Coverage Subject to Deductible</i>
PRESCRIPTION DRUGS	NETWORK PHARMACY	
In-network pharmacy: 30-day supply ⁽³⁾	\$10 co-pay – generic \$20 co-pay – brand preferred formulary \$35 co-pay – brand non-preferred	
90-day supply for maintenance drugs ⁽³⁾	<u>Mail order:</u> \$20 co-pay – generic \$40 co-pay – brand preferred formulary \$70 co-pay – brand non-preferred <u>In-Network pharmacy:</u> \$30 co-pay – generic \$60 co-pay – brand preferred formulary \$105 co-pay – brand non-preferred	
MENTAL HEALTH AND SUBSTANCE ABUSE SERVICES		
Professional fees for outpatient mental health treatment	90%	90% of R&C
Professional fees for inpatient mental health care	80% ⁽¹⁾	80% of R&C ⁽¹⁾
Facility charges for inpatient mental health care	100% for 1 st 30 days per admission, then 80% ⁽¹⁾⁽²⁾	100% of R&C for 1 st 30 days per admission, then 80% of R&C ⁽¹⁾⁽²⁾
Facility charges for inpatient alcohol and substance abuse care	100% for 1 st 30 days per admission, then 80% ⁽¹⁾⁽²⁾	100% of R&C for 1 st 30 days per admission, then 80% of R&C ⁽¹⁾⁽²⁾
Professional fees for inpatient alcohol and substance abuse care	80% ⁽¹⁾	80% of R&C ⁽¹⁾
Professional fees for outpatient alcohol and substance abuse care	100%	80% of R&C
Facility charges for outpatient mental health care	90%	90% of R&C
Facility charges for outpatient alcohol and substance abuse care	90%	90% of R&C

(1) Failure to obtain pre-certification may result in a penalty or possible denial of benefits.

(2) Two partial hospitalization days equal one inpatient hospital day and are paid according to the inpatient benefit level

(3) All brand name drugs for which there is a generic equivalent available are subject to the special pricing rules explained in the Prescription Drug Benefits section of this SPD.

“R&C” (Reasonable and Customary Charge) is explained under the heading “Payment Terms You Should Know”, earlier in this SPD. You are responsible for any charges above R&C.

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.

Student Health Program Covered Services and Supplies

The Student Health Program provides 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 maximums and coinsurance amounts are described in detail in the **Medical Benefits At-A-Glance** chart. The chart highlights the major benefits that will be payable for your care.

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 or therapeutic purposes provided by a licensed acupuncturist), up to \$300 per person per plan year;
- Adult preventive care, including evidence based items or services that have in effect a rating of A or B in the current recommendations of the United States Preventive Services Task Force;
- Ambulance service (professional), to the nearest hospital where necessary care can be given if the emergency is life threatening;
- Ambulatory surgical center;
- Anesthetics and oxygen, and their administration;
- Benefits for covered foreign nationals holding J visas:
 - Expenses for repatriation of remains up to \$7,500;
 - Expenses associated with the medical evacuation of the exchange visitor to his or her home country up to \$10,000;

- Birthing facilities, provided the physician in charge is acting within the scope of his or her license and the birthing facility is a freestanding licensed facility for childbirth which meets state licensing requirements;
- Blood products, if not replaced;
- Casts, splints;
- Chiropractic care for spinal manipulation, misalignment or partial dislocation of or in the vertebral column and correction by manual or mechanical means of nerve interference. Only initial consultation, x-rays and spinal manipulations are covered, up to a \$1,000 plan year maximum.
- Charges for the treatment of cleft lip and cleft palate conditions. These include expenses for oral surgery, otologic, audio logical and speech/language treatment;
- Cosmetic/reconstructive surgery, but only if needed:
 - Due to accidental injury or illness that is or would be covered by the Program;
 - Because of impaired bodily function or deformity resulting from disease, trauma, congenital or developmental anomalies, or previous therapeutic processes, or
 - For morbid obesity, as described below under “Obesity treatment”;
- Dental services if rendered as initial treatment as a result of accidental injury to the jaws, sound natural teeth, mouth, or face, provided care commences within 72 hours of the accident. Injury as a result of chewing or biting shall not be considered an accidental injury. In circumstances where oral surgery or dental treatment are otherwise covered, inpatient facility charges for services that ordinarily could be performed in the provider’s office will be covered only if the patient has a concurrent medical condition that prohibits doing the treatment safely in the provider’s office. The Program will pay surgical benefits for cutting procedures for the treatment of diseases, injuries, fractures and dislocations of the jaw when the service is performed by a physician or dentist. Normal extraction and care of teeth and structures directly supporting the teeth are not included;
- Diabetic supplies for insulin dependent diabetics;
- Diagnostic medical procedures; including colonoscopy screening, EKG, EEG, and other electronic diagnostic medical procedures;
- Doctors’ (including surgeons’) fees for treatment of illness or injury;
- Doctors’ fees and hospital charges for maternity care;
- Doctors’ fees for office visits;
- Drugs and medicines, including those for the treatment of psychiatric illness or chemical dependency, requiring a written prescription order and which are approved for general use by the Food and Drug Administration, and prescribed insulin and syringes used by a diabetic. Such drugs and medicines must be dispensed by a licensed pharmacist;

- Durable medical equipment (rental or purchase), including wheelchairs. If purchased, charges for repair or medically necessary replacement of Durable Medical Equipment will be considered a covered expense.

Durable medical equipment is medical equipment which:

- Can withstand repeated use; and
 - Is primarily and customarily used to serve a medical purpose; and
 - Is generally not useful to a person in the absence of illness or injury; and
 - 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, cutting of infected toenails, treatment of fractures and dislocations of bone in the foot;
 - Foot orthotics that are an integral part of a leg brace and the cost is included in the orthotist's charge, or they are custom-molded and related to a specific medical diagnosis; orthopedic shoes (not integral to a brace) and supportive devices for the feet are not covered;
 - Freestanding dialysis facility;
 - Gastric bypass surgery – see “Obesity treatment” below.
 - Home health care;
 - Hospice care;
 - Hospital charges for covered semi-private room and board and other hospital-provided services and supplies. After the deductible, benefits are paid at 100% of Reasonable and Customary Charges for the first 30 days per admission of inpatient care, and 80% of Reasonable and Customary Charges thereafter. These 30 days include all covered inpatient days;
 - Immunizations for routine use in children, adolescents, and adults that have in effect a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention;
 - Inpatient consultation services for a specialist in the medical field for which the consultation relates, when rendered in a covered facility at the request of the attending professional provider. The Program will pay for one such consultation, limited to three consultations during any one inpatient stay. Staff consultation required by the facility is not covered;
 - Laboratory tests;
 - Mammogram screening (once per 12 months) for women age 40 and older, or age 35 and older with a family history of breast cancer;
 - Mental health and substance abuse benefits;
 - Midwife delivery services, provided that the state in which such services are performed has a licensing or certification process for midwifery, and the midwife is licensed at the time delivery is performed;

- Newborn care;
- Nursing services (professional) in your home by a Registered Nurse (R.N.) or Licensed Practical Nurse (L.P.N.) who is not an immediate relative of the patient (spouse, same-sex domestic partner, child, grandchild, brother, sister, in-law, grandparent, or parent) and who does not ordinarily live with the patient;
- Nutritional counseling, limited to one initial consultation and one follow-up; additional visits must be pre-certified by the Care Management Program;
- Obesity treatment – surgical treatment for morbid obesity when Body Mass Index (BMI) (weight in kilograms/height in meters squared) is greater than or equal to 35 and the patient has at least one of the following conditions:
 - diabetes that is uncontrolled despite taking appropriate medication, with a Hemoglobin A1c test result greater than or equal to 8.5;
 - a specifically diagnosed cardiovascular disease that is uncontrolled despite taking appropriate medication, such as hypertension, coronary artery disease, valvular disease or congestive heart failure;
 - obstructive sleep apnea that is uncontrolled despite use of appropriate continuous positive airway pressure (CPAP) treatment.

Surgery must be pre-certified by the Care Management Program and all services must be provided at Johns Hopkins institutions. You must first participate for at least six months in a medically supervised weight management program that is approved and monitored by the Care Management Program.

- Pre-admission testing;
- Prosthetic devices, such as artificial limbs and eyes, and orthotics that are integral to the device, including charges for repair or medically necessary replacement;
- Rehabilitation facility services;
- Second surgical opinions—must be rendered by a board-certified specialist in the treatment of your particular medical condition, who is not associated professionally or financially with the physician that provided the first surgical opinion consultation. One additional consultation, as a third opinion, is covered in cases where the second opinion disagrees with the first. To avoid unnecessary duplicate testing, you should provide the specialists rendering the surgical opinions with any test results from the doctor who initially recommended surgery;
- Skilled nursing facility services;
- Support garments;
- Surgical dressings and medical supplies when ordered by an appropriate professional provider in connection with medical treatment (excluding self-administered supplies or convenience items);
- Surgical procedures;

- Treatment of Temporomandibular Joint Syndrome (TMJ) and/or myofacial pain, limited to physical therapy, surgery and ortho devices such as mouthguards and intraoral devices (excluding orthodontics and prosthetics); treatment to alter vertical dimension are covered when treatment plan is submitted and approved in advance by Care Management Program;
- Therapies, including:
 - Chemotherapy (inpatient and outpatient)—the treatment of malignant disease by chemical or biological antineoplastic agents, including the cost of the antineoplastic;
 - Dialysis treatment—the treatment of acute renal failure or chronic irreversible renal insufficiency for removal of waste materials from the body, to include hemodialysis or peritoneal dialysis;
 - Physical therapy—the treatment by physical means, hydrotherapy, heat, or similar modalities; physical agents; bio-mechanical and neuro-physical principles; and devices to significantly relieve pain, restore maximum function lost or impaired by disease or accidental injury, and prevent disability following disease, injury or loss of body part (does not include maintenance therapy). These services must be provided by a licensed physical therapist;
 - Occupational therapy—the treatment of a physically disabled person by means of constructive activities designed and adapted to significantly improving the functional restoration of the person’s abilities lost or impaired by disease or accidental injury, to satisfactorily accomplish the ordinary tasks of daily living in the home setting (does not include maintenance therapy);
 - Radiotherapy (inpatient and outpatient)—the treatment of disease by x-ray, gamma ray, accelerated particles, measons, neutrons, radium or radioactive isotopes;
 - Respiration therapy—the introduction of dry or moist gases into the lungs for treatment purposes;
 - Speech therapy—the treatment for the correction of a speech impairment when therapy is aimed at restoring the level of speech the individual had attained before the onset of a condition. Speech therapy for developmental disorders, such as stuttering, articulation disorders, tongue thrust, lispng, etc. is not covered;
- Transplants;
- Vasectomies and tubal ligations;
- Well-child care, including evidence-informed preventive care and screenings provided for in comprehensive guidelines supported by the Health Resources and Services Administration;
- Well-woman care, including evidence-informed preventive care and screenings for women provided for in comprehensive guidelines supported by the Health Resources and Services Administration; and
- X-ray, radium, and radioisotope treatment.

Following are descriptions of other services and supplies that are covered by the Student Health Program when medically necessary.

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.

In an emergency medical situation, you should go to the nearest medical facility for immediate treatment. An emergency medical situation means a medical condition that manifests itself by acute symptoms of sufficient severity (including severe pain) so that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to:

- Place the health of the patient (including the unborn child of a pregnant woman) in serious jeopardy;
- Result in serious impairment to bodily functions; or
- Result in serious dysfunction of any bodily organ or part.

The following visits to an emergency room will be automatically treated as an “emergency medical situation”, regardless of whether the visit satisfies the criteria set forth above:

- visits for children under age two;
- visits where the claim form indicates a “sudden and serious” diagnosis; or
- visits where the Care Management Program is notified by the patient’s physician that the patient was referred to the hospital emergency room.

You do not need to obtain pre-certification under the Care Management Program for treatment of an emergency medical situation. In all cases, if you receive treatment in an emergency room for a condition that is not an emergency medical situation, the Program will not cover the emergency room visit.

Treatment of an emergency medical situation in a hospital emergency room is covered at 100% of the Reasonable and Customary Charge, after the deductible, for treatment received within 72 hours after the onset of the emergency (whether due to an illness or an accident). Otherwise, treatment of an emergency medical situation is covered at 80% of the Reasonable and Customary Charge, after the deductible.

Treatment of an emergency medical situation does not include admission to the hospital for inpatient services. For any treatment other than treatment of an emergency medical situation, you must determine if the treatment is subject to the pre-certification requirements of the Care Management Program. If pre-certification is required, you must initiate the pre-certification process, even if the treatment is for urgent care.

Urgent Care Centers

If your regular provider is unable to see you and believes you need prompt medical attention for a condition which is not serious enough to be an “emergency medical situation” as described above, he or she may refer you to an urgent care center. An urgent care center is a facility (other than a hospital

emergency room) that is licensed to provide medical services for unexpected illnesses or injuries that require prompt medical attention, but are not life- or limb-threatening. Physician visits and diagnostic services and treatment at an EHP Network urgent care center are covered at 100% of the Reasonable and Customary Charge, after the deductible. Treatment at a non-Network urgent care center is covered at 80% of the Reasonable and Customary Charge, after the deductible.

Please Note: An “urgent care center” is a name used to describe a facility that treats medical conditions that are not serious enough to require going to an emergency room. A patient’s condition does not have to meet the definition of “emergency medical situation” set forth above in order for the patient to go to an urgent care center.

Ambulance Services

Your Student Health Program includes coverage for both air and ground professional 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;
 - You are transported directly from a hospital to a skilled nursing facility or rehabilitation facility; or
 - As otherwise specifically approved by the Care Management Program.

Air ambulance is only covered if it is medically necessary to be transported by air instead of by ground.

Maternity Benefits

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

The Student Health Program covers your prenatal care and delivery at the levels set forth in the **Medical Benefits At-A-Glance** chart. 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. If you are an expectant mother, call Student Health Program Customer Service at least eight weeks before your due date and call again after you have been admitted to the hospital for delivery.

The Student Health Program will provide maternity benefits for a mother and a covered newborn child for hospital stays up to:

- 48 hours following a vaginal delivery; or
- 96 hours, if the delivery is performed by caesarean 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), the Care Management Program must authorize the additional time.

Please note that no benefits are provided for the newborn child unless the child is properly enrolled in the Student Health Program within 30 days after birth. See the discussion of *New Children* on page 4 for more information.

Women's Health and Cancer Rights Act

The Student Health Program provides 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
- Prostheses 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 deductibles, coinsurance, and any annual or lifetime maximums will apply.

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 Student Health Program pays benefits toward a variety of these alternative care services.

Home Health Care Benefits

Please note: All home health care benefits 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 skilled nursing care and medical attention. It also offers the comfort of receiving care in familiar surroundings, rather than a hospital room.

The following services and supplies must be provided by a licensed health care organization to be covered. No benefits are paid for services performed by an immediate relative of the patient (spouse, same-sex domestic partner, child, grandchild, brother, sister, in-law, grandparent, or parent) or by someone who ordinarily lives with the patient. Please note that a home health care visit is limited to four hours.

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;
- Medical and surgical supplies when provided by a home health care agency (excluding prescription drugs);
- Oxygen and its administration; and
- Medical and social service consultations.

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

- Domestic or housekeeping services;
- Dietician services;
- Dialysis treatment;
- Maintenance therapy;
- Rental or purchase of equipment or supplies;
- Meals-on-wheels or other similar food arrangements;
- Home care provided in a nursing home or skilled nursing facility (see ***Skilled Nursing Facility Benefits***, discussed below);
- 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.

A physician may recommend continuing care in a skilled nursing facility. The Student Health Program covers all medically necessary eligible charges. To be covered, a skilled nursing facility must be:

- Accredited as a skilled nursing facility by The Joint Commission on Accreditation of Health Care Organizations;
- Recognized and eligible for payment under Medicare as a skilled nursing facility; and
- Recognized by the Program as a skilled nursing facility;

If you are confined in a licensed skilled nursing facility, the Student Health Program will pay 100% of the Reasonable and Customary Charge for medical services for the first 30 days, then 80% of the Reasonable and Customary Charge for additional days. The 30 days that are paid at 100% are in combination with all other covered inpatient days.

Covered 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.

A physician must prescribe care in a skilled nursing facility and the patient must be under a physician's supervision throughout the stay.

In order to be covered by the Program, 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 who are diagnosed to have six months or less to live. 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.

Hospice care is covered at 100% of the Reasonable and Customary Charge.

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.

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.

Covered hospice care services include:

- Inpatient care;
- Nutritional counseling and special meals;
- Part-time nursing;

- Homemaker services;
- Physical and chemical therapy;
- Durable medical equipment;
- Doctor home visits; and
- Bereavement and counseling services for spouse, same sex domestic partner and children during the six-month period following the date of death, limited to a combined maximum of six visits.

Covered hospice care services **do not** include the following:

- Any curative or life prolonging procedures;
- Services of a family member or individual who normally resides in your home; and
- Any period when the individual receiving hospice care is not under a physician's care.

Certain benefits may be paid for outpatient (in-home) hospice care. For details, please call Student Health Program Customer Service. To be covered, the hospice program must be licensed and the attending physician must certify that the terminally ill covered person has a life expectancy of six months or less.

Surgery

Surgery for the treatment of disease or injury, and sterilization procedures are covered under the Student Health Program. Separate payment will not be made for inpatient pre-operative care or post-operative care normally provided by the surgeon as part of the surgical procedure, as these are included in the global surgical fee.

For related operations or procedures performed through the same incision or in the same operative field, the Program pays the surgical allowance for the highest paying procedure.

When two or more unrelated operations or procedures are performed at the same operative session, the Program pays the surgical allowance for the highest cost operation or procedure, plus 50% of the allowance for the next four highest cost operations or procedures. The Program does not pay for any additional operations or procedures performed at the same operative session.

Benefits may also be provided for services of a physician who actively assists the operating surgeon when it is determined that the condition of the patient or the type of surgical service requires such assistance.

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.

The Student Health Program 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 described later in this SPD under **What's Not Covered by the Student Health Program**). The Program will pay covered expenses for human-to-human organ or tissue transplants incurred by you or your dependent as a recipient during a transplant benefit period which begins five days before and ends 18 months after the date of the organ or tissue transplant. Coverage is contingent upon continuing to meet the criteria for Johns Hopkins 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 organ;
- Obtaining, storing, and transporting the organ; and
- Travel expenses for the recipient, if medically necessary, to and from the transplant center, up to \$10,000 for each transplant completed.

Please note that 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 Program who receives the organ in a covered organ transplant. When coordinating with the donor's health plan, the Program 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 Student Health Program provides benefits for inpatient and outpatient mental health and substance abuse care, including alcohol detoxification. Outpatient care includes psychotherapy and counseling for substance abuse. Benefits are only provided when the services are received from independently credentialed mental health/substance abuse providers that are psychiatrists, clinical psychologists, certified addiction counselors or licensed clinical social workers (ACSW, LCSW, MSW). Graduate Student Counselors are not covered providers and benefits are not provided for their services.

Outpatient mental health care: Provider fees for outpatient mental health care are paid at 90% if you access care under Option 1, and at 90% of the Reasonable and Customary Charge if you access care under Option 2. Facility charges for outpatient mental health care are paid at 90% of the Reasonable and Customary Charge.

Inpatient mental health care: Facility charges are paid at 100% of the Reasonable and Customary Charge for the first 30 days of an admission. Thereafter, charges are paid at 80% of the Reasonable and Customary Charge. You pay the remaining 20%, plus any charges above the Reasonable and Customary Charge. You must obtain pre-certification for the inpatient admission or a penalty or complete denial of coverage will apply. Provider fees are paid at 80% of the Reasonable and Customary Charge.

Outpatient substance abuse care: Facility charges for outpatient substance abuse care are paid at 90% of the Reasonable and Customary Charge. Provider fees are paid at 100% if you access care under Option 1, and at 80% of the Reasonable and Customary Charge if you access care under Option 2.

Inpatient substance abuse care: Facility charges are paid at 100% of the Reasonable and Customary Charge for the first 30 days of an admission. Thereafter, charges are paid at 80% of the Reasonable and Customary Charge. You pay the remaining 20%, plus any charges above the Reasonable and Customary Charge. You must obtain pre-certification for the inpatient admission or a penalty or complete denial of coverage will apply. Provider fees will be paid at 80% of the Reasonable and Customary Charge.

Partial Hospitalizations: Two partial hospitalization days will equal one inpatient hospital day and will be paid according to the inpatient benefit level.

Please Note: You must receive pre-certification for all inpatient, inpatient residential and outpatient facility treatment programs for mental health and substance abuse care by calling the confidential Student Health Program number on the back of your I.D. card. Failure to obtain pre-certification will result in a penalty or complete denial of coverage.

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), and other medicines and supplies designated by Johns Hopkins EHP on behalf of the Student Health Program. You can receive a supply of up to 30 days at a retail pharmacy, or a 90-day supply for maintenance drugs. A cost saving 90-day supply is available through the Mail Order program for maintenance drugs. Mail order forms are available at the School of Medicine Registrar's Office, the Student Accounts Office at the Bloomberg School of Public Health, the JHH Schools of Medical Imaging or the JHU School of Nursing. Participating pharmacy directories and mail order forms may also be downloaded from EHP's website at www.ehp.org.

EHP Network Pharmacies

You will receive the highest level of prescription drug benefits if you fill your prescription at a Johns Hopkins EHP Network pharmacy. Your EHP provider directory has a complete list of Network pharmacies, or you can download a list from EHP's website at www.ehp.org. An EHP Network pharmacy has an arrangement to provide prescription drugs to you at a reduced price. When you buy covered drugs from an EHP Network pharmacy, present your Student Health Program identification card to the pharmacist with your prescription. You must pay a co-pay as explained below. You are responsible for the full cost of prescription drugs that are not covered by the Program.

If you purchase prescription drugs from an Out-of-Network pharmacy, you must pay the pharmacy for the purchase and submit for reimbursement from the Student Health Program. You will be reimbursed for the Network pharmacy price for the covered prescription, less the applicable co-pay. To obtain reimbursement, you must complete the Prescription Reimbursement Standard Claim Form, and follow directions on the form for mailing. Contact Student Health Program Customer Service to get a Claim Form or if you have any questions about how to submit a claim for reimbursement.

Please note: Your pharmacist may need to obtain pre-certification before dispensing certain prescription drugs that exceed the standard maximum supply of 90 days or which otherwise require special authorization, which may delay filling your prescription.

Co-pay

For up to a 30-day supply of drugs at a retail pharmacy, you pay a \$10 co-pay for each separate prescription or refill for a generic drug. The retail co-pay is \$20 for a brand name preferred formulary drug and \$35 for a brand name non-preferred drug. If you obtain a brand name drug that is available in generic form, you must pay a \$35 co-pay.

For maintenance drugs, you may receive a 90-day supply at a retail pharmacy by paying three times the normal monthly co-pay for that prescription. Or, you may use the EHP Mail Order program. 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 \$40 for brand name preferred formulary drugs and \$70 for brand name non-preferred drugs. If you have any questions about the Mail Order program, call EHP.

Prescribed oral contraceptives and contraceptive devices are covered, however non-prescribed contraceptives and devices are not covered. Removal of Norplant is covered; however insertion of Norplant is not covered.

Your prescription drug benefits cover erectile dysfunction drugs, provided:

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

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;
- Charges for a prescribed drug or medication that is not approved by the FDA for treatment of the condition;
- Non-prescribed oral contraceptives, contraceptive devices or methods;
- Insertion of Norplant;
- Any charge for *administration* of drugs or insulin;
- Any drugs that are not prescribed for the treatment of an illness or injury. For example, the Program does not cover vitamins, Psoralens, anorexants or diet pills, or Minoxidil;
- Methadone;
- Any drug or medication that is available over-the-counter, except as described in this SPD. A drug or medication is considered to be available over-the-counter if it can legally be purchased without a prescription, even if your doctor gives you a prescription for it;
- Any drug or medication that is used for treatment of a condition for which coverage is otherwise excluded as described elsewhere in this SPD. For example, this means that drugs or medications for artificial reproduction treatment, such as in vitro fertilization, are not covered.
- Immunizing agents or biological serums sold as separate items;
- Medication delivery implants;
- Medications dispensed to you while an inpatient in any facility;
- Prescriptions or refills for medications that are lost, stolen, spilled, spoiled or damaged;
- Any medication used for any cosmetic purpose, including but not limited to, hair growth or hair removal;
- Herbal, mineral, and nutritional supplements.

Please note: Prescriptions are not covered under the Program if written by a member of the Student Health Program. Prescriptions are also not covered if written by an immediate relative of the patient (spouse, same-sex domestic partner, child, grandchild, brother, sister, in-law, grandparent, or parent) or by someone who ordinarily lives with the patient.

Over-the-Counter Drugs

Prescription drug benefits normally do not cover a drug or medication that is available “over-the-counter” (“OTC”). A drug or medication is considered to be available 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 do cover OTC proton pump inhibitors (drugs like Prilosec or Prevacid) and non-sedating antihistamines (drugs like Claritin or Zyrtec), but only if your doctor gives you a prescription for the drug and you show the pharmacist your prescription at time of purchase. No co-pay applies when you obtain these kinds of prescribed OTC drugs, both for brand name or generic

equivalents. Go to the Student Health Program website at www.ehp.org for a complete list of covered OTC drugs.

What's Not Covered by the Student Health Program

The Student Health Program does not cover the following:

- Any charges related to:
 - an injury arising out of, or in the course of, any employment for wage or profit; or
 - a disease covered with respect to employment, by any Workers' Compensation law, occupational disease law, or similar legislation;
- Any condition or injury arising from or occurring while engaged in any illegal activity;
- Any injury sustained or disease resulting from war, act of war, act of terrorism, riot, rebellion, civil disobedience, or from military service in any country;
- Charges by a provider who is an immediate relative of the patient (spouse, domestic partner, child, grandchild, brother, sister, in-law, grandparent or parent) or who resides in the patient's home. Charges for services prescribed for oneself. This exclusion also applies to charges for prescription drugs prescribed by an immediate relative;
- Charges for equipment that does not meet the definition of Durable Medical Equipment earlier in this SPD, including air conditioners, humidifiers, dehumidifiers, purifiers or physical fitness equipment, whether or not recommended by a doctor;
- Charges in excess of the Reasonable and Customary Charge 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.
- Charges incurred when you are not covered under the Student Health Program;
- 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 Program 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 18 months after the expenses were incurred;
- Contraceptive medications, devices or methods that are not prescribed by a physician, and insertion of Norplant;
- 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 except:
 - when resulting from an accidental injury or illness that is or would be covered by the Program;
 - because of a congenital malformation of a child; or

- because of a mastectomy (see **Women's Health And Cancer Rights Act Of 1998**, earlier in this SPD);
- 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 if rendered as initial treatment as a result of accidental injury to the jaws, sound natural teeth, mouth, or face, provided care commences within 72 hours of the accident. Services directly related to the care, filling, removal or replacement of teeth or the treatment of injuries to or diseases of the teeth, gums, or structures directly supporting or attached to the teeth are not covered;
- Drugs that are non-prescription, non-legend, or over-the-counter, or to replace lost or stolen drugs;
- Education, vocational, work hardening or training programs regardless of diagnosis or symptoms that may be present, or for non-medically necessary education. Your school may provide these services to you through another program;
- Emergency room services or treatments in cases other than in emergency medical situations;
- Expenses in connection with an injury arising out of or relating to an accident involving the maintenance or use of a motor vehicle (other than a recreational vehicle not intended for highway use, motorcycle, motor-driven cycle, motorized pedal cycle or like type vehicle). This exclusion shall apply to those expenses up to the minimum amount required by law in the state of residence for any injury arising out of an accident of the type for which benefits are or would be payable under automobile insurance, regardless of whether or not automobile insurance is in force and regardless of any benefit limits under such insurance. However, this exclusion does not apply to a covered person who is a non-driver when involved in an uninsured motor vehicle accident;
- Expenses related to third-party liability, unless otherwise payable as described under the heading **When the Student Health Program May Recover Payment**, later in this SPD;
- Expenses related to exercise programs or use of exercise equipment, special diets or diet supplements, Nutri System Program, Weight Watchers or similar programs and hospital confinements for weight reduction programs;
- Expenses related to artificial reproductive procedures, including but not limited to artificial insemination, in vitro fertilization and related techniques, gamete intra fallopian tube transfer (GIFT), ovum transfer and embryo transfer;
- Experimental treatment, defined as the use of any treatment, procedure, facility, equipment, drug or drug usage, device or supply 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; this principle does not apply to a medical device to the extent Medicare would cover the device in accordance with Medicare Policy Manual Chapter 14;
 - 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; a treatment will not be considered experimental merely because it is the subject of a clinical trial, to the extent Medicare would cover the treatment in accordance with a national coverage determination (or other binding pronouncement).
 - 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 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 informed consent used by the treating facility or by another facility studying substantially the same drug, device, equipment, treatment or procedure;
- Foot devices, unless they are an integral part of a leg brace and the cost is included in the orthotist's charge; or they are custom-molded and related to a specific medical diagnosis. Orthopedic shoes (not integral to a brace), supportive devices for the feet and orthotics used for sport and leisure activities are not covered;
 - Eyeglasses, contact lenses, eye refractions, or the examinations for their fitting or prescription, except when medically necessary after cataract surgery or for aphakic patients and soft lenses or sclera shells intended for use in the treatment of medical conditions or injury;
 - Gardasil vaccine against human papillomavirus, if given before age 9 or after age 26;
 - Hearing aids, or the examination for their fitting or prescription;
 - Hypnosis or biofeedback training;
 - Infertility services for any reasons;
 - Myopia or hyperopia correction by means of corneal microsurgery, such as keratomileusis, keratophakia, and radial keratotomy or laser surgery and all related services;

- Nicotine addiction treatment, or smoking cessation programs;
- Pre-existing conditions, except as described under the heading **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;
- Registered inpatient services if admitted on a Friday, Saturday or Sunday unless required as a result of emergency sickness or accident care. Sunday admissions will only be covered if medically necessary for scheduled surgery on Monday morning;
- 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 where surgery is performed) and orthotics used for sport and leisure activities;
- Services and supplies not recommended and approved by a doctor;
- Services and supplies paid in full or in part under any other plan of benefits or for services and supplies for which you are not required to pay;
- 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 the education, research, or training program;
- Sexual dysfunction treatment not related to organic disease;
- Speech therapy for developmental disabilities such as stuttering, articulation disorders, tongue thrust, lisping, etc.;
- Surgical treatment of obesity or morbid obesity, including when the surgery is for treatment of co-morbid conditions, except as described earlier in this SPD under **Covered Services and Supplies**;
- Surrogate motherhood treatment, including any charges related to giving birth or for treatment of the newborn child resulting from the surrogate motherhood;
- Telephone consultation charges, missed appointment charges, or charges for the completion of forms;
- Transsexualism, gender dysphoria, or sexual reassignment or change, including medication, implants, hormone therapy, surgery, medical, or psychiatric treatment;
- Travel, whether or not recommended by a physician, except as specifically provided in this SPD;
- Treatment which is not medically necessary or above the allowable lifetime or annual maximums;

- Treatment which is not performed by an appropriate licensed professional provider acting within the scope of the provider's license;
- Treatment for which a third party may be liable, unless otherwise payable as described under **When the Program May Recover Payment (Reimbursement and Subrogation)**, later in this SPD; and
- Wigs and artificial hair pieces or any drug—prescription or otherwise—used to treat baldness (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 up to a \$350 maximum benefit as coordinated through the Care Management Program).

Please note: This is not a complete list. If you are not sure if an expense is covered after reviewing this list, please call Student Health Program Customer Service at (410) 424-4485 or (888) 400-0091.

Other Information About Your Benefits

Filing A Claim

You or your provider will need to file a claim in order to receive 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 18 months from the date services or supplies were provided.

Send all claims to:

Johns Hopkins Employer Health Programs
Student Health Program
6704 Curtis Court
Glen Burnie, Maryland 21060

Itemized bills must include the following information:

- The date(s) that services or supplies were received;
- A description and diagnosis of the service(s) 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.

Claim forms are available at The Johns Hopkins University School of Medicine Registrar's Office, the Bloomberg School of Public Health Student Accounts Office, University Health Services (UHS) Benefits Office, the JHU School of Nursing Student Accounts Office, or Johns Hopkins Employer Health Programs. To avoid delay in handling your claim, answer all questions completely and accurately. *Expenses cannot be processed without your signature in the appropriate areas of the form.*

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

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 or same-sex domestic partner's employer. You may also qualify under certain conditions for benefits from state no-fault auto laws.

The Student Health Program, like most group health plans, includes a Coordination of Benefits (COB) provision. The purpose of this provision is to limit the total amount you may receive from all medical plans to no more than 100% of the covered charges.

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 Student Health Program is your Secondary Plan, only covered expenses up to the amount the Program would otherwise pay 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 will be 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 father’s coverage is the Primary Plan and pays first and the mother’s plan is the Secondary Plan.

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. 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

If you have enrolled your spouse/same sex domestic partner in the Student Health Program and your spouse/same sex domestic partner loses coverage under his or her other plan, the Student Health Program becomes primary for both of you and any covered dependent children.

Please note that the Student Health Program is the Secondary Plan to any other plan covering a qualified beneficiary who has elected COBRA.

The Student Health Program is the Primary Plan if you are covered under the Program as an active employee and you are also covered by Medicare or Medicaid. Similarly, if you are covered under the Program as an active employee the Program is the Primary Plan for your covered spouse if your spouse is covered by Medicare. If you are not covered as an employee, the Student Health Program is Secondary to Medicare and Medicaid. In all cases, the Student Health Program is Secondary to Medicare or Medicaid if your same-sex domestic partner is covered by Medicare or Medicaid. If someone is eligible for Medicare but does not enroll for Medicare, the Program will pay Secondary benefits as though he or she had enrolled for Medicare. The Student Health Program is the Primary Plan for your dependent children if they are covered by Medicaid or CHIP.

When the Program is the Secondary Plan, it will deem the Primary Plan to have made all benefit payments that would have been made had the covered person 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 Program will make its 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.

When the Student Health Program May Recover Payment

If you or your dependents have an injury, illness or other condition that is covered by the Student Health Program 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 Student Health Program's Reimbursement and Subrogation rights set forth below.

Reimbursement

The Student Health Program's 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". For purposes of these reimbursement rules and the subrogation rules below, your dependents include your same-sex domestic partner. If you or your dependents have received a Recovery, the Program will subtract the amount of the Recovery from the benefits it would otherwise pay for treatment of the injury, illness or other condition. If there is a possible future Recovery, the Program may delay paying benefits until the Recovery is received, and then subtract the amount of the Recovery.

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

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

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

The Program is only responsible for those legal costs to which it agrees in writing, and will not otherwise bear the legal costs of you and your dependents. If you take any action to prevent the

Program from enforcing its reimbursement rights, you will also be liable to reimburse the Program for any legal expenses that the Program or its agents incur in enforcing the Program's reimbursement rights.

Subrogation

The Student Health Program's 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 Student Health Program has already paid benefits for treatment of the injury, illness or other condition.

The Program is 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 Program is subrogated to the extent of the amount of the benefits it pays to or on behalf of you or your dependents. The Program may assert its subrogation right independently of you and your dependents.

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

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

When Medical Coverage Ends

Your coverage under the Student Health Program described in this SPD will end on the earliest of the following dates:

- The end of the month in which you are no longer registered as a student at the JHU School of Medicine, Bloomberg School of Public Health, JHH Schools of Medical Imaging or the JHU School of Nursing (but see COBRA Continuation Coverage described next);
- The date when you report for active duty as a member of the armed forces of any country;
- The date the Student Health Program is terminated or the date your school terminates its participation in the Program;
- The end of the month in which you elect to no longer be covered under the Student Health Program or the date you stop making required contributions for coverage under the Program.

Coverage for a dependent will end on the earliest of:

- The end of the month in which your coverage ends;
- The end of the month in which he/she no longer qualifies as an eligible dependent as explained earlier in this SPD (but see COBRA Continuation Coverage described next);
- The end of the month in which you elect to no longer cover your dependents under the Student Health Program or the date you stop making required contributions for dependent coverage under the Program;
- The date your dependent enters military service.

For certain of the above events, you or your dependents may be able to continue coverage by self-payment under COBRA, as explained next.

COBRA Continuation Coverage

COBRA allows you, your spouse/same-sex domestic partner or former spouse/same-sex domestic partner, and your and your same-sex domestic partner's dependents to continue your Student Health Program medical coverage 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 the Program on the date of the qualifying event may continue coverage under COBRA. You, your spouse/same-sex domestic partner, and your and your same-sex domestic partner's adult dependents have separate election rights. To continue coverage under COBRA, the covered person must pay the full premium rates, plus a two percent administrative charge.

The Student Health Program voluntarily provides COBRA rights to your same-sex domestic partner and your partner's dependents. COBRA rights for your same-sex domestic partner and your partner's dependents are not required by law, and are only provided as set forth in this Summary Plan Description.

Coverage under the Student Health Program may be continued under COBRA for up to 18 months for you, your spouse/same-sex domestic partner, and your and your partner's eligible dependents, if coverage is lost due to your no longer being registered as a student with any of the schools that sponsor the Program. Coverage may be continued for up to 24 months if you are also employed by one of the schools and 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 or your same-sex domestic partner, adopted by you or your same-sex domestic partner, or placed with you or your same-sex domestic partner for adoption while you or your same-sex domestic partner are covered under COBRA. For such a child to qualify for COBRA, you or your same-sex domestic partner must notify the Plan Administrator 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.

If you, your spouse/same-sex domestic partner, or any of your or your same-sex domestic partner's 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 Plan Administrator must be notified in writing of Social Security Disability within 60 days after the date of determination and before the 18 months of regular COBRA coverage ends, or the 11 additional months of COBRA coverage will not be provided. If Social Security notifies you, your same-sex domestic partner or any of your or your same-sex domestic partner's 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 Plan Administrator within 30 days of the Social Security notice. Please contact the Plan Administrator if you have any questions about your eligibility.

Your spouse/same-sex domestic partner and your or your same-sex domestic partner's dependent children may individually elect COBRA continuation coverage for up to 36 months if coverage ends because of:

- Your divorce;
- Your legal separation;
- The end of your same-sex domestic partnership;
- Your entitlement to Medicare; or
- Your death.

Please note: You may not elect coverage on behalf of a divorced spouse or a former same-sex domestic partner, but he or she may personally elect to continue coverage.

Your and your same-sex domestic partner's dependent children may individually elect COBRA continuation coverage for up to 36 months if they stop being eligible for dependent coverage as explained earlier in this SPD.

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 and before the 18 months has expired, then COBRA coverage may be elected for up to 36 months, measured from the first event. If another event occurs, you, your spouse/same-sex domestic partner, or your or your same-sex domestic partner's dependent children must notify the Plan Administrator in writing within 60 days after the second event. If the Plan Administrator is not notified in time, COBRA may not be continued past 18 months.

You, your spouse/same-sex domestic partner, or your or your same-sex domestic partner's dependents will be informed of the right to continue coverage under COBRA in the event:

- You are no longer registered as a student with any school that sponsors the Program;
- You die.

In the case of divorce, separation, end of a domestic partnership, or a dependent child no longer being eligible for dependent coverage, you, your spouse/same-sex domestic partner, or your or your same-sex domestic partner's child must notify the Plan Administrator in writing within 60 days after that event occurs. If that notice is given on time, your spouse/same-sex domestic partner or the dependent 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/same-sex domestic partner and the dependent child will have no rights to continue coverage under COBRA.

You must notify the Plan Administrator in writing if you, your spouse/same-sex domestic partner or a dependent child change addresses. The Plan Administrator will only send communications to a recipient's last known address.

Electing COBRA Coverage

You, your spouse/same-sex domestic partner or your or your same-sex domestic partner's dependent children will 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 your Student Health Program medical coverage under COBRA. If COBRA coverage is not elected on time, coverage under the Student Health Program will end.

If COBRA coverage is elected on a timely basis, you, your spouse/same-sex domestic partner, or your or your same-sex domestic partner's 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 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/same-sex domestic partner, or dependent children have elected to continue coverage and have paid the required premiums, coverage will be reinstated back to the date regular coverage was lost. The Student Health Program will not pay any claims made in the interim. Upon reinstatement of coverage, invoices may be submitted or re-submitted to the Program for payment.

If the Student Health Program benefits change, or if the coverage costs change, the COBRA continuation coverage benefits and their costs will change as well. Covered persons will be notified of any changes.

The University Health Services Health Center (UHSHC) only provides services to those persons who pay the student health fee, and their dependents.

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.
(Please note: your spouse/same-sex domestic partner and dependent children are entitled to COBRA continuation coverage for 36 months if **you** become covered by Medicare after COBRA coverage for them is elected — this 36-month period begins with the date your COBRA coverage began);
- The premium is not received on a timely basis; or
- The Student Health Program stops providing group medical coverage for all active students.

When You Become Covered By Medicare

If you are still an active participant when you become covered by Medicare, your Student Health Program coverage will coordinate with your Medicare coverage. Be sure to advise your health care provider that you have both coverages. Make clear to your provider that your coverage under the Student Health Plan is because you are a student.

Benefits You Will Receive From Medicare

When you reach age 65, you will be eligible for Medicare hospital (Part A) and medical (Part B) benefits. You will not be covered by Medicare until you enroll. You may become eligible for Medicare benefits at an earlier date if you become permanently disabled or have end stage renal disease. The exact amount of the benefits you receive is determined by the government, and may be adjusted in future years to reflect changes in medical costs.

Basic Administrative Information about Your Benefits

This section of your SPD contains information regarding the administration and funding of the Student Health Program.

Name of Program/Plan

The Johns Hopkins University School of Medicine, Bloomberg School of Public Health and Johns Hopkins University School of Nursing Student Health Program.

Group Number	E00016
Name and Address of Plan Administrator	The Johns Hopkins University School of Medicine 733 N. Broadway Broadway Research Building, Suite 147 Baltimore, MD 21205
Administrator Identification Number	52-0595110
Plan Number	513
Type of Administration	Contract administration by Johns Hopkins Employer Health Programs, Inc.
Plan Sponsor	The Johns Hopkins University School of Medicine, the Bloomberg School of Public Health and the Johns Hopkins University School of Nursing 733 N. Broadway Room 147 Broadway Research Building Baltimore, MD 21205
Plan Supervisor	Johns Hopkins Employer Health Programs 6704 Curtis Court Glen Burnie, MD 21060 410-484-4485 888-400-0091
Agent for Legal Process	Service of legal process may be made upon the Plan Administrator.
Plan Year	July 1 -- June 30.

Source of Program Benefit Payments

Benefits under the Program are paid from the general assets of the Johns Hopkins University School of Medicine, Bloomberg School of Public Health, the Johns Hopkins University School of Nursing and the Johns Hopkins Hospital. Benefits are not paid or administered by an insurance company.

Claims for Benefits

In order for you to receive medical benefits under the Program, you or your provider must file a claim. Following are the Program's procedures for filing claims and appealing claim denials.

The Program'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 precertification 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 Program's procedures also apply to a determination that you are not covered under the Program. If you are covered by the Program and it is determined that you are no longer entitled to coverage for a

reason other than your failure to maintain enrollment or pay the required contribution, your coverage will not end until you have exhausted your rights under these 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.

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**”.

If a service or supply must be pre-certified and it is requested for Urgent Care, it is an “**Urgent Care Claim**”.

A service or supply is considered to be requested for Urgent Care if either of these statements would be true:

- The life or health of the patient or the ability of the patient to regain maximum function could be seriously jeopardized if the pre-certification decision is not made within 72 hours. Whether the “serious jeopardy” test is met 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 serious jeopardy test is met, the physician’s determination will be followed.
- A physician with knowledge of the patient’s medical condition determines that the patient would be subject to severe pain that cannot be adequately managed without the requested service or supply.

If a service or supply does not need to be pre-certified, a claim for payment is a “**Post-Service Claim**”.

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. Claims should be reported promptly, and no claims will be accepted more than 18 months after the treatment was provided.

Unless a different address is shown on the top of the form, send all Post-Service Claims to:

Student Health Program
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;
- 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 University School of Medicine Registrar's Office, the Student Accounts Offices of the Bloomberg School of Public Health, the JHH Schools of Medical Imaging, the JHU School of Nursing and the University Health Services (UHS) Benefits Office 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.

Please 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.

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 24 hours after the claim is properly filed.

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 is denied, you will be notified within 30 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 30 day period ends why an extension is needed and when a decision is expected.

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 Program 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.

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:

Johns Hopkins HealthCare
Appeals Department
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 Appeals Department. You may submit written comments, documents, records and other information relating to your claim. The Appeals Department will consider everything you submit, regardless of whether it 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 Program documents, records and other information relevant to your claim.

During the First Level Appeal process, you will be provided, free of charge, with any new or additional evidence considered, relied upon, or generated by (or at the direction of) the Program in connection with your claim, and with any new or additional rationale for denying your claim. In either case, the evidence or rationale will be provided to you as soon as possible and sufficiently in advance of the date on which the Appeals Department will decide your First Level Appeal, so as to give you a reasonable opportunity to respond prior to that date.

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

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 within 30 days after your appeal is filed.
- **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.

You will be sent a written notice of the Appeals Department's decision. If your appeal is denied, the notice will tell you why and the specific Program 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 the Johns Hopkins HealthCare Appeals Department 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 Appeals Department's denial of your First Level Appeal or (2) 180 days after you were initially notified that your claim was denied.

If the Appeals Department 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 Department's decision. If you file a Final Appeal more than five days after you are notified of the Department'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.

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 Program documents, records and other information relevant to your claim.

During the Final Appeal process, you will be provided, free of charge, with any new or additional evidence considered, relied upon, or generated by (or at the direction of) the Program in connection with your claim, and with any new or additional rationale for denying your claim. In either case, the evidence or rationale will be provided to you as soon as possible and sufficiently in advance of the date on which the Plan Administrator will decide your Final Appeal, so as to give you a reasonable opportunity to respond prior to that date.

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 within 30 days after your Final Appeal is filed.

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 Appeals Department'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.

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 Appeals Department. If you disagree with the Plan Administrator's decision, you may bring a civil action against the Program under ERISA Section 502.

Employer Health Programs and the Plan Administrator may not make any decisions regarding hiring, compensation, termination, promotion or other similar matters regarding any individual based on the likelihood that the individual will support a denial of benefits.

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 Program 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 Program. 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 Programs. 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 Programs 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 Programs, the Program 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.

The IRO's independent review determination is not binding on the Program 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 Program (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 Program may create or obtain information which relates to a Program participant's physical or mental health condition, treatment or payment for health care. When this information is individually identifiable, it is called "Protected Health Information" (PHI) under the Health Insurance Portability and Accountability Act of 1996 and its implementing regulations (collectively "HIPAA").

Permitted Use and Disclosure

The Program (which includes the Program's agents for purposes of this Section) may disclose PHI to the Plan Sponsor (which includes the Plan Sponsor's agents for purposes of this Section), and the Plan Sponsor may use or disclose PHI obtained from the Program, only for the following purposes:

- To assist Program participants with resolution of claims;
- To decide appeals of benefit determinations;
- To select and monitor Program service providers;
- To obtain premium bids from health plans to provide coverage under the Program;
- To evaluate Program design and modify, amend or terminate the Program;
- To disclose information on whether the individual is participating in the Program, or is enrolled in or has disenrolled;
- To consult with the Program's service providers regarding administrative functions, including payment, health care operations and activities performed by the Program which support treatment;
- To seek bids and negotiate for stop-loss insurance coverage (if applicable); and

- As otherwise required by law.

The Program may disclose PHI to the Plan Sponsor for purposes not stated above only after authorization is obtained from the Program participant.

Plan Sponsor's Certification

Except as otherwise permitted or required by law, as a condition to obtaining PHI from the Program, its business associates, insurers and HMOs, the Plan Sponsor agrees to:

- Not use or further disclose PHI other than as permitted above, or as otherwise permitted by HIPAA or as required by law;
- Ensure that any agents or subcontractors who receive PHI from the Plan Sponsor that was obtained from the Program will agree to the same restrictions and conditions that apply to the Plan Sponsor;
- Not use or disclose PHI for employment related actions and decisions or in connection with any other benefit or employee benefit plan of Plan Sponsor;
- Report to the Program any known use or disclosure of PHI that is inconsistent with the uses or disclosures allowed above;
- Make PHI available to the Program for response to a participant's request for access to the participant's PHI in a designated record set, as provided by HIPAA;
- Make PHI available to the Program for amendment, and incorporate any amendments to PHI, as provided by HIPAA;
- Make available to the Program the information required to provide an accounting of disclosures as provided by HIPAA;
- Make its internal practices, books, and records relating to use and disclosure of PHI received from the Program available to the Secretary of the Department of Health and Human Services, for purposes of determining the Program's compliance with HIPAA;
- If feasible, return or destroy all PHI received from the Program when the Plan Sponsor no longer needs the PHI for the purpose for which it was disclosed to the Plan Sponsor, except if return or destruction is not feasible, the Plan Sponsor will limit further uses and disclosures to those purposes that make the return or destruction infeasible; and
- Ensure adequate separation between the Program and the Plan Sponsor, as stated below.

The applicable HIPAA Regulations are set forth at 45 CFR Part 164, including any amendments made to these requirements.

Separation Between Program and Plan Sponsor

Only the following persons under the control of the Plan Sponsor ("Plan Sponsor Representatives") may be given access to PHI from the Program:

- Persons who, in the ordinary course of business, receive PHI relating to treatment, payment or health care operations under the Program, including any persons who hear appeals of claim denials under the Program;
- Plan Sponsor's Associate Dean/Registrar, the Student Benefits Manager and the Student Accounts Coordinator, and those employees of the Plan Sponsor who report to the Associate Dean/Registrar, the Student Benefits Manager and the Student Accounts Coordinator in the ordinary course of performing job duties for the Plan Sponsor that relate to Program administration functions;
- Plan Sponsor's Legal Counsel; and
- Individuals or titles appointed in writing by the Plan Administrator to perform specific tasks for the Program, provided the Plan Administrator documents such appointment in writing and maintains such appointment available for inspection to the same extent as this Program is available for inspection.

These Plan Sponsor Representatives may have access to and may use PHI from the Program only for Program administration functions performed by the Plan Sponsor. Program personnel will assure that the minimum necessary PHI is made accessible to the Plan Sponsor Representatives for these purposes. These Plan Sponsor Representatives will be trained in the limits on access to, and the proper use of, PHI from the Program. In addition, these Plan Sponsor Representatives will be subject to appropriate sanctions, as provided by the Plan Sponsor's policies, for improper access to, or use or disclosure of, PHI from the Program, and for any failure to comply with any provision of the Plan Sponsor's certification.

Security of Electronic PHI

Electronic PHI means Protected Health Information which is (1) transmitted by electronic media, or (2) maintained in electronic media.

Except when the only Electronic PHI disclosed to Plan Sponsor is "summary health information" (as defined in HIPAA) or enrollment/disenrollment information, or is validly authorized by the Program participant, the Plan Sponsor agrees to:

- Implement administrative, physical and technical safeguards that reasonably and appropriately protect the confidentiality, integrity and availability of the Electronic PHI that it creates, receives, maintains or transmits on behalf of the Program;
- Ensure that the separation between the Program and the Plan Sponsor as required above is supported by reasonable and appropriate security measures;
- Ensure that any agent, including a subcontractor, to whom the Plan Sponsor provides Electronic PHI agrees to implement reasonable and appropriate security measures to protect the information; and

- Report to the Program any security incident of which it becomes aware. (For purposes of this provision, “security incident” means the attempted or successful unauthorized access, use, disclosure, modification or destruction of information or interference with system operations in an information system.)

Your Rights Under ERISA

As a participant in the Student Health Program, 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 Program (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 Program participants, ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plans. These people are called fiduciaries. ERISA requires that fiduciaries act prudently and solely in the interest of you and other Program 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 Programs 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 Program 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 Program, 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., NW, Washington, D.C., 20210.

Student Health Program's Rights

The benefit plan described in this SPD is for student participants only. The Johns Hopkins University School of Medicine, the Bloomberg School of Public Health, the Johns Hopkins Hospital School of Medical Imaging and the JHU School of Nursing expect to continue this Program indefinitely, but reserve the right to modify, amend, suspend, or terminate the Program at any time, and for any reason without prior notification. You will be notified of any changes to this Program and how they affect your benefits, if at all. We have attempted to make the explanations of the Program as accurate as possible. However, should there be a discrepancy between this SPD and the provisions of the contracts or other plan documents, the provisions of the contracts or other plan documents will govern. You should not rely on any oral descriptions of the Program, since the written description in this SPD will always govern. To the extent any benefits under the Program are provided by an insurance policy, no benefits are provided by the Program except for those benefits, if any, which are paid by the insurance company which issues the policy.

Plan Administrator's Authority

The Plan Administrator has discretionary authority to interpret the terms of the Student Health Program and to decide any questions of fact which relate to entitlement to benefits under the Program.

For More Information

Please see your Student Health Program enrollment materials for additional information about the Program. If you have questions, you can speak with a Student Health Program Customer Service Representative by calling (888) 400-0091 or (410) 424-4485 or, contact the Registrar's Office, School of Medicine, Student Accounts Office, Bloomberg School of Public Health, the JHH Schools of Medical Imaging or the JHU School of Nursing.

Please Note: This Summary Plan Description has been changed from the version of the Summary Plan Description that was distributed in 2010 so as to reflect certain benefit changes that take effect July 1, 2011. If you have any questions, please contact the Registrar's Office at the School of Medicine, the Student Accounts Office at the Bloomberg School of Public Health, the JHH Schools of Medical Imaging, the JHU School of Nursing or a Student Health Program Customer Service Representative.