



JOHNS HOPKINS
M E D I C I N E

US FAMILY HEALTH PLAN



Johns Hopkins US Family Health Plan **Member Handbook**



QUICK REFERENCE

MEDICAL EMERGENCIES

- For life-threatening emergency treatmentCall 911
- To arrange for emergency or urgent care
 - In area Call your PCM
 - Out of area Call your PCM
 - Out of country Notify Customer Service Department within 7 days of return

PATIENT INFORMATION AND ASSISTANCE

- Johns Hopkins US Family Health Plan**
6704 Curtis Court, Glen Burnie, MD 21060 1-800-80-USFHP (1-800-808-7347)
- Benefits Questions**
Customer Service 410-424-4528 or 1-800-808-7347 or usfhpcustomerservice@jhhc.com
- Billing** 410-424-4835 or 1-888-717-8282 or usfhpcustomerservice@jhhc.com
- Coordination of Benefits** 410-424-4716
- Discounted Dental Plan**
United Concordia Company Inc. 1-866-357-3304
- Disease Management** 1-800-557-6916
- Enrollment Department** 410-424-4528 or 1-800-808-7347 or usfhpcustomerservice@jhhc.com
- Pharmacy Services** 1-800-808-7347
 - Mail-Order Pharmacy 410-338-3300
- Web site** www.hopkinsmedicine.org/usfhp

AFTER-HOURS SERVICES

Call our Nurse Line – Answers for your health questions 24 hours a day: 866-444-3008 PIN 382(Pin # is for the Health Information Library). Or call your Primary Care Provider’s after-hours service.

BEHAVIORAL HEALTH / SUBSTANCE ABUSE SERVICES

- Department of Psychiatry at The Johns Hopkins Hospital 410-424-4830
- Out of area 1-888-281-3186

DEFENSE ENROLLMENT ELIGIBILITY REPORTING SYSTEM (DEERS)

- Manpower Data Center Support Office**
DSO Attention: COA, 400 Gigling Road, Seaside, CA 93955-6771
- Toll Free 1-800-538-9552 FAX: 1-831-655-8317
- Web site <http://www.tricare.osd.mil/DEERS>

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Welcome

to the Johns Hopkins US Family Health Plan (Plan) for retirees, retiree family members and active-duty family members of the seven uniformed services. This *Member Handbook* provides you with the information you will need to get the most from the Plan and to ensure that you know the best way to obtain the services and benefits.

New to the Johns Hopkins US Family Health Plan?

You may have questions and concerns regarding various aspects of your coverage and how the Plan works. Our highly trained customer service representatives are ready to answer your questions, help you locate a primary care provider or a specialist, or provide other assistance you might need. We are available Monday through Friday 8 a.m. to 4:30 p.m.

Telephone: 410-424-4528 or toll free, 1-800-808-7347

E-mail: usfhpcustomerservice@jhhc.com

Read Your Handbook Carefully

The *Member Handbook* is a summary of eligibility requirements, medical coverage, co-payments, definition of terms, exclusions, and other provisions of the US Family Health Plan.

Please note: This handbook is only as current as the date of publication and is subject to change without notice. The *Member Handbook* is also available on our website which is updated monthly and should be used as an additional resource. The handbook is located on the home page at the following address:

www.hopkinsmedicine.org/usfhp

Updates are also provided to members by individual mailings or in *The Patriot Life*, the quarterly member newsletter.

THE JOHNS HOPKINS US FAMILY HEALTH PLAN

Johns Hopkins US Family Health Plan (USFHP) or (The Plan) is a Department of Defense (DoD) sponsored program that delivers TRICARE® Prime benefits to retirees and their family members, active-duty family members and survivors of the seven uniformed services, including the Army, Navy, Marine Corps, Air Force, Coast Guard, Public Health Service, and the National Oceanic and Atmospheric Administration (NOAA).

Johns Hopkins Community Physicians (JHCP) serves as the largest primary care provider group in Maryland and is headquartered at Wyman Park Medical Center in Baltimore. Composed of more than 240 physicians and other health professionals practicing in many neighborhood locations throughout Central Maryland, JHCP offers the full range of primary care services. Some locations also offer additional on-site services, including pharmacy, labs, X-ray, ophthalmology and optometry. USFHP also partners with community primary care providers in other locations including Pennsylvania and Maryland. Specialty care is available by referral to Johns Hopkins specialist physicians or the Plan's extensive network of local community participating providers.

LONG HISTORY WITH THE UNIFORMED SERVICES

Johns Hopkins' history of providing health care to the military began when seven U.S. Public Health Service Hospitals were transferred to private health care entities with the stipulation that they continue to care for the uniformed services beneficiaries through their federal designation as Uniformed Services Treatment Facilities. Following the closure of the Baltimore U.S. Public Health Service Hospital, the Wyman Park Health System was established (1982) and was subsequently acquired by the Johns Hopkins Health System (1986).

In 1993 the DoD reorganized these facilities into the Uniformed Services Family Health Plan. It was the first DoD-sponsored, full-risk, managed health care plan and the first to serve military beneficiaries 65 and over.

The USFHP has been serving military families for 30 years and is a permanent part of the military health system known as TRICARE.

HOW THE PLAN WORKS

Johns Hopkins US Family Health Plan is a managed care plan, designed to provide comprehensive TRICARE Prime medical benefits to enrolled individuals at a low out-of-pocket cost. A managed care plan is an organized system of health care delivery that relies on a primary care manager (PCM)—a pediatrician, family practitioner or internist—to arrange for all of your health care needs with specific providers and hospitals. Payment for these services is handled by the Plan. Full coverage for covered benefits are available only from Plan providers except during a medical emergency. There are no claim forms when Plan-approved providers are used.

Johns Hopkins Community Physicians (JHCP) serves as the largest primary care provider group for the Plan in Maryland. Primary care is also available in other locations through select network community providers.

Specialty care is available by referral to Johns Hopkins specialist physicians or the Plan's extensive network of local community participating providers.

Because the Plan provides or arranges for your care and pays the cost of all authorized services, every effort will be made to provide efficient and effective delivery of health care services.

GETTING STARTED

MEMBER HANDBOOK

To ensure you get off to a good start, please read the information included in the new member packet carefully and save this *Member Handbook* for future reference, as it has important information about the best way to use the benefits and services provided by Johns Hopkins US Family Health Plan.

WEBSITE / HEALTHLINK SECURE WEB PORTAL

After you review this handbook and the other information in the packet, please visit <http://www.hopkinsmedicine.org/usfhp> for the latest updates on Plan benefits and services, news, and the latest copy of the Plan newsletter. You can also create an account on our secure online portal HealthLINK@Hopkins. Among other features, this portal allows you to:

- Search for providers by location, language spoken, gender and professional qualifications
- Change your primary care doctor, also called your primary care manager (PCM)
- Review and maintain your personal health record (PHR)
- Review your eligibility and benefit coverage
- Access pharmacy benefit information
- Send secure messages

CUSTOMER SERVICE

We also have a specially trained staff of customer service representatives available to you between 8 a.m. and 4:30 p.m. Monday through Friday. You may reach a representative by calling 1-800-808-7347.

INTERPRETER SERVICES

Many of our physicians and hospitals have on-site interpreting services. To request an interpreter, please call Customer Service at 1-800-808-7347. Assistance for the hearing impaired can be accessed through a Teletype (TTY) line number at 1-800-201-7165.

HOW TO SELECT YOUR PROVIDERS

Members have access to a fully accredited network made up of 8,800 primary care and specialty physicians as well as 30 hospitals, ensuring that you can find care and services near you.

To locate a doctor (primary care or specialty care), visit www.hopkinsmedicine.org/usfhp and click on Find a Provider. This feature allows you to search for a doctor by city, county, field of practice and much more. If you want more information regarding a health care practitioner's background, qualifications and experience, call Customer Service at 410-424-4528 or toll-free at 1-800-808-7347.

Note: If you are currently receiving medical services outside the Johns Hopkins US Family Health Plan network, you will need to change to Plan-approved providers. Your new primary care office will assist you in transferring your records to the Plan. Remember that in order to be fully covered, all outside services must be authorized by your primary care manager (PCM).

PRIMARY CARE LOCATIONS

The Johns Hopkins US Family Health Plan has many primary care locations throughout Maryland and South Central Pennsylvania. We are always adding providers to our network. For a complete listing and map for locations, please visit our website at www.hopkinsmedicine.org/usfhp or call customer service at 1-800-808-7347.

MEMBER ID CARD

The most important piece in the packet is the membership ID card for each member of your family. The card provides important information about your Plan membership, relating to coverage for primary care, specialty care, pharmacy benefits and other covered benefits. Additionally, your card provides information about co-payments and important telephone numbers, and will authorize you to receive services under the Plan. (See below for details.)

Please carry your card with you at all times and show it at each office visit.

If your membership card gets lost or damaged, please contact Customer Service at 410-424-4528 or 1-800-808-7347, Monday through Friday from 8 a.m. to 4:30 p.m.

The diagram shows the front of a membership ID card with the following callouts:

- Your unique membership identification number:** Points to the Member # field.
- Effective date:** Points to the Effective date field.
- Co-payments applicable to your membership plan:** Points to the Office Co-pays, RX Co-pays, and Brand co-pays fields.
- Identifying number to assist Rite Aid in processing your prescriptions:** Points to the RAHSRXS BIN# field.
- Your medical practice or PCM:** Points to the JHCP AT WYMAN PARK (410) 338-3000 field.
- Your birth date:** Points to the 02/11/1940 F field.
- Your unique prescription plan number and plan type:** Points to the RX Member # and Plan # fields.
- Your co-pays:** Points to the ER Co-pay and Brand co-pays fields.

The diagram shows the back of the membership ID card with the following information:

US Family Health Plan MEMBER INFORMATION  

EMERGENCY CARE:
If you are experiencing a life-threatening emergency, call 911 or proceed to the nearest emergency room. You must notify your primary care provider within 24 hours of an emergency room visit and any follow-up care must be pre-approved. If you are unsure if your condition is life-threatening, call your primary care provider first.

AFTER-HOURS CARE:
Call our NurseLine - Answers for Your Health Questions 24 Hours a Day: 866-444-3008, PIN 382 or call your primary care provider's after-hour service.

MENTAL HEALTH SERVICES: 1-888-281-3186.

BENEFITS: For information, call Customer Service at 410-424-4528 or 1-800-808-7347.

HOSPITAL PROVIDER INFORMATION
Call the plan five days prior to an elective admission or outpatient procedure to obtain certification. If patient holds other commercial health insurance, bill that carrier as primary.
DO NOT BILL MEDICARE except for ESRD and services not covered by the US Family Health Plan.

Billing Address: Johns Hopkins Medical Services Corporation
Attn: Claims Department, P.O. Box 33, Glen Burnie, MD 21060-0033

The information on the back of your membership card helps you obtain care you may require unexpectedly. It also gives health care providers information on how to process your claims. Please remember to carry this membership card with you at all times.

THE ROLE OF YOUR PRIMARY CARE MANAGER

As a member of the Plan, you will establish a relationship with a USFHP primary care manager (PCM) who will get to know you, your medical history and your individual health care needs. Our primary care managers are trained in family practice, internal medicine or pediatrics.

Your PCM sees you for all of your routine health needs, monitors the medications you receive, orders tests or special services like physical therapy and maintains your medical records. If you have a complex problem, your PCM may refer you to one of Johns Hopkins US Family Health Plan's many qualified specialists. Your PCM and the Plan specialist will work together as a team to meet your health care needs.

IF YOU NEED SPECIALTY CARE

To see a specialist or other type of provider, you must obtain a referral from your PCM. The only exceptions are:

- Life-threatening medical emergencies
- The first eight outpatient mental health visits
- Routine annual vision screening exams.

Your PCM will choose an appropriate specialist for your care. If, at the time you enroll, you are under the care of a medical specialist who practices outside the Johns Hopkins network, your PCM may transfer your specialty care to a Plan provider. Every effort will be made to ensure that there is continuity in your care. Each time you choose to see a non-Plan provider for a covered service in a non-emergency situation, the service(s) will be paid under the point of service (POS) provision. Please see page 10 for a full explanation of the POS benefit.

Note: Any request for outpatient services at Kennedy Krieger Institute (KKI) will require pre-authorization from your PCM and the Plan.

IF YOU ARE ADMITTED TO A HOSPITAL

If you require hospitalization, your PCM or specialist will make the necessary arrangements for you. Inpatient care will be provided at any of our participating hospitals. Your hospital care will be coordinated by your PCM or another Plan provider. Emergency care will be covered at any hospital.

Note: If you are admitted to a hospital as an emergency, your PCM must be notified as soon as possible or the next business day.

CHOOSING YOUR PRIMARY CARE MANAGER

The first and most important decision you will make is the selection of a primary care manager. Each enrollee in your family should select a PCM with whom he or she is comfortable. Family members do not need to select the same PCM, and their selections may be changed upon request.

You can locate primary care managers (PCMs) two ways. You can visit www.hopkinsmedicine.org/usfhp and click on Find a Provider. This feature allows you to search for a doctor by city, county, field of practice and much more. Be sure to search for a PCM by choosing, family practitioners, pediatricians, internists and nurse practitioners. You can also review the "locations" section of the website at http://www.hopkinsmedicine.org/usfhp/members_visitors/PCLocations. This provides PCM only information by location, including address and telephone numbers. This listing also includes photos and brief bios of the providers.

If you don't have access to a computer, call Customer Service at 410-424-4528 or toll-free at 1-800-808-7347 to request a paper copy.

HOSPITAL SERVICES

The Plan provides a comprehensive range of hospital benefits with no dollar or day limit when hospitalization occurs under the care of a Plan provider. There is an \$11-per-day co-payment or \$25 minimum charge per admission for retirees and their family members. Active-duty families and retirees with current Medicare Part B are not subject to the co-payment. All medically necessary services are covered, including:

- Semiprivate room accommodations (a private room may be covered if a Plan provider determines it is medically necessary)
- Specialized care units, such as intensive care or cardiac care units
- Physician services related to medical treatment or surgery
- General nursing services
- Operating room, anesthesia and supplies
- Prescribed inpatient drugs
- Inpatient physical therapy and rehabilitation at the appropriate level of care
- Other medically necessary supplies and service

EMERGENCY CARE

The Plan covers emergency care for sudden and unexpected onset of life-, limb-, or sight-threatening conditions requiring immediate attention, even when you are traveling outside the Plan area.

If you believe that your health is in serious danger or you are concerned that you may have experienced serious damage to an organ or other part of your body, seek medical care immediately by going to the nearest emergency room or by dialing 9-1-1 for an ambulance. Some examples of a medical emergency are:

- Major injury such as a broken leg or large wound
- Heart attack symptoms: chest pain, shortness of breath, sweating and nausea
- Heavy bleeding
- Bleeding during pregnancy
- Major burn
- Loss of consciousness
- Difficulty breathing
- Poisoning
- Severe head pain or dizziness

Members who receive emergency care for non life-threatening situations without a referral may be responsible for the cost of the non-emergent care. If you receive emergency care when away from home, the Plan will review your claim and, if the care was medically necessary, pay emergency benefits directly to the providers. Any follow-up care must be coordinated through your PCM. If you are unsure if your condition is life-threatening, call your PCM for guidance at anytime, 24 hours a day, seven days a week.

At the time of the ER visit, retirees without Medicare Part B and their family members will be asked to pay a \$30 co-payment. If they are later admitted as an inpatient, only the inpatient co-payment applies. Active-duty family members and retirees with Medicare Part B do not pay co-payments for emergency room visits.

If you require follow-up care such as removal of stitches or X-rays after your ER visit, your PCM will provide or coordinate your care. Do not return to the emergency room for follow-up care unless your PCM refers you there. Reduced or no payment will be made for unauthorized follow-up care. To ensure coverage, call your PCM within 24 hours or the next business day after receiving care. Your PCM will send a referral to the Johns Hopkins US Family Health Plan, authorizing your care, if appropriate.

AFTER HOURS SERVICES

New 24-Hour Services For USFHP Members

NURSELINE

Now USFHP members can call the USFHP NurseLine telephone number to speak directly to a registered nurse any time of the day or night. Nurses will answer questions and provide information about your medical concerns.

USFHP NurseLine: 1-866-444-3008

NURSE CHAT LINE

For members preferring to use the Internet to obtain general health information, Nurse Chat provides live access to registered nurses.

Nurse Live Chat Line at www.nurselinechat.com/jhucusfhp and click on the Nurse Live Chat icon.

HEALTH INFORMATION LIBRARY (HIL)

Health Information Library (HIL) is a prerecorded library of health topics designed to provide members with information about health topics ranging from mild illnesses to injuries to more serious medical conditions.

Dial 1-866-444-3008 and, when asked for the PIN number, enter 382.

NON-EMERGENCY URGENT CARE

IN THE PLAN AREA

For non-emergency medical conditions requiring prompt attention, call your PCM before seeking care. Most PCM offices have evening or extended hours. They will make every attempt to see you. If you call after office hours, your call will be directed to the after-hours service to provide you with information or authorize treatment at a specific medical facility.

Examples of conditions that might require after-hours care include ear infection, fever, some cuts and burns, and serious respiratory infections.

- Sprains and strains
- Illnesses such as respiratory infections, chicken pox
- Backaches, earaches, sore throat

Note: If you are unsure whether your condition meets the definition of urgent, call your health center or the nurse advice line first.

OUTSIDE THE PLAN AREA

If you become ill or injured and require urgent, but not emergency, care while traveling, call your PCM office during regular office hours or after-hours service. For advice, you may contact the 24-hour nurse line at the number on the back of your Member ID card. You must be referred by your PCM prior to seeking care to ensure that the care will be covered by the Plan.

EMERGENCY OR URGENT CARE OUT OF THE COUNTRY OR AT SEA

If you become ill or injured while in another country or at sea and require urgent care, go to the nearest emergency room or medical facility to receive the necessary treatment. The hospital or facility may demand immediate payment; if they do, be sure to ask for treatment information, bills and receipts. Within seven (7) days of your return, submit itemized bills and receipts to the Customer Service Department along with an explanation of the services and the identification information from your US Family Health Plan card.

Remember: If you forget to notify your PCM within the seven-day required time frame, you may be responsible for the full cost of the care (emergency room/medical facility).

If approved, payment equivalent to what the Plan would have reimbursed if you received care in the service area, will be sent to you (the member). If denied, you will receive notice of the decision, including the reason(s) for the denial. You may appeal the denial in accordance with the procedure outlined in the section titled Appeals Procedure. (see page 28)

EMERGENCY PRESCRIPTIONS

Prescriptions may be filled at any Rite Aid pharmacy in the United States. Locations in other states can be found on www.riteaid.com.

Note: If you are unable to locate a Rite Aid pharmacy and need to fill a prescription due to an emergent situation, please refer to page 23 of this handbook for details regarding coverage for emergent, out of network pharmacy claims.

BENEFITS

COVERED BENEFITS

Johns Hopkins US Family Health Plan provides a comprehensive range of preventive, diagnostic and treatment services as defined by the DoD and the TRICARE Prime benefit. A complete listing of covered benefits, non-covered benefits and coverage limitations may be found online at <http://tricare.mil/mybenefit/>.

Although a specific benefit or service may be listed as covered, it will be provided and paid for only if, in the judgment of your plan provider, it is medically necessary for the prevention, diagnosis, or treatment of an illness or condition.

Note: No oral statement of any personnel shall modify or otherwise affect these benefits, limitations and exclusions. Nor shall an oral statement of any personnel, convey or void any coverage, increase or reduce any benefits under this Plan, or be used in the prosecution or defense of a claim under this Plan.

Covered Services:

- Office visits to your primary care manager (PCM)
- Prescription drugs
- Authorized office visits to Plan specialists when your PCM refers you
- Preventive health services: well-baby, well-child and well-adult care
- Covered outpatient surgical procedures and anesthesia upon referral from your PCM
- After-hours services at a Plan health center or designated facility when authorized
- Maternity (prenatal and postpartum) and newborn care
- Routine eye exams
- Emergency room visits for a medical emergency or when authorized by the Plan

Please review the chart on page 11 of this handbook for a list of standard medical services that are covered by the Plan.

POINT OF SERVICE (POS) OPTION

Covered services provided by a non-participating provider without prior authorization will be considered for payment at the lesser amount of 50% of our allowable charges or billed charges after a \$300 individual or \$600 family deductible has been met and paid under the point of service option. For example, if a non-participating provider charges \$500 for an office visit and USFHP's allowable charge is \$350, USFHP would pay \$25 under the point of service option. You would be responsible for the deductible (\$300), the 50% coinsurance (\$25) and the difference between our allowable and the non-participating providers charges (\$150) for a total out of pocket expense of \$475. Any amounts accrued under the point of service option do not accrue to the catastrophic cap. To minimize out of pocket expenses, we strongly encourage all members to seek care within our extensive network of participating providers.

CATASTROPHIC LOSS PROTECTION BENEFIT (CATASTROPHIC CAP)

As Johns Hopkins US Family Health Plan members, your family has an annual catastrophic loss protection limit (or catastrophic cap) for your health care costs. This means there is a limit to your out-of-pocket expenses.

The catastrophic cap per enrollment year for active-duty family members is \$1,000 per family, and \$3,000 for retirees, retiree family members and survivors, per family. The enrollment year is based on the 12-month enrollment period following your effective enrollment date. Out-of-pocket expenses that contribute toward your cap include enrollment fees, co-payments and cost shares. Once your catastrophic cap has been met, you and your family members will not have to pay any more out-of-pocket expenses for the remainder of that enrollment year.

US Family Health Plan encourages you to keep track of your out-of-pocket expenses. A catastrophic cap calculation worksheet is provided on the reverse side of your enrollment-fee bill for you to record your enrollment fee, co-payments and cost shares. If you find a discrepancy in the amount the Plan has credited toward your cap, please send receipts with sponsor's name and membership identification number to:

**Johns Hopkins US Family Health Plan
Premium Billing Department
6704 Curtis Court
Glen Burnie, MD 21060
410-424-4835
toll-free: 1-888-717-8282
fax: 410-424-4608
usfhppremiumbilling@jhhc.com**

Note: Dental charges under United Concordia's Dental Value Network do not count toward the catastrophic cap.

(Continued on page 13)

USFHP TRICARE Prime Benefits Chart

	Cost for active-duty family members	Cost for retirees, family members, and survivors	Cost for retirees and family members enrolled in Medicare Part B
Outpatient Services:			
Office visit	\$0	\$12	\$0
Maternity care (prenatal, postnatal)	\$0	\$0	\$0
Well-child care (birth to age 6)	\$0	\$0	\$0
Routine physical examinations	\$0	\$0	\$0
X-ray and lab tests ¹	\$0	\$0	\$0
Ambulatory surgery (same day)	\$0	\$25	\$0
Physical therapy (when medically necessary)	\$0	\$12	\$0
Cardiac Rehabilitation ⁹	\$0	\$12	\$0
Inpatient Services:			
Hospitalization (semiprivate room and board)	\$0	\$11 per day/\$25 min. charge per admission	\$0
Maternity care (prenatal, delivery, postnatal hospital and professional services)	\$0	\$11 per day/\$25 min. charge per admission	\$0
Physician services	\$0	\$0	\$0
General nursing services	\$0	\$0	\$0
Diagnostic test, including lab and X-ray	\$0	\$0	\$0
Operating room, anesthesia, and supplies	\$0	\$0	\$0
Medically necessary supplies and services	\$0	\$0	\$0
Physical therapy (when medically necessary)	\$0	\$0	\$0
Mental Health Services:			
Outpatient care individual (subject to medical review) ²	\$0	\$25 per visit	\$0
Outpatient care group (subject to medical review) ²	\$0	\$17 per visit	\$0
Partial hospitalization, mental health (up to 60 days per Plan year)	\$0	\$40 per day	\$0
Inpatient hospital psychiatric care (subject to medical review) ³	\$0	\$40 per day	\$0
Substance Abuse Treatment:			
Outpatient care individual ⁴	\$0	\$25 per visit	\$0
Outpatient group/family therapy	\$0	\$17 per visit	\$0
Inpatient services (up to 7 days for detoxification per year) ⁵	\$0	\$40 per day	\$0
Inpatient rehabilitation (up to 21 days per year) ⁵	\$0	\$40 per day	\$0
Other Services:			
Ambulance services (when medically necessary)	\$0	\$20 per occurrence	\$0
Dental care—basic preventive care	Reduced fees	Reduced fees	Reduced fees
Durable medical equipment and supplies	\$0	20%	\$0
Emergency room services (including out of area) ⁶	\$0	\$30	\$0
Hospice care	\$0	\$12 per day	\$0
Routine eye examination (1 per year)	\$0	\$0	\$0
Family planning services	\$0	\$12	\$0
Radiation/chemotherapy office visits	\$0	\$12	\$0
Prescription drug co-pays ⁷ (up to a 30 day supply) (Rite Aid Retail)	\$5 generic, \$12 brand, \$25 non-preferred brand	\$5 generic, \$12 brand, \$25 non-preferred brand	\$5 generic, \$12 brand, \$25 non-preferred brand
Prescription drug co-pays ⁷ (up to a 90 day supply) (Rite Aid Retail & Home Delivery)	\$0 generic, \$9 brand, \$25 non-preferred brand	\$0 generic, \$9 brand, \$25 non-preferred brand	\$0 generic, \$9 brand, \$25 non-preferred brand
Skilled nursing facility care	\$0	\$11 per day/\$25 min. charge per admission	\$0
Home health care (part-time skilled nursing care)	\$0	\$12 per visit	\$0
Out of area (emergency services only)	\$0	\$30	\$0
Catastrophic Cap (Maximum out-of-pocket expense per family):	\$1,000 per plan year	\$3,000 per plan year	\$3,000 per plan year
Enrollment Fee:	\$0	\$260 individual ⁸ \$520 family ⁸	\$0 (with proof of Part B enrollment)

Footnotes to chart on previous page

1. If lab services are provided on the same day as the office visit and a co-pay is collected for the visit, no additional co-pay will be collected. No co-pay will be collected when services are billed and provided as clinical preventive services. Exceptions: Co-pay may be required for certain radiation oncology, vascular and pulmonary procedures and studies. Contact Customer Service for details.
2. One hour of therapy, no more than two times per week, when medically necessary. Includes in-home services.
3. With authorization, up to 30 days per enrollment year for adults (age 19+), up to 45 days per enrollment year for children under age 19; up to 150 days of residential treatment for children and adolescents.
4. Exclusive of drug maintenance programs.
5. Maximum of one rehabilitation program per year and three per lifetime. Detoxification and rehabilitation days count toward limit for mental health benefits.
6. Unless you are admitted to the hospital, in which case only the inpatient co-payment applies.
7. Prescription drug availability is limited to drugs prescribed by a Plan provider and covered as a Plan benefit. Availability of non-emergency prescriptions when out of the area is also limited. Over-the-counter medications and supplies are not covered. Retail vendor for prescriptions is Rite Aid Pharmacy.
8. Medicare-eligible enrollees showing evidence of current Part B payment do not have to pay the enrollment fee.
9. Outpatient treatment following the initial intake evaluation and testing is limited to a maximum of 36 sessions per cardiac event.

LIMITATIONS TO BENEFITS

The Plan does not provide coverage and will not pay for:

- Services not considered medically necessary or clinically appropriate for diagnosis and treatment as determined by a physician
- Services or procedures that are experimental or of a research nature, except for approved NCI trials
- Any services (including vaccinations) provided for employment, licensing, immigration, recreational travel, or other administrative reasons
- Care or supplies not furnished or prescribed by a Plan provider
- Cosmetic, plastic, or reconstructive surgery not related to medical treatment
- Most custodial or convalescent care (caring for someone's daily needs, such as eating, dressing and simple bandage changes) in an institution or at home
- Routine dental care and dental X-rays; treatment of teeth, gums, alveolar process or gingival issues; cranial mandibular disorders, and other issues related to the joint. (Call United Concordia at 1-866-357-3304 for information on discounts provided by US Family Health Plan Dental Plan)
- Services provided or charges incurred prior to the effective date of coverage under the Plan
- Services provided or received after the date your coverage is terminated under the Plan

Note: This list is not complete and other limitations may exist.

Examples of Specific Exclusions and Limitations:

- Abortions (routine)
- Acupuncture and acupressure
- Artificial insemination, in vitro fertilization and other such therapies to induce pregnancy
- Autopsy and postmortem
- Aversion therapy (electric shock and alcohol) as negative reinforcement (except Antabuse®)
- Bed-wetting correctional devices
- Birth control (over-the-counter)
- Chiropractic and naturopathic services
- Corrective lenses and frames
- Counseling services, unless medically necessary
- Cutting nails, trimming corns or calluses (except if diabetic or peripheral vascular disease)
- Drug maintenance programs (e.g., methadone maintenance)
- Education or training
- Food, food substitutes or supplements, and vitamins consumed outside a hospital except for home parenteral nutrition therapy
- Learning disorders treatment
- Massage therapy
- Megavitamins and orthomolecular psychiatric therapy
- Over-the-counter drugs, vitamins or food supplements
- Orthodontia
- Orthopedic shoes and orthotics, except when part of a brace or in connection with medical treatment, e.g., diabetes treatment
- Private hospital rooms, unless ordered by the attending physician for medical reasons or if a semiprivate room is not available
- Radial keratotomy
- Retirement homes
- Sex change procedures
- Some sexual dysfunction treatments
- Smoking-cessation programs and prescriptions
- Sterilization reversals
- Weight-control or weight-reduction services and supplies
- Work-related illnesses or injuries that are covered under workers' compensation programs

Other exclusions may apply as defined by the TRICARE Prime benefit.
Check with a customer service representative for further clarification.

OTHER SERVICES

AMBULANCE SERVICE

Benefits are provided for medically necessary, life-sustaining, ambulance-transport services furnished when use of any other method of transportation is inadvisable. If you are a retiree over age 65 or a retiree family member and you do not carry Medicare Part B, your co-payment is \$20 per occurrence for ambulance services. Active-duty family members and retirees with current Medicare Part B do not have a co-payment for ambulance services.

DENTAL CARE

The Johns Hopkins US Family Health Plan, under a separate agreement, has arranged for members to receive dental services from participating community dentists under a discounted fee structure referred to as the Dental Value Network (DVN).

Call United Concordia Companies Inc., at 1-800-332-0366 or visit the Johns Hopkins US Family Health Plan clients corner page at www.ucci.com/jhusfhp for more information about specific dental benefits.

What's Covered

Two routine dental cleanings per year are covered. (Billing codes associated with the routine cleanings are D1110 for adults, defined as those members who are age 13 and up, and D1120 for children up to age 13.)

How to Obtain Your Free Cleaning

- Call or go to to the UCCI clients corner page for the list of United Concordia Dental Value Network providers in your area
- Select a provider. Call for an appointment
- Confirm that the provider participates in the United Concordia Dental Value Network
- At the time of the appointment, show your US Family Health Plan membership card when you check in
- Your dentist will bill United Concordia directly for the cost of the cleaning. You will have no out-of-pocket expense for the cleaning

Visiting a dentist outside of Maryland?

In Pennsylvania, in the counties of Adams, Cumberland, Franklin, Fulton, Lancaster and York you can receive discounts on dental services along with your two free cleanings per year by visiting a Concordia advantage network dentist. Visit the client's corner page or contact UCCI customer service for a listing of participating providers.

Coverage Limitations

Other services that may be associated with the cleaning, such as X-rays, fillings, etc., are not covered by the Johns Hopkins US Family Health Plan; however, discounts for these other services exist. If you receive other services listed on the Dental Value Network Member Fee Schedule, you will be expected to pay the dentist directly at our reduced rate. If you receive a service that is not listed on the fee schedule or you receive dental care outside of the service area, you will be responsible for the dentist's normal charges for that visit.

VISION CARE

Covered Benefit

- One routine eye examination per year, including refractions and written lens prescription, may be obtained from designated Plan providers. You may obtain eye care at any Johns Hopkins Wilmer Eye Institute, Block Vision provider location, or contracted community provider. Call USFHP Customer Service at 1-800-808-7347 for a list of the nearest locations.
- Diagnosis and treatment of eye disease is covered in the same manner as any other medical specialty and requires a referral from your primary care manager (PCM).

Non-Covered Benefit

- Corrective lenses, frames, contact lenses and contact lens fittings are not covered.
- Corrective vision surgery is not covered (e.g., LASIK, radial keratotomy, PRK, etc).

Note: Under a separate agreement, US Family Health Plan has arranged for Plan members to receive discounted prices for corrective lenses and frames at all Wilmer Optical Shops and Block Vision locations.

DIAGNOSTIC SERVICES

If authorized by your primary care manager or specialist, the following are covered without an additional co-payment:

- Pathology/lab services
- Nuclear medicine services
- Cardiovascular studies
- Radiology/ultrasound services

However, if you have a PCM or specialist office visit on the same day as the diagnostic services, a co-pay will be collected from retirees and their family members who do not carry Medicare Part B for the PCM/specialist visit. Active-duty family members and retirees with current Medicare Part B are not required to pay co-pays for most services.

HOSPICE CARE

Hospice care is a program that provides an integrated set of services and supplies for the care of the terminally ill. This type of care emphasizes palliative care and symptom management through supportive services, such as some limited multidisciplinary home care, inpatient symptom management and periodic, brief, inpatient respite-care stays. The benefit provides coverage for a humane and sensible approach to care during the end of life for terminally ill patients.

Note: Eligibility determinations and referrals to approved hospice care providers are made by primary care managers or specialists using established medical criteria.

BEHAVIORAL HEALTH

What Is Covered

The Plan provides medically and psychologically necessary services for the diagnosis and treatment of substance abuse and mental health conditions provided by licensed professionals including psychiatrists, psychologists, social workers, substance-abuse counselors and licensed clinical professional counselors.

Covered services include:

- Diagnostic evaluation
- Behavioral therapy (positive reinforcement methods only)

- Psychological testing
- Psychiatric treatment (including individual and group therapy)
- Hospitalization (including inpatient professional services), subject to medical review
- Marital and/or couples counseling

Johns Hopkins US Family Health Plan members may self-refer to a participating mental health provider for the first eight outpatient mental health visits by calling 410-424-4830 or 1-888-281-3186. All subsequent services must be authorized by the Plan. For behavioral health care provider locator and appointment assistance, please call 888-309-4573.

Treatment for chemical and alcohol dependency at approved inpatient or outpatient treatment facilities is covered when preauthorized by the Plan. Both detoxification and rehabilitation days are counted toward mental health maximums. Substance-abuse rehabilitation services are limited to one admission per year, with a lifetime maximum of three admissions.

If a new Plan member is currently under treatment for a mental health condition or chemical or alcohol dependency from a non-Plan provider, please call 410-424-4830 or 1-888-281-3186 to transfer your care to a Plan provider. The Plan covers only approved services from a participating provider.

What Is Not Covered

Mental health and substance-abuse services require Plan certification of medical necessity. Every effort is made to assist members to obtain the necessary services at the right level of care. There are some exclusions to the Plan. The following are examples of excluded services:*

- Opioid replacement therapy such as methadone
- Treatment of disorders of sexual functioning
- Support services and groups that are not time-limited or not conducted by a licensed professional
- Learning disabilities including psychological testing for academic and intelligence testing
- Light-box therapy

* Other limitations may exist.

NATIONAL CANCER INSTITUTE CLINICAL TRIALS

Through our contract with the DoD the Plan has access to the National Cancer Institute (NCI) to treat our patients who suffer from cancer. Plan members who meet specific criteria will have access to promising new cancer therapies in test stages. If accepted to a clinical trial, patients will have access to treatment. The DoD finances some of the sponsored studies including Phase II and Phase III protocols approved by the NCI for all types of cancer. Phase I cancer trials will be covered for USFHP on a case by case basis. Medical review and approval will be done to validate criteria for coverage has been met. More information is available about this program at www.cancer.gov. If you are interested in participating in the program, please contact the Plan's Care Management Department at 1-800-556-0196.

DURABLE MEDICAL EQUIPMENT

Durable medical equipment may be covered if deemed medically necessary and authorized by your primary care manager and purchased or rented from a Plan provider. A 20% co-insurance is applied for retirees and their family members who do not carry Medicare Part B. Active-duty family members and retirees with current Medicare Part B are not responsible for the co-payment.

EXTENDED CARE HEALTH OPTION (ECHO)

ECHO provides financial assistance only for active-duty family members with specific qualifying mental or physical conditions. Some conditions include (please note this is not an all-inclusive list):

- Diagnosis of a neuromuscular developmental condition or other condition in an infant or toddler expected to precede a diagnosis of moderate or severe mental retardation or serious physical disability
- Extraordinary physical or psychological condition causing the beneficiary to be homebound
- Moderate or severe mental retardation
- Multiple disabilities (may qualify if there are two or more disabilities affecting separate body systems)
- Serious physical disability

Note: Johns Hopkins USFHP does not participate in the Autism Demonstration Project.

ECHO Benefits

ECHO benefits, services and supplies are not available through the basic Johns Hopkins US Family Health Plan (USFHP) program. ECHO benefits provides such coverage as:

- Assistive services (e.g., those from a qualified interpreter or translator)
- Durable equipment, including adaptation and maintenance
- Expanded in-home medical services through TRICARE ECHO Home Health Care (EHHC)
- Medical and rehabilitative services
- In-home respite care services (can only be used in a month when at least one other ECHO benefit is being received):
 - ECHO respite care—up to 16 hours per month (limited to the 50 United States, the District of Columbia, Puerto Rico, the U.S. Virgin Islands and Guam)
 - EHHC respite care—up to eight hours per day, five days per week for those who qualify
Note: The EHHC benefit cap is equivalent to what TRICARE would reimburse if the beneficiary was in a skilled nursing facility
- Training to use assistive technology devices
- Institutional care when a residential environment is required
- Special education (which can include applied behavioral analysis)
- Transportation under certain limited circumstances (includes the cost of a medical attendant when needed to safely transport the beneficiary)

All ECHO services require preauthorization through Johns Hopkins USFHP Care Management.

ECHO Eligibility Process

For general questions, potential ECHO enrollees or family members may call the USFHP customer service telephone number at 410-424-4528 or 1-800-808-7347. USFHP also has a dedicated ECHO team. A member of the ECHO team will assist members by answering more detailed questions regarding the eligibility and enrollment process.

To enroll in the ECHO program, members must be currently enrolled in Johns Hopkins USFHP, enrolled in the Exceptional Family Member Program (EFMP) of their branch of service and provide medical documentation that a qualifying condition exists. USFHP will grant provisional ECHO enrollment (for 90 days) while the sponsor completes the EFMP forms. Upon receipt of the application and documentation, members will receive a decision letter with their eligibility status.

ECHO Costs

Active-duty sponsors pay a cost-share that is based on their pay grade and is separate from other USFHP program cost-shares. The monthly cost-share is one fee per sponsor, not per ECHO beneficiary.

SPONSOR'S PAY GRADE	MONTHLY COST-SHARE	SPONSOR'S PAY GRADE	MONTHLY COST-
E-1 to E-5	\$25	CWO-5, O-5	\$65
E-6	\$30	O-6	\$75
E-7, O-1	\$35	O-7	\$100
E-8, O-2	\$40	O-8	\$150
E-9, WO/WO-1, CWO-2, O-3	\$45	O-9	\$200
CWO-3, CWO-4, O-4	\$50	O-10	\$250

The maximum government cost-share is \$36,000 per beneficiary, per fiscal year (FY) (October 1-September 30). Sponsors are responsible for the cost of ECHO benefits that exceed this limit.

Note: The ECHO Home Health Care (EHHC) benefit is not subject to the \$36,000 per FY maximum government cost-share. The sponsor's cost-share does not count toward the annual catastrophic cap. ECHO costs cannot be shared between family members.

For more information about ECHO, you can also visit www.tricare.mil (see benefit information) or go to <http://www.hopkinsmedicine.org/usfhp/ECHO/index.html>.

EVALUATION OF NEW TECHNOLOGY, DRUGS AND BENEFITS

A TRICARE benefit must meet three basic requirements:

- It cannot be excluded by law (statute) or regulation (Code of Federal Regulations)
- It must be medically necessary and appropriate (proven, safe and effective) and represent the standard for good health care in the united states
- It must be funded and administratively added to the TRICARE program

New benefits or revisions of existing benefits are made by the Department of Defense TRICARE Management Activity (TMA) after extended research, review, and collaboration. The need for benefit changes are identified by:

- Reviewing changes to federal law
- Monitoring changes in national health care coverage and reimbursement
- Requests for scientific review from within and outside TMA
- Researching and reviewing appeals of denied services under the current benefit program

CARE MANAGEMENT

POPULATION HEALTH INITIATIVE

At no cost to you, the USFHP Care Management program offers you the tools and ongoing support you need to better understand and manage your health through the Care Management Population Health Initiative.

The Population Health Initiative was developed to give you individual support and services that are designed to help you understand and self-manage your medical conditions. Assistance through the initiative is offered on three different levels, depending on your need.

Complex Care Management

Complex care management is the highest level of intervention and is provided for adults and children with diabetes and asthma, as well as all adults with chronic obstructive pulmonary disease (COPD) and cardiovascular disease. Once a member is identified with complex medical conditions or a special need, our highly qualified staff determines the specific services the member needs. A wide range of services are managed by our staff of nurses and social workers who are trained to help these members coordinate

services, access available resources and serve as member-health advocates.

Note: USFHP members with complex specialty needs also require intense oversight and management by case managers.

Case management is also available for the following programs:

- High-risk pregnancy
- Cancer
- HIV/AIDS
- Children with conditions such as sickle-cell conditions, genetic conditions, complications from prematurity, obesity, neurological problems
- End-stage renal disease and members on dialysis
- Members with rehabilitation needs for spinal cord injury, traumatic brain injury, severe burns, trauma from motor vehicle accidents, and stroke

Monitored Care Management

Members with less complicated asthma and diabetes conditions receive a moderate intensity intervention. These members may benefit from ongoing monitoring and improvement of self-management skills.

Once a member is identified with asthma and/or diabetes and may have risk factors for developing other conditions or complications, our skilled staff of personal care managers monitor the member's health status and ongoing needs over time. These personal care managers encourage progress towards health goals. They provide guidance and tools aimed at improving overall self-management of asthma and diabetes.

Lifestyle Management

There are some members with conditions that are more easily kept under control. In this low level of intervention, members receive routine mailings of materials about their condition. These educational materials focus on keeping the member's self-management skills up-to-date so they can continue to lead full lives and avoid any future complications.

CARE MANAGERS/MEMBER ADVOCATES

Care managers work closely with members and all their health care providers to share information to achieve the best possible health for the member. Care managers help members to improve their health and quality of life by:

- Assessing each member's physical, psychosocial, spiritual and financial needs
- Educating members on ways to manage their health
- Assisting with referrals to specialty providers
- Coordinating care with our outreach and health promotion and wellness department, home health and other health and community agencies
- Providing ongoing communication to check member's progress and to review for continuing services

OTHER SERVICES

Other Population Health-based services include periodic mailings of educational materials focused on increasing self-management skills and preventing complications

- Use of the TeleWatch Patient Monitoring System, which allows members to enter health status data from home, to be checked by their care manager and physician
- Review of medications and discussion with our clinical pharmacy services if needed
- Assistance with obtaining behavioral health services. This service can be reached by calling the toll-free number at 1-888-309-4573
- Assistance to members moving from a hospital to a lower level of care and then home. Staff works with providers, members, and families on discharge planning, care coordination, and member and family education.

HOW TO SELF-REFER

We encourage you to take advantage of the services and programs provided by Care Management. Our Care Management Population Health Initiative services are voluntary and are provided at no cost to members. Members identified with certain needs may be automatically enrolled but there is no obligation to participate in these programs.

If you have questions about our Population Health Initiative or other Care Management services, or if you would like to refer yourself or a loved one to a program, call 410-762-5206 or toll-free at 1-800-557-6916. We are available Monday through Friday, 8:30 a.m. to 5:00 p.m. Any voicemail messages received after normal business hours will be addressed the next business day. We can also be contacted by e-mail at populationhealth@jhhc.com.

For more information about how to use Care Management services, go to www.hopkinsmedicine.org/usfhp.

UTILIZATION MANAGEMENT

The USFHP's Utilization Management department ensures that the right care is provided to members at the right time and in the right setting. It evaluates requests for services for medical care, mental health treatment and substance-abuse treatment based on appropriate clinical criteria or guidelines and local health care delivery options. Often this requires prior authorization by the provider for certain services for elective hospital admissions. All review decisions are based upon appropriate care and service and the existence of coverage. Registered nurses and physicians administer the Utilization Management department policies and procedures.

To contact Utilization Management, call 410-424-4480 or 800-261-2421.

HEALTH EDUCATION

As a member of the Johns Hopkins US Family Health Plan, you are eligible to use the USFHP Health Education Program. This comprehensive program provides members with the education, skills, and tools to help people of all ages improve their overall health and reduce the risk of disease.

USFHP health educators work to help you understand your personal health needs and to make choices that will contribute to a healthier lifestyle. Free informational materials and one-to-one counseling are available on a variety of wellness topics. Group classes are available on weight management, smoking cessation and living well with chronic disease. Additionally, the health educators make scheduled visits to primary care provider locations to present information on a variety of health topics.

For more information or to speak to a health educator, call 1-800-957-9760 or visit www.hopkinsmedicine.org/usfhp/education/.

HEALTH COACH PROGRAM

As a member of the Johns Hopkins US Family Health Plan, you may be eligible to participate in the FREE Health Coach Program. The Health Coach Program gives you the opportunity to work one-on-one with a health coach to improve health behaviors. By joining the program, you will receive individualized support and a plan of action from a personal health coach on a monthly basis. Whether you want to quit smoking, lose weight, increase fitness, improve nutrition, or manage stress, a health coach will provide you with the information and encouragement you are looking for. Coaching sessions are flexible to accommodate your busy schedule and are conducted over the telephone. If you want to adopt lifestyle changes that will help you lead a fulfilling and healthy life, we encourage you to inquire about our Health Coach Program by calling 1-800-957-9760 or email healthcoach@jhhc.com.

PHARMACY AND PRESCRIPTION DRUG SERVICES

FLU VACCINE

The Centers for Disease Control (CDC) recommends that everyone 6 months of age and older receive the flu vaccine. Vaccination is especially important for health care workers, young children, pregnant women, people with chronic health conditions and people age 65 years and older.

Influenza is a contagious disease spread by coughing, sneezing, and nasal secretions. Vaccination is the best protection against getting the flu! Getting a flu vaccine at your Rite Aid pharmacy this fall can protect you from flu symptoms this winter, at no cost to you.

USFHP members (18 years of age and older) can receive a free flu vaccine at Rite Aid pharmacies. This convenient option lets you get a vaccine even if you can't make it to your physician's office. And best of all, there is no cost to you at all Rite Aid pharmacy locations that provide vaccines!

To locate a Rite Aid pharmacy near you, visit www.riteaid.com/stores/locator/.

FILLING YOUR PRESCRIPTION

You may obtain your prescriptions at any of the 5,100 Rite Aid pharmacies nationwide or through home delivery. For the location of a Rite Aid pharmacy near you, call 1-800-748-3243 or visit www.riteaid.com.

Note: You may not obtain prescriptions from a military treatment facility while enrolled in the USFHP. Prescriptions that originated at a military treatment facility may not be transferable to Rite Aid pharmacies.

Any prescriptions filled outside the Rite Aid network in a non-emergent situation will be reviewed for medical necessity and if approved, will be reimbursed at the USFHP contracted rate less applicable co-payment.

RETAIL PHARMACY NETWORK

This option allows you to fill your prescriptions at any of the approximately 5,100 Rite Aid network pharmacies without having to submit a claim. You may fill prescriptions for up to a 30-day supply of medication at any Rite Aid pharmacy. The Plan also allows beneficiaries to obtain a 90-day supply of most medications for chronic conditions for the same copay as home delivery. To fill a prescription, present your Johns Hopkins USFHP Member ID Card to the pharmacist with your prescription. You will be required to pay a co-payment (co-pay) at the time of service. The co-pay levels are printed on your ID card. Your ID card also contains important information to allow the pharmacy to process your claim correctly. To locate a Rite Aid pharmacy near you, visit www.riteaid.com/stores/locator/.

HOME DELIVERY

Home delivery is available for up to a 90-day supply of approved medications through Rite Aid at Wyman Park. With home delivery you enjoy the convenience of free delivery to your home or any designated address. Home delivery is best suited for medications you take on a regular basis. To obtain your prescription through home delivery, complete the mail order form (found at www.hopkinsmedicine.org/usfhp/members_visitors/member_forms) and send it in with your new prescription or, for a refill, with your prescription number, plus a check or credit card number for your co-payment. Your prescription order is processed promptly and most orders are received within two weeks. To ensure you receive a refill before your current supply runs out, re-order at least two weeks before you need your refill.

Rite Aid Pharmacy
3300 Wyman Park Drive
Baltimore, MD 21211
410-338-3300 or 1-855-239-2952

FORMULARY AND CO-PAYMENTS

Johns Hopkins USFHP utilizes the TRICARE pharmacy formulary. The TRICARE pharmacy formulary is a list of generic and brand prescription drugs that are covered under the TRICARE benefit.

USFHP members are responsible for a portion of the cost of their medications. The TRICARE formulary contains three cost levels for USFHP members. The cost shares are as follow:

Type of Pharmacy:	CoPay:
Rite Aid Retail (up to a 30 day supply)	Generic: \$5 / Brand Name: \$12 / Non-Formulary: \$25 (unless you establish medical necessity)
Rite Aid Retail & Home Delivery (up to a 90 day supply for maintenance medications)	Generic: \$0 / Brand Name: \$9 / Non-Formulary: \$25 (unless you establish medical necessity)

You can view the cost share for a medication using the TRICARE formulary search tool at http://pec.ha.osd.mil/formulary_search.php. You can also search for lower cost alternative medications to a medication you are currently taking.

COVERED MEDICATIONS

The USFHP Pharmacy Program provides outpatient coverage to beneficiaries for medications that are approved for marketing by the U.S. Food and Drug Administration (FDA) and that generally require prescriptions. Other covered medications include:

- Compounded medications of which at least one ingredient is a legend drug
- Insulin
- Insulin syringes and needles
- Glucose test strips
- Lancets
- Alcohol swabs

NON-COVERED MEDICATIONS

Prescription medications used to treat conditions that are not currently covered by USFHP either by statute or regulation are likewise excluded from the pharmacy benefit. Excluded medications include:

- Drugs prescribed for cosmetic purposes
- Fluoride preparations
- Food supplements
- Homeopathic and herbal preparations
- Multivitamins
- Over-the-counter products (except insulin and diabetic supplies)
- Smoking cessation products
- Weight reduction products

FORMULARY

USFHP utilizes the TRICARE pharmacy formulary. The TRICARE formulary and pharmaceutical management policies are developed by the Department of Defense Pharmacy and Therapeutics Committee. The TRICARE formulary is a tiered, open formulary and includes generic drugs (Tier 1), preferred brand drugs (Tier 2), and non-preferred brand drugs (Tier 3). Additional information about the DoD Pharmacy and Therapeutics review and list of formulary drugs can be found at www.tricare.mil/uniformformulary.

GENERIC DRUG POLICY

DoD's policy on generic drugs require the pharmacy to substitute generic medications for brand-name medications when a generic equivalent is available. Brand-name drugs with a generic equivalent may be dispensed only if your physician submits a medical necessity request and approval is granted by USFHP. In those cases you will pay the brand-name co-payment. If you insist on having a prescription filled with a brand-name drug when a generic equivalent is available, and medical necessity for the brand name drug has not been established, you will be responsible for the entire cost of the prescription. The form for establishing medical necessity can be found at www.hopkinsmedicine.org/usfhp/members_visitors/member_forms.

Generic drugs are chemically identical to their branded counterparts. They are made with the same active ingredients, and produce the same effects as their brand name equivalents. The Food and Drug Administration (FDA) requires generic drugs to have the same quality, strength, purity, and stability as brand name drugs. Also, the FDA requires that all drugs, including generic drugs be safe and effective. Although generic drugs are chemically identical to their branded counterparts, and are held to the same FDA standards for safety and performance as brand name drugs, they sell for 30-75 percent less. You can save money on your co-payment by choosing generic drugs when applicable. Additional information on generic drugs is available on the FDA web site at, www.fda.gov/Drugs/ResourcesForYou/Consumers/QuestionsAnswers/ucm100100.htm

QUANTITY LIMITS

The Department of Defense Pharmacy and Therapeutics Committee has established quantity limits for certain medications.

If your medical condition warrants use of quantities greater than listed quantity limit for your medication, your provider may submit a Prior Authorization request for use of the higher quantity. Your physician must provide medical justification for use of the higher quantity. View the list of drugs subject to TRICARE Quantity Limits at www.tricare.mil/mybenefit/home/Prescriptions/Medications/QuantityLimits

PRIOR AUTHORIZATION AND MEDICAL NECESSITY

Some medications require prior authorization before they can be dispensed.

For a list of prior authorization drugs and request forms, please visit the TRICARE Pharmacy Prior Authorization Page at www.tricare.mil/mybenefit/home/Prescriptions/Medications/PriorAuthorization

To initiate a prior-authorization: your provider must complete and fax the Prior Authorization form to the Johns Hopkins Healthcare Pharmacy department at 410-424-4607.

To download a copy of the Pharmacy Prior-Authorization form, visit here: www.hopkinsmedicine.org/usfhp/members_visitors/member_forms

Prior Authorization requests are reviewed within 48 hours of receipt by Johns Hopkins USFHP. Requests marked as "Urgent" are reviewed within 24 hours.

MEDICAL NECESSITY FOR NON-FORMULARY MEDICATIONS

(at Formulary Co-payments)

Medical necessity criteria are established by the DoD Pharmacy & Therapeutics (P&T) Committee for each non-formulary medication. If the medical-necessity criteria are met, the beneficiary may receive the non-formulary medication at a lower co-payment. Your provider can establish medical necessity by completing and submitting the Pharmacy Prior-Authorization form.

OUT OF NETWORK CLAIMS

In the event that you fill a prescription at a non-network pharmacy due to an emergent situation, you may seek reimbursement for incurred cost. To obtain reimbursement, complete the Prescription Drug Claim form (at www.hopkinsmedicine.org/usfhp/members_visitors/member_forms), and mail to the address indicated on the form. You will be reimbursed for the cost of the prescription less applicable co-payment. Any prescriptions filled outside the Rite Aid network in a non-emergent situation will be reviewed for medical necessity and if approved, will be reimbursed at the USFHP contracted rate less applicable co-payment.

ONLINE COORDINATION OF BENEFITS

US Family Health Plan beneficiaries who have other health insurance (OHI) can take advantage of online coordination of benefits (COB). Tell your pharmacist you have US Family Health Plan coverage in addition to your OHI when you have your prescription filled at your retail network pharmacy. Your pharmacist will submit your prescription online to both plans at the same time.

Advantages of having your COB claims processed online include:

- Zero out-of-pocket expense
- No need to submit paper claims
- Reduced or eliminated up-front costs

US Family Health Plan becomes the first payer when:

- The drug is not covered by your OHI, but is covered by TRICARE
- Coverage under your OHI is exhausted for the benefit year

If you are using a mail-order program available through your OHI, online COB is not an option

SPECIALTY MEDICATIONS

Specialty medications are usually high-cost, self-administered, injectable, oral, or infused drugs that treat serious chronic conditions. These drugs typically require special storage and handling, and may not be readily available at your local pharmacy. Specialty medications may also have side effects that require pharmacist and/or nurse monitoring. Many specialty medications (oral and injectables) are available through the retail pharmacy network. However, some medications may not be available at retail because the medication's manufacturer limits the medication to specific pharmacies. If your physician submits a request for use of a restricted distribution drug, upon approval USFHP will forward the request to a contracted specialty pharmacy. The specialty pharmacy will coordinate delivery of the medication to patient's home or physician office.

DRUG INFORMATION

To view information on a drug, including how to take the medication, possible side effects and drug interactions go to: www.riteaid.com/pharmacy/monographs/

SKILLED NURSING CARE

INPATIENT SKILLED NURSING CARE

The Plan provides inpatient skilled nursing care in an accredited, contracted skilled nursing facility when it is medically necessary. Coverage includes:

- Bed, board and skilled nursing services in a subacute or rehabilitation facility
- Drugs, biologicals, supplies, and equipment ordinarily provided or arranged by the facility when authorized by a Plan provider
- Other medically necessary treatments and services deemed appropriate

Note: Short- or long-term custodial care is not covered. Inpatient hospice is only covered for symptomatic care and respite care (5 days a month).

HOME CARE

The Plan provides medically necessary home care for beneficiaries who are homebound or whose condition is such that home visits are indicated, including:

- Durable medical equipment such as wheelchairs, hospital beds, oxygen, and respirators when arranged by the Plan
- Home physical therapy, speech therapy, or occupational therapy for short, defined periods when significant improvement can be expected

Note: Home care is covered only when such care is medically necessary and authorized by the Plan and is limited to skilled services. Assistance with the ordinary activities of daily living such as eating, dressing, etc., is not covered.

ENROLLMENT IN THE PLAN

Enrollment in Johns Hopkins US Family Health Plan is for a one-year period. Once enrolled, members may not disenroll until after the 12-month period, unless their eligibility status changes, they move out of the area, or they fail to pay applicable enrollment fees. Upon disenrollment, a beneficiary can continue to see his or her primary care manager under TRICARE Standard, Extra, or Medicare/TRICARE For Life as long as the beneficiary is still eligible through the Defense Enrollment Eligibility Reporting System (DEERS).

ELIGIBILITY

To maintain your enrollment in the Plan, you must be registered with DEERS as eligible to receive health care benefits and have a valid military I.D. To maintain your coverage, keep your DEERS record up to date. If you have any questions about your DEERS eligibility, call 1-800-538-9552 or go to <http://tricare.osd.mil/DEERS>

BENEFICIARY WEB ENROLLMENT (BWE)

You can make changes to your DEERS account as well as enroll in US Family Health Plan using TRICARE'S Beneficiary Web Enrollment (BWE) portal. You can access the portal by logging onto www.hopkinsmedicine.org/usfhp and going to the "Sign Up Now" section.

To log on you must have one of the following:

- Valid CAC (Certified Common Access Card)
- DFAS (Defense Financial and Accounting Services) myPay login ID and password
- Department of Defense Self-Service Logon

Some of the features include:

- Enroll or transfer enrollment
- Update contact information in DEERS
- Edit/update address
- Make initial credit card payment
- Convert enrollment from active duty to retiree status up to 60 days before retirement (DEERS must reflect retirement status)
- Add information about other health insurance to your DEERS record
- View enrollment information

MILITARY TREATMENT FACILITY PRIVILEGES

As a condition of membership, Plan members are not permitted to use a military treatment facility (MTF) for non-emergency care, including the MTF pharmacy. However, should you experience a life- or limb-threatening emergency, you are permitted to use the nearest civilian or military emergency facility. You must notify your primary care manager within 24 hours of receiving care. Claims for emergency treatment should be submitted to the Plan for payment.

CHANGES AFFECTING ELIGIBILITY

Additions to Your Family

If your family has a birth or legal adoption, a Change of Enrollment Form must be completed and submitted within 30 days of the addition of the new family member to obtain coverage. Change of Enrollment forms are available from the Enrollment Department at 410-424-4780. Newborns must be reported to the Enrollment Department within 30 days of birth and must be enrolled on DEERS within 60 days of birth or coverage will cease.

Change of Address

Please send your new address to: Johns Hopkins US Family Health Plan
Enrollment Department
6704 Curtis Court
Glen Burnie, MD 21060

Retirement

If an active-duty Plan member sponsor is planning to retire, he or she must inform the USFHP Enrollment Department of his or her desire to continue in the Plan. If the member has retired without reenrolling and paying the enrollment fee as of the date of retirement, the member will automatically be disenrolled.

TRICARE Standard, TRICARE Extra, TRICARE for Life

By enrolling in the Plan, you have agreed to receive your health care through the Johns Hopkins US Family Health Plan. DoD has required as a condition of membership that you agree not to use TRICARE Standard, Extra, or TRICARE for Life while a member of the USFHP.

Medicare Eligible

If you are Medicare-eligible and enrolled in the Johns Hopkins US Family Health Plan, your Medicare coverage remains in effect. However, as a condition of membership, you have agreed not to use Medicare Parts A and B or to enroll in a Medicare-sponsored managed care plan (HMO) such as Medicare Advantage plans while enrolled in the Plan. You are expected to receive all health care services through the Plan. Using Medicare benefits while a Plan member may result in disenrollment. However, you may use Medicare for certain benefits that are not covered by the Plan.

Contact Customer Service prior to using Medicare for non-covered benefits to ensure that such use does not compromise your membership in the US Family Health Plan.

Medicare Part B

Even though you are now a Plan member, you are advised to continue your Medicare Part B to avoid penalties or waiting periods should you choose to leave the Plan and need to use your Medicare benefits.

Note: Retirees with current Medicare Part B are not required to pay USFHP co-pays (except pharmacy) or annual enrollment fees.

If You Are About to Become Eligible for Medicare Benefits

If you become Medicare-eligible, you are advised to accept Medicare Part B coverage when first eligible to avoid late Medicare Part B enrollment penalties and waiting periods should you later choose to leave the Plan and need to use your Medicare benefits.

Medicare and the USFHP

It is important to remember:

- Medicare must not be billed for services covered by the Plan
- Members filing Medicare claims or who have claims filed on their behalf are in violation of the conditions of participation for the Plan and may be disenrolled
- Members who have coverage under both the Plan and Medicare may only use Medicare benefits for services not covered by the Plan such as chiropractic care or end-stage renal disease (ESRD)
- For all medical services, Medicare will be billed (as primary) for members with ESRD.

ENROLLMENT FEES

Retirees, retiree family members and survivors of military retirees who do not participate in Medicare Part B are required to pay an enrollment fee. The enrollment fee is payable at the time of enrollment in the Plan. You may pay your enrollment fee in one payment, quarterly installments, or monthly allotments. Please make your check or money order payable to Johns Hopkins Medical Services Corporation. Credit card payments will also be accepted. After you have been enrolled for three months, you may request to pay monthly by allotment or electronic funds transfer (EFT).

Enrollment Fees:

- Individual Enrollment: \$260 annually, \$65.00 quarterly or \$21.66 monthly
- Family Enrollment: \$520 annually, \$130 quarterly or \$43.33 monthly

If you are Medicare-eligible and currently enrolled in Medicare Part B, upon verification by the Enrollment Staff, your portion of the enrollment fee will be waived by indicating Part B coverage on the enrollment form. Should you become Medicare-eligible while enrolled in the Plan and have chosen to pay the enrollment fee quarterly, please notify the Enrollment Department, and upon verification of Part B coverage, your portion of the enrollment fee will be considered paid in full for the remaining quarter(s).

Whenever possible, all family members should enroll at the same time and payment of the applicable fee should be made in accordance with DoD requirements.

Quarterly Payment of Enrollment Fees

If you choose to pay your enrollment fee on a quarterly basis, please remember the following:

- When paying enrollment fees on a quarterly basis, you will receive a bill 30 days prior to your next quarterly payment due date.
- If you fail to make a timely payment, you will be subject to disenrollment. You will be responsible for the deductible and cost shares applicable under TRICARE Standard and TRICARE Extra for any health care received after the termination date.
- If you are disenrolled for non-payment of your quarterly enrollment fees, you may not reenroll in the Plan or any TRICARE Prime program for 12 months. You may use TRICARE Standard or TRICARE Extra during this lockout period.

Retired sponsors with eligible family members living at different addresses must coordinate the enrollment fee payment for all family members enrolling in the Plan. For example, if a single family member is enrolled and the enrollment fee has been paid based on an individual status, any additional family member living at a different address will not be enrolled without payment of the additional fee.

ENROLLMENT PORTABILITY

TRICARE Prime enrollment portability lets a family continue its coverage when moving from one DoD service region to another. Enrollment fees and enrollment anniversary dates transfer along with Prime enrollment.

Transferring Enrollment to Another US Family Health Plan

If you are moving to another state that has a US Family Health Plan program, you may transfer your enrollment. Simply contact the new plan to begin the transfer process. To find out if another US Family Health Plan exists where you are relocating, go to www.usfhp.org.

US Family Health Plan members who are retirees age 65 or older may transfer enrollment between US Family Health Plan programs only.

Portability

Retirees and their family members may move within the same TRICARE region an unlimited number of times and retain the TRICARE Prime benefit; however, the number of region-to-region moves is limited to two changes per enrollment year, as long as the second move is back to the original region of enrollment. There is no limit on transfers for active-duty families.

SPLIT ENROLLMENT

The split enrollment provision permits multiple family members to enroll in TRICARE Prime under different contractors. A family will pay enrollment fees totaling no more than the standard fee regardless of the enrollment location of each family member. If your family has a split enrollment arrangement, be sure to provide the enrollment office in each TRICARE region with proof of payment of your enrollment fee. This will ensure that you pay your fee only once per family. You must also monitor your combined enrollment year catastrophic cap accumulations. Each contractor maintains catastrophic cap accumulations separately. Please notify us when your family's combined payments have met or exceeded the cap.

DISENROLLMENT

Once you have been accepted in the Plan, your membership will be renewed automatically for each successive year unless you move out of the area, your eligibility status changes in DEERS, or you fail to pay applicable enrollment fees.

To disenroll, submit the USFHP disenrollment form (available online or from Customer Service) to the Enrollment Department at the address shown on the form or write a letter including the sponsor's name, Social Security number, address and phone number, the reason for disenrollment, and the names and birth dates of all the sponsor's dependents who are disenrolling. If you are disenrolled as a result of non-payment of applicable enrollment fees, you will not be permitted to join the Plan or use TRICARE Prime for 12 months.

Note: In compliance with federal regulations, members will be subject to disenrollment if they use Medicare benefits to receive covered services from any provider.

OTHER INSURANCE

Reporting other health insurance is a Plan requirement. Please call the Coordination of Benefits department at 410-424-4716 to report any other insurance plans.

COORDINATION OF BENEFITS

The Johns Hopkins US Family Health Plan/TRICARE Prime contract with the DoD requires that any other comprehensive health insurance you have must be billed first before using TRICARE funds to

pay your medical bills. After your other insurance pays, the Plan will pay any eligible balance up to the allowable charge.

THIRD-PARTY LIABILITY AND WORK-RELATED INJURY

If you receive care for injuries from an auto accident or a work-related injury for which a third-party insurer is responsible for payment, you must inform the Coordination of Benefits department by calling 410-424-4716. You should advise the Plan whether or not you intend to seek compensation. Failure to report this could result in loss of coverage for care related to this injury.

INSURANCE CHANGES

If you change your insurance coverage, or if you obtain commercial insurance coverage after joining Johns Hopkins US Family Health Plan, you must report it by calling the Coordination of Benefits department at 410-424-4716.

CUSTOMER SERVICE

If you would like to get information on benefits and services, check on the status of a claim or lodge a complaint with the Complaints and Grievance department, the Customer Service department will assist you.

To contact the Customer Service department:

Telephone

Call: 410-424-4528 or toll free 1-800-808-7347, Monday through Friday, between 8 a.m. and 4:30 p.m.

Fax: 410-424-4895

Assistance for the hearing impaired: Contact Maryland Relay at 1-800-201-7165.

Write to

Johns Hopkins US Family Health Plan
Customer Service Department
6704 Curtis Court
Glen Burnie, MD 21060

E-mail

usfhpcustomerservice@jhhc.com

Internet / HealthLINK Portal

www.hopkinsmedicine.org/usfhp

Visit

A representative is available at Wyman Park, Odenton and Annapolis one day each month. Please contact the Customer Service department for dates and times. Walk-ins are welcome during that time. However, if you schedule an appointment in advance, the representative can research your questions ahead of time to more efficiently serve you. Scheduled visits are welcome at the Glen Burnie office during regular business hours.

CLAIMS AND MEMBER REIMBURSEMENTS

Members of the US Family Health Plan should never receive a claim or a bill from a participating provider for a covered service except for their applicable co-payments. Participating providers are required to bill the Plan directly for all covered services provided to members. If you should receive a claim or a bill in error, call the USFHP Customer Services department at 410-424-4528 or 1-800-808-7347 and ask the representative to contact the provider to correct the error.

There is one exception to this policy: If you are traveling outside the service area and require urgent or emergency care, the provider should bill the USFHP at the address shown on the back of your member ID card. However, some providers (especially if they are outside of the United States) may require immediate payment from you. If so, be sure to obtain a receipt and a copy of the bill and submit them along with a Reimbursement Form to the Plan for reimbursement on your return. The form can be found at http://www.hopkinsmedicine.org/usfhp/members_visitors/member_forms and can be submitted by mail or faxed to 410-762-5212.

GRIEVANCES, COMPLAINTS AND APPEALS

Grievance Procedure

The USFHP appreciates member feedback and would like to know if you ever have a grievance (also known as complaint) about our services or services received from a network provider. We accept both written and verbal comments.

Grievances may be called in to the Johns Hopkins US Family Health Plan Customer Services at 1-800-808-7347 or mailed to:

Johns Hopkins US Family Health Plan
6704 Curtis Ct.
Glen Burnie, MD 21060
ATTN: Customer Services Department

Written Grievance Procedure

You also have access to a formal grievance system. Formal grievances made in writing should be sent to the following address:

Johns Hopkins US Family Health Plan
6704 Curtis Court
Glen Burnie, MD 21060
Attn: USFHP Complaints and Grievances Department

After receiving your formal grievance, a Complaints and Grievances representative will notify you of its receipt and begin appropriate research.

Appeals Procedure

You can appeal certain Johns Hopkins US Family Health Plan/TRICARE Prime decisions. The following issues are subject to reconsideration (i.e., can be appealed) if you as the beneficiary and/or your provider are dissatisfied with an initial denial:

- Medical necessity and appropriateness of the services furnished or proposed to be furnished

- Appropriateness of the setting in which the services were or are proposed to be furnished
- A determination regarding benefits under this program

If you believe that a claim was improperly denied, in whole or in part, you may file an appeal. Appeals relating to factual determinations involve issues other than medical necessity (e.g., whether a service is covered under TRICARE policy or regulation). Appeals must be filed in writing within 90 calendar days of the date of the initial denial determination. Include patient's name, address, phone number, Johns Hopkins US Family Health Plan I.D. number, sponsor's name, and the reason for the appeal and copies of any other documents related to the issue.

Mail appeal to:

Johns Hopkins US Family Health Plan
 P. O. Box 33
 Glen Burnie, MD 21060
 Attn: Appeals Department, USFHP

A request for a reconsideration of a concurrent review denial (e.g., you, as the patient, are still in the facility) or a request for an expedited reconsideration of a preadmission/preprocedure denial must be filed within a much shorter time. Contact the Customer Service department at 410-424-4528 or 1-800-808-7347 for further details relating to the appeal process.

The National Quality Monitoring Contractor (NQMC), an independent review body contracted by the DoD, is the final appeals level for medical necessity and appropriateness of care setting.

Customer Service can assist you with the appeal process. Call 410-424-4528 or 1-800-808-7347.

MEMBERS' RIGHTS AND RESPONSIBILITIES

We value you as a member of the Johns Hopkins US Family Health Plan(USFHP) health care family. As a member, you have the following rights and responsibilities:

You have the right to:

- Be treated with respect for your dignity and privacy.
- Discuss all appropriate treatment options for a condition regardless of cost or benefit coverage.
- Receive information, including information on treatment options and alternatives in a manner you can understand.
- Participate in decisions regarding your health care, including the right to refuse treatment.
- Be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience or retaliation.
- Request and receive a copy of your medical records and request that they be amended or corrected as allowed.
- Exercise your rights and to know that the exercise of those rights will not adversely affect the way that USFHP or our providers treat you.
- File complaints, appeals and grievances with us.
- Request that ongoing benefits be continued during appeals (although you may have to pay for the continued benefits if our decision is upheld in the appeal).
- Receive a second opinion from another doctor in USFHP's network if you disagree with your doctor's opinion about the services that you need. Contact us at 1-800-808-7347 for help with this.
- Receive other information about us such as how we are managed. You may request this

information by calling 1-800-808-7347.

- Receive information about the organization, its services, its practitioners, and providers and member rights and responsibilities.
- Make recommendations regarding the organization's member rights and responsibilities policy.

You have the responsibility to:

- Carry your membership card with you at all times and know your eligibility status with USFHP. If you lose your card, you can obtain a new one by calling Customer Service.
- Follow your plan's referral and prior-authorization guidelines and policies.
- Cancel doctor's appointments if you cannot keep them.
- Pay any applicable co-pay, coinsurance and deductible at the time of service.
- Report any other health insurance coverage to your doctor and to USFHP.
- Report any communicable diseases, family history, problem with substance abuse, and any other information your doctor may need in order to provide adequate care.
- Cooperate with health care providers and follow their instructions.
- Understand your health problems and participate in developing mutually agreed-upon treatment goals, to the degree possible.

PRIVACY AND CONFIDENTIALITY

It is the policy of Johns Hopkins US Family health plan (USFHP) to protect the privacy and security rights of all of its health plan members; to maintain the confidentiality of Health Plan information (oral, written, and electronic); and to comply with all applicable federal and state privacy and security laws and regulations, including those under the Health Insurance Portability and Accountability Act (HIPAA).

Information provided to the Plan is kept confidential and will only be used by the Health Plan for such purposes as but not limited to:

- Care Coordination
- Claims processing
- Coordination of benefits with other plans
- Subrogation of claims, review of a disputed claim
- Program integrity activities (examples: investigation of fraud, waste, abuse, or privacy theft)
- Quality improvement activities
- Other health care operations and/or payment purposes

To ensure responsible maintenance of your PHI, the Plan has implemented internal policies and procedures to address how we further protect, secure and limit use and disclosure of your oral, written, and electronic health Plan information. USFHP verifies the identities of both the member and requestor prior to responding to a request for a member's PHI. Examples of such contact include but are not limited to:

1. Questions about your care management or payment activities
2. Requests to look at, copy, obtain or amend your plan records
3. Requests to obtain a list of plan disclosures of your health information

The Plan secures and limits access to hardcopy and electronic files. Electronic data is password protected. Internal controls are in place to ensure that only those workforce members with a "need to know" have access to information required to perform their specific job functions. All workforce members are required to only utilize and/or access the "minimum necessary" information to perform their assigned tasks.

FRAUD AND ABUSE

The US Family Health Plan (USFHP) wants to find and stop health care fraud. Fraud is any dishonest act that results in a benefit to the person doing the act or someone else that he or she is not entitled to. Some examples of health care fraud are:

- Using someone else's USFHP insurance card to get health care services.
- Loaning your USFHP insurance card to another person so that they can receive health care services.
- Selling prescription medicine or items provided to you under the USFHP.
- Forging or changing prescription forms.
- Receiving bills for equipment or services you never received.

As a member you can help reduce health care fraud by following these simple rules:

- Never loan your USFHP insurance card to anyone
- Report all suspicions of fraud
- Report lost or stolen insurance cards to the USFHP Customer Service Department at 1-800-808-7347 or 410-424-4528.

The Compliance Department at Johns Hopkins USFHP investigates all charges of actual or suspected health care fraud. Reporting is simple. To contact the Compliance Department:

Call: 410-424-4996

Write: USFHP Compliance Department, 6704 Curtis Ct., Glen Burnie, MD 21060

E-mail: Compliance@jhhc.com

Fax: 410-424-4996

DEFINITION OF TERMS

ATTENDING PHYSICIAN

The physician who is primarily responsible for your care in an inpatient hospital setting.

AUTHORIZED SERVICES

Those services authorized by the Plan to be provided to you, upon recommendation by your primary care manager (PCM).

CATASTROPHIC CAP

An upper limit on out-of-pocket expense placed on Johns Hopkins US Family Health Plan covered medical bills. The enrollment year limit for an active-duty family is \$1,000. Plan retiree families have a catastrophic loss protection limit of \$3,000 per enrollment year. Dental charges under United Concordia's Dental Value Network do not count toward these caps.

CONTRACTOR(S)

Johns Hopkins US Family Health Plan programs or Managed Care Support Contractors.

CO-PAYMENT

The fee you are required by law to pay at the time of service.

CUSTODIAL CARE

Care provided by the non-medically skilled, mainly to help patients with activities of everyday living.

DEFENSE ENROLLMENT ELIGIBILITY REPORTING SYSTEM (DEERS)

The worldwide computerized Military Health System that lists all Uniformed Services beneficiaries. Active-duty members are listed automatically.

DEPENDENT

The spouse, eligible child, adult disabled child, or parents of a military sponsor deemed to be entitled to military benefits as determined by military regulations.

DURABLE MEDICAL EQUIPMENT

Medical equipment such as wheelchairs, hospital beds, oxygen, and respirators. Covered when medically necessary and arranged by the Plan.

ELIGIBLE PERSON

A Military Health System (MHS) beneficiary who remains eligible in DEERS. See DEERS.

EMERGENCY

Sudden and unexpected onset of life-, limb-, or sight-threatening conditions requiring immediate medical attention.

ENROLLEE

A Uniformed Services beneficiary who voluntarily and affirmatively seeks and is accepted for enrollment in the Plan. Eligibility for enrollment in the Plan is based on eligibility for military health care benefits, as indicated in DEERS.

ENROLLMENT PERIOD

The period of time during which enrollees agree to receive covered services solely under the Plan. In general, each enrollment period is 12 months.

INPATIENT

A person treated overnight in a hospital as a registered bed patient incurring a charge for room and board, upon the recommendation of a physician.

MANAGED CARE SUPPORT CONTRACTOR (MCSC)

The civilian contractor designated by DoD to operate TRICARE in a particular region in partnership with the MTFs. The MCSC for Region 1 North is Health Net Federal Services.

MEDICALLY NECESSARY

Services that are (1) provided for the diagnosis or care and treatment of a medical condition as determined by a physician; (2) appropriate and necessary for the symptoms, diagnosis or treatment of a medical condition; and (3) within standards of medical practice recognized within the local medical community.

MHS

Military Health System.

OUTPATIENT CARE

Outpatient care includes diagnostic and treatment services, supplies, and medicines provided and used at a hospital or other covered facility under the direction of a physician.

PLAN

Johns Hopkins US Family Health Plan as presented in this document.

PRIMARY CARE MANAGER (PCM)

Each Johns Hopkins US Family Health Plan member has a primary care manager who knows the member's medical history, provides most of the member's health care, writes referrals for and monitors any specialist care or tests that are necessary and helps the member prevent medical problems in the future. US Family Health Plan primary care managers specialize in internal medicine, family practice or pediatrics.

PROVIDER

A health care professional, institution, facility or agency licensed by the appropriate authority and operating according to law, including a hospital, physician, doctor of podiatry (D.P.M.), licensed clinical psychologist (Ph.D.), certified nurse practitioner, physicians assistant, certified nurse-midwife, or mental health counselor.

REFERRAL

A formal, written recommendation from a PCM that directs an enrollee to receive health care services from another specified care provider. Entitlement to such services shall not exceed the limits of the referral and is subject to all terms and conditions of the group contract. For referred services to be paid for by the Plan, a referral is necessary.

ROOM AND BOARD

Charges made by a hospital or other covered institution for the cost of a room, general-duty nursing care, and other services routinely provided to all inpatients, not including special care units.

SEMI-PRIVATE CHARGE

The charge made by a hospital for a room containing two (2) or more beds, but not including the charge made by the hospital for special care units.

SERVICE AREA

Johns Hopkins US Family Health Plan service area includes the zip codes in the geographic service area approved by DoD. Moving outside the service area is a valid reason to disenroll from the Plan.

SKILLED NURSING FACILITY (SNF)

An institution that meets all the following requirements: (1) is licensed by the appropriate public authority as a skilled nursing facility, (2) is accredited in whole or in a specific part as a skilled nursing facility for the treatment and care of inpatients, (3) is engaged mainly in providing skilled nursing care under the supervision of a physician in addition to providing room and board, and (4) is a freestanding or a designated unit of another licensed health care facility.

SPLIT ENROLLMENT

Refers to multiple family members enrolled in TRICARE Prime under different Lead Agents/contractors, including Managed Care Support (MCS) contractors and Johns Hopkins Uniformed Services Family Health Plan (USFHP) designated providers.

TRICARE EXTRA

The TRICARE option that operates like a civilian preferred provider network, or PPN. These participating providers have agreed to charge the TRICARE-allowable fees. However, for using this network of preferred physicians and specialists, the government will pay a slightly larger share of the medical costs incurred. As with TRICARE Standard, no enrollment or referrals are required.

TRICARE PRIME

This benefit provides the most comprehensive coverage for health care benefits at the lowest cost. Each member has a primary care physician who manages all the individual's health care.

TRICARE STANDARD

The new name for the health care option formerly known as CHAMPUS. Under TRICARE Standard, eligible beneficiaries may choose any physician they want for health care and the government will pay a percentage of the cost. Eligible beneficiaries are not required to enroll or pay an enrollment fee.

JOHNS HOPKINS US FAMILY HEALTH PLAN MEMBER CARD

The card issued by the Plan, identifying a military beneficiary as a member of the Johns Hopkins US Family Health Plan. It includes important benefit and compliance information. This card should be kept with you at all times.



Johns Hopkins US Family Health Plan
6704 Curtis Court, Glen Burnie, MD 21060

www.hopkinsmedicine.org/usfhp



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The information contained in this booklet is subject to certain terms, conditions, and limitations and is not intended as a complete description of Plan benefits.

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