

The Johns Hopkins Health System Corporation/The Johns Hopkins Hospital

Employee Benefits Plan

For Non-Represented Employees

\* \* \* \* \*

**Intrastaff**

**Summary Plan Description**

**for the**

**EHP Medical Plan and Dental Plan**

January 1, 2018

## Important Telephone Numbers and Websites

<b>Claims or Coverage Questions</b>	Johns Hopkins EHP	(410) 424-4450 or (800) 261-2393 <a href="http://www.ehp.org">www.ehp.org</a>
	Intrastaff Office	(410) 583-2950 (press 0)
<b>Care Management Program (Preauthorization of services)</b>	Johns Hopkins EHP	(410) 424-4450
<b>COBRA Questions</b>	Johns Hopkins EHP	(410) 424-4450
<b>Claim Forms</b>	Intrastaff Office	(410) 583-2950 (press 0)
		<a href="http://www.ehp.org">www.ehp.org</a>

# Table Of Contents

---

<b>General Information About Your Benefits .....</b>	<b>1</b>
Who Is Eligible.....	2
<i>Employee Coverage</i> .....	2
<i>Dependent Coverage</i> .....	2
<i>Domestic Partner Coverage</i> .....	3
When Coverage Begins .....	3
Changing Your Coverage.....	4
Special Enrollment Rights For EHP Medical and Dental Coverage.....	5
Coverage Costs.....	7
<b>The Johns Hopkins EHP Medical Plan .....</b>	<b>8</b>
Network Providers.....	8
Primary Care Physicians .....	8
Three Ways to Receive Care .....	9
<i>Hopkins Preferred and EHP Network Provider</i> .....	9
<i>Pay Tiers</i> .....	10
<i>Out-of-Network Providers</i> .....	11
Payment Terms You Should Know.....	11
Care Management Program.....	13
Chronic Care Management Program.....	15
Health Coach Program .....	15
EHP Customer Service.....	16
<b>What’s Covered by the Johns Hopkins EHP Medical Plan.....</b>	<b>17</b>
Medical Benefits At-A-Glance.....	17
Covered Services and Supplies .....	26
<i>In General</i> .....	26
<i>Emergency Services</i> .....	31
<i>Out-Of-Area Care and Coverage for Students</i> .....	32
<i>Ambulance Services</i> .....	32
<i>Vision Benefits</i> .....	33
<i>Maternity Benefits</i> .....	34
<i>Infertility Treatment</i> .....	35
<i>Medical and Modified Foods</i> .....	37
<i>Obesity Treatment</i> .....	37
<i>Women’s Health and Cancer Rights Act</i> .....	38
<i>Gender Reassignment</i> .....	38
<i>Physical, Occupational and Speech Therapy</i> .....	38
<i>Home Health Care</i> .....	39
<i>Skilled Nursing/Rehabilitation Facility Care</i> .....	40

<i>Hospice Care</i> .....	41
<i>Transplants</i> .....	42
Mental Health and Substance Abuse Treatment .....	43
Prescription Drug Benefits .....	44
<b>What's Not Covered by The EHP Medical Plan.....</b>	<b>49</b>
<b>Johns Hopkins EHP Dental Plans .....</b>	<b>55</b>
Dental Benefits At-A-Glance .....	56
What the EHP Dental Plans Cover.....	58
<i>Diagnostic and Preventive Services</i> .....	58
<i>Basic Services</i> .....	58
<i>Major Services</i> .....	58
<i>Orthodontia</i> .....	59
Pre-Treatment Review.....	59
Use Delta Dental PPO Dentists and Save .....	60
Alternate Treatment.....	60
What The EHP Dental Plans Do Not Cover.....	61
Election of No Dental Benefits .....	62
<b>Administrative Information About Your Johns Hopkins EHP Benefits.....</b>	<b>63</b>
Filing A Claim With Employer Health Programs .....	63
What Happens When You Have Duplicate Coverage.....	63
Coverage Under Other EHP Medical Plans .....	65
Employees Whose Worksite Is Outside The United States .....	65
When the EHP Medical Plan May Recover Payment .....	65
Benefits Paid by Mistake.....	68
When Benefit Plan Coverage Ends .....	68
COBRA Continuation Coverage .....	69
<i>Length of COBRA Coverage</i> .....	69
<i>Electing COBRA Coverage</i> .....	71
<i>When COBRA Coverage Ends</i> .....	71
Benefit Coverage During FMLA Leaves of Absence .....	72
When You Become Covered By Medicare .....	72
Medicare and End Stage Renal Disease .....	73
Non-Discrimination in Benefits .....	73
Plan Information.....	74
Prohibition On Assignment Of Benefits .....	76
Claims And Appeals.....	76
<i>Filing a Claim</i> .....	77
<i>Claims and Appeals Procedures</i> .....	79
<i>If Your Claim is Denied</i> .....	80
<i>First Level Appeal</i> .....	81

<i>Final Appeal</i> .....	83
External Review .....	85
Protected Health Information .....	89
Your Rights Under ERISA.....	89
Intrastaff's Rights.....	90
For More Information.....	91

# ***GENERAL INFORMATION***

---

## **General Information About Your Benefits**

Intrastaff offers you and your family health care benefits under the EHP Medical and Dental Plans to help you pay for medical, vision and dental care when you need it.

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

Intrastaff's formal name is Johns Hopkins Medical Management Corporation. Throughout this SPD, we refer to Johns Hopkins Medical Management Corporation as Intrastaff.

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

**This January 2018 version of the SPD replaces the prior version of the SPD dated January 2016. This January 2018 version applies to all claims incurred on or after January 1, 2018.**

**IMPORTANT NOTE – Federal law requires that you also be provided with a “Summary of Benefits and Coverage” that briefly summarizes the benefits provided by your EHP Medical Plan in a limited number of pages. Your entitlement to benefits is determined only by this Summary Plan Description and not by the Summary of Benefits and Coverage. For information about your benefits, you should refer to this Summary Plan Description and should not rely on the Summary of Benefits and Coverage.**

# ***GENERAL INFORMATION***

---

## **Who Is Eligible**

### ***Employee Coverage***

#### Initial Eligibility

If you work an average of 30 hours per week during your first 30 days of employment with Intrastaff, you are eligible to elect coverage under the EHP Medical and Dental Plans that would start on the first day of the month that begins after the end of your first 30 days of employment.

If you do not work an average of 30 hours per week during your first 30 days of employment, you must instead work an average of 30 hours per week measured over a calendar quarter to be eligible to elect coverage. In that event, you would be eligible to elect coverage that would start on the first day of the month that begins after the end of the calendar quarter.

#### Continued Eligibility

Once you meet the initial eligibility requirement, you must continue to work an average of 30 hours per week measured over each calendar quarter to remain eligible for coverage in the following quarter. If your weekly average over a calendar quarter falls below 30 hours per week, eligibility for coverage ends on the last day of that quarter. In that event, you must again work an average of 30 hours per week measured over a future calendar quarter to be eligible to elect coverage.

### ***Dependent Coverage***

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

- ◆ Your legal spouse. You must submit proof that you are married that is satisfactory to the Plan Administrator the first time you enroll your spouse. The Plan Administrator will usually accept a copy of your marriage license/certificate, but can require additional proof. You may not cover your former spouse after a divorce has become final.
- ◆ Your children, through the end of the month in which they turn age 26. You must submit a copy of your child's birth certificate the first time you enroll your child. To be eligible, a child must be your natural child, a stepchild, a foster child, a child legally adopted or placed with you for adoption, or a child for whom you are the legal guardian. You may not cover a child for whom you only have legal custody.
- ◆ Your physically or mentally disabled dependent child of any age, provided the physical or mental disability began while the child was eligible as described above.

## ***GENERAL INFORMATION***

---

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

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

If your spouse also works for Intrastaff (or for Johns Hopkins Health System Corporation/The Johns Hopkins Hospital (JHHSC/JHH)), you cannot be covered as both an employee and a dependent. Likewise, if your eligible child also works for Intrastaff (or JHHSC/JHH), he or she cannot be covered as both an employee and a dependent. Please note that your eligible children may only be covered by one parent's plan.

If you have any questions about coverage, please contact the Intrastaff Office at 410-583-2950 (press 0).

### ***Domestic Partner Coverage***

Coverage under the EHP Medical and Dental Plans is not available for domestic partners (same or opposite sex) or their children.

### ***Qualified Medical Child Support Order (QMCSO)***

Your child or children will automatically be enrolled in the Medical or Dental Plans if called for by a Qualified Medical Child Support Order or a National Medical Support Notice (a "QMCSO"). A QMCSO is a court or agency order setting responsibility for health care expenses for non-custodial children. If the Intrastaff Office receives a QMCSO related to your child or children, required contributions for their coverage will automatically be withheld from your paycheck.

### **When Coverage Begins**

If you meet the initial eligibility requirement described above under **Who is Eligible** during your first 30 days of employment, you must complete and submit all required enrollment forms before the end of those 30 days in order to have coverage. In that event, coverage would start on the first day of the month that begins after the end of your first 30 days of employment.

If you don't become eligible during your first 30 days of employment, but instead meet the eligibility requirement during a later calendar quarter, you must complete and submit all required enrollment forms before the last day of the calendar quarter in which you meet the eligibility requirement in order



## ***GENERAL INFORMATION***

---

to have coverage. In that event, coverage would begin on the first day of the month after the end of the calendar quarter.

If you do not complete and submit all required enrollment forms on time, you cannot elect coverage until the next annual open enrollment unless you have a family status change or qualify for a ***Special Enrollment*** as explained in the Special Enrollment Rights for EHP Medical and Dental Coverage section.

If you terminate employment and are later rehired by Intrastaff, you must satisfy the eligibility requirements all over again just like a new hire.

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

Coverage for your dependents will begin at the same time as your own if you properly enroll them. If you have a new baby, adopt a child, or have a child placed with you for adoption, and you enroll this dependent within 30 days, your child's coverage becomes effective on the date of the birth or adoption. If you marry and you enroll your spouse within 30 days after your marriage, your spouse's coverage becomes effective on the first day of the month following the date you submit the enrollment forms.

### **Changing Your Coverage**

During the annual open enrollment period, you may change your EHP Medical or Dental Plans coverage. Outside of the annual open enrollment period, you may start or stop coverage, add new dependents, or drop a dependent from your coverage *only* if you have a qualifying family status change or a ***Special Enrollment*** situation (see the **Special Enrollment Rights for EHP Medical and Dental Coverage** section).

Examples of IRS-qualified changes in family status include:

- ◆ Marriage, legal separation, annulment or divorce;
- ◆ Birth, death or adoption of a dependent;
- ◆ Placement for adoption of a dependent;
- ◆ A change in your dependent's employment status (for example: your dependent terminates employment or starts a new job);

## ***GENERAL INFORMATION***

---

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

Any employee, spouse or dependent child whose coverage under any other group health plan suddenly or unexpectedly ends may possibly be permitted coverage under the EHP Medical or Dental Plans without waiting until the next open enrollment. Please notify the Intrastaff Office about your situation to see if coverage is available.

Any change in your benefit coverage must correspond directly to the change in family status. If you submit your new enrollment form and a copy of proof of the family status change (such as a marriage or birth certificate or adoption papers) within 30 days after the status change, the new coverage will become effective on the first of the month following the date you submit the new enrollment form. If you do not change your coverage by submitting a new enrollment form within 30 days after the status change, you must wait until the next annual open enrollment before the new coverage can become effective.

### **Special Enrollment Rights For EHP Medical and Dental Coverage**

Following are special situations in which you can elect coverage under the EHP Medical or Dental Plans outside of the annual open enrollment period. In each situation, you must also be eligible to elect coverage as described above under **Who Is Eligible**.

## ***GENERAL INFORMATION***

---

### ***Losing other coverage***

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

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

### ***New Children***

Children whom you acquire through birth, adoption, or placement for adoption may be granted special enrollment, as long as you enroll them for coverage by submitting the required enrollment forms within 30 days following the date you acquired the child. If enrolled on time, coverage will become effective on the date of the birth, adoption or placement for adoption. If you do not have coverage for yourself, your spouse or any of your other children, you must also enroll yourself, and you may also enroll your spouse or any of your other children when you enroll your new child.

### ***Marriage***

If you get married, your new spouse may be granted special enrollment, as long as you enroll your new spouse for coverage by submitting the required enrollment forms within 30 days following the date of marriage. If enrolled on time, coverage will become effective on the first day of month following the date your enrollment materials are received in the Intrastaff office. If you do not have coverage for yourself or any of your children, you must also enroll yourself, and you may also enroll any of your children when you enroll your new spouse.

### ***Medicaid and Children's Health Insurance Program***

If you or your child have health insurance coverage under Medicaid or a Children's Health Insurance Program ("CHIP") and you or your child lose eligibility for that coverage, you may enroll for EHP Medical Plan coverage. You must request this special enrollment by submitting the required enrollment forms within 60 days of losing your Medicaid or CHIP coverage. If enrolled on time, coverage will become effective on the first day of the month following the date your required enrollment forms are received in the Intrastaff Office.

If you or your child become eligible to receive assistance from Medicaid or CHIP to pay your required contributions for coverage under the EHP Medical Plan, you may enroll for EHP Medical Plan

## ***GENERAL INFORMATION***

---

coverage. You must request this special enrollment by submitting the required enrollment forms within 60 days of becoming eligible for the assistance. If enrolled on time, coverage under the EHP Medical Plan will become effective on the first day of the month following the date your enrollment materials are received in the Intrastaff Office.

### **Coverage Costs**

Intrastaff subsidizes part of the cost of your Medical Plan coverage, but you still must contribute in order to have Medical or Dental Plan coverage. Required employee contributions are deducted from your paycheck on a pre-tax basis. Because your contributions are deducted before taxes, you reduce your taxable income and save on federal and state income taxes, and Social Security taxes. Special rules may apply for state taxes if you live in Pennsylvania or New Jersey.

For the exact contributions required by the EHP Medical and Dental Plans, please contact the Intrastaff Office.

# ***EHP MEDICAL PLAN***

---

## **The Johns Hopkins EHP Medical Plan**

The EHP Medical Plan described in this SPD is designed to provide you and your family with quality health care services in the most cost effective settings. The EHP Medical Plan offers you the security of a wide range of health care benefits, including coverage for inpatient and outpatient hospital care, medical and surgical services, prescription drugs, vision care and mental health and substance abuse services. The EHP Medical Plan also offers vital preventive care benefits, such as coverage for routine physicals; well-woman care, including Pap tests and mammograms; and well-child care, including immunizations and check-ups.

### **Network Providers**

The EHP Medical Plan gives you access to The Johns Hopkins Hospital, Johns Hopkins Bayview Medical Center, Howard County General Hospital, Suburban Hospital, Sibley Memorial Hospital, Johns Hopkins All Children's Hospital, Mt. Washington Pediatric Hospital, and a Network of local and regional community hospitals. There are two parts to the Network:

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

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

### **Primary Care Physicians**

You are encouraged (but not required) to designate a Primary Care Physician (PCP) to coordinate your medical care. However, you never need a referral from a PCP. (Certain services require preauthorization, as explained later in this SPD.) Having a designated PCP ensures that preventive services are addressed and allows you the opportunity for a relationship with your PCP and to feel comfortable with your choice of provider. Also, if you designate a PCP, a lower copay applies to

## ***EHP MEDICAL PLAN***

---

primary care office visits to your designated PCP.

You can designate or change your PCP by calling an EHP Customer Service Representative at 1-800-261-2393 or 410-424-4450, or go to [www.ehp.org](http://www.ehp.org) and sign in to HealthLink@Hopkins to send a secure email to EHP. Your PCP change will become effective on the date you request the change.

Your designated PCP is responsible for helping to keep you well, providing routine treatment, or referring you to an EHP Network specialist when necessary. There are no claims to file — the EHP Network provider receives payment directly from the Plan. You may select a pediatrician as the designated PCP for your children.

*Go online for the Johns Hopkins EHP provider search for PCPs, available on the EHP Web site at [www.ehp.org](http://www.ehp.org). You and your dependents may designate any listed PCP who is available.*

### **Three Ways to Receive Care**

The EHP Medical Plan offers *three* ways to receive care. The highest level of benefits is paid for treatment by Hopkins Preferred providers in the EHP Network. The next highest level of benefits is paid for treatment by EHP Network providers that are not Hopkins Preferred providers. The lowest level of benefits is paid for treatment by Out-of-Network providers.

You do not have to designate a Primary Care Physician and you never need a referral. Certain services require preauthorization, as explained later in this SPD.

#### ***Hopkins Preferred and EHP Network Provider***

If you receive treatment from a Hopkins Preferred provider in the EHP Network, most services are covered at 90%, after meeting the annual deductible.

If you receive treatment from an EHP Network provider that is not a Hopkins Preferred provider, most services are covered at 80%, after meeting the annual deductible.

There are no claims to file — Hopkins Preferred and EHP Network providers receive payment directly from the Plan. Some services are only available thru Hopkins Preferred or EHP Network providers, as described later in this SPD under **Covered Services and Supplies**.

Preventive care services from both Hopkins Preferred and EHP Network providers are usually covered at 100%. Most inpatient services also require a \$150 copay per admission, and a small copay applies to certain other services. The **Medical Benefits At-A-Glance** chart later in this SPD lists the specific coinsurance and copay amounts.

## ***EHP MEDICAL PLAN***

---

The following hospitals are Hopkins Preferred providers:

- Johns Hopkins Hospital
- Johns Hopkins Bayview Medical Center
- Howard County General Hospital
- Suburban Hospital
- Sibley Memorial Hospital
- Johns Hopkins All Children's Hospital (St. Petersburg, FL)
- Mt. Washington Pediatric Hospital

Physicians associated with the following groups are Hopkins Preferred providers:

- Johns Hopkins Clinical Practice Association/School of Medicine
- Johns Hopkins Community Physicians
- Johns Hopkins Part-Time Faculty

The member companies of Johns Hopkins Home Care Group are Hopkins Preferred providers for covered home health care services and durable medical equipment.

### ***Pay Tiers***

#### **Annual deductible**

For services from Hopkins Preferred and EHP Network providers, your calendar year annual deductible depends on the "Pay Tier" you are in for the year. If your base annual salary as of January 1 is:

- less than \$50,000, you are in the "Lower Pay Tier", and your annual deductible is \$150 per person and \$300 per family
- \$50,000 or more but less than \$120,000, you are in the "Middle Pay Tier", and your annual deductible is \$200 per person and \$400 per family
- \$120,000 or more, you are in the "Higher Pay Tier", and your annual deductible is \$300 per person and \$600 per family

If you are first hired after January 1, your Pay Tier for the year of hire is determined by your base annual salary on date of hire. Any changes in your base annual salary that take effect after January 1, or after your date of hire, do not change your Pay Tier for the year. This rule still applies even if your job title, position or work schedule changes, or if you terminate employment and are rehired in the

## ***EHP MEDICAL PLAN***

---

same year.

Amounts paid for treatment from Hopkins Preferred and EHP Network providers are combined for purposes of the annual deductible.

### **Annual medical out-of-pocket maximum**

For services from Hopkins Preferred and EHP Network providers, after you meet the annual deductible, you pay the applicable coinsurance percentage (usually 10% or 20%) until you reach an annual medical out-of-pocket maximum. After you reach the medical out-of-pocket maximum, benefits for covered services are paid at 100% for the remainder of that calendar year.

Your annual medical out-of-pocket maximum for services from Hopkins Preferred and EHP Network providers also depends on the Pay Tier you are in for the year.

- Lower Pay Tier – \$1,500 per person and \$3,000 per family
- Middle Pay Tier – \$2,000 per person and \$4,000 per family
- Higher Pay Tier – \$3,000 per person and \$6,000 per family.

Amounts paid for treatment from Hopkins Preferred and EHP Network providers are combined for purposes of the annual medical out-of-pocket maximum.

### ***Out-of-Network Providers***

The Plan pays benefits if you go to a provider outside of the Johns Hopkins EHP Network. You must first meet an annual deductible of \$750 per person and \$1,500 per family. (The Out of Network deductible is the same for all Pay Tiers.) After the deductible and any applicable copay, the Plan pays 70% of the Allowed Benefit (see **Payment Terms You Should Know** discussed below), and you pay the remaining 30%, until you reach an annual medical out-of-pocket maximum of \$3,500 per person and \$7,000 per family. After you reach the medical out-of-pocket maximum, benefits for covered services are paid at 100% of the Allowed Benefit for the remainder of that calendar year. You are responsible for any amounts over the Allowed Benefit, and those amounts do not count towards the annual deductible or the medical out-of-pocket maximum.

### **Payment Terms You Should Know**

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

- ◆ **Allowed Benefit (AB):** for any service or supply, the lesser of (1) the provider's actual charge or (2) the amount that would be allowed by Medicare, increased by a percentage determined by Johns Hopkins Employer Health Programs, not to exceed 150% of the amount that would be allowed by



## ***EHP MEDICAL PLAN***

---

Medicare. If Medicare does not provide an allowance for a service or supply, then Allowed Benefit means the prevailing, reasonable fee paid to similar providers for the same service or supply in the same geographic area, as determined by Johns Hopkins Employer Health Programs. Hopkins Preferred providers and EHP Network providers will not charge more than the Allowed Benefit, but Out-of-Network providers can charge more and you are responsible for charges above the Allowed Benefit.

- ◆ **Coinsurance:** Your percentage share of the charge for certain medical expenses. The **Medical Benefits At-A-Glance** chart later in this SPD lists the specific coinsurance amounts.
- ◆ **Copay:** The amount you pay for certain services and prescription drugs. The **Medical Benefits At-A-Glance** chart later in this SPD lists the specific copay amounts. You pay the copay directly to the provider at the time of service.
- ◆ **Deductible:** The amount you must pay each calendar year before the Plan begins to pay benefits for most services. The Hopkins Preferred and EHP Network provider combined deductible is explained above under **Pay Tiers**. The Out-of-Network deductible is \$750 per person and \$1,500 per family. The **Medical Benefits At-A-Glance** chart later in this SPD lists which services the deductible applies to.

Expenses incurred and applied to your Hopkins Preferred and EHP Network provider combined deductible apply to your Out-of-Network deductible, and vice versa.

Expenses incurred and applied to your deductible in October, November and December of a calendar year are also carried over and applied to the next calendar year's deductible. Expenses incurred by two or more persons can meet the family deductible. However, no one person will be required to satisfy more than the per-person deductible.

- ◆ **Out-of-Pocket Maximum:** Since you are responsible for a portion of the cost of certain of your medical expenses, the Plan includes two annual out-of-pocket maximums to protect you in the event of high medical bills.

The **medical out-of-pocket maximum** applies to all your expenses under the EHP Medical Plan other than expenses under the **Prescription Drug Benefit** and the **Vision Benefit**. The Hopkins Preferred and EHP Network provider combined annual medical out-of-pocket maximum is explained above under **Pay Tiers**. The Out-of-Network annual medical out-of-pocket maximum is \$3,500 per person and \$7,000 per family.

Medical expenses incurred and applied to your Hopkins Preferred and EHP Network provider combined medical out-of-pocket maximum apply to your Out-of-Network medical out-of-pocket maximum, and vice versa.

## ***EHP MEDICAL PLAN***

---

The medical out-of-pocket maximum includes the deductible, coinsurance and copays, but does not include penalties, amounts in excess of the Allowed Benefit, amounts in excess of Plan maximums and any charges for services which are not covered. Please note that ***Vision Benefit*** expenses are not subject to the out-of-pocket maximum.

The **prescription drug out-of-pocket maximum** applies to copays under the ***Prescription Drug Benefit*** for drugs obtained from an EHP Network Pharmacy. After your prescription drug copays reach the annual prescription drug out-of-pocket maximum of \$3,600 per person and \$7,200 per family, you pay no copays for covered prescription drugs for the remainder of that calendar year. The prescription drug out-of-pocket maximum is the same for all Pay Tiers.

There is no coverage at all, and therefore no out-of-pocket maximum, for prescription drugs obtained at an out-of-network pharmacy.

- ◆ **Providers:** a provider is any hospital, skilled nursing/rehabilitation facility, individual, organization, or agency licensed to provide professional services and acting within the scope of that license. Benefits will only be paid for covered services from providers who meet this definition. Benefits will not be paid for any services and related charges provided by a close relative of the patient (spouse, child, grandchild, brother, sister, brother-in-law, sister-in-law, parent or grandparent).

### **Care Management Program**

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

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

Before you can receive benefits for certain medical services and supplies under the EHP Medical Plan, you must have these services and supplies preauthorized by the Johns Hopkins EHP Care Management Program. Your provider will initiate the preauthorization process if you receive care from a Hopkins Preferred provider or an EHP Network provider. You or your Out-of-Network provider are required to initiate the preauthorization process if you receive Out-of-Network care. If you do not obtain

## ***EHP MEDICAL PLAN***

---

preauthorization, coverage for services and supplies will be denied. The following services and supplies require preauthorization by the Care Management Program:

- ◆ Biofeedback therapy
- ◆ Cardiac and pulmonary therapy
- ◆ Dialysis
- ◆ Durable medical equipment and medical supplies
- ◆ Habilitative services
- ◆ Hearing aids for dependent children
- ◆ Home health care
- ◆ Hospice care
- ◆ Hospital inpatient stays
- ◆ Hyperbaric oxygen therapy
- ◆ Home infusion therapy
- ◆ Infertility treatment
- ◆ Mental health and substance/alcohol abuse inpatient treatment, partial hospital facility and Intensive Outpatient Program days, and methadone management
- ◆ Nutrition counseling after six visits per calendar year
- ◆ Physical/occupational therapy after 12 visits per calendar year
- ◆ Prosthetic devices and orthotics
- ◆ Skilled nursing/rehabilitation facility stays
- ◆ Speech therapy
- ◆ Surgical procedures (certain procedures only, including gastric bypass, as described on a list maintained by Johns Hopkins Employer Health Programs)
- ◆ Transplant services
- ◆ Use of certain drugs and medications (as described on a list maintained by Johns Hopkins Employer Health Programs)

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

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

# ***EHP MEDICAL PLAN***

---

## **Chronic Care Management Program**

The Johns Hopkins EHP Medical Plan is committed to supporting you in managing your health. If you have asthma, diabetes, cardiovascular problems or other complex conditions and meet certain criteria, the EHP Medical Plan provides an innovative Chronic Care Management Program to help you.

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

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

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

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

## **Health Coach Program**

Another program to assist you in managing your health is the Health Coach program. This free, voluntary program encourages interest in healthier lifestyles. If you have well managed chronic conditions or are at risk for developing chronic conditions, you may benefit from this program. Risk factors may include hypertension, high cholesterol, obesity, smoking, and pre-diabetes.

Health coaching provides one-on-one assistance to guide you in adopting healthy lifestyle behaviors. Program duration is 6 to 10 months and sessions are conducted by telephone each month. Primary areas of interest for enrolling in the program are weight loss, nutrition, fitness, stress management and tobacco cessation. The health coach will work with you on monthly goal setting and create an individualized action plan based on your needs. Throughout the program, various assessments are taken to evaluate your progress, health status, and program satisfaction, and modifications to your action plan are made as needed.

You may self-refer into the program or be referred by your health care provider or case manager. If you are appropriate for the program you will be contacted by your assigned health coach.

## ***EHP MEDICAL PLAN***

---

Your eligibility for benefits under the EHP Medical Plan is not affected if you do not participate in the program or if you withdraw from the program after you start.

We encourage you to take advantage of this free program to assist you in managing your health. You may contact the program at [healthcoach@jhhc.com](mailto:healthcoach@jhhc.com) or call 1-800-957-9760.

### **EHP Customer Service**

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

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

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

Only you and your covered dependents are permitted to use the identification card. It is illegal to loan your card to persons who are not covered under the EHP Medical Plan. If you lose your identification card, call a Johns Hopkins EHP Customer Service Representative immediately to request a new card. You may also print a temporary ID card by going to [www.ehp.org](http://www.ehp.org) and signing in through Member Login.

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

# ***MEDICAL BENEFITS AT-A-GLANCE***

## **What's Covered by the Johns Hopkins EHP Medical Plan**

### **Medical Benefits At-A-Glance**

The following chart summarizes most of the benefits and services available under the Johns Hopkins EHP Medical Plan. This chart is not a complete description of benefits. For more information, please refer to the rest of this SPD.

	<b>EHP NETWORK PROVIDERS</b>	<b>OUT-OF-NETWORK PROVIDERS</b>	<b>HOPKINS PREFERRED PROVIDERS</b>
<b>CALENDAR YEAR DEDUCTIBLE</b>			
Per person	\$150 Lower Pay Tier \$200 Middle Pay Tier \$300 Higher Pay Tier Combined with Hopkins Preferred providers	\$750	Combined with EHP Network providers
Per family	\$300 Lower Pay Tier \$400 Middle Pay Tier \$600 Higher Pay Tier Combined with Hopkins Preferred providers	\$1,500	Combined with EHP Network providers
<b>OUT-OF-POCKET MAXIMUM (includes deductibles, coinsurance and copays)</b>			
Per person	\$1,500 Medical Lower Pay Tier \$2,000 Medical Middle Pay Tier \$3,000 Medical Higher Pay Tier Combined with Hopkins Preferred providers  \$3,600 Prescription Drugs all Pay Tiers	\$3,500 Medical  Prescription Drugs not covered	Combined with EHP Network providers
Per family	\$3,000 Medical Lower Pay Tier \$4,000 Medical Middle Pay Tier \$6,000 Medical Higher Pay Tier Combined with Hopkins Preferred providers  \$7,200 Prescription Drugs all Pay Tiers	\$7,000 Medical  Prescription Drugs not covered	Combined with EHP Network providers
<b>PENALTY FOR NOT OBTAINING PREAUTHORIZATION</b>			
	Not applicable	Denial of benefits	Not applicable

Hopkins Preferred provider facilities include Johns Hopkins Hospital, Johns Hopkins Bayview Medical Center, Howard County General Hospital, Suburban Hospital, Sibley Memorial Hospital, Mt. Washington Pediatric Hospital and Johns Hopkins All Children's Hospital. Preferred provider physicians include Johns Hopkins Clinical Practice Associates/School of Medicine, Johns Hopkins Community Physicians, and Johns Hopkins Part-Time Faculty.

EHP Network providers and Hopkins Preferred providers have agreed to accept the EHP fee schedule as full payment and will not balance bill, other than required copays, coinsurance and deductibles. Out-of-Network providers can balance bill for charges in addition to deductibles and coinsurance.

# ***MEDICAL BENEFITS AT-A-GLANCE***

---

Only medically necessary services and supplies are covered.

## ***MEDICAL BENEFITS AT-A-GLANCE***

<b>SERVICES PROVIDED</b>	<b>EHP NETWORK PROVIDERS</b>	<b>OUT-OF-NETWORK PROVIDERS</b>	<b>HOPKINS PREFERRED PROVIDERS</b>
<b>1. TREATMENT OF ILLNESS OR INJURY</b>			
Primary care office visit for medical treatment	100% after \$10 copay if medical PCP is designated 100% after \$20 copay if medical PCP is not designated (no deductible)	70% of AB after deductible	Refer to EHP Network Providers Benefit
Primary care office visit for GYN treatment from GYN PCP	100% after \$10 copay (no deductible)	70% of AB after deductible	Refer to EHP Network Providers Benefit
Specialty care office visit	80% after deductible	70% of AB after deductible	90% after deductible
Diagnostic services and treatment, facility fees	80% after deductible	70% of AB after deductible	90% after deductible
<b>2. PREVENTIVE SERVICES</b>			
General preventive exam (adult physical, GYN and well child care)	100% (no deductible)	70% of AB after deductible	100% (no deductible)
Diagnostic services for exam	100% (no deductible)	70% of AB after deductible	100% (no deductible)
Mammogram and well-woman care	100% (no deductible)	70% of AB after deductible	100% (no deductible)
Screening colonoscopy	100% (no deductible)	70% of AB after deductible	100% (no deductible)
Routine hearing exam	100% (no deductible)	70% of AB after deductible	100% (no deductible)
<b>3. IMMUNIZATIONS AND INOCULATIONS</b>			
As recommended by Centers for Disease Control and Prevention	100% (no deductible)	70% of AB after deductible	100% (no deductible)
Travel immunizations	100% (no deductible)	70% of AB after deductible	100% (no deductible)

This chart is not a complete description of benefits. For more information, please refer to the rest of this SPD.

Only medically necessary services and supplies are covered. "AB" means Allowed Benefit, which is explained under **Payment Terms You Should Know**, earlier in this SPD.



## ***MEDICAL BENEFITS AT-A-GLANCE***

SERVICES PROVIDED	EHP NETWORK PROVIDERS	OUT-OF-NETWORK PROVIDERS	HOPKINS PREFERRED PROVIDERS
<b>4. ALLERGY TESTS AND PROCEDURES</b>			
Allergy tests	80% after deductible	70% of AB after deductible	90% after deductible
Desensitization materials/serum	80% after deductible	70% of AB after deductible	90% after deductible
<b>5. LABORATORY</b>			
Laboratory tests and pathology	80% after deductible	70% of AB after deductible	90% after deductible
<b>6. RADIOLOGY</b>			
CT scans, PET scans and MRIs	80% after deductible	70% of AB after deductible	90% after deductible
All other imaging studies, including x-rays and ultrasound	80% after deductible	70% of AB after deductible	90% after deductible
<b>7. SURGERY</b>			
Professional services for inpatient and outpatient surgery; Care Management preauthorization may be required	80% after deductible	70% of AB after deductible	90% after deductible
Surgical treatment for morbid obesity; Care Management preauthorization required	Covered at Bayview Medical Center and Sibley Memorial Hospital only	Covered at Bayview Medical Center and Sibley Memorial Hospital only	\$150 copay, then 90% after deductible Covered at Bayview Medical Center and Sibley Memorial Hospital only
<b>8. REPRODUCTIVE HEALTH</b>			
Physician office visits (for prenatal care only)	80% after deductible	70% of AB after deductible	90% after deductible
Inpatient maternity care and delivery, including physician, hospitalization, lab and X-ray services	\$150 copay, then 80% after deductible	\$500 copay, then 70% of AB after deductible <sup>(1)</sup>	\$150 copay, then 90% after deductible
Newborn nursery care and NICU	80% after deductible; \$150 copay for NICU	70% of AB after deductible <sup>(1)</sup>	90% after deductible; \$150 copay for NICU
Birth centers (licensed facility)	90% after deductible	70% of AB after deductible <sup>(1)</sup>	90% after deductible
Voluntary sterilization	100% (no deductible)	70% of AB after deductible <sup>(1)</sup>	100% (no deductible)
Interruption of pregnancy	80% after deductible	70% of AB after deductible <sup>(1)</sup>	90% after deductible
Infertility treatment (such as artificial insemination and in-vitro fertilization); Care Management preauthorization required	Covered at Johns Hopkins Fertility Center only	Covered at Johns Hopkins Fertility Center only	90% after separate \$1,000 lifetime deductible Covered at Johns Hopkins Fertility Center only

This chart is not a complete description of benefits. For more information, please refer to the rest of this SPD.

Only medically necessary services and supplies are covered. "AB" means Allowed Benefit, which is explained under **Payment Terms You Should Know**, earlier in this SPD.

(1) Failure to obtain preauthorization for hospitalization will result in a denial of benefits.

## ***MEDICAL BENEFITS AT-A-GLANCE***

<b>SERVICES PROVIDED</b>	<b>EHP NETWORK PROVIDERS</b>	<b>OUT-OF-NETWORK PROVIDERS</b>	<b>HOPKINS PREFERRED PROVIDERS</b>
<b>9. URGENT CARE CENTER</b>			
Physician visit	100% after \$25 copay (no deductible)	70% of AB after deductible	100% after \$25 copay (no deductible)
Diagnostic services and treatment	100% (no deductible)	70% of AB after deductible	100% (no deductible)
<b>10. EMERGENCY SERVICES</b>			
Care in emergency room for emergency medical situations only	100% after \$250 copay and deductible (copay waived if admitted)	100% of AB after \$250 copay and deductible (copay waived if admitted);	100% after \$250 copay and deductible (copay waived if admitted)
<b>11. AMBULANCE TRANSPORTATION</b>			
Ground or air transportation when medically necessary	100% after deductible	100% of AB after deductible	100% after deductible
<b>12. HOSPITAL CARE</b>			
Inpatient facility care (semi-private, unless private room is medically necessary); Care Management preauthorization required	\$150 copay per admission, then 80% after deductible	\$500 copay per admission, then 70% of AB after deductible <sup>(1)</sup>	\$150 copay per admission, then 90% after deductible
Inpatient professional services (excluding surgical)	80% after deductible	70% of AB after deductible	90% after deductible
Skilled nursing/rehabilitation facility (120 days per calendar year combined maximum; Care Management preauthorization required)	90% for first 30 days per year, then 80% for remaining days after deductible	70% of AB after deductible <sup>(1)</sup>	90% after deductible
Outpatient professional services, including testing prior to outpatient surgery	80% after deductible	70% of AB after deductible	90% after deductible
Outpatient surgery facility charges including freestanding surgical centers	80% after deductible	70% of AB after deductible	90% after deductible
Observation care	100% after \$250 copay and deductible (copay waived if admitted)	100% of AB after \$250 copay and deductible (copay waived if admitted)	100% after \$250 copay and deductible (copay waived if admitted)
<b>13. CHEMOTHERAPY/ RADIATION THERAPY</b>			
Physician visit	80% after deductible	70% of AB after deductible	90% after deductible
Materials and treatment	80% after deductible	70% of AB after deductible	90% after deductible

This chart is not a complete description of benefits. For more information, please refer to the rest of this SPD.

Only medically necessary services and supplies are covered. "AB" means Allowed Benefit, which is explained under **Payment Terms You Should Know**, earlier in this SPD.

(1) Failure to obtain preauthorization for hospitalization will result in a denial of benefits.

## ***MEDICAL BENEFITS AT-A-GLANCE***

SERVICES PROVIDED	EHP NETWORK PROVIDERS	OUT-OF-NETWORK PROVIDERS	HOPKINS PREFERRED PROVIDERS
<b>14. ACUPUNCTURE</b>			
For anesthesia, pain control and therapeutic purposes; 20 visit per calendar year combined maximum	80% after deductible	70% of AB after deductible	90% after deductible
<b>15. HOME HEALTH CARE</b>			
40 visits per calendar year combined maximum; Care Management preauthorization required	90% after deductible	70% of AB after deductible	90% after deductible
<b>16. HOSPICE CARE</b>			
Inpatient and home; Care Management preauthorization required	90% after deductible	70% of AB after deductible <sup>(1)</sup>	90% after deductible
<b>17. SPEECH THERAPY</b>			
Care Management preauthorization required; 30 visits per calendar year combined maximum	80% after deductible	70% of AB after deductible	90% after deductible
<b>18. PHYSICAL/OCCUPATIONAL THERAPY</b>			
Licensed therapist only; 60 visits per calendar year combined maximum; Care Management preauthorization required after 12 visits	80% after deductible	70% of AB after deductible	90% after deductible
<b>19. HABILITATIVE SERVICES</b>			
Under age 19 only; Care Management preauthorization required	80% after deductible	70% of AB after deductible	90% after deductible
<b>20. CHIROPRACTIC CARE</b>			
Restricted to initial exam, X-rays and spinal manipulations; 20 visit per calendar year combined maximum	80% after deductible	70% of AB after deductible	90% after deductible

This chart is not a complete description of benefits. For more information, please refer to the rest of this SPD.

Only medically necessary services and supplies are covered. "AB" means Allowed Benefit, which is explained under **Payment Terms You Should Know**, earlier in this SPD.

(1) Failure to obtain preauthorization for hospitalization will result in a denial of benefits.

## ***MEDICAL BENEFITS AT-A-GLANCE***

<b>SERVICES PROVIDED</b>	<b>EHP NETWORK PROVIDER:</b>	<b>OUT-OF-NETWORK PROVIDERS</b>	<b>HOPKINS PREFERRED PROVIDERS</b>
<b>21. DURABLE MEDICAL EQUIPMENT AND SUPPLIES</b> (Care Management preauthorization required where indicated)			
Non-custom equipment and medical supplies	80% after deductible	70% of AB after deductible	90% after deductible, thru Johns Hopkins Home Care Group
Custom equipment/wheelchairs (preauthorization required)	90% after deductible	70% of AB after deductible	90% after deductible
Insulin pumps and related supplies	90% after deductible	70% of AB after deductible	90% after deductible
Breast pumps (standard) and related supplies	100% (no deductible)	70% of AB after deductible	100% (no deductible) thru Johns Hopkins Home Care Group
Contraceptive devices	100% (no deductible)	70% of AB after deductible	100% (no deductible)
Custom molded orthotics (preauthorization required)	80% after deductible	70% of AB after deductible	90% after deductible
Prosthetic devices (preauthorization required)	90% after deductible	70% of AB after deductible	90% after deductible
Hearing aids for children under 26 (preauthorization required)	90% after deductible	70% of AB after deductible	90% after deductible
<b>22. NUTRITION COUNSELING</b>			
Care Management preauthorization required after six visits per calendar year	80% after deductible	70% of AB after deductible	90% after deductible
<b>23. DIALYSIS</b>			
Care Management preauthorization required	80% after deductible; 90% at Fresenius/Davita Dialysis Centers after deductible	70% of AB after deductible	Refer to EHP Network Providers Benefit
<b>24. HYPERBARIC OXYGEN THERAPY</b>			
Care Management preauthorization required	80% after deductible	70% of AB after deductible	90% after deductible
<b>25. CARDIAC AND PULMONARY THERAPY</b>			
Care Management preauthorization required	80% after deductible	70% of AB after deductible	90% after deductible

This chart is not a complete description of benefits. For more information, please refer to the rest of this SPD. Only medically necessary services and supplies are covered. "AB" means Allowed Benefit, which is explained under **Payment Terms You Should Know**, earlier in this SPD.

(1) Failure to obtain preauthorization for hospitalization will result in a denial of benefits.

## ***MEDICAL BENEFITS AT-A-GLANCE***

SERVICES PROVIDED	EHP NETWORK PROVIDERS	OUT-OF-NETWORK PROVIDERS	HOPKINS PREFERRED PROVIDERS
<b>26. INFUSION THERAPY</b>			
Home infusion therapy; Care Management preauthorization required	80% after deductible	70% of AB after deductible	90% after deductible, thru Johns Hopkins Home Care Group
Outpatient infusion therapy	80% after deductible	70% of AB after deductible	90% after deductible
<b>27. INJECTIONS</b>			
Injections, materials and serum	80% after deductible	70% of AB after deductible	90% after deductible
<b>28. MENTAL HEALTH AND SUBSTANCE ABUSE</b>			
Inpatient care facility fees; Care Management preauthorization required)	80% after \$150 copay per admission and deductible	\$500 copay per admission, then 70% of AB after deductible <sup>(1)</sup>	90% after \$150 copay per admission and deductible
Inpatient care professional fees	80% after deductible	70% of AB after deductible	90% after deductible
Outpatient care facility fees	100% after \$10 copay per visit (no deductible)	70% of AB after deductible	100% after \$10 copay per visit (no deductible)
Outpatient care professional fees	100% after \$10 copay per visit (no deductible)	70% of AB after deductible	100% after \$10 copay per visit (no deductible)
Biofeedback; Care Management preauthorization required	80% after deductible	70% of AB after deductible	90% after deductible
Partial hospital facility and Intensive Outpatient Program days; Care Management preauthorization required	100% after \$10 copay per day (no deductible)	70% of AB after deductible	100% after \$10 copay per day (no deductible)
Medication management	100% after \$10 copay per visit (no deductible)	70% of AB after deductible	100% after \$10 copay per visit (no deductible)
Mental health testing and procedures; Care Management preauthorization required	100% after \$10 copay per visit (no deductible)	70% of AB after deductible	100% after \$10 copay per visit (no deductible)
Methadone treatment; Care Management preauthorization required	100% after \$10 copay per visit (no deductible)	70% of AB after deductible	100% after \$10 copay per visit (no deductible)

This chart is not a complete description of benefits. For more information, please refer to the rest of this SPD.

Only medically necessary services and supplies are covered. "AB" means Allowed Benefit, which is explained under **Payment Terms You Should Know**, earlier in this SPD.

(1) Failure to obtain preauthorization for hospitalization will result in a denial of benefits.

## ***MEDICAL BENEFITS AT-A-GLANCE***

<b>29. PRESCRIPTION DRUGS</b>											
In-network pharmacy only; 30-day supply; No copay for certain generic contraceptives	\$10 copay – generic \$40 copay – brand preferred \$65 copay – brand non-preferred \$65 copay – brand if generic available, plus cost difference										
In-network pharmacy only; 30-day supply for these prescribed generic Over-the-Counter drugs	\$10 copay – prescribed OTC generic equivalents of Prilosec, Nexium, Prevacid and Zegerid No copay for prescribed OTC generic equivalents of Claritin, Claritin D, Allegra, Allegra D, Zyrtec or Zyrtec D Must have prescription and present it to the pharmacy										
90-day supply for maintenance drugs (excludes specialty medications); No copay for certain generic contraceptives	<table border="0" style="width: 100%;"> <tr> <td style="width: 50%; text-align: center;"><u>Mail order:</u></td> <td style="width: 50%; text-align: center;"><u>In-network pharmacy:</u></td> </tr> <tr> <td style="text-align: center;">\$20 copay – generic</td> <td style="text-align: center;">\$30 copay – generic</td> </tr> <tr> <td style="text-align: center;">\$80 copay – brand preferred</td> <td style="text-align: center;">\$120 copay – brand preferred</td> </tr> <tr> <td style="text-align: center;">\$130 copay – brand non-preferred</td> <td style="text-align: center;">\$195 copay – brand non-preferred</td> </tr> <tr> <td style="text-align: center;">\$130 copay – brand if generic available, plus cost difference</td> <td style="text-align: center;">\$195 copay – brand if generic available, plus cost difference</td> </tr> </table>	<u>Mail order:</u>	<u>In-network pharmacy:</u>	\$20 copay – generic	\$30 copay – generic	\$80 copay – brand preferred	\$120 copay – brand preferred	\$130 copay – brand non-preferred	\$195 copay – brand non-preferred	\$130 copay – brand if generic available, plus cost difference	\$195 copay – brand if generic available, plus cost difference
<u>Mail order:</u>	<u>In-network pharmacy:</u>										
\$20 copay – generic	\$30 copay – generic										
\$80 copay – brand preferred	\$120 copay – brand preferred										
\$130 copay – brand non-preferred	\$195 copay – brand non-preferred										
\$130 copay – brand if generic available, plus cost difference	\$195 copay – brand if generic available, plus cost difference										
Specialty medications; 30-day supply; In-network pharmacy only	\$10 copay – generic \$40 copay – brand preferred \$65 copay – brand non-preferred										

This chart is not a complete description of benefits. For more information, please refer to the rest of this SPD.

Only medically necessary services and supplies are covered.

## ***COVERED SERVICES AND SUPPLIES***

---

### **Covered Services and Supplies**

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

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

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

In the case of an inpatient admission, medically necessary also means treatment that could not adequately be provided on an outpatient basis. A treatment is not medically necessary if it violates the Employer Health Programs fraud, waste and abuse policy. The Plan Administrator may rely on Employer Health Programs policies to determine whether a treatment is medically necessary.

Benefit limits, coinsurance and copay amounts are shown in the **Medical Benefits At-A-Glance** chart.

### ***In General***

The EHP Medical Plan covers the following services and supplies, when medically necessary and subject to any conditions or limitations described elsewhere in this SPD:

- ◆ Abortion
- ◆ Acupuncture for anesthesia, pain control and therapeutic purposes, when provided by a licensed acupuncturist
- ◆ Ambulance services – see below
- ◆ Anesthetics and oxygen, and their administration
- ◆ Artificial limbs and eyes
- ◆ Biofeedback therapy (Care Management preauthorization required)

## ***COVERED SERVICES AND SUPPLIES***

---

- ◆ Birthing facilities
- ◆ Blood products, if not replaced
- ◆ Cardiac and pulmonary therapy (Care Management preauthorization required)
- ◆ Casts, splints
- ◆ Chiropractic care for misalignment or partial dislocation of or in the vertebral column and correction by manual or mechanical means of nerve interference
- ◆ Consultation services by a specialist in the medical field for which the consultation relates. Staff consultation required by the facility is not covered
- ◆ Contraceptive devices provided for in comprehensive guidelines supported by the Health Resources and Services Administration and approved by the Food and Drug Administration
- ◆ Convalescent facility care and home health care (Care Management preauthorization required)
- ◆ Cosmetic/reconstructive surgery when due to:
  - accidental injury or illness that is or would be covered by the Plan
  - correction of a congenital malformation of a child
  - treatment for morbid obesity – see “Obesity treatment” below
  - as provided for under ***Women’s Health and Cancer Rights Act*** below in this SPD
- ◆ Dental services if rendered as initial treatment as a result of an accident causing injury to sound natural teeth and treatment is provided within 48 hours of the accident
- ◆ Diabetic supplies
- ◆ Diagnostic X-rays and laboratory services
- ◆ Dialysis (Care Management preauthorization required)
- ◆ Doctors’ (including surgeons’) fees for treatment of illness or injury
- ◆ Doctors’ fees and hospital charges for maternity care
- ◆ Doctors’ fees for office visits



## ***COVERED SERVICES AND SUPPLIES***

---

- ◆ Durable medical equipment, including wheelchairs. (Care Management preauthorization required.)  
Durable medical equipment is medical equipment which:
  - Can withstand repeated use
  - Is primarily and customarily used to serve a medical purpose
  - Is generally not useful to a person in the absence of illness or injury
  - Is appropriate for use in the home, and
  - Is not primarily for the convenience of the patient
  
- ◆ Emergency Services – see below
  
- ◆ Foot care for incision and drainage of infected tissues of the foot, removal of lesions, treatment of fractures and dislocations of bone in the foot
  
- ◆ Foot orthotics that are custom-molded and related to a specific medical diagnosis, or an integral part of a leg brace and the cost is included in the orthotist’s charge (Care Management preauthorization required)
  
- ◆ Gastric bypass surgery – see “Obesity treatment” below
  
- ◆ Gender reassignment – see below
  
- ◆ Habilitative services – see Physical, Occupational and Speech Therapy below
  
- ◆ Hearing aids for a dependent child under age 26, up to \$1,400 per aid. The aids must be prescribed, fitted, and dispensed by a licensed audiologist. Replacement aids are available only once every three years (Care Management preauthorization required).
  
- ◆ Home health care – see below
  
- ◆ Hospice care – see below
  
- ◆ Hospital charges for covered semi-private room and board and other hospital-provided services and supplies (Care Management preauthorization required for admission)
  
- ◆ Hyperbaric oxygen therapy(Care Management preauthorization required)

## *COVERED SERVICES AND SUPPLIES*

---

- ◆ Immunizations for routine use in children, adolescents, and adults that have in effect a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention
- ◆ Infertility treatment – see below
- ◆ Laboratory tests
- ◆ Maternity benefits – see below
- ◆ Medical and modified foods – see below
- ◆ Midwifery services
- ◆ Newborn care
- ◆ Nursing services (professional) by a registered nurse or licensed practical nurse who is not a close relative (spouse, child, grandchild, brother, sister, brother-in-law, sister-in-law, parent, or grandparent) of the patient
- ◆ Nutrition counseling (Care Management preauthorization required after six visits per calendar year)
- ◆ Obesity treatment – see below
- ◆ Out-Of-Area Care – see below
- ◆ Outpatient surgical center
- ◆ Physical, occupational and speech therapy – see below
- ◆ Preventive care for adults, children and adolescents, including evidence based items or services that have in effect a rating of A or B in the current recommendations of the United States Preventive Services Task Force. No cost sharing applies to this preventive care from a Hopkins Preferred or EHP Network provider.
- ◆ Prosthetic devices and orthotics that are integral to the device (Care Management preauthorization required)
- ◆ Rehabilitation services (Care Management preauthorization required)

## *COVERED SERVICES AND SUPPLIES*

---

- ◆ Second surgical opinions
- ◆ Skilled nursing and rehabilitation facility care – see below
- ◆ Surgical dressings and medical supplies
- ◆ Surgical procedures (Care Management preauthorization required for certain procedures)
- ◆ Telephone consultation charges, if the consultation is medically necessary for treatment of a condition otherwise covered by the Plan
- ◆ Temporomandibular Joint Syndrome (TMJ) treatment and/or orthognathic surgery, limited to physical therapy, surgery and ortho devices such as mouthguards and intraoral devices (excludes orthodontics and prosthetics)
- ◆ Tobacco cessation intervention, as covered by United States Preventive Services Task Force preventive care recommendations with a rating of A or B
- ◆ Transplants – see below
- ◆ Treatment of cleft lip and cleft palate
- ◆ Vasectomies and tubal ligations
- ◆ Vision benefits – see below
- ◆ Well-child care, including evidence-informed preventive care and screenings provided for in comprehensive guidelines supported by the Health Resources and Services Administration. No cost sharing applies to this preventive care from a Hopkins Preferred or EHP Network provider.
- ◆ Well-woman care, including evidence-informed preventive care and screenings for women provided for in comprehensive guidelines supported by the Health Resources and Services Administration. No cost sharing applies to this preventive care from a Hopkins Preferred or EHP Network Provider.
- ◆ X-ray, radium, and radioisotope treatment.

# ***COVERED SERVICES AND SUPPLIES***

---

## ***Emergency Services***

In an **emergency medical situation**, you should go to the nearest medical facility for immediate care.

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

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

## **Emergency Room**

Treatment by an emergency room (hospital or freestanding) for an emergency medical situation is covered under the Hopkins Preferred provider benefit regardless of whether or not the emergency room is a Hopkins Preferred provider or participates in the EHP Network. Emergency room facility charges are covered in full, after the deductible and a \$250 copay. The copay is waived if you are admitted. If you go to an Out-of-Network emergency room, the EHP Medical Plan will not pay more than the Allowed Benefit for your treatment.

If you are being treated at an Out-of-Network emergency room and your condition stabilizes so that it is no longer an emergency medical situation, and if you can be moved to an EHP Network facility and you choose not to be moved, then services and supplies provided after you can be moved will be paid under the Out-of-Network benefit at 70% of the Allowed Benefit, after the deductible.

If you receive treatment in an emergency room for a condition that is not an emergency medical situation, the EHP Medical Plan will not pay benefits. You must still pay the \$250 copay.

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

## **Urgent Care Center**

An urgent care center is a facility (other than a hospital emergency room) that is licensed to provide medical services for unexpected illnesses or injuries that require prompt medical attention, but are not life- or limb-threatening. If you need prompt medical attention, you may go to an urgent care center.

## ***COVERED SERVICES AND SUPPLIES***

---

If you go to an EHP Network urgent care center, your care will be covered at 100% with no deductible, after a \$25 copay.

If you go to an Out-of-Network urgent care center, your care will be covered at 70% of the Allowed Benefit, after the deductible. You are responsible for any amounts over the Allowed Benefit.

### ***Out-Of-Area Care and Coverage for Students***

The following **Out-of-Area Care** rules apply when you are travelling outside the EHP Network service area and need medical care that is not covered by the ***Emergency Services*** provisions described above. The following **Out-of-Area Care** rules apply based on whether care is foreseeable or unforeseeable. ***Unforeseeable*** care means medical treatment or prescription drugs received before it is safe to return to the EHP Network service area and that could not have reasonably been anticipated before leaving the area. ***Foreseeable*** care means all other medical treatment or prescription drugs.

Claims for ***unforeseeable*** medical care or prescription drugs received while outside the EHP Network service area will be paid on the same terms as apply to care received from an EHP Network provider. However, benefits are calculated based only on the Allowed Benefit for the care received. In addition to any copay or coinsurance that might apply, you are responsible for all charges above the Allowed Benefit. Remember that a MultiPlan provider is an in-network provider and therefore will not charge you above the Allowed Benefit.

Claims for ***foreseeable*** out-of-area medical care from a MultiPlan provider will be paid under the EHP Network benefit. Claims for ***foreseeable*** out-of-area medical care from a non-MultiPlan provider or for prescription drugs will be covered at the Out-of-Network benefit level. This means that no coverage is provided for ***foreseeable*** prescription drugs that are obtained from a non-network pharmacy.

If your covered child goes to school outside the EHP Network service area, care received for medical treatment or prescription drugs is covered under the **Out-of-Area Care** rules.

***You (or someone on your behalf) must notify Johns Hopkins EHP at 410-424-4450 or 800-261-2393 of any Out-of-Area Care that results in an inpatient hospitalization within 48 hours after admission. If notice is not given on time, coverage may be denied.***

### ***Ambulance Services***

The EHP Medical Plan covers both air and ground ambulance transportation services when one of the following criteria are met:

## ***COVERED SERVICES AND SUPPLIES***

---

- ◆ Because of an accident or emergency medical situation, it is medically necessary to transport you to the hospital.
- ◆ It is medically necessary to transport you from a hospital as an inpatient to another hospital, because:
  - The first hospital lacks the equipment or expertise necessary to care for you;
  - You are transported directly from a hospital to a skilled nursing/rehabilitation facility; or
  - As determined medically appropriate by the Care Management Program.
- ◆ You are medically stable and wish to transfer from a facility that is not a Hopkins Preferred provider to a facility that is a Hopkins Preferred provider.

Air ambulance is covered only if it is medically necessary to be transported by air and not by ground. It is not medically necessary to be transported by air if a facility that can provide the necessary medical care can be safely accessed by ground transportation. In no event will the Plan pay more than the Allowed Benefit for air ambulance transportation.

### ***Vision Benefits***

The EHP Medical Plan covers a full range of optometry and ophthalmology vision care services through the Johns Hopkins Routine Vision Care Network. The Plan also covers vision care services from Out-of-Network providers. You can receive Johns Hopkins Routine Vision Care Network services at any of these provider sites: Wilmer Comprehensive Eye Care Services (located at The Wilmer Eye Institute at The Johns Hopkins Hospital), Green Spring Station, Severna Park, and the Bayview Medical Center. You can also receive Network optometry services at Pearle Vision Centers and other locations throughout the Baltimore Metropolitan area. For a complete listing of Network provider sites, refer to the Vision section of the EHP provider search, available on [www.ehp.org](http://www.ehp.org), or contact EHP Customer Service at 410-424-4450.

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

<b><i>Covered Vision Services</i></b>	<b><i>Johns Hopkins Routine Vision Care Network</i></b>	<b><i>Out-of-Network</i></b>
Routine exam or contact lens fitting fee (once every 12 months)	100%, after \$10 copay	Up to \$35
Materials (once every 12 months):	\$10 copay, then:	
Single Vision	Up to \$75	Up to \$70
Bifocal	Up to \$92	Up to \$80
Trifocal	Up to \$117	Up to \$110

## ***COVERED SERVICES AND SUPPLIES***

---

Lenticular	Up to \$176	Up to \$160
Frames	Up to \$70	Up to \$70
Contact Lenses		
Medically Necessary	Up to \$165	Up to \$165
Elective	Up to \$95	Up to \$95

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

Charges for the following are not covered under the EHP Medical Plan:

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

### ***Maternity Benefits***

The EHP Medical Plan provides benefits during your pregnancy and delivery.

The Plan covers 90% of your prenatal care and routine tests when care is provided by a Hopkins Preferred OB/GYN, after you meet the deductible. The Plan covers 80% of your prenatal care and

## ***COVERED SERVICES AND SUPPLIES***

---

routine tests when care is provided by an EHP Network OB/GYN after you meet the deductible. Midwife delivery services provided by a licensed midwife are also eligible for coverage.

Delivery at an EHP Network licensed birthing center is covered at 90% after the deductible. For delivery at a Hopkins Preferred hospital, the copay is \$150 and the Plan pays 90% of covered charges after the deductible. For delivery at an EHP Network hospital, the copay is \$150 and the Plan pays 80% of covered charges after the deductible.

Care received from an Out-of-Network OB/GYN and Out-of-Network hospital or birthing center expenses are covered at 70% of the Allowed Benefit, after the deductible, and you are responsible for any remaining charges. You must pay a \$500 copay for a hospital admission. Midwife delivery services provided by a licensed midwife are also eligible for coverage.

The EHP Medical Plan provides maternity benefits for a mother and newborn child for hospital stays up to:

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

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

### ***Infertility Treatment***

Infertility treatment (such as artificial insemination (AI) and in-vitro fertilization (IVF)) is available for female employees and covered female spouses. The following requirements must be met:

#### ***In all cases:***

- You (the employee) must have one continuous year of coverage by the EHP Medical Plan before treatment begins;
- Care Management Program must preauthorize treatment, and there must be a physician recommended treatment plan;
- Treatment must be provided at the Johns Hopkins Fertility Center. This requirement is waived for IVF services if the Fertility Center does not have the necessary facilities to provide IVF services for the patient in question. In that event, treatment must be provided at an EHP Network provider approved by the Care Management Program. Otherwise, treatment received anywhere other than at the Johns Hopkins Fertility Center is not covered, even if the provider is in-network;



## ***COVERED SERVICES AND SUPPLIES***

---

- The order of infertility treatment options must have followed a logical succession of medically appropriate and cost-effective care;
- You must first pay a separate \$1,000 lifetime deductible for infertility treatment; after the deductible, charges are covered at 90% and you pay the remaining 10%;
- There is a \$30,000 lifetime maximum benefit for all infertility treatment combined including prescription drugs, lab work and X-rays; this maximum applies per employee, not per spouse;
  - No lifetime maximum applies to charges for infertility testing, infertility counseling, and up to six attempts per live birth for artificial insemination and intrauterine insemination. However, these charges do count against the lifetime maximum for all other infertility treatment;
- There is a maximum of three IVF attempts (any implantation of oocyte). This maximum applies per birth mother's lifetime. However, if a female employee with individual coverage subsequently becomes covered under the coverage of another employee (husband and wife or family), any attempts during the employee's individual coverage do not count against the three attempt limit under the subsequent coverage of the other employee;
- All expenses connected with obtaining donor sperm or donor eggs are not covered;
  - Expenses for acquisition, freezing, storing or thawing of sperm, eggs or embryos, whether or not from a donor, are not covered; coverage is provided for implantation only;
- Infertility must not be related to a previous sterilization by you or your spouse; and
- No coverage is provided for surrogate motherhood purposes.

### ***For married opposite sex couples:***

- The husband's sperm and the wife's egg must be used, unless there is a documented medical condition unrelated to age whereby use of the husband's sperm and/or the wife's egg is not possible;
- The mother must be covered by the Plan for one continuous year before treatment begins; and
- Medications required to be taken by the husband are covered if the husband is covered by the Plan.

### ***For single females:***

- Your egg must be used, unless there is a documented medical condition unrelated to age whereby use of your egg is not possible.

### ***For married female same sex couples:***

- If your spouse will be the birth mother, she must be covered by the Plan for one continuous year before treatment begins; and
- The birth mother's egg must be used, unless there is a documented medical condition unrelated to age whereby use of the birth mother's egg is not possible.

## ***COVERED SERVICES AND SUPPLIES***

---

### ***Medical and Modified Foods***

The EHP Medical Plan covers medical foods and low protein modified food products for the treatment of inherited metabolic diseases if the foods or products are prescribed as medically necessary for the therapeutic treatment of inherited metabolic diseases and administered under the direction of a physician. For this purpose:

- an "inherited metabolic disease" must be caused by an inherited abnormality of body chemistry, and includes a disease for which the State of Maryland screens newborn babies.
- a "low protein modified food product" must be specially formulated to have less than 1 gram of protein per serving and intended to be used under the direction of a physician for the dietary treatment of an inherited metabolic disease, and does not include a natural food that is naturally low in protein.
- a "medical food" must be intended for the dietary treatment of a disease or condition for which nutritional requirements are established by medical evaluation and formulated to be consumed or administered enterally under the direction of a physician.

The EHP Medical Plan covers amino acid-based elemental formula, regardless of delivery method, if the patient's physician states in writing that the formula is medically necessary for the treatment of one of the following diseases or disorders:

- Immunoglobulin E and non-Immunoglobulin E mediated allergies to multiple food proteins;
- severe food protein induced enterocolitis syndrome;
- eosinophilic disorders, as evidenced by the results of a biopsy; or
- impaired absorption of nutrients caused by disorders affecting the absorptive surface, functional length, and motility of the gastrointestinal tract.

### ***Obesity Treatment***

The EHP Medical Plan covers the following services for treatment of obesity:

- Non-surgical treatment for employees only, as part of the Johns Hopkins Weight Management Program. Your employer pays 50% of the charges for your participation in the Program. The other 50% is charged to you and covered by the Plan as follows. You must first pay a \$300 annual deductible. After that, the Plan covers 70% of the amount charged to you and you pay the remaining 30%. The maximum benefit payment by the Plan per calendar year is \$1,000.
- Surgical treatment for morbid obesity when Body Mass Index (BMI) (weight in kilograms/height in meters squared) is greater than 40, or equal to or greater than 35 with a co-morbid medical condition, including hypertension, a cardiopulmonary condition, sleep apnea,

## ***COVERED SERVICES AND SUPPLIES***

---

or diabetes. Care Management preauthorization is required and all services must be provided at Johns Hopkins Bayview Medical Center or Sibley Memorial Hospital.

- Surgical treatment for overhanging, stretching or laxity of skin, but only if medically necessary as a result of surgical or non-surgical treatment for morbid obesity. Limited to a lifetime benefit maximum of \$5,000 (Care Management preauthorization required).

### ***Women's Health and Cancer Rights Act***

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

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

The manner of coverage is determined in consultation with the attending physician and patient. 3-D nipple tattooing of a reconstructed breast is also covered, but only if the tattoo artist is recommended by the provider of the reconstructive surgery, and possesses a license to provide tattoos if a license is required. Normal plan copays, coinsurance and lifetime maximums will apply.

### ***Gender Reassignment***

The EHP Medical Plan covers gender reassignment treatment for members as follows.

Coverage is provided only for members who have a diagnosis of gender dysphoria in accordance with the Johns Hopkins HealthCare Medical Policy for Gender Reassignment Procedures. Gender reassignment therapy (including hormone therapy and psychotherapy) and surgical procedures (and complications therefrom) are covered only to the extent the member meets the criteria for a determination that the therapy or procedure is medically necessary as set forth in the Policy. Procedures that are determined to be cosmetic and not medically necessary under the Policy are not covered.

Benefits are determined in accordance with the otherwise applicable provisions of the EHP Medical Plan as set forth in this SPD, based on the nature of the treatment provided. Except as described above, treatment of transsexualism, gender dysphoria, or sex or gender reassignment or affirmation is not covered by the Plan.

### ***Physical, Occupational and Speech Therapy***

## ***COVERED SERVICES AND SUPPLIES***

---

***Care Management*** preauthorization is required except for the first 12 physical and occupational therapy visits per calendar year.

The EHP Medical Plan covers physical, occupational and speech therapy provided by a licensed physical, occupational or speech therapist, that is required because of an illness or accidental injury.

Physical, occupational and speech therapy is also covered if required for the treatment of a person under age 19 with a congenital or genetic birth defect in order to enhance the person's ability to function. Congenital or genetic birth defect means a defect existing at or from birth, including a hereditary defect, and includes autism or an autism spectrum disorder, cerebral palsy, intellectual disability, Down syndrome, spina bifida, hydroencephalocele, and congenital or genetic developmental disabilities. Unless caused by a congenital or genetic birth defect, treatment of stuttering, articulation disorders, tongue thrust, lisping and occupational, physical and speech maintenance therapy are not covered.

### ***Home Health Care***

*All home health care services must be preauthorized by **Care Management**.*

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

Home health care services and supplies must be provided by a licensed health care organization to be covered. No benefits are paid for services performed by a close relative or anyone living in your household. Each home health care visit is limited to four hours. Up to 40 home health care visits per calendar year are covered.

The Plan pays 90% of the charges for covered home health care services received from Hopkins Preferred or EHP Network providers, after the deductible. The Plan pays 80% of covered charges, after the deductible, for home infusion therapy provided by an EHP Network provider. If the provider is a member of the Johns Hopkins Home Care Group, the Plan pays 90% of covered charges for home infusion therapy, after the deductible.

The Plan pays 70% of the Allowed Benefit, after the deductible, for covered services (including home infusion therapy) received from Out-of-Network providers and you are responsible for any remaining charges.

Covered home health care services include:

- ◆ Part-time or intermittent skilled nursing care by a nurse;

## ***COVERED SERVICES AND SUPPLIES***

---

- ◆ Part-time or intermittent home health aide services for a patient who is receiving covered nursing or therapy services;
- ◆ Physical, respiratory, occupational and speech therapy when provided by a home health care agency;
- ◆ Medical and surgical supplies when provided by a home health care agency (excluding non-injectable prescription drugs);
- ◆ Injectable prescription drugs (subject to copay as described under **Prescription Drug Benefits**);
- ◆ Oxygen and its administration; and
- ◆ Medical and social service consultations.

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

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

### ***Skilled Nursing/Rehabilitation Facility Care***

*Your stay in a skilled nursing/rehabilitation facility must be preauthorized by **Care Management**.*

A skilled nursing/rehabilitation facility is a special facility that offers 24-hour nursing care outside of a traditional hospital setting. Your stay in a skilled nursing/rehabilitation facility must be for treatment of the same or related condition for which you were hospitalized. The Plan covers up to 120 days per calendar year in a skilled nursing/rehabilitation facility.

The Plan pays 90% of the charges, after the deductible, for stays in a Hopkins Preferred skilled nursing/rehabilitation facility. The Plan pays 90% of the charges, after the deductible, for the first 30 days per calendar year in an EHP Network skilled nursing/rehabilitation facility, and 80% of the charges after the first 30 days.

The Plan pays 70% of the Allowed Benefit, after the deductible, for stays in an Out-of-Network skilled nursing/rehabilitation services facility and you are responsible for any remaining charges.

Covered skilled nursing/rehabilitation facility services include:

## ***COVERED SERVICES AND SUPPLIES***

---

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

The patient's physician must prescribe care in a skilled nursing/rehabilitation facility and the patient must be under a physician's supervision throughout the stay. Charges will not be covered for more than 120 days per calendar year.

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

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

### ***Hospice Care***

*Hospice care must be preauthorized by Care Management.*

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

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

The Plan pays 90% of the charges for covered hospice care services from Hopkins Preferred and EHP Network providers, after the deductible.

The Plan pays 70% of the Allowed Benefit, after the deductible, for covered hospice care services from Out-of-Network providers and you are responsible for any remaining charges.

Covered hospice care services include:

## ***COVERED SERVICES AND SUPPLIES***

---

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

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

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

### ***Transplants***

*All transplants must be preauthorized by **Care Management**. Procurement of the organ and performance of the transplant must take place at a Johns Hopkins Employer Health Programs designated transplant center in the United States.*

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

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

No benefits will be paid for the following:

- ◆ Organ transplant charges incurred without preauthorization by the Care Management Program, or at a transplant center which was not designated by Johns Hopkins Employer Health Programs;
- ◆ The transplant of an organ which is synthetic, artificial, or obtained from other than a human body;
- ◆ An organ transplant or organ procurement performed outside the United States;

## ***COVERED SERVICES AND SUPPLIES***

---

- ◆ An organ transplant which the Plan Administrator determines to be experimental; and
- ◆ Expenses of an organ donor, except when the recipient is a participant in this Plan who receives the organ in a covered organ transplant. When coordinating with the donor's health plan, the EHP Medical Plan will be secondary. If an organ is sold (i.e., not donated), no benefits are paid for the donor's expenses.

### **Mental Health and Substance Abuse Treatment**

The Johns Hopkins EHP Medical Plan provides benefits for inpatient and outpatient mental health and substance/alcohol abuse treatment on the same terms that apply to other inpatient or outpatient medical treatment. Mental health and substance/alcohol abuse treatment is subject to the same copay, coinsurance, deductibles, limits and other requirements that apply to medical treatment, based on whether you receive treatment from Hopkins Preferred, EHP Network or Out-of-Network providers.

Like any other medical treatment, mental health and substance/alcohol abuse treatment is only covered if it is *medically necessary* (see the definition at the beginning of the **Covered Services and Supplies** section).

Like any other medical treatment, the Care Management Program must preauthorize any inpatient admission (including inpatient residential, "partial hospitalization" day treatment programs and intensive outpatient care).

Outpatient mental health and substance/alcohol abuse treatment does not have to be preauthorized by the Care Management Program. However, if you have your treatment preauthorized by the Care Management Program, you can be assured that your treatment will be considered medically necessary and therefore covered. The Care Management Program has mental health professionals who will help you determine the best course of treatment for you. Your Program manager will refer you to a provider (usually a Hopkins Preferred or EHP Network provider). If you wish, you may instead refer yourself to any provider in or out of the EHP Network. The choice is yours. However, if you refer yourself to a provider your treatment will only be covered if it is determined to be medically necessary.

You can contact the Care Management Program at 410-424-4476 or 800-261-2429.

### **Hopkins Preferred and EHP Network Providers**

Hopkins Preferred and EHP Network providers include a variety of specialists to meet your needs, including psychiatrists, psychologists and licensed certified social workers. All Hopkins Preferred and EHP Network providers are experienced, licensed professionals. They share the philosophy of quality care provided in the least restrictive manner. Mental health and substance/alcohol abuse providers offer a full range of counseling services, including individual and group therapy, family counseling and addiction recovery programs.



## ***COVERED SERVICES AND SUPPLIES***

---

**Note:** You must receive preauthorization by Care Management before all inpatient admissions (including inpatient residential, partial hospitalization day treatment programs and intensive outpatient care) for mental health and substance/alcohol abuse treatment. The confidential number to call is 410-424-4476 or 800-261-2429. Failure to obtain preauthorization will result in denial of coverage.

### **Prescription Drug Benefits**

The EHP Medical Plan covers prescription drugs designated as such under federal law, as well as injectable insulin, diabetic supplies (needles and syringes when prescribed with insulin only), and other medicines and supplies designated by Johns Hopkins Employer Health Programs.

### **EHP Network Pharmacies**

You **must** obtain prescription drugs from an EHP Network pharmacy to receive benefits under the EHP Medical Plan. Your Johns Hopkins EHP provider search at [www.ehp.org](http://www.ehp.org) has a complete list of Network pharmacies. *No benefits are provided if drugs are purchased from an Out-of-Network pharmacy.*

An EHP Network pharmacy has an arrangement to provide prescription drugs to you at an agreed upon price. When you buy covered drugs from an EHP Network pharmacy, present your EHP Medical Plan identification card to the pharmacist. You should request and retain a paid receipt for your copay amount if you need it for income tax purposes.

*Please note: As explained below, your physician may need to obtain prior authorization before certain drugs may be dispensed.*

### **Copay**

You pay a \$10 copay for each separate prescription or refill of up to a 30-day supply of a generic drug. No copay applies for contraceptives that are required to be covered without cost-sharing under comprehensive guidelines supported by the Health Resources and Services Administration. Normally, no copay only applies to generic contraceptives. However, if your provider determines that a brand name contraceptive is medically necessary, no copay will apply to that contraceptive.

Otherwise, the copay for up to a 30-day supply is \$40 for brand name preferred drugs and \$65 for brand name non-preferred drugs. The copay is \$65 for brand name drugs if a generic version is available. You must also pay the difference in cost between the generic and the brand name drug. (In no event would you have to pay more than the full cost of the brand name drug itself.)

If a brand name drug has a generic equivalent, but the brand name drug is prescribed by your provider

## ***COVERED SERVICES AND SUPPLIES***

---

as medically necessary, you can request a prior authorization for the drug. If the prior authorization is approved, you must pay the \$65 copay, but do not have to pay the difference in cost between the generic and the brand name drug.

The copay for specialty medications is \$10 for generic drugs, \$40 for brand name preferred drugs and \$65 for brand name non-preferred drugs. Specialty medications are only covered at an in-network pharmacy and only for up to a 30-day supply.

For maintenance drugs (excluding specialty medications), you may obtain a 90-day supply at an in-network retail pharmacy for three times the normal monthly copay for that prescription. Or, you may use the EHP Medical Plan's Mail Order program, presently offered through CVS Caremark. Through this program, you can obtain a 90-day supply of maintenance drugs each time you order for only two times the normal monthly copay. Your copay through the Mail Order program is \$20 for each separate prescription or refill of a generic drug. The Mail Order copay is \$80 for brand name preferred drugs and \$130 for brand name non-preferred drugs. The copay is \$130 for brand name drugs if a generic version is available. You must also pay the difference in cost between the generic and the brand name drug. (In no event would you have to pay more than the full cost of the brand name drug itself.)

If a brand name drug has a generic equivalent, but the brand name drug is prescribed by your provider as medically necessary, you can request a prior authorization for the drug. If the prior authorization is approved, you must pay the \$130 Mail Order copay, but do not have to pay the difference in cost between the generic and the brand name drug.

If you have any questions about the Mail Order program, call EHP.

Annual copays are subject to the Prescription Drug out-of-pocket maximum shown in the **Medical Benefits-At-A-Glance** chart earlier in this SPD.

### **Prior Authorization, Quantity Limits and Step Therapy**

The EHP Medical Plan has a Prior Authorization program, a Quantity Limits (Managed Drugs Limitation) program and a Step Therapy program for certain drugs. Some drugs require prior authorization before coverage is approved, to assure medical necessity, clinical appropriateness and/or cost effectiveness. Coverage of these drugs is subject to specific criteria approved by physicians and pharmacists on the Pharmacy and Therapeutics Committee. Certain drugs have specific dispensing limitations for quantity and maximum dose. Other drugs have Step Therapy requirements, which means they are not covered until you have first tried other drugs to treat the condition.

You can find out if a drug is subject to Prior Authorization, Quantity Limits and Step Therapy by going to the EHP website at [www.ehp.org](http://www.ehp.org). Go to "Plan Benefits", then "Pharmacy", then your

## ***COVERED SERVICES AND SUPPLIES***

---

employer's name, then "Prior Authorization" and follow the instructions. Call EHP customer service at 410-424-4450 if you need assistance.

If your physician determines that use of a drug that requires Prior Authorization is necessary, your physician must complete a Pharmacy Prior Authorization Form (available on the EHP website at the link to Forms) and fax it to EHP at the number shown on the Form. If your physician determines that dosage of a drug in a greater quantity than is allowed under the Quantity Limits program is needed, or that a drug subject to Step Therapy should be covered instead of other drugs to treat the condition, your physician can submit a request by also using the Pharmacy Prior Authorization Form. EHP will notify you and your physician of approval or denial of the request. If the request is denied, you may appeal the denial to the EHP Appeals Department in accordance with the appeal rules for pre-service claims set forth below in this SPD.

### **Caremark Formulary Drugs**

CVS Caremark manages the EHP Medical Plan's prescription drug benefit, and maintains the prescription drug Advanced Control Formulary, which can be accessed on the EHP website. The Formulary lists those prescription drugs that are regularly covered by the EHP Medical Plan.

If a drug is not listed on the Formulary, you must pay the full cost for the drug unless Caremark issues a prior authorization for medical necessity for the drug. Caremark will only do so if your physician can demonstrate that it is medically necessary for you to take the non-Formulary drug instead of the other optional drugs that are listed on the Formulary. To request prior authorization for medical necessity for a non-Formulary drug, your physician must complete the CVS Caremark electronic prior authorization process or call CVS Caremark. The link for the electronic process and the phone number are available on the Johns Hopkins HealthCare provider website. If Caremark grants your request for prior authorization for a non-Formulary drug, you must pay the copay that applies to brand name non-preferred drugs. If Caremark denies your request for prior authorization for a non-Formulary drug, you can make a First Level Appeal to Caremark in accordance with the directions included on the denial letter. If Caremark denies your First Level Appeal, you may make a Final Appeal to the Plan Administrator in accordance with the appeal rules for pre-service claims set forth below in this SPD (which will also be described in the First Level Appeal denial letter).

### **What's Not Covered**

No prescription drug benefits will be paid for the following:

- ◆ Any amounts you are required to pay directly to the pharmacy for each prescription or refill
- ◆ Any charge for administration of drugs or insulin
- ◆ Smoking cessation drugs that are not prescribed by a physician
- ◆ Drugs that are excluded from coverage for a reason set forth later in this SPD under **What's Not**

## ***COVERED SERVICES AND SUPPLIES***

---

### **Covered by the EHP Medical Plan**

- ◆ Methadone
- ◆ Schedule V-exempt narcotics
- ◆ Hypodermic needles and syringes (other than for diabetic use and for self-administered injections)
- ◆ Drugs that are non-prescription, non-legend or over-the-counter (except for certain prescribed OTC drugs as explained below, or as required to be covered for preventive care)
- ◆ Drugs or devices not approved by the FDA for marketing and/or for the prescribed treatment of a specific diagnosis unless approved by the Care Management Program. This exclusion does not apply to a medical device to the extent Medicare would cover the device in accordance with Medicare Policy Manual Chapter 14
- ◆ Drugs to treat cosmetic conditions resulting from normal aging process
- ◆ Drugs whose sole use is treatment of hair loss, hair thinning or related conditions
- ◆ Drugs dispensed in excess of the amounts prescribed or refills of any prescription in excess of the number of refills specified by the prescriber or allowed by law
- ◆ Replacement of drugs that are lost or stolen
- ◆ Drugs dispensed for any illness or injury covered by any workers compensation or occupational disability law
- ◆ Immunization agents, biological sera, blood or blood plasma (however, Flu, Pneumonia and Shingles vaccines are covered at network pharmacies)
- ◆ Drugs taken by or administered to the member while a patient in a hospital, sanitarium, extended care facility, nursing home, or similar institution that has on its premises a facility for dispensing pharmaceuticals
- ◆ Drug delivery implants or devices
- ◆ Herbal, mineral and nutritional supplements

### **Over-the-Counter Drugs**

Prescription drug benefits are normally not provided for drugs that are available “over-the-counter” (OTC). A drug is considered to be available OTC if it can be obtained without a prescription, regardless of whether or not your doctor gives you a prescription for it. However, prescription drug benefits are provided for the following generic OTC drugs, but only if your doctor prescribes these drugs and you show the pharmacist your prescription at time of purchase.

- Generic non-sedating antihistamines such as OTC Loratadine and Loratadine D (generic equivalents of Claritin/Claritin D), OTC Fexofenadine/Fexofenadine D (generic equivalents of Allegra/Allegra D) and OTC Cetirizine/Cetirizine D (generic equivalents of Zyrtec/Zyrtec D) – no copay
- Generic proton pump inhibitors such as OTC Omeprazole (generic equivalent of Prilosec), OTC Esomeprazole (generic equivalent of Nexium), OTC Lansoprazole (generic equivalent of

## ***COVERED SERVICES AND SUPPLIES***

---

Prevacid), and OTC Omeprazole/Sodium Bicarbonate (generic equivalent of Zegerid) – \$10 copay per 30-day supply

### **Preventive Care Drugs**

Prescription drug benefits also cover prescribed OTC drugs that are included in the United States Preventive Services Task Force preventive care recommendations with a rating of A or B.

## ***WHAT'S NOT COVERED***

---

### **What's Not Covered by The EHP Medical Plan**

The Johns Hopkins EHP Medical Plan does not cover the following:

- ◆ Charges excluded under the **Coordination of Benefits** provisions set forth later in this SPD
- ◆ Charges that would not be made if no coverage by the Plan existed
- ◆ Charges for which you are not legally required to pay
- ◆ Charges in excess of the Allowed Benefit or above the allowable lifetime or annual maximums
- ◆ Charges denied by another plan as a penalty for non-compliance with that plan's requirements
- ◆ Charges for the completion of claim forms
- ◆ Claims filed more than 12 months after the expenses were incurred
- ◆ Contraceptive devices, unless required to be covered in comprehensive guidelines supported by the Health Resources and Services Administration and approved by the Food and Drug Administration
- ◆ Controlled substances, hallucinogens or narcotics not administered on the advice of a doctor
- ◆ Convenience items, such as telephone and television rental, slippers, meals for family members, or first aid kits and supplies
- ◆ Copying charges
- ◆ Cosmetic/reconstructive surgery. However, cosmetic/reconstructive surgery is covered if needed:
  - because of an accidental injury or illness that is or would be covered by the Plan
  - because of a congenital malformation of a child
  - following treatment for morbid obesity, as described earlier in this SPD under ***Obesity Treatment***; or
  - as provided for under ***Women's Health and Cancer Rights Act*** earlier in this SPD
- ◆ Custodial care, residential care or rest cures
- ◆ Dental treatment except in connection with an accidental injury to sound natural teeth that is part of the initial emergency treatment within 48 hours after the accident

## ***WHAT'S NOT COVERED***

---

- ◆ Drugs or devices not approved by the FDA for marketing and/or for the prescribed treatment of a specific diagnosis unless approved by the Care Management Program. This exclusion does not apply to a medical device to the extent Medicare would cover the device in accordance with Medicare Policy Manual Chapter 14
- ◆ Emergency room services in other than emergency medical situations
- ◆ Equipment that does not meet the definition of Durable Medical Equipment provided earlier in this SPD under **Covered Services and Supplies**, including air conditioners, humidifiers, dehumidifiers, purifiers or physical fitness equipment, whether or not recommended by a doctor
- ◆ Experimental treatment, defined as the use of any treatment, procedure, equipment, device, drug or drug usage which the Plan Administrator determines, in its sole and absolute discretion, is being studied for safety, efficiency and effectiveness and/or which has not received or is awaiting endorsement for general use within the medical community by government oversight agencies, or other appropriate medical specialty societies at the time services are rendered.

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

- If the drug or device cannot be lawfully marketed without approval of the U.S. Food and Drug Administration and approval for marketing has not been given at the time the drug or device is furnished; this principle does not apply to a medical device to the extent Medicare would cover the device in accordance with Medicare Policy Manual Chapter 14.
- If the drug, device, equipment, treatment or procedure, or the patient informed consent document utilized with the drug, device, equipment, treatment or procedure, was reviewed and approved by the treating facility's Institutional Review Board or other body serving a similar function, or if Federal law requires such review or approval.
- If Reliable Evidence shows that the drug, device, equipment, treatment or procedure is the subject of ongoing phase II clinical trials, is the subject of research, experimental study or the investigational arm of ongoing phase III clinical trials, or is otherwise under study to determine its maximum tolerated dose, its toxicity, its safety, its efficacy or its efficacy as compared with a standard means of treatment or diagnosis. A treatment, procedure, equipment, device, drug or drug usage will generally not be considered experimental merely because it is the subject of a clinical trial, to the extent Medicare would cover it in accordance with a national coverage determination (or other binding pronouncement).
- If Reliable Evidence shows that the prevailing opinion among experts regarding the drug, device, equipment, treatment or procedure is that further studies or clinical trials are necessary to determine its maximum tolerated dose, its toxicity, its safety, its efficacy or its efficacy as compared with a standard means of treatment or diagnosis.

## ***WHAT'S NOT COVERED***

---

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

Notwithstanding the exclusion of coverage for experimental treatment, but only to the extent necessary to comply with Public Health Service Act Section 2709, coverage is not excluded for, nor are limits or additional conditions imposed on coverage of, routine patient costs for treatment furnished in connection with participation by a qualified individual in an approved clinical trial.

- Routine patient costs include services and supplies otherwise covered by the Plan for a patient not enrolled in a clinical trial, but do not include (1) the investigational item, device or service itself, (2) services and supplies not used in the direct clinical management of the patient but which instead are provided solely to satisfy data collection and analysis needs, or (3) a service that is clearly inconsistent with widely accepted and established standards of care for the patient’s particular diagnosis.
  - A qualified individual is a patient who is otherwise covered by this Plan and who is eligible to participate in an approved clinical trial according to the trial protocol for the treatment of cancer or other life threatening disease or condition, and either (1) the referring health care professional is an EHP Network provider who has concluded that the patient’s participation in the clinical trial would be appropriate based upon meeting the conditions of the trial protocol, or (2) the patient provides medical and scientific information establishing that participation in the clinical trial would be appropriate based upon meeting the conditions of the trial protocol.
  - An approved clinical trial is a phase I, II, III or IV clinical trial that is conducted in relation to the prevention, detection or treatment of cancer or other life threatening disease or condition, and that (1) is approved or funded by the federal government, (2) is conducted under an investigational new drug application reviewed by the Food and Drug Administration, or (3) is a drug trial that is exempt from having such an investigational new drug application.
- 
- ◆ Foot devices, unless (1) they are an integral part of a leg brace and the cost is included in the orthotist’s charge; or (2) they are custom-molded and related to a specific medical diagnosis. Orthopedic shoes (not integral to a brace), diabetic shoes, supportive devices for the feet and orthotics used for sport and leisure activities are not covered.
  - ◆ Glasses, contact lenses, eye refractions, or the examinations for their fitting or prescription, except when medically necessary after cataract surgery or as described under ***Vision Benefits***, earlier in this SPD



## ***WHAT'S NOT COVERED***

---

- ◆ Habilitative services (except for therapy for a person under age 19 with a congenital or genetic birth defect as described under ***Physical, Occupational and Speech Therapy*** earlier in this SPD)
- ◆ Hearing aids, or the examination for their fitting or prescription (except for dependent children as described under **Covered Services and Supplies** earlier in this SPD)
- ◆ Hypnosis
- ◆ Immunizations related to travel unless approved by the Center for Disease Control guidelines for the countries to be visited
- ◆ Injury sustained or an illness contracted while committing a crime
- ◆ Injury sustained or an illness resulting from war, act of war, act of terrorism, riot, rebellion, civil disobedience, or from military service in any country
- ◆ Injury sustained while riding on a motorcycle, unless the covered person was wearing a helmet that meets applicable safety standards issued by the National Highway Traffic Safety Administration. This exclusion applies even when riding in a state that does not require wearing a helmet.
- ◆ Marital counseling
- ◆ Missed appointment charges
- ◆ Myopia or hyperopia correction by means of corneal microsurgery, such as keratomileusis, keratophakia, radial keratotomy or laser surgery and all related services
- ◆ Nicotine addiction treatment or smoking cessation programs, except as described under ***Tobacco Cessation and Tobacco Free Credit*** earlier in this SPD, or as covered by United States Preventive Services Task Force preventive care recommendations with a rating of A or B
- ◆ Obesity treatment, including surgical procedures for weight reduction or for treatment of conditions resulting from being overweight, except as described under ***Obesity Treatment*** earlier in this SPD
- ◆ Private duty nursing
- ◆ Private room charges beyond the amount normally charged for a semi-private room, unless a private room is medically necessary

## ***WHAT'S NOT COVERED***

---

- ◆ Replacement of braces or prosthetic devices, unless there is sufficient change in the patient's physical condition to make the original brace or device no longer functional
- ◆ Reversals of sterilization procedures, such as vasectomies and tubal ligations
- ◆ Routine foot care (including any service or supply related to corns, calluses, flat feet, fallen arches, non-surgical care of toenails, and other symptomatic complaints of the feet)
- ◆ Self-inflicted injury or illness and expenses resulting therefrom, unless the self-infliction was the result of a mental illness such that application of this exclusion would violate ERISA Section 702
- ◆ Services or supplies received before your (or your dependent's) effective date of coverage under the Plan or after the termination date of coverage
- ◆ Services and supplies paid in full or in part under any other plan of benefits provided by Intrastaff (or JHHSC/JHH), a school, or a government, or for services you are not required to pay for
- ◆ Services and supplies not recommended or approved by a doctor
- ◆ Services and supplies required as a condition of employment
- ◆ Services and supplies not specifically listed as covered in this SPD
- ◆ Services performed by a doctor or other professional provider enrolled in an education, research, or training program when such services are primarily provided for the purposes of the education, research, or training program
- ◆ Sexual dysfunction treatment not related to organic disease
- ◆ Support garments
- ◆ Surgical treatment for overhanging, stretching or laxity of skin, except as described under ***Obesity treatment*** earlier in this SPD
- ◆ Surrogate motherhood treatment, including any charges related to giving birth or for treatment of the newborn child resulting from the surrogate motherhood. This exclusion does not apply to charges for treatment of the newborn child if the child is a covered eligible dependent of the member.
- ◆ Telephone consultation charges, unless the consultation is medically necessary for treatment of a condition otherwise covered by the Plan

## ***WHAT'S NOT COVERED***

---

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

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

## ***SHORT TERM DISABILITY BENEFITS***

---

### **Johns Hopkins EHP Dental Plans**

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

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

If you have any questions about your benefits under the EHP Dental Plans, call Delta Dental Customer Service at 1-800-932-0783.

### **Out-of-pocket Expenses**

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

### **Maximum Benefits**

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

## ***SHORT TERM DISABILITY BENEFITS***

---

### **Dental Benefits At-A-Glance**

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

<b>Covered Services</b>	<b>Comprehensive Plan</b>		<b>High Plan</b>	
	<i>Delta Dental PPO dentists</i>	<i>Non-PPO dentists</i>	<i>Delta Dental PPO dentists</i>	<i>Non-PPO dentists</i>
Calendar year deductible (waived for Diagnostic and Preventive Services and Orthodontia)	None	\$50 per person \$150 per family	None	\$50 per person \$150 per family
Calendar year benefit maximum	\$1,500 combined per person per year		\$3,000 combined per person per year	
<b>Diagnostic and Preventive services</b>				
Exams (two per calendar year)	100%	80% of AB	100%	80% of AB
X-rays (once every 36 months)	100%	80% of AB	100%	80% of AB
Bitewing X-rays (once per calendar year)	100%	80% of AB	100%	80% of AB
Sealants for children under age 15	100%	80% of AB	100%	80% of AB
Topical fluoride treatment for children under age 18	100%	80% of AB	100%	80% of AB

NOTE: “AB” (“Allowed Benefit”) is the contracted fee charged by Delta Dental PPO dentists. Delta Dental determines what is the Allowed Benefit. A dentist in the Delta Dental Premier network will not charge you more than the Allowed Benefit. However, dentists that are neither Delta Dental PPO dentists nor Delta Dental Premier dentists can charge more than the Allowed Benefit and you will be responsible for the difference.

## ***SHORT TERM DISABILITY BENEFITS***

---

Covered Services	Comprehensive Plan		High Plan	
	<i>Delta Dental PPO dentists</i>	<i>Non-PPO dentists</i>	<i>Delta Dental PPO dentists</i>	<i>Non-PPO dentists</i>
<b>Basic services</b>				
Fillings	80%	60% of AB	80%	60% of AB
Endodontics	80%	60% of AB	80%	60% of AB
Oral surgery	80%	60% of AB	80%	60% of AB
Treatment of gum disease (Periodontics)	80%	60% of AB	80%	60% of AB
General anesthesia	80%	60% of AB	80%	60% of AB
<b>Major services*</b>				
Crowns, Inlays and Onlays	50%	30% of AB	60%	40% of AB
Bridges	50%	30% of AB	60%	40% of AB
Dentures and implants	50%	30% of AB	60%	40% of AB
Orthodontia	Not covered	Not covered	50%, up to lifetime max of \$1,500	50% of AB, up to lifetime max of \$1,500

NOTE: “AB” (“Allowed Benefit”) is the contracted fee charged by Delta Dental PPO dentists. Delta Dental determines what is the Allowed Benefit. A dentist in the Delta Dental Premier network will not charge you more than the Allowed Benefit. However, dentists that are neither Delta Dental PPO dentists nor Delta Dental Premier dentists can charge more than the Allowed Benefit and you will be responsible for the difference.

*\*Pre-treatment review is recommended for all major services. Bridges, dentures and implants are not covered until you have been covered under an EHP Dental Plan for 12 consecutive months.*

## ***SHORT TERM DISABILITY BENEFITS***

---

### **What the EHP Dental Plans Cover**

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

#### ***Diagnostic and Preventive Services***

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

#### ***Basic Services***

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

#### ***Major Services***

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

## ***SHORT TERM DISABILITY BENEFITS***

---

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

Note: Bridges, dentures and implants are not covered until you have been covered under an EHP Dental Plan for 12 consecutive months.

### ***Orthodontia***

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

### **Prosthesis Replacement Rule**

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

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

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

### **Pre-Treatment Review**

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



## ***SHORT TERM DISABILITY BENEFITS***

---

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

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

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

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

### **Use Delta Dental PPO Dentists and Save**

Your Johns Hopkins EHP Dental Plans offer you the choice to receive dental services from Delta Dental PPO dentists or from Non-PPO dentists. However, you can save money on your dental bills by using Delta Dental PPO dentists. That's because Delta Dental PPO dentists have agreed to charge reduced fees for their services, and both Plans pay a higher level of benefits for services received from Delta Dental PPO dentists. To find a Delta Dental PPO dentist go to [www.deltadentalins.com](http://www.deltadentalins.com) and look under Find a Dentist.

### **Alternate Treatment**

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

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

## ***SHORT TERM DISABILITY BENEFITS***

---

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

### **What The EHP Dental Plans Do Not Cover**

The EHP Dental Plans do not cover the following:

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

## ***SHORT TERM DISABILITY BENEFITS***

---

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

### **Election of No Dental Benefits**

The EHP Dental Plans are optional benefits and are not included as part of EHP Medical Plan coverage. No coverage by the Dental Plans is provided unless you properly elect coverage.

## ***ADMINISTRATIVE INFORMATION***

---

### **Administrative Information About Your Johns Hopkins EHP Benefits**

#### **Filing A Claim With Employer Health Programs**

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

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

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

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

Itemized bills must include the following information:

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

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

#### **What Happens When You Have Duplicate Coverage**

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

## ***ADMINISTRATIVE INFORMATION***

---

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

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

If the EHP Medical Plan is your Secondary Plan, only covered expenses up to the Plan's fee schedule may be covered. Any applicable copays, coinsurance or deductibles under the two plans still apply.

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

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

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

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

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

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

## ***ADMINISTRATIVE INFORMATION***

---

The EHP Medical Plan is the Primary Plan if you are covered under the Plan as an active employee and you are also covered by Medicare or Medicaid. Similarly, the EHP Medical Plan is the Primary Plan for your covered spouse if your spouse is covered by Medicare and if you are an active employee. The Medical Plan is the Primary Plan for your dependent children if they are covered by Medicaid or CHIP.

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

If you are covered under the EHP Medical Plan as a dependent child and you are also covered under your spouse's plan, your spouse's plan is the Primary Plan and the EHP Medical Plan is the Secondary Plan.

If none of the Coordination of Benefits rules in this section apply, then the plan that has covered the person in question for the longer period of time is the Primary Plan, and the plan that has covered the person for the shorter period of time is the Secondary Plan.

### **Coverage Under Other EHP Medical Plans**

Benefits provided by any prior version of the EHP Medical Plan before 2018, such as the Basic Plan, Premium Plan, 90/10 Plan or 80/20 Plan, are treated as benefits provided under this EHP Medical Plan when applying lifetime limits.

### **Employees Whose Worksite Is Outside The United States**

Employees whose worksite is outside the United States do not have coverage under the EHP Medical or Dental Plans. Instead, an insurance policy (currently issued by MetLife) provides the health and dental insurance coverages.

### **When the EHP Medical Plan May Recover Payment**

If you or your dependents have an injury, illness or other condition that is covered by the EHP Medical Plan and for which a third party might be liable, you must notify Johns Hopkins Employer Health Programs as soon as possible. You must comply with the EHP Medical Plan's Reimbursement and Subrogation rights set forth below as a condition of receiving benefits. Failure to comply is grounds for denial of your claim.

## ***ADMINISTRATIVE INFORMATION***

---

### **Reimbursement**

The EHP Medical Plan's reimbursement provisions apply when you or your dependents receive, or in the future may receive, any amounts by settlement, verdict or otherwise, including from an insurance carrier, for an injury, illness or other condition. We call these amounts a "Recovery". If you or your dependents have received a Recovery, the Plan will subtract the amount of the Recovery from the benefits it would otherwise pay for treatment of the injury, illness or other condition. If there is a possible future Recovery, the Plan may delay paying benefits until the Recovery is received, and then subtract the amount of the Recovery.

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

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

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

The Plan is only responsible for those legal costs to which it agrees in writing, and will not otherwise bear the legal costs of you and your dependents. If you take any action to prevent the Plan from enforcing its reimbursement rights, you will also be liable to reimburse the Plan for any legal expenses that the Plan or its agents incur in enforcing the Plan's reimbursement rights.

### **Subrogation**

The EHP Medical Plan's subrogation provisions apply when another party (including an insurance carrier) is or may be liable for your or your dependents' injury, illness or other condition, and the EHP Medical Plan has already paid benefits for treatment of the injury, illness or other condition.

## ***ADMINISTRATIVE INFORMATION***

---

The Plan is subrogated to all of your and your dependents' rights against any party (including an insurance carrier) that is or may be liable for your and your dependents' injury, illness or other condition or for paying for treatment of the injury, illness or other condition. The Plan is subrogated to the extent of the amount of the medical benefits it pays to or on behalf of you or your dependents. The Plan may assert its subrogation right independently of you and your dependents.

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

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

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



## ***ADMINISTRATIVE INFORMATION***

---

### **Benefits Paid by Mistake**

If the Plan pays benefits that you are not entitled to under the terms of the Plan, this is called a benefit paid by mistake. If the Plan pays a benefit by mistake, the Plan is entitled to recover the mistaken payment from the person it was paid to. If a mistaken payment is made to you, then you agree to hold the mistaken payment for the benefit of the Plan and to repay it to the Plan.

### **When Benefit Plan Coverage Ends**

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

- ◆ The end of the month in which you end your employment or are no longer an eligible employee. You will be considered an employee who is eligible for benefits so long as you are eligible under the terms of your employer's leave of absence policy, or so long as you are receiving short term disability benefits from your employer;
- ◆ The end of the month preceding the effective date of your waiver of coverage under the plan;
- ◆ The end of the month for which you last make the required contributions for coverage;
- ◆ The date the plan is discontinued;
- ◆ The date on which you report for active duty as a full-time member of the armed forces of any country.

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

- ◆ The date your coverage ends;
- ◆ The end of the month in which he/she no longer qualifies as an eligible dependent;
- ◆ The end of the month preceding the effective date of your election to drop dependent coverage;
- ◆ The end of the month for which you last make the required contribution for dependent coverage; or
- ◆ The date on which your dependent enters military service.

For certain of the above events, you or your dependents may be able to continue coverage by self-payment under COBRA, as explained next. If you take an unpaid medical leave of absence from your employment (including a leave covered by the Family and Medical Leave Act (FMLA)), you must continue making your required contributions for benefit plan coverage to remain in effect. If you do not make your required contributions, your benefit plan coverage will end at the end of the month preceding the date you stop making the required contributions. If your leave is covered under FMLA, you may be allowed to resume coverage upon your return from leave. Leaves of absence are discussed in more detail below under **Benefit Coverage During FMLA and Other Leaves of Absence**.

## ***ADMINISTRATIVE INFORMATION***

---

### **COBRA Continuation Coverage**

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

#### ***Length of COBRA Coverage***

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

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

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

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

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

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

## ***ADMINISTRATIVE INFORMATION***

---

Please contact the Intrastaff Office if you have any questions about your eligibility.

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

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

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

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

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

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

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

The employer will notify the Intrastaff Office of one of the above events no later than 30 days after the date you lose regular coverage.

If one of the above events that allow COBRA coverage to be continued for 36 months occurs after an event that allows COBRA coverage to be continued for 18 months but before the 18 months has expired, then COBRA coverage (if initially elected) may be continued for up to 36 months, measured from the date regular coverage ends because of the first event. If another event occurs, you, your spouse or dependent child must notify the Intrastaff Office in writing within 60 days after the second event. If the Intrastaff Office is not notified in time, COBRA may not be continued past 18 months.

## ***ADMINISTRATIVE INFORMATION***

---

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

### ***Electing COBRA Coverage***

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

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

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

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

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

### ***When COBRA Coverage Ends***

The right to COBRA continuation coverage will end before the conclusion of the coverage periods set forth above, whichever applies, if:

- ◆ A covered individual becomes covered under another group medical plan after COBRA coverage is elected (unless a pre-existing condition limitation would prevent the individual from receiving benefits from the new plan for a particular illness or injury);
- ◆ A covered individual becomes covered by Medicare after COBRA coverage is elected;
- ◆ The premium is not received on a timely basis; or
- ◆ Intrastaff/JHHSC/JHH stops providing group medical coverage for all active employees.

## ***ADMINISTRATIVE INFORMATION***

---

### **Benefit Coverage During FMLA Leaves of Absence**

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

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

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

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

For more information about the Family and Medical Leave Act, please contact the Intrastaff Office.

### **When You Become Covered By Medicare**

When you reach age 65, you will be eligible for Medicare benefits. You may become eligible for Medicare benefits at an earlier date if you become permanently disabled. If you are still an active employee when you reach age 65 and become covered by Medicare, your EHP Medical Plan coverage will continue as your primary medical plan so long as you continue to elect EHP Medical Plan coverage.

Before your 65<sup>th</sup> birthday, you should get an explanation of Medicare benefits from the Social Security Administration. Make sure that you are actually enrolled for Medicare when you turn age 65.

## ***ADMINISTRATIVE INFORMATION***

---

Enrollment does not happen automatically – you must go to the Social Security Administration and apply in order to have Medicare coverage.

If you do not enroll in Medicare when first eligible, you may incur penalties and delays in obtaining Medicare coverage later. However, you may generally delay enrolling in Medicare without penalty as long as you remain covered by the EHP Medical Plan.

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

### **Medicare and End Stage Renal Disease**

If you have End Stage Renal Disease (ESRD) and need kidney dialysis treatment, you are generally eligible for Medicare starting with your fourth month of dialysis. You should enroll for Medicare Part A and Part B as soon as possible, regardless of your age. If you are eligible for EHP Medical Plan coverage as an active employee, the EHP Medical Plan will continue as your primary insurance for up to 30 months after your Medicare coverage can begin. Thereafter, the EHP Medical Plan will only pay as your secondary insurance to the benefits provided by Medicare Part A and Part B. If you fail to enroll for Medicare Part A or Part B, the EHP Medical Plan will still pay secondary to the benefits that would have been provided by Parts A and B as if you had enrolled. This could result in your having no coverage for the dialysis treatment until you enroll.

### **Non-Discrimination in Benefits**

In accordance with Section 1557 of the Affordable Care Act, the Plan will not deny or limit coverage of a claim or impose additional cost-sharing or other limitations or restrictions on coverage:

- ◆ on the basis of race, color, national origin, sex, age or disability
  - the Plan will not discriminate on the basis of pregnancy, gender identity, sex stereotyping and sexual orientation
- ◆ for sex-specific health services provided to transgender individuals just because the individual seeking such services identifies as belonging to another gender
  - the Plan will not discriminate based on the fact that an individual’s sex assigned at birth, gender identity or recorded gender is different than the one to which the health care services are ordinarily or exclusively available

## ***ADMINISTRATIVE INFORMATION***

---

- ◆ for specific health services related to gender transition if those result in discrimination against a transgender individual.

Johns Hopkins Employer Health Programs (EHP) complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability or sex. EHP does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex. EHP:

- Provides free aids and services to people with disabilities to communicate effectively with EHP, such as: qualified sign language interpreters, written information in other formats (large print, audio, accessible electronic formats, other formats).
- Provides free language services to people whose primary language is not English, such as qualified interpreters and information written in other languages.

If you need these services, contact EHP's Compliance Coordinator.

If you believe EHP has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with the Johns Hopkins HealthCare Compliance Grievance Coordinator, Johns Hopkins HealthCare Corporate Compliance Department at 6704 Curtis Court, Glen Burnie, MD 21060, phone: 1-844-422-6957, fax: 1-410-762-1527, and email: [compliance@jhhc.com](mailto:compliance@jhhc.com).

You can file a grievance in person or by mail, fax or email. If you need help filing a grievance, an EHP Compliance Coordinator is available to help you. You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>, or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Avenue SW, Room 509F, HHH Building, Washington, DC 20201, 1-800-368-1019, 1-800-537-7697 (TDD). Complaint forms are available at <http://www.hhs.gov/ocr/office/file/index.html>.

### **Plan Information**

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

#### **Plan Sponsor**

The Johns Hopkins Hospital sponsors the Johns Hopkins Health System Corporation/The Johns Hopkins Hospital Employee Benefits Plan for Non-Represented Employees, which contains the benefit plans described in this SPD. Johns Hopkins Medical Management Corporation (Intrastaff) is an adopting Employer of the EHP Medical and Dental Plans described in this SPD.

## ***ADMINISTRATIVE INFORMATION***

---

The Johns Hopkins Hospital's Employer Identification Number (EIN) is 52-0591656. Intrastaff's Employer Identification Number is 52-1250028.

### **Plan Administrator**

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

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

Intrastaff Office  
10751 Falls Road  
Falls Concourse, Suite 275  
Lutherville, MD 21093  
Telephone: 410-583-2950 (press 0)

### **Plan Year**

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

### **Plan Funding**

The benefits provided by the Employee Benefits Plan are not financed or administered by an insurance company. Benefits are paid from the general assets of Intrastaff through a contract with Johns Hopkins Employer Health Programs. You can contact Johns Hopkins Employer Health Programs at:

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

### **Plan Number**

The plan number is 506.

### **Legal Action**

The agent for service of legal process is:

JHHSC/JHH General Counsel  
600 N. Wolfe Street



## ***ADMINISTRATIVE INFORMATION***

---

Administration Building  
Baltimore, Maryland 21287

You may also serve legal process on the Plan Administrator.

### **Prohibition On Assignment Of Benefits**

No benefit payment, or claim of a right to or cause of action for a benefit payment under the Plan may be transferred or assigned to another person or entity, and no attempted transfer or assignment will be recognized by the Plan. The Plan may make direct payment of benefits to providers in accordance with arrangements between the Plan and the providers. However, such a payment does not make the provider an assignee, does not constitute acceptance by the Plan of an attempt to assign a benefit payment or claim of right to or cause of action for a benefit payment, and in no way confers upon the provider any rights that a participant has under the Plan or ERISA.

### **Claims And Appeals**

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

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

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

The Plan's procedures also apply to a determination by your employer that you are not covered under the Plan. If you are covered by the Plan and your employer determines that you are no longer entitled to coverage for a reason other than your failure to maintain enrollment or pay the required employee contribution, your coverage will not end until you have exhausted your rights under these procedures.

The filing requirements, and other procedures related to claims and appeals, differ depending on whether you have an "Urgent Care Claim," a "Pre-Service Claim" or a "Post-Service Claim". There are special rules if a pre-approved course of treatment is reduced or terminated, or if you want to

## ***ADMINISTRATIVE INFORMATION***

---

extend a pre-approved course of treatment. Medical benefits claims can be any of the foregoing types of claims. On the other hand, claims for Dental benefits are always handled under the Post-Service Claims rules.

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

Certain services and supplies must be preauthorized by Care Management in order to be covered or to avoid a penalty. See the earlier discussion in this SPD about the **Care Management Program** and the **Medical Benefits At-A-Glance** chart. If a service or supply must be preauthorized, a request for preauthorization is a “**Pre-Service Claim**”. (Pre-treatment review for major Dental services is recommended so you and your provider will know in advance what benefits will be paid. However, pre-treatment review is not required in order for the services to be covered and there is no penalty for failing to request review.)

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

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

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

If a service or supply does not need to be preauthorized, a claim for payment is a “**Post-Service Claim**”. (All Dental benefit claims are Post-Service Claims.)

### ***Filing a Claim***

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

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

## ***ADMINISTRATIVE INFORMATION***

---

Intrastaff  
EHP Medical Plan  
c/o Johns Hopkins Employer Health Programs  
6704 Curtis Court  
Glen Burnie, Maryland 21060

Itemized bills must include the following information:

- ◆ the date(s) the services, drugs or supplies were received;
- ◆ the diagnosis;
- ◆ a description of the treatment received;
- ◆ the charge for each service, drug or supply;
- ◆ the name, address and professional status of the provider; and
- ◆ the full name of the patient.

Claim forms are available at the Intrastaff Office and from Johns Hopkins Employer Health Programs at [www.ehp.org](http://www.ehp.org). To avoid delay in handling your claim, answer all questions completely and accurately. *Claims cannot be processed without your signature where required on the form.*

### ***Reducing or Terminating an Approved Course of Treatment***

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

### ***Extending an Approved Course of Treatment***

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

### ***Authorized Representative***

An authorized representative may file a claim or appeal a denial of benefits for you. To name an authorized representative, you must use a Designation of Authorized Representative form which you

## ***ADMINISTRATIVE INFORMATION***

---

can get from Employer Health Programs on [www.ehp.org](http://www.ehp.org) or by calling an EHP Customer Service Representative.

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

### ***Claims and Appeals Procedures***

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

#### **Urgent Care Claims**

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

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

#### **Pre-Service Claims**

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

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

#### **Post-Service Claims**

Unless additional information is needed, if a Post-Service Claim for medical or dental benefits is denied, you will be notified within 30 days after the claim is properly filed. If there are matters beyond Employer Health Programs' control, this period may be extended up to 15 more days. If an extension

## ***ADMINISTRATIVE INFORMATION***

---

is needed, you will be told before the initial 30 day period ends why an extension is needed and when a decision is expected.

### ***If Additional Information is Needed***

#### **Pre-Service and Post-Service Claims**

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

#### **Urgent Care Claims**

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

You will be notified of Employer Health Programs' decision on your Urgent Care Claim within 24 hours after the earlier of when (1) you supply the additional information or (2) the time for you to supply the additional information expires. If you do not supply the information within 48 hours, your claim will be processed without the additional information, and Employer Health Programs may draw reasonable presumptions from your failure to supply the additional information.

### ***If Your Claim is Denied***

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

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

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

## ***ADMINISTRATIVE INFORMATION***

---

### ***First Level Appeal***

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

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

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

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

Johns Hopkins HealthCare  
Appeals Department  
6704 Curtis Court  
Glen Burnie, MD 21060

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

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

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

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

## ***ADMINISTRATIVE INFORMATION***

---

If your claim for treatment in an emergency room was denied on the grounds that you did not have an emergency medical situation, your First Level Appeal may be referred to an Independent Review Organization (IRO) for determination. In that event, the IRO takes the place of the Appeals Department under these claims procedures, and any reference in these procedures to the Appeals Department should be read as a reference to the IRO.

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

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

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

### ***When Your First Level Appeal Will Be Decided***

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

**Urgent Care Claim**—You will be notified of the decision within 36 hours after your First Level Appeal is filed.

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

**Post-Service Claim** -- You will be notified of the decision on a medical or dental benefit claim within 30 days after your First Level Appeal is filed.

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

## ***ADMINISTRATIVE INFORMATION***

---

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

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

### ***Final Appeal***

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

If your First Level Appeal for treatment in an emergency room was referred to an Independent Review Organization (IRO), your Final Appeal will still be handled by the Plan Administrator.

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

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

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

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



## ***ADMINISTRATIVE INFORMATION***

---

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

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

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

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

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

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

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

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

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

## ***ADMINISTRATIVE INFORMATION***

---

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

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

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

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

**If you want to bring a civil action against the Plan, including an action against the Plan Administrator, you must do so within one year after the date you are notified of the Plan Administrator's decision on your Final Appeal. If you do not bring such an action within one year after the date you are notified, you lose all rights to bring an action against the Plan or the Plan Administrator.**

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

The Plan Administrator may delegate the fiduciary responsibility to decide Final Appeals to the person serving in the position of Director, HR Administration and Pension (or successor thereto), or to any other person the Plan Administrator decides to delegate the fiduciary responsibility to. The person is delegated all power and authority that the Plan Administrator has to decide Final Appeals, including the discretionary authority to interpret the terms of the plan documents and to decide any questions of fact which relate to entitlement to benefits.

### **External Review**

If your Final Appeal is denied in whole or in part, you may be eligible to request External Review of the denial by an Independent Review Organization (IRO).

## ***ADMINISTRATIVE INFORMATION***

---

Except as explained below, you must complete all levels of the internal Claims and Appeals process described above before you can request External Review. Your Authorized Representative may act for you in the External Review process.

The notice of denial of your Final Appeal will explain if you are eligible to request External Review and how to do so, and will include a copy of the Request for External Review Form.

You must submit the completed Request for External Review Form to EHP at the address shown on the Form within 123 days after the date you receive the notice of denial of your Final Appeal. If you do not request External Review in writing within 123 days, you cannot submit your claim to External Review.

You are not required to submit your claim to External Review, and doing so will not affect your right to bring a civil action against the Plan under ERISA Section 502. Whether or not you submit your claim to External Review will have no effect on your rights to any other benefits under the Plan. There is no charge for you to submit your claim to External Review. The External Review process will be administered in accordance with regulations and guidance issued by the Department of Labor under Public Health Service Act Section 2719.

### **Request for External Review**

You can request External Review if both A **and** B are met:

- A. Your Final Appeal has been denied in whole or in part; **or** EHP or the Plan Administrator do not follow the internal Claims and Appeals process set forth above.
- B. Your appeal relates to a rescission of your coverage (meaning a retroactive cancellation of coverage that was previously in effect), **or** your claim being appealed involves medical judgment (meaning whether the treatment was medically necessary or experimental).

A failure to follow the internal Claims and Appeals process does not entitle you to External Review if the failure was minor, not likely to harm you, for good cause or beyond EHP or the Plan Administrator's control, and part of an ongoing good faith exchange between you and EHP or the Plan Administrator.

An appeal based on your eligibility for coverage (other than retroactive cancellation) is not eligible for External Review.

### **Preliminary Review**

## ***ADMINISTRATIVE INFORMATION***

---

Within six business days following receipt of your request for External Review, EHP will notify you in writing whether you are eligible for External Review and whether your request contains all necessary paperwork.

If your request is not eligible for External Review, the notice will explain why. If your request is incomplete, the notice will describe the additional information needed. You must supply the additional information before the end of the original 123 day request period (or within 48 hours after receipt of the notice, if later).

### **Referral to IRO**

If your request is eligible for External Review, EHP will assign an accredited IRO to conduct the External Review, and will provide the IRO with the documents and other information considered during the internal appeal process. Note that information submitted to the IRO will include your “Protected Health Information” (described below in this SPD). EHP will notify you in writing when your request is accepted for External Review by the IRO. Within 10 business days after you receive this notice, you may submit to EHP any additional information that you want considered by the IRO as part of the External Review. The IRO may, but is not required to, consider information that you submit after 10 business days.

The IRO will review all of the information and documents you timely submit. In reaching a decision on your claim, the IRO will not be bound by any decisions or conclusions reached during the internal claims and appeals process. In addition to the information and documents provided, in reaching a decision the IRO will consider the following (if available and considered appropriate by the IRO):

- Your medical records;
- The treating provider’s recommendation;
- Reports from appropriate health care professionals and other documents submitted by EHP, the Plan Administrator, you or your treating provider;
- The terms of the Plan (unless inconsistent with the law);
- Appropriate practice guidelines, including evidence-based standards and other practice guidelines developed by the Federal government, national or professional medical societies, boards, and associations;
- Clinical review criteria developed and used by EHP (unless inconsistent with the Plan or the law); and
- The opinion of the IRO's clinical reviewer(s) after considering the above information.

EHP will provide you with written notice of the IRO’s External Review decision within 45 days after the IRO receives the request for the External Review. The IRO will maintain records of all materials associated with its External Review decision for six years, and will make the records available for your

## ***ADMINISTRATIVE INFORMATION***

---

examination upon written request, except where disclosure would violate State or Federal privacy laws.

Following receipt of an External Review decision that reverses a denial of your claim, the Plan will provide coverage or payment in accordance with the decision, subject to the right of the Plan and the Plan Administrator to seek judicial review of the decision and other remedies available under state or federal law. The IRO's External Review decision is binding on you and the Plan, except to the extent that other remedies are available under state or federal law. If you submit your claim to External Review, the statute of limitations deadline by which you would have to bring a civil action against the Plan (and any other defense based on timeliness) is "tolled" (i.e., suspended) from the time you submit until the IRO issues its decision.

### **Expedited External Review**

You may make a written request for an expedited External Review if:

- Your Urgent Care Claim is denied, you have filed a request for an expedited internal appeal, and you have a medical condition where the timeframe for completion of the expedited internal review process would seriously jeopardize your life or health or would jeopardize your ability to regain maximum function; or
- Denial of your Urgent Care Claim is upheld on Final Appeal, and either:
  - you have a medical condition where the timeframe for completion of the standard External Review process would seriously jeopardize your life or health or would jeopardize your ability to regain maximum function; or
  - your Claim concerns an admission, availability of care, continued stay, or health care item or service for which you received emergency services, but have not been discharged from a facility.

As soon as possible following receipt of your written request for expedited External Review, EHP will notify you in writing whether you are eligible for expedited External Review and whether your request contains all necessary paperwork. If eligible, EHP will assign your request to an IRO as explained above using the most expeditious means of transmission reasonably available.

EHP will provide you with oral or written notice of the IRO's decision on your request for expedited External Review as expeditiously as possible under the circumstances of your medical condition, but not later than 72 hours after the IRO receives the request. If the notice is oral, EHP will provide written confirmation of the IRO's decision within 48 hours after the oral notice was given.

## ***ADMINISTRATIVE INFORMATION***

---

### **Protected Health Information**

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

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

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

### **Your Rights Under ERISA**

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

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

### **Additional ERISA Rights**

In addition to creating rights for plan participants, ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plans. These people are called fiduciaries. ERISA requires that fiduciaries act prudently and solely in the interest of you and other plan participants and beneficiaries.

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

## ***ADMINISTRATIVE INFORMATION***

---

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

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

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

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

### **Intrastaff's Rights**

The Johns Hopkins Medical Management Corporation (Intrastaff) and the Johns Hopkins Health System Corporation/The Johns Hopkins Hospital expect to continue the EHP Medical and Dental plans indefinitely, but reserve the right to amend or terminate any plan at any time, and for any reason without prior notification except as required by law. You will be notified of any changes to these plans and how they affect your benefits, if at all. The plans described in this SPD are governed by contracts and plan documents, which are available for examination in the Intrastaff Office. You should not rely on any oral descriptions of the plans, since the written descriptions in this SPD will always govern. To the extent any benefit under a plan is provided by an insurance policy, no benefits are provided by the plan except for those benefits, if any, which are paid by the insurance company which issues the policy.

### **Not A Contract Of Employment**

## ***ADMINISTRATIVE INFORMATION***

---

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

### **Plan Administrator's Authority**

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

### **For More Information**

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