

The Johns Hopkins University

Student Health Program

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Summary Plan Description

July 1, 2022

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GENERAL INFORMATION

General Information About Your Benefits

The Student Health Program offers you the security of a wide range of health care benefits, including coverage for inpatient and outpatient hospital care, medical and surgical services, prescription drugs, and mental health and substance use disorder treatment. The Program offers you the flexibility to receive care from the physicians of your choice.

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

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

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

This SPD is effective for expenses incurred on and after July 1, 2022. For expenses incurred before that date, please refer to the July 1, 2021 version of this SPD.

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 Student Health Program 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

- Any individual holding pre- or postdoctoral student status (including Leave of Absence status and persons hired to work as House Staff) in the following schools:
 - JHU School of Medicine
 - Bloomberg School of Public Health
 - JHU School of Nursing
 - JHH Schools of Medical Imaging
- Any individual holding postdoctoral student status (including Leave of Absence status) in any other JHU school.

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

- Your legal spouse;
- Your domestic partner, as defined by the Johns Hopkins University, who is listed on your affidavit of domestic partnership;
- Your or your spouse/domestic partner's children, until they turn age 26.
- Your or your spouse/domestic partner's physically or mentally disabled dependent child of any age provided the physical or mental disability began prior to age 26. To be considered disabled, a child must be entitled to Supplemental Security Income (SSI) benefits on account of disability. However, if the child has not applied for SSI, you can instead demonstrate to the Plan Administrator's satisfaction that the child meets the SSI disability criteria for adults -- the inability to engage in any substantial gainful activity as a result of any medically determinable physical or mental impairment(s) which can be expected to result in death, or has already lasted, or can be expected to last, for a continuous period of not less than 12 months.

Children whom you may enroll must be your natural children, stepchildren, and foster children, children legally adopted or placed for adoption, and any children for whom you are the legal guardian. You may not cover a child for whom you only have legal custody.

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

If your spouse is also eligible for enrollment in the Student Health Program, he or she may choose to be covered as a participant rather than as a dependent, but not as both. Please note that your eligible children may only be covered by one parent's plan.

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If you have any questions about coverage, please call the benefits representative for your School at the following numbers:

- JHU School of Medicine – Registrar’s Office at 410-614-3301.
- Bloomberg School of Public Health – Student Accounts Office at 410-955-5725.
- JHH Schools of Medical Imaging – 410-528-8208.
- JHU School of Nursing – 410-955-7547.
- JHU Berman Institute for Bioethics – Finance and Administration at 410-614-5222
- JHU Sheridan Libraries – Human Resources at 410-516-8326
- JHU Krieger School of Arts and Sciences – Human Resources at 410-516-6808
- JHU Whiting School of Engineering – Human Resources at 410-516-6808
- JHU School of Education – Human Resources at 410-516-4475

Qualified Medical Child Support Order (QMCSO)

Your child or children will automatically be enrolled in the Student Health Program if called for by a Qualified Medical Child Support Order or a National Medical Support Notice (QMCSO). A QMCSO is a court or agency order setting responsibility for health care expenses for non-custodial children. If you are served with a QMCSO, please send the order to the benefits representative for your School by contacting them at the number shown above as soon as possible.

When Coverage Begins

Students are eligible to participate in the Student Health Program upon registration and/or the effective date of appointment with no waiting period. If you are hired to work as House Staff or as an ACGME accredited fellow, you can start coverage as of your first day of orientation. In either case, there is no coverage until you submit a properly completed application.

Medical coverage for your dependents will begin at the same time as your own if you have properly enrolled them. If you have a new baby, adopt a child, or have a child placed with you for adoption, and you enroll this dependent within 30 days, your child’s coverage becomes effective on the date of the birth or adoption. If you marry and you enroll your spouse within 30 days after your marriage, your spouse’s coverage becomes effective on the date of marriage.

GENERAL INFORMATION

Changing Your Coverage

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

Examples of IRS-qualified changes in family status include:

- ◆ Marriage, legal separation, annulment, or divorce;
- ◆ Birth, death, or adoption of a dependent;
- ◆ Placement for adoption of a dependent;
- ◆ Your dependent becomes eligible or is no longer eligible for coverage under the Student Health Program;
- ◆ You are required to cover your child due to a QMCSO;
- ◆ You or your dependent 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 student, spouse or dependent child whose coverage under any other group health plan ends may possibly be permitted to enroll in coverage under the Program within 30 days of the date of the loss of other coverage as explained below under **Special Enrollment Rights**. Please contact the benefits representative for your School (see page 3) about your situation to see if coverage is available.

Any change in your benefit enrollment must correspond directly to the change in family status. You must submit a new enrollment form or a change of information form within 30 days after the change. If your completed form is received on time, coverage will be effective on the date of the change in family status. If you delay past 30 days, you must wait until the next open enrollment before coverage can become effective. Please keep your School informed of any changes in family status.

GENERAL INFORMATION

Special Enrollment Rights for Medical Coverage

Losing other coverage

If you did not enroll in the Student Health Program because you had coverage through another source (such as a spouse's employer or COBRA), and you subsequently lose that coverage, you may enroll for medical coverage under the Student Health Program. You must request this special enrollment by submitting a properly completed enrollment form within 30 days of losing your other coverage. If your completed form is received on time, coverage will be effective on the date you lost the other coverage, with no waiting period.

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 request coverage by submitting a properly completed enrollment form within 30 days following the date you acquired the child. Contact the benefits representative for your School (see page 3) to request special enrollment. 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 request coverage by submitting a properly completed enrollment form within 30 days following the date of marriage. If enrolled on time, coverage will become effective on the date of marriage. If you do not have EHP 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, your spouse or your child have health insurance coverage under Medicaid or a Children's Health Insurance Program ("CHIP") and you, your spouse or your child lose eligibility for that coverage, you, your spouse or your child may enroll for medical coverage under the Student Health Program. You must request this special enrollment by submitting a properly completed enrollment form 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 after you submit your enrollment form.

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If you, your spouse or your child become eligible to receive assistance from Medicaid or CHIP to pay your required contributions for coverage under the Student Health Program, you, your spouse or your child may enroll for Student Health Program coverage. You must request this special enrollment by submitting a properly completed enrollment form within 60 days of becoming eligible for the assistance. If enrolled on time, coverage under the Student Health Program will become effective on the first day of the month following the date you submit your enrollment form.

If you do not have Student Health Program 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 spouse or child.

Contact the benefits representative for your School (see page 3) to request any of the above special enrollments.

YOUR STUDENT HEALTH PROGRAM

Your Student Health Program

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

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

- **Johns Hopkins EHP Network.** The Program's primary network of providers throughout Maryland and parts of adjoining states.
- **Cigna PPO Network.** The Medical Plan's alternate network of providers throughout the United States. Many providers in the EHP Network are also in the Cigna PPO Network, and vice versa.

Any reference to Network providers in this SPD means both EHP and Cigna PPO Network providers.

You should ask your provider if they are in the EHP Network or the Cigna PPO Network before you receive services. For a complete listing of EHP Network or Cigna PPO Network providers, please see the provider directory available at www.ehp.org, or call 410-424-4450 or 800-261-2393.

The University Health Services Health Center (UHSHC) is also a covered provider for those persons who pay the student health fee, and their adult dependents. The UHSHC does not provide pediatric care.

Options for Coverage

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

Option 1 – a higher level of benefits is provided for treatment by EHP/Cigna PPO Network providers.

Option 2 – a lower level of benefits is provided for treatment by Out-of-Network providers.

The various coverage levels and deductibles for each Option are shown on the Medical Benefits At-A-Glance chart later in this SPD.

As you will see on the chart, sometimes the 100% coverage only applies if you access care through Option 1. Other times, the 100% coverage applies for care accessed through Option 2 as well. However, the Program only covers charges up to the Allowed Benefit (“AB”) (explained below under

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Payment Terms You Should Know). Providers under Option 1 will never charge more than the Allowed Benefit, but Out-of-Network providers under Option 2 can charge more than the Allowed Benefit, and you must pay the difference.

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

Payment Terms You Should Know

The following terms are used throughout this SPD.

- ◆ **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 when appropriate by a percentage determined by Johns Hopkins Employer Health Programs. 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. EHP/Cigna PPO Network providers (Option 1) will not charge more than the Allowed Benefit, but Out-of-Network providers (Option 2) 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.
- ◆ **Deductible:** The amount you must pay each plan year (July 1 – June 30) before the Program begins to pay benefits for most services. Expenses incurred and applied to your deductible in April, May and June of a plan year are also carried over and applied to the next plan year's deductible. Expenses incurred by two or more persons can meet the family deductible. However, no one person will be required to satisfy more than the per person deductible. If you transfer from one student status to a different status that is still eligible for coverage under the Program, and you do not have any lapse of coverage, any amounts you paid towards a year's deductible will still be counted and the deductible carryover feature will continue to apply. Please note that your coinsurance payments (i.e., your percentage or share of expenses) and any amounts over the Allowed Benefit do not apply toward the deductible.

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

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covered expenses incurred for those children as a result of the multiple birth.

- ◆ **Facility charges and Professional fees:** Some providers may separately bill for professional fees and facility charges. If so, you might receive two separate bills. The professional fee covers the services delivered to you by a physician or other healthcare practitioner. The facility charge covers the cost of maintaining the facility where the professional services are provided.
- ◆ **Out-of-Pocket Maximum:** Since you are responsible for a portion of the cost of certain of your medical expenses, the Program includes two plan year out-of-pocket maximums to protect you in the event of high medical bills. One out-of-pocket maximum applies to all expenses other than prescription drug copays, and a separate out-of-pocket maximum applies just to prescription drug copays.

Expenses other than prescription drug copays. After you have paid the plan year out-of-pocket maximum of \$3,000 per person or \$9,000 per family, the Program covers any additional expenses incurred in the same plan year at 100% of the Allowed Benefit. The out-of-pocket maximum applies on a per person basis, regardless of your level of coverage (individual, husband and wife, family, etc.). For example, if you have individual coverage, your maximum is \$3,000. If you have family coverage, your maximum and the separate maximum for each member of your family is still \$3,000. Plus, once you have paid \$9,000 during a plan year for all members of your family in total, then all members of your family have met the maximum.

The out-of-pocket maximum includes the deductible and coinsurance but does not include prescription drug copays, charges above Program maximums, charges for services which are not covered, or charges above the Allowed Benefit.

Prescription drug copays. There is a separate out-of-pocket maximum of \$3,350 per person or \$3,700 per family that applies just to prescription drug copays. The separate prescription drug copay out-of-pocket maximum applies using the same rules that apply to the out-of-pocket maximum for all other expenses, except that charges for prescription drugs that are obtained from a non-Network pharmacy do not apply to the out-of-pocket maximum.

- ◆ **Provider:** A 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, domestic partner, child, grandchild, brother, sister, brother-in-law, sister-in-law, parent or grandparent).

The University Health Services Health Center (UHSHC) is also a covered provider for those persons who pay the student health fee, and their adult dependents. The UHSHC does not provide pediatric care.

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Preauthorization Requirement – Utilization Management

Certain services and supplies are not covered by the Program unless they are preauthorized. Your EHP Network provider will request preauthorization for you from EHP Utilization Management. Cigna handles preauthorization requests if you receive care from a Cigna PPO Network provider (who is not in the EHP Network) or from an Out-of-Network provider. If you receive Out-of-Network care, you or your Out-of-Network provider must request preauthorization from Cigna. **Unless preauthorization is received, there is no coverage for the services and supplies in question.** The services and supplies that currently require preauthorization are set forth in the **Medical Benefits At-A-Glance** chart and under **Covered Services and Supplies** later in this SPD.

Because medical treatments are constantly changing, Johns Hopkins EHP and Cigna can determine that preauthorization is required for additional services and supplies not shown in this SPD. EHP/Cigna PPO Network providers have access to an updated list of additional services and supplies that require preauthorization, and will request preauthorization as needed. **Before you receive Out-of-Network care, you or your Out-of-Network provider must check with Cigna to see if the services or supplies involved require preauthorization, and if so must request preauthorization.** Contact information for Cigna is on your EHP Medical Plan Identification card, or call EHP Customer Service at 410-424-4450 or 800-261-2393.

You can also view a list of some of the outpatient procedures that require preauthorization at [outpatient-guidelines.pdf \(ehp.org\)](#).

Special Rules for Certain Treatment by Out-of-Network Providers

Special rules apply to coverage of charges for treatment furnished by Out-of-Network providers if you receive non-emergency services by an Out-of-Network provider during or in connection with a visit to an EHP/Cigna PPO Network facility. For these special rules, "facility" means a hospital (including the outpatient department) or an ambulatory surgical center.

When these special rules apply, charges by the Out-of-Network provider are covered under the Program as though you received treatment from an EHP/Cigna PPO Network provider. This means:

- The same cost sharing requirements (deductible, copay, coinsurance) apply to the Out-of-Network provider charges as would apply to EHP/Cigna PPO Network provider charges for the same treatment. Your cost sharing payments will be based on the **recognized amount**, not the amount charged by the Out-of-Network provider.

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- Except as described below, you are not legally responsible for Out-of-Network provider charges that exceed the **recognized amount**, and the Out-of-Network provider cannot "balance bill" you for those charges.

Recognized amount means the median in network rate recognized by the Student Health Program in accordance with regulations issued under ERISA Section 716.

Notice and Consent Exception

Charges for certain non-emergency services furnished by Out-of-Network providers during or in connection with a visit to an EHP/Cigna Network facility are exempt from the prohibition on balance billing set forth above, but only if the provider gives you (or your authorized representative) advance written notice that you will be responsible for charges that exceed the **recognized amount**, and you (or your authorized representative) consent to be responsible for the charges.

The following items and services are **not** eligible for the notice and consent exception, and therefore remain subject to the prohibition on balance billing described above:

- ancillary services, meaning items and services related to emergency medicine, anesthesiology, pathology, radiology, and neonatology, whether provided by a physician or non-physician practitioner;
- items and services provided by assistant surgeons, hospitalists, and intensivists;
- diagnostic services, including radiology and laboratory services;
- items and services provided by an Out-of-Network provider if there is no EHP/Cigna PPO Network provider who can furnish the item or service at the In Network facility;
- items or services furnished as a result of unforeseen, urgent medical needs that arise at the time an item or service is furnished, regardless of whether the Out-of-Network provider satisfied the notice and consent requirements.

The notice and consent requirements are regulated by federal law and enforced by the United States Department of Health and Human Services. The Student Health Program, Johns Hopkins Employer Health Programs and your school are not involved in the notice and consent process. The Student Health Program does not cover balance billing by an Out-of-Network provider under any circumstances.

Continuity of Care

If you are a continuing care patient (defined below) who is being treated by an EHP/Cigna PPO Network provider or as an inpatient in an EHP/Cigna PPO Network facility, and the provider or facility leaves the Network and becomes an Out-of-Network provider, the following continuity of care

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provisions will apply to you. These provisions do not apply if the provider or facility leaves the Network due to failure to meet applicable quality standards or for fraud.

You will be notified that the provider or facility is leaving the Network, and of your right to notify the Student Health Program that you need continuing transitional care. If you notify the Student Health Program that you need continuing transitional care, you will be given the opportunity to elect continuing transitional care from the provider or in the facility. If you make the continuing transitional care election, your treatment by that provider or in that facility as a continuing care patient will be covered by the Program as though the provider or facility had not left the Network. This continuing transitional care will last until 90 days after the notice that the provider or facility is leaving the Network was sent to you, or until you are no longer a continuing care patient of that provider or in that facility, whichever comes first.

A continuing care patient is someone who, in connection with treatment by an EHP/Cigna PPO Network provider, or while an inpatient in an EHP/Cigna PPO Network facility, is:

- undergoing a course of treatment for a serious and complex condition
- undergoing a course of institutional or inpatient care
- scheduled to undergo nonelective surgery, including receipt of postoperative care
- pregnant and undergoing a course of treatment for the pregnancy, or
- determined to be terminally ill (meaning a life expectancy of six months or less) and is receiving treatment for such illness

Serious and complex condition means:

- in the case of an acute illness, a condition that is serious enough to require specialized medical treatment to avoid the reasonable possibility of death or permanent harm, or
- in the case of a chronic illness or condition, a condition that is life-threatening, degenerative, potentially disabling, or congenital, and that requires specialized medical care over a prolonged period of time.

Care Management Programs

When faced with health challenges, you are not alone. Johns Hopkins EHP has a care management team of nurses, social workers and community health workers available to help you better manage your health.

These dedicated care managers are available to support you in coordinating medical care for both acute and chronic illnesses. They will work closely with you and your other medical providers to ensure that you have access to appropriate services. Your care manager may also suggest alternative care options

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and coordinate with providers to improve standards for the medical care you receive. Your care manager can also help you identify non-medical resources in the community.

- ◆ **Transition of Care** -- if you are faced with an inpatient admission, care management will assist in making sure you have everything you need in the transition period after discharge.
- ◆ **Complex Care** -- if you are faced with a serious medical event or a long-term health condition, care management can provide support by coordinating care, understanding and managing your medical event or condition, and facilitating necessary services covered by your Student Health Program benefits.
- ◆ **Preventive Care** -- if you have a chronic health condition, care management can support you with understanding and managing your condition, getting connected to providers and community resources, and helping you maintain or reach your best level of health.
- ◆ **Behavioral Health Care** -- if you are living with a mental health condition such as depression, autism spectrum disorder, anxiety or addiction, care management can provide confidential care coordination.
- ◆ **Maternal/Child Health Care** -- supporting you through your pregnancy and delivering a healthy baby is everyone's goal. After delivery, care management provides tools to assist in caring for your child when they have additional needs through young adulthood.

The right care at every stage of life can help you stay healthy, avoid or delay the onset of disease, or keep a condition you may already have from becoming worse. You and your covered family members may self-refer into these programs by going to [https://www.ehp.org/plan-benefits/health-programs and resources/](https://www.ehp.org/plan-benefits/health-programs-and-resources/), by contacting care management at caremanagement@jhhc.com, or by calling 800-557-6916, Monday-Friday 8 a.m. – 5 p.m.

Health Education

Johns Hopkins EHP is committed to helping you achieve optimal health.

Staying healthy should not be difficult. Living a healthy life is all about making good choices, and EHP can help you do that through a variety of programs free of charge:

- ◆ Health Education Classes
- ◆ Health Information, Tips and Interactive Tools
- ◆ Education Materials and Newsletters
- ◆ Health Assessments

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We encourage you to take advantage of these free health education programs. Contact healtheducation@jhhc.com, healthcoach@jhhc.com, or call 800-957-9760.

Your Student Health Program Identification Card

A Student Health Program identification card will be issued to you and each of your covered dependents. Carry your identification card with you at all times and show it to 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 Program. If you lose your identification card, contact the benefits representative for your School (see page 3) or a Customer Service Representative immediately to request a new card.

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

Customer Service

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

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

MEDICAL BENEFITS AT-A-GLANCE

Medical Benefits At-A-Glance

The following chart summarizes most of the benefits and services available under the Student Health Program. This chart is not a complete description of benefits. For more information, please refer to the rest of this SPD.

<i>Services and Supplies</i>	<i>Option 1 EHP/Cigna Network Providers</i>	<i>Option 2 Out of Network Providers</i>
PLAN YEAR DEDUCTIBLE (BOTH OPTIONS COMBINED)		
Individual		\$150
Family		\$450
ANNUAL MAXIMUM PER PLAN YEAR (BOTH OPTIONS COMBINED)		
Individual		\$3,000 (expenses other than prescription drug copays) \$3,350 (prescription drug copays)
Family		\$9,000 (expenses other than prescription drug copays) \$3,700 (prescription drug copays)
TREATMENT OF ILLNESS OR INJURY		
Primary care office visit (age 19 and older)	80%	70% of AB
Adult specialty care office visit	90%	70% of AB
Pediatric care office visit (under age 19)	100%	90% of AB
Pediatric specialty care office visit	90%	70% of AB
Podiatry care office visit	90%	70% of AB
Diagnostic services and treatment	90%	70% of AB
PREVENTIVE SERVICES		
General preventive exam (adult physical)	100% (no deductible)	70% of AB
Diagnostic services for exam	100% (no deductible)	70% of AB
Well-child care: office visits, immunizations and PKU, flu vaccine, urinalysis and lead testing	100% (no deductible)	90% of AB
Mammogram and well-woman care	100% (no deductible)	90% of AB
Screening colonoscopy	100% (no deductible)	70% of AB

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

<i>Services and Supplies</i>		<i>Option 1 EHP/Cigna Network Providers</i>	<i>Option 2 Out of Network Providers</i>
Annual GYN exam Once per 12 month period		100% (no deductible)	70%
Annual PAP test (pathology) Once per 12 month period		100% (no deductible)	70% of AB
Adult immunizations and inoculations, as recommended by Centers for Disease Control and Prevention; Gardasil is covered only for FDA approved age range 9 – 45		100% (no deductible)	70%
SURGICAL PROCEDURES			
Professional fees for inpatient and outpatient surgery; preauthorization required		80%	70%
Reconstructive and/or surgically implanted prosthetics; preauthorization required		80%	70%
LABORATORY AND RADIOLOGY PROCEDURES			
Laboratory tests, imaging exams, X-rays and ultrasound		90%	70% of AB
Consultation and follow-up		90%	70% of AB
REPRODUCTIVE HEALTH			
Physician office visits (prenatal care only)		Routine visits 100% All other visits 90%	70% of AB
Inpatient maternity care and delivery, facility charges, lab and radiology services; preauthorization required		90%	90% of AB
Inpatient maternity care and delivery, professional fees		80%	70% of AB
Newborn care Initial and discharge visits only		90%	90% of AB
Newborn care All other inpatient visits		80%	80% of AB
Birthing center, facility charges (licensed facility only)		90%	90% of AB
Birthing center, professional fees		80%	70% of AB
Voluntary sterilization		100% (no deductible)	80% of AB
Infertility treatment (such as artificial insemination and in-vitro fertilization); preauthorization required		50% \$1,500 lifetime deductible and \$100,000 lifetime maximum for advanced reproductive techniques	Not Covered
ALLERGY TESTS AND PROCEDURES			
Allergy tests		90%	90% of AB
Desensitization materials and serum		80%	80% of AB

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.

Because medical treatments are constantly changing, Johns Hopkins EHP and Cigna can determine that preauthorization is required for additional services and supplies not shown in this chart.

MEDICAL BENEFITS AT-A-GLANCE

<i>Services and Supplies</i>	<i>Option 1 EHP/Cigna Network Providers</i>	<i>Option 2 Out of Network Providers</i>
URGENT CARE CENTER		
Emergency department visit	100%	100% of AB
Emergency department services and treatment	100%	100% of AB
EMERGENCY CARE		
Emergency department for emergency medical services only; facility charges and professional fees	\$50 copay (waived if admitted) then 100%	\$50 copay (waived if admitted) then 100% of AB ⁽¹⁾
HOSPITAL CARE		
Inpatient facility care (semi-private, unless private room is medically necessary); preauthorization required	90%	90% of AB
Outpatient care	90%	90% of AB
Outpatient services	90%	90% of AB
Professional fees (excluding surgical)	80%	80% of AB
Skilled nursing/rehabilitation facility; preauthorization	90%	90% of AB
Preoperative exams and testing prior to surgery	90%	90% of AB
Outpatient surgery facility charges, including freestanding ambulatory centers	90%	90% of AB

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.

Because medical treatments are constantly changing, Johns Hopkins EHP and Cigna can determine that preauthorization is required for additional services and supplies not shown in this chart.

(1) See *Emergency Care* later in this SPD, for an explanation of how Out-of-Network emergency department charges are covered.

MEDICAL BENEFITS AT-A-GLANCE

<i>s and Supplies</i>	<i>Option 1 EHP/Cigna Network Providers</i>	<i>Option 2 Out of Network Providers</i>
CHEMOTHERAPY/RADIATION THERAPY		
Professional fees	100%	80% of AB
Materials and treatment	80%	80% of AB
ACUPUNCTURE		
\$300 maximum per plan year	80%	70% of AB
HOME HEALTH CARE		
Must be provided by a licensed health care organization; preauthorization required	100% for 1 st 90 visits per plan year, then 80%	90% of AB for 1 st 90 visits per plan year, then 80% of AB
HOSPICE CARE		
Inpatient and home; preauthorization required	100%	100% of AB
AMBULANCE TRANSPORTATION		
Ground or air transportation when medically necessary; preauthorization required for air or ground ambulance in non-emergencies	100%	100% of AB ⁽¹⁾
SPEECH THERAPY		
Restorative, non-developmental therapy only; preauthorization required	80%	80% of AB
PHYSICAL/OCCUPATIONAL THERAPY		
Licensed therapist only; excludes maintenance therapy	80%	80% of AB
CHIROPRACTIC CARE		
Restricted to initial exam, X-rays and spinal manipulations;	80%	80% of AB
DURABLE MEDICAL EQUIPMENT AND SUPPLIES		
Custom made equipment, prosthetic appliances and medical supplies; preauthorization required	80%	80% of AB
Non-custom equipment, prosthetic appliances and medical supplies	80%	80% of AB
Hearing aids; preauthorization required	80%	80% of AB
Breast pumps (standard) and related supplies	100% (no deductible)	70% of AB

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.

Because medical treatments are constantly changing, Johns Hopkins EHP and Cigna can determine that preauthorization is required for additional services and supplies not shown in this chart.

(1) See *Air Ambulance Transportation by Out-of-Network Provider* later in this SPD, for an explanation of how Out-of-Network air ambulance charges are covered.

MEDICAL BENEFITS AT-A-GLANCE

<i>and Supplies</i>	<i>Option 1 EHP/Cigna Network Providers</i>	<i>Option 2 Out of Network Providers</i>
CARDIAC REHABILITATION		
Limited to 60 visits per plan year; preauthorization required		90% 90% of AB
PULMONARY REHABILITATION		
Limited to one program per lifetime; preauthorization required		90% 90% of AB
HABILITATIVE SERVICES		
Under age 19 only; preauthorization required		80% 80% of AB
PRESCRIPTION DRUGS		
		NETWORK PHARMACY
In-network pharmacy: 30-day supply		\$15 copay – generic (Tier 1) \$25 copay – brand preferred (Tier 2) \$40 copay – brand non-preferred (Tier 3)
In-network pharmacy only; 30-day supply for these prescribed generic Over-the-Counter drugs		\$10 copay – prescribed OTC generic equivalents of Prilosec, Prevacid and Zegerid No copay for prescribed OTC generic equivalents of Claritin, Allegra, Allegra D, Zyrtec or Zyrtec D Must have prescription and present it to the pharmacist
90-day supply for maintenance drugs		<u>Mail order:</u> \$30 copay – generic (Tier 1) \$50 copay – brand preferred (Tier 2) \$80 copay – brand non-preferred (Tier 3) <u>In-Network pharmacy:</u> \$45 copay – generic (Tier 1) \$75 copay – brand preferred (Tier 2) \$120 copay – brand non-preferred (Tier 3)
MENTAL HEALTH AND SUBSTANCE USE DISORDER		
Professional fees for outpatient mental health care	90%	90% of AB
Professional fees for inpatient mental health care	80%	80% of AB
Facility charges for inpatient mental health care and substance use disorder; preauthorization required	100% for 1 st 30 days per admission, then 90%	100% of AB for 1 st 30 days per admission, then 90% of AB
Professional fees for inpatient substance use disorder	80%	80% of AB
Professional fees for outpatient substance use disorder	100%	80% of AB
Facility charges for outpatient mental health care and substance use disorder	90%	90% of AB
Partial hospital days facility charges for mental health care and substance use disorder	90%	90% of AB

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.

Because medical treatments are constantly changing, Johns Hopkins EHP and Cigna can determine that preauthorization is required for additional services and supplies not shown in this chart.

COVERED SERVICES AND SUPPLIES

Covered Services and Supplies

The Student Health Program provides benefits for the services and supplies listed in this section. Only services and supplies that are *medically necessary* are covered.

A medically necessary service or supply is one that the Plan Administrator, Cigna or CVS Caremark 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, Cigna and CVS Caremark may rely on Employer Health Programs, Cigna and CVS Caremark 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.

The Student Health Program covers the services and supplies described below, when medically necessary and subject to any conditions or limitations described elsewhere in this SPD:

Ambulance Services

The Student Health Program covers both air and ground ambulance transportation services when one of the following criteria are met:

- ◆ Because of an **emergency medical condition** (defined below under *Emergency Care*), 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 preauthorized by EHP Utilization Management or Cigna based on special medical circumstances

COVERED SERVICES AND SUPPLIES

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. *Except for an **emergency medical condition**, air ambulance transportation must be preauthorized, or it will not be covered.*

In no event will the Program pay more than the Allowed Benefit for ground ambulance transportation, or more than the **qualifying payment amount** (defined below) for air ambulance transportation.

Air Ambulance Transportation by Out-of-Network Provider

Charges for transportation by an Out-of-Network air ambulance provider are covered as though you received transportation by an EHP/Cigna PPO Network air ambulance provider.

You are not legally responsible for Out-of-Network air ambulance transportation charges that exceed the **qualifying payment amount**, and the Out-of-Network provider cannot "balance bill" you for those charges. **Qualifying payment amount** means the charges for Out-of-Network air ambulance transportation that are recognized by the Student Health Program in accordance with regulations issued under ERISA Section 717. The Student Health Program does not cover balance billing for Out-of-Network air ambulance transportation charges under any circumstances.

Emergency Care

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

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

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

The following visits to an emergency department will be automatically treated as an **emergency medical condition**, regardless of whether the visit satisfies the criteria set forth above:

- visits for children under age two
- visits where the claim form indicates a "sudden and serious" diagnosis, or

COVERED SERVICES AND SUPPLIES

- visits where EHP Utilization Management of Cigna is notified by the patient's physician that the patient was referred to the hospital emergency department

You do not need to obtain preauthorization from EHP Utilization Management or Cigna for treatment of an **emergency medical condition**. If you receive treatment in an emergency department for a condition that is not an **emergency medical condition**, the Program will not pay benefits and you are responsible for all charges.

Emergency Department

Emergency services provided by the emergency department of a hospital or by an independent freestanding emergency department for treatment of an **emergency medical condition** are covered under the Option 1 In-Network benefit regardless of whether the emergency department participates in the EHP/Cigna PPO Network. Emergency department charges are covered at 100%, after the deductible. A \$50 copay applies to each visit to an emergency department (hospital or freestanding). The copay is waived if you are admitted to the hospital as an inpatient.

Except for **emergency services**, treatment of an **emergency medical condition** does not include admission to the hospital for inpatient services. For any treatment other than treatment of an **emergency medical condition** (including **emergency services**), you must determine if the treatment is subject to the preauthorization requirements explained in this SPD. If preauthorization is required, you must initiate the preauthorization process, even if the treatment is for urgent care.

If you go to an Option 2 Out-of-Network emergency department, any cost sharing you pay for Out-of-Network **emergency services** will be based on the **recognized amount**. **Recognized amount** means the charges for **emergency services** that are recognized by the Student Health Program in accordance with regulations issued under ERISA Section 716, or when applicable the rate established by state law for facility charges.

You are not legally responsible for Out-of-Network charges that exceed the **recognized amount**, and the Out-of-Network provider cannot "balance bill" you for those charges. The Student Health Program does not cover balance billing for Out-of-Network emergency services under any circumstances.

Besides treatment to stabilize the **emergency medical condition** itself, **emergency services** also include:

- ◆ *Initial services* – an appropriate medical screening examination within the capability of the emergency department, including ancillary services routinely available in the emergency department, to evaluate whether an **emergency medical condition** exists.
- ◆ *Post-stabilization services* – additional services and supplies furnished in any department of the

COVERED SERVICES AND SUPPLIES

hospital after the patient is stabilized and as part of outpatient observation, or an inpatient or outpatient stay, with respect to the visit for which the initial services were provided.

- ◆ *Services in other departments* – treatment in any department of the hospital (other than the emergency department) that is needed to stabilize the **emergency medical condition**.

If you are being treated at an Out-of-Network emergency department, or if you are admitted to an Out-of-Network hospital from the emergency department, your condition stabilizes so that it is no longer an **emergency medical condition**, and your attending physician determines that you can travel to an EHP/Cigna PPO Network facility within a reasonable travel distance using nonmedical transportation or non-emergency medical transportation, but you choose not to so travel, then services and supplies provided after you can so travel will be paid under the applicable Option 2 Out-of-Network benefit percentage of the Allowed Benefit, after the deductible, but only if the determination, notice and consent requirements of Public Health Services Act Section 2799A-1 are met.

If you are admitted to an Out-of-Network hospital from the emergency department, you must notify EHP of the admission within 24 hours by calling 410-424-4476 or 800-261-2429.

Urgent Care Centers

If your regular provider is unable to see you, and you believe you need prompt medical attention for a condition that is not serious enough to be an emergency medical condition as described above, you may go to an urgent care center. An urgent care center is a facility (other than an emergency department) that is licensed to provide medical services for unexpected illnesses or injuries that require prompt medical attention, but are not life- or limb-threatening. Physician visits and diagnostic services and treatment at an EHP/Cigna PPO Network urgent care center are covered at 100%, after the deductible. Treatment at an Out-of-Network urgent care center is covered at 80% of the Allowed Benefit, after the deductible. You are responsible for any charges over the Allowed Benefit.

Please Note: An “urgent care center” is a name used to describe a facility that treats medical conditions that are not serious enough to require going to an emergency department. A patient’s condition does not have to be an **emergency medical condition** in order for the patient to go to an urgent care center.

Gender Affirmation

The Student Health Program covers gender affirmation treatment for members as follows.
Preauthorization is required for all gender affirmation treatment.

Coverage is provided only for members age 18 and older who have a diagnosis of gender dysphoria in accordance with the Johns Hopkins HealthCare Medical Policy for Gender Affirmation Procedures.

COVERED SERVICES AND SUPPLIES

Gender affirmation 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 Program as set forth in this SPD, based on the nature of the treatment provided and whether treatment is obtained under Option 1 or Option 2. Except as described above, treatment of transsexualism, gender dysphoria, or sex or gender reassignment or affirmation is not covered by the Program.]]

Habilitation Services

Preauthorization is required for all habilitation services.

Physical, occupational, and speech therapy are covered if provided by a licensed physical, occupational or speech therapist and 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.

Adaptive behavior treatment, such as Applied Behavior Analysis, is covered if medically necessary for the treatment of a person under age 19 with autism or autism spectrum disorder. Services must be provided by a licensed and appropriately qualified provider, such as a board certified behavior analyst. *Preauthorization is not required for Applied Behavior Analysis.*

Coverage is not provided for services provided in early intervention and school services.

Home Health Care

Preauthorization is required for all home health care.

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 of the patient (spouse,

COVERED SERVICES AND SUPPLIES

domestic partner, child, grandchild, brother, sister, brother-in-law, sister-in-law, parent or grandparent) or anyone living in the patient's household. Each home health care visit is limited to four hours.

Covered home health care services include:

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

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

- ◆ Domestic or housekeeping services
- ◆ Dietician services
- ◆ Dialysis treatment
- ◆ Maintenance therapy
- ◆ Rental or purchase of equipment or supplies
- ◆ Meals-on-wheels or other similar food arrangements
- ◆ Care provided in a nursing home or skilled nursing/rehabilitation facility (see ***Skilled Nursing/Rehabilitation Facility Care*** below);
- ◆ Home care for mental health conditions
- ◆ Custodial care

Hospice Care

Preauthorization is required for hospice care.

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 their family. Patients who can no longer be helped by a hospital, but require acute medical care, can be moved to a hospice facility or receive hospice care at home.

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
- ◆ Bereavement and counseling services, limited to a maximum of six visits

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

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

Infertility Treatment

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

- *Preauthorization is required.*
- You (the participant) must be covered by the Student Health Program.
- If the birth mother is your spouse or domestic partner, she must be covered by the Student Health Program.
- There must be a physician recommended treatment plan.
- Treatment must be provided by an EHP Network provider. Treatment provided by an Out-of-Network provider, or by a Cigna PPO Network provider who is not also an EHP Network provider, is not covered.
- The order of infertility treatment options must have followed a logical succession of medically appropriate and cost-effective care.
- You must pay 50% of covered charges.
- For coverage of advanced reproductive techniques such as in vitro fertilization (IVF), ovum transplants, gamete intrafallopian transfer (GIFT) and zygote intrafallopian transfer (ZIFT) procedures (collectively "ART" treatment), you must first pay a separate \$1,500 lifetime deductible, which does not count towards your regular annual deductible. Amounts you pay for ART treatment do not apply towards your annual out-of-pocket maximum. A lifetime maximum benefit payment of \$100,000 applies to ART treatment. No lifetime maximum benefit payment applies to artificial insemination (AI) and intrauterine insemination (IUI) treatment. However, benefit payments for AI/IUI treatment will count against the \$100,000 lifetime maximum benefit payment for ART treatment.

COVERED SERVICES AND SUPPLIES

- Expenses connected with obtaining donor sperm and donor eggs (oocytes) are only covered if the covered person's sperm or eggs are not viable and donor sperm or eggs are recommended as part of the treatment plan.
 - Expenses connected with freezing and thawing (but not storage) of embryos are covered.
 - Otherwise, all expenses connected with obtaining donor sperm or eggs are not covered, including expenses for acquisition, freezing, storing or thawing of sperm or eggs.
- Infertility must not be related to a previous sterilization by you or your spouse/domestic partner.
- For married opposite sex couples, the husband's sperm must be used, unless there is a documented medical condition unrelated to age whereby use of the husband's sperm is not possible.
- No coverage is provided for surrogate motherhood or gestational carrier purposes. This exclusion does not apply to charges for treatment of the newborn child if the child is a covered eligible dependent of the member.

Injectable Drugs

The Student Health Program provides benefits for injectable drugs that are administered by your physician. (Self-administered injectable drugs are covered as described under **Prescription Drug Benefits** later in this SPD.)

Injectable drugs must be preauthorized or they will not be covered. Your physician can request preauthorization by completing the CVS Caremark Electronic Prior Authorization process or by calling CVS Caremark. The link for the Electronic Prior Authorization process and the phone number are available on the Johns Hopkins HealthCare provider website. CVS Caremark will review the request and notify your physician of approval or denial of the request. If CVS Caremark denies the request for prior authorization, you or your physician can make a First Level Appeal to the EHP Appeals Department in accordance with the appeal rules for pre-service claims set forth later in this SPD under Claims and Appeals. If the EHP Appeals Department denies your First Level Appeal, you can make a Final Appeal to the Plan Administrator.

Maternity Care

The Student Health Program provides benefits during your pregnancy and delivery, including prenatal care and routine tests. Midwife delivery services provided by a licensed midwife, at a birthing center or at home, are also eligible for coverage. Doula care is *not* covered.

The Student Health Program covers your prenatal care and delivery at the levels set forth in the **Medical Benefits At-A-Glance** chart. Hospital or birthing center expenses are treated just like any other covered hospital stay. If you are an expectant mother, call Student Health Program Customer

COVERED SERVICES AND SUPPLIES

Service at least eight weeks before your due date and call again after you have been admitted to the hospital for delivery.

The Student Health Program covers maternity care 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. *Preauthorization is required if the stay is to be longer than 48 hours (or 96 hours).*

Please note that no benefits are provided for the newborn child unless the child is properly enrolled in the Student Health Program within 30 days after birth. See the discussion of ***New Children*** under **Special Enrollment Rights** earlier in this SPD for more information.

Obesity Treatment

The Student Health Program covers surgical treatment for morbid obesity when Body Mass Index (BMI) (weight in kilograms/height in meters squared) is (1) greater than or equal to 40, or (2) greater than or equal to 35 and the patient has at least one of the following co-morbid conditions:

- diabetes that is uncontrolled despite taking appropriate medication, with a Hemoglobin A1c test result greater than or equal to 8.5
- a specifically diagnosed cardiovascular disease that is uncontrolled despite taking appropriate medication, such as hypertension, coronary artery disease, valvular disease or congestive heart failure
- obstructive sleep apnea that is uncontrolled despite use of appropriate continuous positive airway pressure (CPAP) treatment

Preauthorization is required for obesity treatment. You must first participate for at least six months in a medically supervised weight management program that is approved and monitored by EHP Utilization Management.

Outside the United States Care

Medical care you receive outside the United States will be covered at the Out-of-Network benefit level. You must submit a claim in accordance with the rules for services from an Out-of-Network provider as set forth under Administrative Information later in this SPD. The itemized bill(s) that you attach should be in English for faster processing. Ask the provider for an English language bill. If the

COVERED SERVICES AND SUPPLIES

provider cannot provide an English language bill, you may submit a foreign language bill but processing of your claim will be delayed while the bill is translated.

Be sure to include proof that you paid the bill, such as a credit card receipt or other evidence of payment.

If you have any questions about submitting a claim, contact an EHP Customer Service Representative at 888-400-0091 or 410-424-4485.

Skilled Nursing/Rehabilitation Facility Care

Your stay in a skilled nursing/rehabilitation facility must be preauthorized.

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.

To be covered by the Student Health Program, a skilled nursing/rehabilitation facility must be:

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

Covered skilled nursing/rehabilitation facility services include:

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

In order to be covered, a skilled nursing/rehabilitation facility may not:

- ◆ Be used mainly as a place for rest or a place for the aged

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- ◆ 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

Surgery

Surgery for the treatment of disease or injury, and sterilization procedures are covered under the Student Health Program. *Preauthorization is required for certain procedures, as set forth on a list maintained by Johns Hopkins Employer Health Programs.*

Separate payment will not be made for inpatient pre-operative care or post-operative care normally provided by the surgeon as part of the surgical procedure, as these are included in the global surgical fee.

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

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

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

Telemedicine

The Student Health Program covers telemedicine visits (video, audio and telephone) with your health care provider. Telemedicine visits are covered on the same terms and are subject to the same requirements as in-person visits. Telemedicine visits by Out-of-Network providers are covered at the Out-of-Network benefit level.

You can also use Johns Hopkins OnDemand Virtual Care. This service allows you to connect with a provider for a general medical visit 24/7 from the comfort of your home or anywhere you may travel in the United States. This service can be used as an alternative if you are unable to see your PCP. Use of this service is intended for common, minor ailments, such as a cough, rash, seasonal allergies, cold and flu symptoms, pink eye, sinus infection, sore throat, and more. This service is not for medical emergencies.

COVERED SERVICES AND SUPPLIES

You can access OnDemand Virtual Care at **ondemand.hopkinsmedicine.org**. Services provided by OnDemand Virtual Care are covered at 100%, with no copay, coinsurance or deductible.

Therapies

The Student Health Program covers the following therapies:

- Chemotherapy (inpatient and outpatient)—the treatment of malignant disease by chemical or biological antineoplastic agents, including the cost of the antineoplastic
- Dialysis treatment—the treatment of acute renal failure or chronic irreversible renal insufficiency for removal of waste materials from the body, to include hemodialysis or peritoneal dialysis
- Physical therapy—the treatment by physical means, hydrotherapy, heat, or similar modalities; physical agents; bio-mechanical and neuro-physical principles; and devices to significantly relieve pain, restore maximum function lost or impaired by disease or accidental injury, and prevent disability following disease, injury or loss of body part (does not include maintenance therapy). These services must be provided by a licensed physical therapist.
- Occupational therapy—the treatment of a physically disabled person by means of constructive activities designed and adapted to significantly improving the functional restoration of the person's abilities lost or impaired by disease or accidental injury, to satisfactorily accomplish the ordinary tasks of daily living in the home setting (does not include maintenance therapy)
- Radiotherapy (inpatient and outpatient)—the treatment of disease by x-ray, gamma ray, accelerated particles, measons, neutrons, radium or radioactive isotopes
- Respiration therapy—the introduction of dry or moist gases into the lungs for treatment purposes
- Speech therapy—the treatment for the correction of a speech impairment when therapy is aimed at restoring the level of speech the individual had attained before the onset of a condition (i.e., before an illness or injury). Speech therapy for developmental disorders is only covered as explained above under **Habilitation Services**.

Transplants

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

The Student Health Program will pay benefits for non-experimental and non-investigational transplants of the human heart, kidney, lung, heart/lung, bone marrow, liver, pancreas, pancreas/kidney, cornea and any other solid or non-solid organ. No benefits are paid for transplants that are experimental (as

COVERED SERVICES AND SUPPLIES

defined later in this SPD under **What's Not Covered by the Student Health Program**). The Program will pay covered expenses for human-to-human organ or tissue transplants incurred by you or your dependent as a recipient during a transplant benefit period which begins five days before and ends 18 months after the date of the organ or tissue transplant. Coverage is contingent upon continuing to meet the criteria for Johns Hopkins Employer Health Programs transplant approval until the date of the transplant. Covered services include:

- ◆ Inpatient or outpatient hospital charges for treatment and surgery by a Johns Hopkins Employer Health Programs designated transplant center
- ◆ Tissue typing
- ◆ Removal of the organ
- ◆ Obtaining, storing, and transporting the organ
- ◆ Travel expenses for the recipient, if medically necessary, to and from the transplant center, up to \$10,000 for each transplant completed

Covered transplant services **do not** include:

- ◆ Organ transplant charges incurred without preauthorization, or at a transplant center that was not designated by Johns Hopkins Employer Health Programs
- ◆ The transplant of an organ which is synthetic, artificial, or obtained from other than a human body
- ◆ An organ transplant or organ procurement performed outside the United States
- ◆ An organ transplant that the Plan Administrator determines to be experimental
- ◆ Expenses of an organ donor, except when the recipient is a participant in this Program who receives the organ in a covered organ transplant. When coordinating with the donor's health plan, the Program will be secondary. If an organ is sold (i.e., not donated), no benefits are paid for the donor's expenses.

Other Services and Supplies

In addition to the services and supplies described above, the Student Health Program also covers the following, 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, up to \$300 per person per plan year
- ◆ Adaptive behavior treatment for autism -- see ***Habilitation Services*** above

COVERED SERVICES AND SUPPLIES

- ◆ Anesthetics and administration
- ◆ Benefits for covered foreign nationals holding J visas:
 - Expenses for repatriation of remains up to \$25,000
 - Expenses associated with the medical evacuation of the exchange visitor to their home country up to \$50,000
- ◆ Birthing facilities, provided the physician in charge is acting within the scope of their license and the birthing facility is a freestanding licensed facility for childbirth which meets state licensing requirements
- ◆ Blood products
- ◆ Bone mass measurement, consisting of a radiological or radioisotopic procedure or other scientifically proven technology for the purpose of identifying bone mass or detecting bone loss; only covered for (1) an estrogen deficient individual at clinical risk for osteoporosis, (2) an individual with a specific sign suggestive of spinal osteoporosis, including roentgenographic osteopenia or roentgenographic evidence suggestive of collapse, wedging or ballooning of one or more thoracic or lumbar vertebral bodies who is a candidate for therapeutic intervention or for an extensive diagnostic evaluation for metabolic bone disease, (3) an individual receiving long term glucocorticoid (steroid) therapy, (4) an individual with primary hyperparathyroidism, or (5) an individual being monitored to assess the response to or efficacy of an approved osteoporosis drug therapy
- ◆ Cancer screening for prostate and colorectal cancer as set forth in the current recommendations of the American Cancer Society
- ◆ Cardiac rehabilitation, involving medical evaluation, prescribed exercise, cardiac risk factor modification, education and counselling, including continuous EKG telemetric monitoring during exercise, EKG rhythm strip with interpretation, physician's revision of exercise prescription, and follow-up examination to adjust medication or change regimen. Coverage is not provided for maintenance programs that preserve the present level of function and prevent regression of that function. *Preauthorization is required.*
- ◆ Casts
- ◆ Chiropractic care for spinal manipulation, misalignment or partial dislocation of or in the vertebral column and correction by manual or mechanical means of nerve interference. Only initial consultation, x-rays and spinal manipulations are covered.

COVERED SERVICES AND SUPPLIES

- ◆ Cleft lip and cleft palate conditions treatment. These include expenses for oral surgery, otologic, audio logical and speech/language treatment.
- ◆ Contraceptive devices provided for in comprehensive guidelines supported by the Health Resources and Services Administration and approved by the Food and Drug Administration. No cost sharing applies to such devices.
- ◆ Cosmetic/reconstructive surgery when due to:
 - accidental injury or illness that is or would be covered by the Program, or
 - impaired bodily function or deformity resulting from disease, trauma, congenital or developmental anomalies, or previous therapeutic processes
- ◆ Cosmetic/reconstructive surgery when due to a mastectomy, including:
 - reconstruction of the breast on which the mastectomy was performed,
 - surgery and reconstruction of the other breast to provide a symmetrical appearance,
 - prostheses and physical complications for all stages of a mastectomy, including lymphedemas (swelling associated with the removal of lymph nodes) , and
 - 3-D nipple tattooing of a reconstructed breast, 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.
- ◆ Dental services if rendered as initial treatment as a result of accidental injury to the jaws, sound natural teeth, mouth, or face, provided care commences within 72 hours of the accident. Injury as a result of chewing or biting shall not be considered an accidental injury. In circumstances where oral surgery or dental treatment are otherwise covered, inpatient facility charges for services that ordinarily could be performed in the provider's office will be covered only if the patient has a concurrent medical condition that prohibits doing the treatment safely in the provider's office. The Program will pay surgical benefits for cutting procedures for the treatment of diseases, injuries, fractures and dislocations of the jaw when the service is performed by a physician or dentist. Normal extraction and care of teeth and structures directly supporting the teeth are not included.
- ◆ Diabetic supplies
- ◆ Dialysis (*preauthorization required*)
- ◆ Diagnostic medical procedures; including colonoscopy screening, EKG, EEG, and other electronic diagnostic medical procedures
- ◆ Durable medical equipment, including wheelchairs (*preauthorization required for custom made equipment*). If purchased, charges for repair or medically necessary replacement of durable

COVERED SERVICES AND SUPPLIES

medical equipment will be considered a covered expense. 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
- ◆ Foot care for incision and drainage of infected tissues of the foot, removal of lesions, cutting of infected toenails, treatment of fractures and dislocations of bone in the foot
 - ◆ Gastric bypass (bariatric) surgery – see ***Obesity Treatment*** above
 - ◆ Hearing aids. The aids must be prescribed, fitted, and dispensed by a licensed audiologist. Replacement aids are available only once every three years. (*preauthorization required*).
 - ◆ Hospital charges for covered semi-private room and board and other hospital-provided services and supplies (*preauthorization required*)
 - ◆ 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
 - ◆ Injectable drugs provided in a physician's office – see ***Injectable Drugs*** above
 - ◆ Inpatient consultation services for a specialist in the medical field for which the consultation relates, when rendered in a covered facility at the request of the attending professional provider. The Program will pay for one such consultation, limited to three consultations during any one inpatient stay. Staff consultation required by the facility is not covered.
 - ◆ Laboratory tests
 - ◆ Midwifery services – see ***Maternity Care*** above
 - ◆ Newborn care
 - ◆ Nursing services (professional) by a registered nurse or licensed practical nurse who is not a close relative (spouse, domestic partner, child, grandchild, brother, sister, brother-in-law, sister-in-law, parent or grandparent) of the patient

COVERED SERVICES AND SUPPLIES

- ◆ Nutrition counseling
- ◆ Observation care (*preauthorization required after 24 hours*)
- ◆ Orthotics for the foot 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 (*preauthorization required*). Orthopedic shoes (not integral to a brace) and supportive devices for the feet are not covered.
- ◆ Outpatient surgical center
- ◆ Oxygen and its delivery
- ◆ Pre-admission testing
- ◆ 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 EHP/Cigna PPO Network providers.
- ◆ Prosthetic devices and orthotics that are integral to the device, including charges for repair or medically necessary replacement (*preauthorization required*)
- ◆ Pulmonary rehabilitation services for persons diagnosed with significant pulmonary disease or who have undergone certain surgical procedures of the lung, as defined by Johns Hopkins EHP (*preauthorization required*). Coverage is not provided for maintenance programs that preserve the present level of function and prevent regression of that function.
- ◆ Rehabilitation services (*preauthorization required*)
- ◆ Second surgical opinions—must be rendered by a board-certified specialist in the treatment of your particular medical condition, who is not associated professionally or financially with the physician that provided the first surgical opinion consultation. One additional consultation, as a third opinion, is covered in cases where the second opinion disagrees with the first. To avoid unnecessary duplicate testing, you should provide the specialists rendering the surgical opinions with any test results from the doctor who initially recommended surgery.
- ◆ Splints
- ◆ Support garments

COVERED SERVICES AND SUPPLIES

- ◆ Surgical dressings and medical supplies when ordered by an appropriate professional provider in connection with medical treatment (excluding self-administered supplies or convenience items)
- ◆ Temporomandibular Joint Syndrome (TMJ) and/or myofacial pain treatment, limited to physical therapy, surgery and ortho devices such as mouthguards and intraoral devices (excluding orthodontics and prosthetics). Treatment to alter vertical dimension is covered when treatment plan is submitted and approved in advance by EHP Utilization Management.
- ◆ Testing and treatment required to be covered by the Families First Coronavirus Response Act
- ◆ Vasectomies and tubal ligations
- ◆ Well-child care, including evidence-informed preventive care and screenings provided for in comprehensive guidelines supported by the Health Resources and Services Administration. No cost sharing applies to this preventive care from EHP/Cigna PPO Network providers.
- ◆ 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 EHP/Cigna PPO Network providers.
- ◆ X-ray, radium, and radioisotope treatment

Pediatric Vision Benefits

The Student Health Program covers certain optometry and ophthalmology vision care services for persons under age 20 through the Johns Hopkins Routine Vision Care Network. The Program also covers vision care services from Out-of-Network providers. Johns Hopkins Routine Vision Care Network services are available 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. Network optometry services can also be received 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, or contact EHP Customer Service at 410-424-4450.

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

<i>Covered Vision Services</i>	<i>Johns Hopkins Routine Vision Care Network</i>	<i>Out-of-Network</i>
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COVERED SERVICES AND SUPPLIES

	<i>Program Pays</i>	<i>Program Pays</i>
Routine exam or contact lens fitting fee (once every 12 months)	100%	Up to \$30
Materials (once every 12 months):		
Single Vision	100%	Up to \$25
Bifocal	100%	Up to \$35
Trifocal	100%	Up to \$45
Lenticular	100%	Up to \$45
Standard Frames	100%	Up to \$30
Non-standard Frames	Up to \$150; 20% discount on charges above \$150	Up to \$30
Contact Lenses		
Medically Necessary (preauthorization required)	Up to \$600	Up to \$225
Elective	Up to \$150; 15% discount on charges above \$150	Up to \$75

The following supplies are only covered when obtained from In-Network providers, subject to the following copayments:

- ultraviolet protective coating no copay
- polycarbonate lenses \$30
- blended segment lenses \$20
- intermediate vision lenses \$30
- standard progressive lenses no copay
- select progressive lenses \$70
- premium progressive lenses \$90
- ultra progressive lenses \$195
- photochromic glass lenses \$20
- plastic photosensitive lenses no copay
- polarized lenses \$75

COVERED SERVICES AND SUPPLIES

- standard anti-reflective coating \$35
- premium anti-reflective coating \$48
- ultra anti-reflective coating \$60
- hi-index lenses \$55

Please Note: Benefits are provided for necessary or elective contact lenses in lieu of lenses and frames. This means the patient can get either eyeglasses or contact lenses in a 12-month period, but not both. Network providers offer a group of selected standard frames covered as set forth above. You are responsible for charges above the maximum benefit.

Eyeglass lenses include glass or plastic lenses, all lens powers (single vision, bifocal, trifocal, lenticular), fashion and gradient tinting, oversized and glass-grey #3 prescription sunglass lenses. Standard scratch resistance coating is covered with no additional copayment.

The following benefits for low vision treatment are provided:

- one comprehensive low vision evaluation every five years, up to a maximum payment of \$300
- low vision aid allowance of \$600 per aid, up to a lifetime maximum of \$1,200, for items such as high-power spectacles, magnifiers and telescopes
- four follow-up care visits in any five year period, up to a maximum payment of \$100 each visit

EHP Utilization Management preauthorization is required for all low vision treatment.

Except as expressly provided above, and in addition to the general exclusions set forth later in this SPD under **What's Not Covered By the Student Health Program**, charges for the following are not covered under the Pediatric Vision Benefit:

- ◆ Services or supplies obtained after attaining age 20
- ◆ Any eye examination or any corrective eye wear required as a condition of employment
- ◆ Charges for lost or broken lenses and frames, except at the normal intervals when services are otherwise covered
- ◆ 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
- ◆ 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

COVERED SERVICES AND SUPPLIES

Mental Health and Substance Use Disorder Treatment

The Student Health Program provides benefits for inpatient and outpatient mental health and substance use disorder treatment on the same terms that apply to other inpatient or outpatient medical treatment. Mental health and substance use disorder treatment is subject to the same copay, coinsurance, deductibles, limits and other requirements that apply to medical treatment, based on whether you receive treatment under Option 1 (EHP/Cigna PPO Network providers) or Option 2 (Out-of-Network). Outpatient care includes psychotherapy and counseling for substance/alcohol use disorder. Benefits are only provided when the services are received from independently credentialed mental health/substance use disorder providers that are psychiatrists, clinical psychologists, certified addiction counselors or licensed clinical social workers (ACSW, LCSW, MSW). Graduate Student Counselors are not covered providers and benefits are not provided for their services.

Like any other medical treatment, mental health and substance use disorder 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, *any inpatient admission (including inpatient residential treatment centers) must be preauthorized.*

Outpatient mental health and substance use disorder treatment does not have to be preauthorized. However, if you have your treatment preauthorized, you can be assured that your treatment will be considered medically necessary and therefore covered. Through the preauthorization process you can talk to mental health professionals who will help you determine the best course of treatment for you. They will refer you to a provider (usually an EHP/Cigna PPO Network provider). If you wish, you may instead refer yourself to any provider in or out of the EHP/Cigna PPO 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 Utilization Management at 410-424-4476 or 800-261-2429.

Note: *You must receive preauthorization before all inpatient admissions (including inpatient residential, treatment centers) for mental health and substance use disorder 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 Program 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

COVERED SERVICES AND SUPPLIES

medicines and supplies designated by Johns Hopkins Employer Health Programs. You can receive a supply of up to 30 days at a retail pharmacy, or a 90-day supply for maintenance drugs. A cost saving 90-day supply is available through the Mail Order program for maintenance drugs. Participating pharmacy directories and mail order forms may be accessed on EHP's website at www.ehp.org.

Self-administered injectable drugs are covered by these Prescription Drug Benefits. Injectable drugs that are administered by your physician are covered as described under ***Injectable Drugs*** earlier in this SPD.

EHP Network Pharmacies

You will receive the highest level of prescription drug benefits if you fill your prescription at a Johns Hopkins EHP Network pharmacy. Your EHP provider search at www.ehp.org has a complete list of EHP Network pharmacies. 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 Student Health Program identification card to the pharmacist. You must pay a copay as explained below. You are responsible for the full cost of prescription drugs that are not covered by the Program.

If you purchase prescription drugs from a Non-Network pharmacy, you must pay the pharmacy for the purchase and submit for reimbursement from the Student Health Program. You will be reimbursed for the EHP Network pharmacy price for the covered prescription, less the applicable copay. To obtain reimbursement, you must complete the Prescription Reimbursement Standard Claim Form, and follow directions on the form for mailing. Contact Student Health Program Customer Service to get a Claim Form or if you have any questions about how to submit a claim for reimbursement. Charges for prescription drugs purchased from a Non-Network pharmacy do not apply to the prescription drug out-of-pocket maximum.

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

Copay

You pay a \$15 copay for each separate prescription or refill of up to a 30-day supply of a generic drug (Tier 1). 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 \$25 for brand name preferred drugs (Tier 2) and \$40 for brand name non-preferred drugs (Tier 3), regardless of whether a generic version is available.

COVERED SERVICES AND SUPPLIES

For maintenance drugs, you may obtain a 90-day supply at a retail pharmacy for three times the normal monthly copay for that prescription. Or, you may use the 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 \$30 for each separate prescription or refill of a generic drug. The Mail Order copay is \$50 for brand name preferred drugs and \$80 for brand name non-preferred drugs. If you have any questions about the Mail Order program, call EHP.

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

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 Student Health Program 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. Go to “Plan Benefits”, then “Pharmacy”, then “Prior Authorization” and follow the instructions. Call EHP Customer Service at 410-424-4450 or 800-261-2393 if you need assistance.

If your physician determines that use of a drug that requires Prior Authorization is necessary, your physician must complete the CVS Caremark Electronic Prior Authorization process or call CVS Caremark. The link for the Electronic Prior Authorization process and the phone number are available on the Johns Hopkins HealthCare provider website. 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 also complete the CVS Caremark Electronic Prior Authorization process or call CVS Caremark. CVS Caremark will review the request and notify your physician of approval or denial of the request. If Caremark denies the request for prior authorization, you or your physician can make a First Level Appeal to Caremark in accordance with the directions included on the denial letter. If Caremark

COVERED SERVICES AND SUPPLIES

denies the 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 later in this SPD under Claims and Appeals.

Caremark Formulary Drugs

CVS Caremark manages the Student Health Program'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 Student Health Program.

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 the 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 the request for prior authorization for a non-Formulary drug, you or your physician can make a First Level Appeal to Caremark in accordance with the directions included on the denial letter. If Caremark denies the 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 under Claims and Appeals (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
- Drugs that are excluded from coverage for a reason set forth later in this SPD under **What's Not Covered by the Student Health Program**
- 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 Utilization Management. This exclusion does not apply to a medical device to the extent Medicare would cover the device in accordance with Medicare

COVERED SERVICES AND SUPPLIES

Policy Manual Chapter 14

- Non-prescribed oral contraceptives, contraceptive devices or methods
- Insertion of Norplant
- Any drugs that are not prescribed for the treatment of an illness or injury. For example, the Program does not cover vitamins, Psoralens, anorexants or diet pills, or Minoxidil
- Any drug that is available over-the-counter, except as described in this SPD. A drug or medication is considered to be available over-the-counter if it can legally be purchased without a prescription, even if your doctor gives you a prescription for it
- Any drug that is used for treatment of a condition for which coverage is otherwise excluded as described elsewhere in this SPD.
- 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
- 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 In-Network pharmacies)
- Drug delivery implants or devices
- Drugs taken by or administered 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
- Replacement of drugs that are lost, stolen, spilled, spoiled or damaged
- Drugs used for any cosmetic purpose, including but not limited to, hair growth or hair removal
- Herbal, mineral, and nutritional supplements

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

Over-the-Counter Drugs

Prescription drug benefits 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

COVERED SERVICES AND SUPPLIES

- Generic proton pump inhibitors such as OTC Omeprazole (generic equivalent of Prilosec), OTC Esomeprazole (generic equivalent of Nexium), OTC Lansoprazole (generic equivalent of 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 Student Health Program

The Student Health Program does not cover the following:

- ◆ Charges by a provider who is a close relative of the patient (spouse, domestic partner, child, grandchild, brother, sister, in-law, grandparent or parent) or who resides in the patient's home
- ◆ Charges for services prescribed for oneself
- ◆ Charges in excess of the Allowed Benefit, or above the allowable lifetime or annual maximums
- ◆ Charges incurred when you are not covered under the Student Health Program
- ◆ Charges excluded under the **Coordination of Benefits** provisions set forth later in this SPD
- ◆ Charges that would not be made if no coverage by the Program existed
- ◆ Charges for which you are not legally required to pay
- ◆ Charges for the completion of claim forms
- ◆ Charges denied by another plan as a penalty for non-compliance with that plan's requirements;
- ◆ Charges incurred by a person who is not a United States citizen for services performed within that person's home country (i.e., the country of that person's citizenship), to the extent the charges were eligible for coverage by a government provided health care program in that country
- ◆ Claims filed more than 18 months after the expenses were incurred
- ◆ Contraceptive medications, devices or methods that are not prescribed by a physician, and insertion of Norplant
- ◆ 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

WHAT'S NOT COVERED

- ◆ Cosmetic/reconstructive surgery, except as expressly provided for under ***Obesity Treatment*** and ***Other Services and Supplies*** earlier in this SPD
- ◆ Custodial care, residential care, or rest cures
- ◆ Dental treatment except if rendered as initial treatment as a result of accidental injury to the jaws, sound natural teeth, mouth, or face, provided care commences within 72 hours of the accident. Services directly related to the care, filling, removal or replacement of teeth or the treatment of injuries to or diseases of the teeth, gums, or structures directly supporting or attached to the teeth are not covered.
- ◆ Doula services
- ◆ Drugs or devices not approved by the FDA for marketing and/or for the prescribed treatment of a specific diagnosis unless approved by Utilization Management. 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.
- ◆ Education, vocational, work hardening or training programs regardless of diagnosis or symptoms that may be present, or for non-medically necessary education. Your school may provide these services to you through another program.
- ◆ Emergency department services for other than an emergency medical condition
- ◆ Equipment that does not meet the definition of Durable Medical Equipment provided earlier in this SPD under ***Other Services and Supplies***, including air conditioners, humidifiers, dehumidifiers, purifiers or physical fitness equipment, whether or not recommended by a doctor
- ◆ Exercise programs or use of exercise equipment, special diets or diet supplements, Nutri System Program, Weight Watchers or similar programs and hospital confinements for weight reduction programs
- ◆ Experimental treatment, defined as the use of any treatment, procedure, equipment, device, drug or drug usage which the Plan Administrator, Cigna or CVS Caremark 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, Cigna or CVS Caremark will make a determination on a case by case basis, using the following principles as generally establishing that something is experimental:

WHAT'S NOT COVERED

- 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.

“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 Program 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.

WHAT'S NOT COVERED

- A qualified individual is a patient who is otherwise covered by this Program 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/Cigna PPO 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.
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- ◆ Eyeglasses, contact lenses, eye refractions, or the examinations for their fitting or prescription, except as provided earlier in this SPD under **Pediatric Vision Benefits**, or when medically necessary after cataract surgery or for aphakic patients and soft lenses or sclera shells intended for use in the treatment of medical conditions or injury
 - ◆ 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.
 - ◆ Gardasil vaccine against human papillomavirus, if given before age 9 or after age 45
 - ◆ Hearing aids, or the examination for their fitting or prescription (except as described under ***Other Services and Supplies*** earlier in this SPD)
 - ◆ Hypnosis or biofeedback training
 - ◆ Immunizations required or recommended for travel. This exclusion does not apply to immunizations that must be covered by the Program under federal regulations based on a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention for routine use in the United States. Thus, for example, the following immunizations are not covered: Japanese Encephalitis, Polio (IPV) Adult Booster, Typhoid Oral Vaccine, Typhoid Vi Injectable and Yellow Fever.
 - ◆ Injury arising out of or relating to an accident involving the maintenance or use of a motor vehicle (other than a recreational vehicle not intended for highway use, motorcycle, motor-driven cycle,

WHAT'S NOT COVERED

motorized pedal cycle or like type vehicle). This exclusion shall apply to those expenses up to the minimum amount required by law in the state of residence for any injury arising out of an accident of the type for which benefits are or would be payable under automobile insurance, regardless of whether or not automobile insurance is in force and regardless of any benefit limits under such insurance. However, this exclusion does not apply to a covered person who is a non-driver when involved in an uninsured motor vehicle accident.

- ◆ Injury sustained or an illness contracted while committing a crime, including but not limited to operating a motor vehicle, boat or watercraft while under the influence of alcohol or drugs
- ◆ 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
- ◆ 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, unless 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
- ◆ Recreational therapy and all costs associated with a stay in a recreational, outdoor or wilderness type facility. This exclusion does not apply to medically necessary medical, mental health or substance use disorder treatment received in such facility that would otherwise be covered by the Program, including any preauthorization requirement.
- ◆ Registered inpatient services if admitted on a Friday, Saturday or Sunday unless required as a result of emergency sickness or accident care. Sunday admissions will only be covered if medically necessary for scheduled surgery on Monday morning.
- ◆ Replacement of braces or prosthetic devices, unless there is sufficient change in the patient's

WHAT'S NOT COVERED

physical condition to make the original brace or device no longer functional

- ◆ Reversals of sterilization procedures such as vasectomies and tubal ligations
- ◆ Routine foot care (including any service or supply related to corns, calluses, flat feet, fallen arches, non-surgical care of toenails, and other symptomatic complaints of the feet where surgery is performed) and orthotics used for sport and leisure activities
- ◆ 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 and supplies not recommended or approved by a health care professional acting within the scope of their license
- ◆ 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
- ◆ Speech therapy for developmental disabilities such as stuttering, articulation disorders, tongue thrust, lisping, etc.
- ◆ Surgical treatment for overhanging, stretching or laxity of skin, except as described under ***Obesity Treatment*** earlier in this SPD
- ◆ Surrogate motherhood or gestational carrier treatment, including any charges related to giving birth or for treatment of the newborn child resulting from the surrogate motherhood or gestational carrying. 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 covered as described under ***Telemedicine*** earlier in this SPD
- ◆ Travel, whether or not recommended by a physician, except as specifically provided in this SPD
- ◆ Treatment which is not medically necessary, as described under **Covered Services and Supplies** earlier in this SPD

WHAT'S NOT COVERED

- ◆ 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 for which a third party may be liable, unless otherwise payable as described under **Reimbursement and Subrogation**, later in this SPD
- ◆ Vision therapy/training or eye exercises to increase or enhance visual activity or coordination
- ◆ Wigs and artificial hair pieces or any drug—prescription or otherwise—used to treat baldness, except in cases of baldness resulting from chemotherapy, radiation therapy, or surgery, in which case benefits are limited to one wig once every 24 months up to a \$350 maximum benefit, as preauthorized by EHP Utilization 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 Student Health Program Customer Service at 410-424-4485 or 888-400-0091.

OTHER INFORMATION ABOUT YOUR BENEFITS

Other Information About Your Student Health Program Benefits

Filing A Claim With Employer Health Programs

You do not have to file a claim with Employer Health Programs if you receive services from a Network provider under the Student Health Program. Network providers will file claims for you.

You do need to file a claim with Employer Health Programs if you receive services from an Out-of-Network provider, 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. You also need to file a claim if you purchase prescription drugs from an Out-of-Network pharmacy, as explained under Prescription Drug Benefits.

To submit your claim, complete a claim form, attach your itemized bills to it, and send it to the address shown on the form. Claims should be reported promptly, and no claims will be accepted after 18 months from the date services or supplies were provided.

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

Claim forms are available online at www.ehp.org. To avoid delay in handling your claim, answer all questions completely and accurately. ***Expenses cannot be processed without your signature in the appropriate areas of the form.***

More information about your claims and appeals rights is set forth later in this SPD under **Claims and Appeals**.

Coordination of Benefits

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

OTHER INFORMATION ABOUT YOUR BENEFITS

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

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

If the Student Health Program is the Secondary Plan, only covered expenses up to the Program'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 or School 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.

In cases where parents are divorced or legally separated, the Coordination of Benefits rules only apply when a child is actually covered under the separate plans of both parents. In that event, the plan of the parent with a court order or legal agreement setting responsibility for health care expenses is the Primary Plan, and the plan of the other parent is the Secondary Plan. If there is no such court order or legal agreement, the birthday rule applies.

If you are married or have a domestic partner, the plan of your spouse/domestic partner is the Primary Plan for expenses incurred by your spouse/domestic partner and the Student Health Program is the Secondary Plan. The plan of your spouse/domestic partner is the Secondary Plan for expenses incurred by you and the Student Health Program is the Primary Plan.

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

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

The Student Health Program is the Primary Plan if you are covered under the Program as an active employee and you are also covered by Medicare or Medicaid. Similarly, if you are covered under the

OTHER INFORMATION ABOUT YOUR BENEFITS

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

When the Program is the Secondary Plan, it will deem the Primary Plan to have made all benefit payments that would have been made had 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 Program will make its Secondary Plan payment based on the payment the Primary Plan would have made if you submitted the claim on time or if you obtained the required preauthorization.

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

The Student Health Program is always the Secondary Plan to your automobile no-fault coverage, personal injury protection coverage, medical payments coverage, or coverage required by law. This rule applies even if any such coverage states that it is secondary to health insurance coverage. You should review your automobile insurance policy to ensure that uncoordinated medical benefits have been chosen so that the automobile insurance policy is the Primary 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.

Reimbursement and Subrogation

If you or your dependents have an injury, illness or other condition that is covered by the Student Health Program and for which a third party might be liable, you must notify Johns Hopkins Employer Health Programs as soon as possible. By participating in the Program, you agree to comply with the reimbursement and subrogation provisions of this section as a condition of receiving benefits from the Program. Failure to comply is grounds for denial of your claim, and could require you to repay any benefits previously received and pay for costs incurred by the Program.

Any reference to "you" or "your" in this section includes your spouse and your dependents, and the legal representative, guardian, estate or heirs of you, your spouse and your dependents.

OTHER INFORMATION ABOUT YOUR BENEFITS

The Program's reimbursement and subrogation rights in this section extends to all insurance coverage available to you due to an injury, illness or condition for which the Program has paid or may pay medical benefits including, but not limited to, liability coverage, uninsured motorist coverage, underinsured motorist coverage, personal umbrella coverage, medical payments coverage, workers compensation coverage, no fault automobile coverage or any first party insurance coverage.

The Program is always secondary to your automobile no-fault coverage, personal injury protection coverage, or medical payments coverage.

Any third party who is contracted by the Program to enforce the reimbursement and subrogation provisions of this section has the authority and discretion to interpret the provisions of this section and to make any findings of fact necessary to enforce the Program's rights.

Your obligations

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

You or your legal representative must provide written notice to the Program as soon as practicable (but in no event later than 30 days) after notice is given by you or on your behalf to any party against whom you intend to pursue a claim.

If you enter into litigation or settlement negotiations regarding the obligations of other parties, you must not prejudice the Program's reimbursement and subrogation rights in this section in any way. This includes, but is not limited to, refraining from making any settlement or recovery that attempts to reduce or exclude the full cost of all benefits provided by the Program. The Program has the right to withhold or offset future benefit payments up to the amount of any settlement, judgment, or recovery you obtain, regardless of whether the settlement, judgment or recovery is designated to cover future medical benefits or expenses.

You may not assign any rights you may have to recover medical expenses from any person or entity to your minor child or children without the prior express written consent of the Program.

OTHER INFORMATION ABOUT YOUR BENEFITS

Failure to comply with your obligations under this section may result in the termination of your Program coverage or the institution of legal proceedings against you.

By participating in the Program, you agree to pay all attorneys' fees the Program incurs in successful attempts to recover amounts the Program is entitled to under this section, where such fees were incurred by the Program due to your failure to comply with your obligations. You agree that the Program has the right to choose the jurisdiction and venue of any dispute involving the Program's rights under this section.

Reimbursement

The Program's reimbursement rights apply when you 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. These amounts are called a "Recovery". If you receive a Recovery, the Program will subtract the amount of the Recovery from the benefits it would otherwise pay for treatment of the injury, illness or other condition or for disability. If there is a possible future Recovery, the Program may delay paying benefits until the Recovery is received, and then subtract the amount of the Recovery.

You must not disburse, or agree to the disbursement of, any portion of a Recovery until the Program's rights under this section have been satisfied.

If the Program has already paid benefits to you or on your behalf for treatment of an injury, illness or other condition or for disability, you must promptly reimburse the Program from any Recovery received for the amount of benefits paid by the Program. Reimbursement must be made on a first dollar basis regardless of whether you are fully compensated ("made whole") by the Recovery. The Program does not waive its reimbursement rights where your Recovery is not sufficient to fully compensate you for your damages.

The Program is not required to contribute to the fees and costs of your personal injury attorney. The Program's reimbursement rights apply to all settlements and judgments in your favor, no matter how characterized or designated. The Program is entitled to reimbursement regardless of whether any liability for payment is admitted, and regardless of whether the settlement or judgment identifies the medical benefits the Program provided or purports to allocate any portion of such settlement or judgment to payment of expenses other than medical expenses. The Program is entitled to recover from any and all settlements or judgments, even those designated as pain and suffering, non-economic damages and/or general damages only. The Program's claim will not be reduced due to your own negligence.

OTHER INFORMATION ABOUT YOUR BENEFITS

In order to secure the Program's reimbursement rights, you, to the full extent of the Program's claim for reimbursement, (1) grant the Program a first priority lien against the proceeds of any Recovery received and against any party who is in possession of funds that may ultimately be used for your Recovery; (2) assign to the Program any benefits you may have under any insurance policy or other coverage and (3) agree to hold in constructive trust as a fiduciary for the Program the proceeds of any Recovery received. Failure to hold such proceeds in trust will be deemed a breach of your fiduciary duties to the Program. By paying, or being obligated to pay, any claims to you or on your behalf, the Program automatically has the lien and other rights described in this section.

Subrogation

The Program's subrogation rights apply when another party (including an insurance carrier) is or may be liable for your injury, illness or other condition, and the Program has already paid, or may in the future pay, benefits for treatment of the injury, illness or other condition or for disability.

Subrogation means the right of the Program to pursue a responsible party for expenses paid, or that may in the future be paid, by the Program resulting from an accident or injury. The Program has the right to "step into your shoes" to recover from any source of recovery available to you, and you assign to the Program any rights of recovery you may have.

The Program is subrogated to all of your rights against any party (including an insurance carrier) that is or may be liable for your injury, illness or other condition or for paying for treatment of the injury, illness or other condition. The Program is subrogated to the extent of the amount of the medical benefits it pays to you or on your behalf. The Program may assert its subrogation right independently of you, without your consent, and whether or not you decide to pursue a claim. The Program is not required to pay you part of any recovery it may obtain, even if the Program files suit in your name.

The Program's rights

The Program has the right to conduct an investigation regarding your injury, illness or condition to identify potential sources of recovery. The Program may notify all parties and their agents of the Program's lien under this section. Agents include, but are not limited to, insurance companies and attorneys.

The Program has the right under federal and state law, including under the HIPAA privacy regulations, to share your personal health information in exercising its subrogation and reimbursement rights.

The Program's legal costs in reimbursement and subrogation matters will be borne by the Program. However, if you take any action to prevent the Program from enforcing its reimbursement or

OTHER INFORMATION ABOUT YOUR BENEFITS

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

The Program is only responsible for those legal costs to which it agrees in writing, and will not otherwise bear your legal costs. Your legal costs will be borne by you and not by the Program.

Workers Compensation Recovery

If the Program pays benefits related to an incident, and determines you received Workers Compensation benefits for the same incident, the Program has the rights of recovery as described above under Reimbursement and Subrogation. The Program can exercise its rights of recovery against you.

The recovery rights can be applied even though:

- The Workers Compensation benefits are in dispute or are made by means of settlement or compromise;
- No final determination is made that bodily injury or illness was sustained in the course of or resulted from your employment;
- The amount of Workers Compensation due to the medical or health care received is not agreed upon or defined by you or the Workers Compensation carrier; or
- The medical or health care benefits are specifically excluded from the Workers Compensation settlement or compromise.

As a participant in the Program, you agree to notify the Plan Administrator of any Workers Compensation claim you make, and you agree to the Program's rights of reimbursement and subrogation as described above.

Benefits Paid by Mistake

If the Program pays benefits that you are not entitled to under the terms of the Program, this is called a benefit paid by mistake. If the Program pays a benefit by mistake, the Program 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 Program and to repay it to the Program.

When Medical Coverage Ends

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

OTHER INFORMATION ABOUT YOUR BENEFITS

- ◆ The end of the month in which you no longer meet the requirements for coverage as set forth under **Who is Eligible** earlier in this SPD;
- ◆ The date on which you report for active duty as a full-time member of the armed forces of any country;
- ◆ The date the Student Health Program is terminated or the date your school terminates its participation in the Program;
- ◆ The end of the month in which you elect to no longer be covered under the Student Health Program or the date you stop making required contributions for coverage under the Program.

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

- ◆ The date your coverage ends;
- ◆ The end of the month in which they no longer qualify as an eligible dependent;
- ◆ The end of the month in which you elect to no longer cover your dependents under the Student Health Program or the date you stop making required contributions for dependent coverage under the Program;
- ◆ The date your dependent enters military service.

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

COBRA Continuation Coverage

COBRA allows you, your spouse/domestic partner or former spouse/domestic partner, and your and your domestic partner's dependents to continue your Student Health Program medical coverage for a specified period of time after certain qualifying events take place. Except as explained below for newborn or adopted children, only persons who are actually covered under the Program on the date of the qualifying event may continue coverage under COBRA. You, your spouse/domestic partner, and your and your domestic partner's adult dependents have separate election rights. To continue coverage under COBRA, the covered person must pay the full premium rates, plus a two percent administrative charge.

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

Length of COBRA Coverage

OTHER INFORMATION ABOUT YOUR BENEFITS

Coverage under the Student Health Program may be continued under COBRA for up to 18 months for you, your spouse/domestic partner, and you and your partner's eligible dependents, if coverage is lost due to your no longer being registered as a student with any of the schools that participate in the Program. Coverage may be continued for up to 24 months if you are also employed by one of the schools and your employment ends because you are called up for military duty that is covered by the Uniformed Services Employment and Reemployment Rights Act (commonly known as "USERRA").

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

If you, your spouse/domestic partner, or any of your or your domestic partner's dependents is Social Security disabled at any time during the first 60 days of COBRA coverage, coverage for the disabled individual, and each of the individual's family members, may be extended for an additional 11 months, for a total of 29 months. Premiums for the additional 11 months will increase from 102% to 150% of the full cost. The Plan Administrator must be notified in writing of 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, your domestic partner or any of your or your domestic partner's dependents that they are no longer disabled, then the additional 11 months of COBRA coverage no longer applies and you must notify the Plan Administrator within 30 days of the Social Security notice.

Please contact the Plan Administrator if you have any questions about your eligibility.

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

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

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

OTHER INFORMATION ABOUT YOUR BENEFITS

Your and your domestic partner's 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 under **Who Is Eligible** earlier in this SPD.

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

You, your spouse/domestic partner, or your or your domestic partner's dependents will be notified of the right to continue coverage under COBRA if:

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

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/domestic partner, or your or your domestic partner's dependent child must notify the Plan Administrator in writing within 60 days after the second event. If the Plan Administrator is not notified in time, COBRA may not be continued past 18 months.

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

Electing COBRA Coverage

You, your spouse/domestic partner or your or your domestic partner's 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 your Student Health Program medical coverage under COBRA. If COBRA is not elected, coverage under the Student Health Program will end.

OTHER INFORMATION ABOUT YOUR BENEFITS

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

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

Each individual who elects to continue coverage 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/domestic partner, 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 Student Health Program will not pay any claims made in the interim. Upon reinstatement of coverage, invoices may be submitted or re-submitted to the Program for payment.

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

The University Health Services Health Center (UHSHC) only provides services to those persons who pay the student health fee, and their adult dependents. The UHSHC does not provide pediatric care.

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
- ◆ The Student Health Program stops providing group medical coverage for all active students.

When You Become Covered By Medicare

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

OTHER INFORMATION ABOUT YOUR BENEFITS

When you reach age 65, you will be eligible for Medicare benefits. You will not be covered by Medicare until you enroll. You may become eligible for Medicare benefits at an earlier date if you become permanently disabled.

The Student Health Program 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 Program's prescription drug benefit constitutes "creditable coverage" for Medicare Part D purposes.

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 Student Health Program coverage as an active employee of your school, the Program will continue as your primary insurance for up to 30 months after your Medicare coverage can begin. Thereafter, or if you are eligible for Student Health Program coverage only as a student, the Program 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 Student Health Program 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 Program 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 Program 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 Program 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
- ◆ for specific health services related to gender transition if those result in discrimination against a transgender individual.

OTHER INFORMATION ABOUT YOUR BENEFITS

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 7231 Parkway Drive, Suite 100, Hanover, MD 21076, phone: 1-844-422-6957, fax: 1-410-762-1527, and email: 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>.

Administrative Information

Following is information regarding the administration and funding of the Student Health Program.

Name of Program/Plan

The Johns Hopkins University Student Health Program.

Plan Administrator

The Johns Hopkins University School of Medicine
733 N. Broadway

OTHER INFORMATION ABOUT YOUR BENEFITS

Miller Research Building, Suite 147
Baltimore, MD 21205

Administrator Identification Number

52-0595110

Plan Number

513

Plan Sponsors

The Student Health Program is sponsored by the Schools listed on page 2 under **Who Is Eligible**

Agent for Legal Process

Service of legal process may be made upon the Plan Administrator.

Plan Year

July 1 -- June 30.

Source of Program Benefit Payments

Benefits under the Program are paid from the general assets of the Schools that sponsor the Program. Benefits are not paid or administered by an insurance company.

Prohibition On Assignment Of Benefits

No benefit payment, or claim of a right to or cause of action for a benefit payment under the Program may be transferred or assigned to another person or entity, and no attempted transfer or assignment will be recognized by the Program. The Program may make direct payment of benefits to providers in accordance with arrangements between the Program and the providers. However, such a payment does not make the provider an assignee, does not constitute acceptance by the Program 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 Program, ERISA or other law.

OTHER INFORMATION ABOUT YOUR BENEFITS

Claims And Appeals

In order for you to receive medical benefits under the Program, you or your provider must file a claim. Claims are filed for you by Network providers. An Out-of-Network provider can file your claim for you, but if your provider doesn't file the claim you must file it yourself.

Certain drugs require preauthorization as described under ***Injectable Drugs*** and **Prescription Drug Benefits** earlier in this SPD. Rules for appealing a denial of preauthorization are set forth in those descriptions, which at certain points in the process direct you to these appeal rules.

Following are the Program's procedures for filing claims and appealing claim denials.

The Program's procedures do not apply until a claim is filed. A "claim" is a request to Employer Health Programs for coverage of treatment you already received or a request for preauthorization of coverage by EHP Utilization Management or by Cigna for treatment you want to receive. A decision by your doctor or other provider that you do not need a certain treatment is not a claim covered by the procedures.

The Program's procedures also apply to a determination by your school that you are not covered under the Program. If you are covered by the Program and it is determined that you are no longer entitled to coverage for a reason other than your failure to maintain enrollment or pay the required contribution (a "Rescission Determination"), your coverage will not end until you have exhausted your rights under these procedures.

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

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

Certain services and supplies must be preauthorized by EHP Utilization Management (for EHP Network providers) or by Cigna (for Cigna PPO Network and Out-of-Network providers) in order to be covered. See the earlier discussion in this SPD about **Preauthorization Requirement -- Utilization Management** 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**".

OTHER INFORMATION ABOUT YOUR BENEFITS

If a 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, or
- ◆ could cause the patient to be in danger to self or others.

In general, whether a service or supply is for Urgent Care is determined by Employer Health Programs or Cigna 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**”.

Rescission Determination

A “**Rescission Determination**” is a cancellation or discontinuance of coverage that has a retroactive effect, except to the extent it is attributable to a failure to pay required premiums or contributions towards the cost of coverage. The Program will provide 30 days advance written notice of any proposed Rescission of coverage for any individual.

Filing a Claim

See the **Preauthorization Requirement - Utilization Management** 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, your provider or your Authorized Representative must complete and submit a claim form and attach itemized bills with the information described below. (Remember, a Network provider will file claims for you.) Claims should be reported promptly, and no claims will be accepted more than 18 months after the treatment was provided. Unless a different address is shown on the top of the form, send all Post-Service Claims to:

Student Health Program
c/o Johns Hopkins Employer Health Programs
7231 Parkway Drive, Suite 100
Hanover, Maryland 21076

OTHER INFORMATION ABOUT YOUR BENEFITS

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;
- ◆ proof of payment (e.g., cancelled check, credit/debit card receipt); and
- ◆ the full name of the patient.

Claim forms are available from Johns Hopkins Employer Health Programs at 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 EHP Utilization Management or Cigna preauthorizes a specific period or number of treatments, they may in rare cases later determine that the preauthorized period or number of treatments should be reduced or terminated. If that happens, EHP Utilization Management/Cigna 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.*

If EHP Utilization Management or Cigna preauthorizes a course of treatment, the Program may not deny reimbursement to the Health Care Provider for the preauthorized treatment delivered to the patient unless:

- The information submitted regarding the treatment was fraudulent or intentionally misrepresentative;
- Critical information required by EHP Utilization Management or Cigna was omitted such that Utilization Management's or Cigna's determination would have been different had it known the critical information;
- The preauthorized course of treatment for the patient was not substantially followed by the Health Care Provider; or
- On the date the preauthorized treatment was delivered:
 - the patient was not covered by the Program;
 - Employer Health Programs maintained an automated eligibility verification system that was available to the Health Care Provider by telephone or via the Internet; and
 - according to the verification system, the patient was not covered by the Program.

OTHER INFORMATION ABOUT YOUR BENEFITS

Extending an Approved Course of Treatment

If EHP Utilization Management or Cigna preauthorizes a specific period or number of treatments, and you or your provider want the period or number to be extended, you, your provider or your Authorized Representative 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 and Health Care Provider

Your Authorized Representative or your Health Care Provider may file a claim, appeal a denial of benefits, or file a Complaint with the Maryland Insurance Commissioner for you. To name an Authorized Representative, you must use a Designation of Authorized Representative form, which you can get from Employer Health Programs at www.ehp.org or by calling an EHP Customer Service Representative. A Health Care Provider is an individual acting on your behalf who has provided treatment to you and who is licensed under Maryland or other state law to provide health care services in the ordinary course of business or practice of a profession, and includes a licensed hospital.

Claims for Children

You do not need a Designation of Authorized Representative form to file or discuss claims or appeals for your child under age 18. However, for you to file or discuss claims or appeals for your child age 18 or older, your child must file a Designation of Authorized Representative form naming you as their representative.

Claims and Appeals Procedures

If your claim for benefits (Urgent Care, Pre- or Post-Service) is denied in whole or in part, or if you are the subject of a Rescission Determination, the procedures in this section must be followed and your appeal rights must be exhausted before you may file suit in court. You, your Authorized Representative or your Health Care Provider may also have the right to file a Complaint with the Maryland Insurance Commissioner as explained below under “**Filing Complaints with the Commissioner**”. Once your claim has been filed, it will be processed as set forth below and you, your Authorized Representative or your Health Care Provider will be notified of the decision in writing. Notice of the decision will also be orally communicated if it involves a utilization review determination that a proposed or delivered health care service is or was not medically necessary, appropriate or efficient, and the determination may result in noncoverage of the health care service. When notice is orally communicated, written notice of the decision will be provided within five

OTHER INFORMATION ABOUT YOUR BENEFITS

working days after the decision is made, except that in the case of an Urgent Care Claim written notice of the decision will be provided within one day after the decision is made.

All notices of claim decisions, whether oral or written, will be provided in a manner calculated to be understood by you, your Authorized Representative or your Health Care Provider, and will be provided in a culturally and linguistically appropriate manner as required by regulations under the Affordable Care Act. Notices will state the name, business address and business telephone number of an Employer Health Programs employee responsible for the Claims and Appeals process, and will include a description of the right to file a Complaint with the Maryland Insurance Commissioner within four months after receipt of the notice of the decision. Notices will include the Commissioner's address, telephone number and fax number. Notices will include a statement that the Health Advocacy Unit is available to assist you or your Authorized Representative in both mediating and filing appeals under these procedures, and will include the address, telephone number, fax number and email address of the Health Advocacy Unit.

Urgent Care Claims

If an Urgent Care Claim is improperly filed, whoever filed the claim (referred to as the "claimant") will be notified within 24 hours. The notice may be oral, unless the claimant requests that it be written.

Unless additional information is needed, the claimant will be orally notified of an Urgent Care Claim decision within 24 hours after the claim is properly filed. If an Urgent Care Claim involves a request to extend an approved course of treatment, and the request is received at least 24 hours before the end of the approved course of treatment, the claimant will be orally notified of the decision within 24 hours. In either case, written notification will be sent to the claimant within one day after oral notice is given.

Pre-Service Claims

If a Pre-Service Claim is improperly filed, the claimant will be notified within five days. The notice may be oral, unless the claimant requests that it be written.

Unless additional information is needed, the claimant will be notified of a Pre-Service Claim decision within 15 days after the claim is properly filed, but not later than five days after the decision has been made. If there are matters beyond Employer Health Programs' or Cigna's control, this period may be extended up to 15 more days. If an extension is needed, the claimant will be told before the initial 15 day period ends why an extension is needed and when a decision is expected.

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If a Pre-Service Claim involves an initial determination regarding a nonemergency course of treatment, the decision will be made within two working days after receipt of the information necessary to make the decision, and your provider will be promptly notified of the decision.

If a Pre-Service Claim involves an extended stay in a health care facility or additional health care services, the decision will be made within one working day after receipt of the information necessary to make the decision, and your provider will be promptly notified of the decision.

If within three calendar days after receipt of the initial request for health care services Employer Health Programs or Cigna does not have sufficient information to make a determination, it will inform the health care provider that additional information must be provided.

If prior authorization is required for an emergency inpatient admission, or an admission for residential crisis services for treatment of a mental, emotional or substance abuse disorder, Employer Health Programs or Cigna will make all determinations on whether to authorize or certify such an inpatient admission or admission for residential crisis services within two hours after receipt of the information necessary to make the determination, and will promptly notify the health care provider of the determination.

Post-Service Claims

Unless additional information is needed, if a Post-Service Claim is denied, the claimant will be notified within 30 days after the claim is properly filed, but not later than five days after the decision has been made. If there are matters beyond Employer Health Programs' or Cigna's control, this period may be extended up to 15 more days. If an extension is needed, the claimant 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 more information is needed to decide a Pre-Service or Post-Service Claim, the claimant will be told what additional information is needed and will have 45 days to supply it. The time limit to decide the claim is suspended until the claimant supplies the additional information. If the claimant does not supply the information within 45 days, the claim will be processed without the additional information, and reasonable presumptions may be drawn from the failure to supply the additional information. The decision on the claim will take into account all the information available to Employer Health Programs or Cigna.

Urgent Care Claims

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If more information is needed to decide an Urgent Care Claim, the claimant will be told by telephone within 24 hours what additional information is needed and will have 48 hours to supply it. The caller will offer to assist the claimant, the claimant's representative or the health care provider in gathering the necessary information. The time limit to decide the Urgent Care Claim is suspended until the claimant supplies the additional information.

The claimant will be notified by telephone of the decision on the Urgent Care Claim within 24 hours after the earlier of when (1) the claimant supplies the additional information or (2) the time to supply the additional information expires. If the claimant does not supply the information within 48 hours, the claim will be processed without the additional information, and reasonable presumptions may be drawn from the failure to supply the additional information. The decision on the claim will take into account all the information available to Employer Health Programs or Cigna.

If A Claim is Denied

The claimant will be notified in writing if a claim (Urgent, Pre- or Post-Service) is denied in whole or in part. You will be notified in writing if you are the subject of a Rescission Determination. The claimant will be orally notified of the decision if it involves a utilization review determination that a proposed or delivered health care service is or was not medically necessary, appropriate or efficient, and the determination may result in noncoverage of the health care service. When oral notice is given, written notice of the decision will be provided within five working days after oral notice is given. The written notice will state why the claim was denied or coverage rescinded and the specific Program provisions and factual bases on which the denial or rescission is based. It will also describe any additional information that could change the decision. The notice will state how and when the denial or rescission can be appealed.

The notice will state if an internal rule or guideline was relied on to deny the claim, and how to request a free copy of the rule or guideline. The notice will state if the 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. The notice will reference the specific criteria and standards, including interpretive guidelines, on which the decision was based, and will not solely use generalized terms such as "experimental procedure not covered", "cosmetic procedure not covered", "service included under another procedure" or "not medically necessary".

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

If a claim is denied, the notice will state that you, your Authorized Representative or your Health Care Provider have the right to file a Complaint with the Maryland Insurance Commissioner within four months after receipt of a denial of a First Level Appeal, as explained below under **Filing Complaints**

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with the Commissioner. The Final Appeal process does not have to be completed before filing a Complaint with the Commissioner. The notice will also state that you, your Authorized Representative or your Health Care Provider have the right to file a Complaint with the Commissioner without completing the First Level Appeal process, for the reasons set forth below under **Filing Complaints with the Commissioner.** The notice will state the name, business address and business telephone number of an Employer Health Programs employee responsible for the Claims and Appeals process. The notice will include the Commissioner's address, phone number and fax number, a statement that the Health Education and Advocacy Unit is available to assist you, your Authorized Representative or your Health Care Provider in both mediating and filing an appeal under the Program's Claims and Appeals process, and the Health Education and Advocacy Unit's address, phone number, fax number and email address.

First Level Appeal

If you, your Authorized Representative or your Health Care Provider think a mistake was made in denying a 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, your Authorized Representative or your Health Care Provider may file a First Level Appeal. You may also file a First Level Appeal if you are the subject of a Rescission Determination.

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

If a First Level Appeal is not filed within the time allowed, you lose all rights to appeal.

Except for an appeal of a denial of an Urgent Care Claim, a First Level Appeal must be in writing. The Appeal may be hand delivered to Employer Health Programs or filed by mail. If filed by mail, a notice of receipt will be sent to the filer. The address for First Level Appeals is:

Johns Hopkins HealthCare
Appeals Department
7231 Parkway Drive, Suite 100
Hanover, MD 21076

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If a First Level Appeal involves a refusal by Cigna to preauthorize treatment, the Appeal must be mailed to the address provided by Cigna in the notice that preauthorization is denied.

A First Level Appeal of a denial of an Urgent Care Claim may be made orally or in writing. All information for an Urgent Care Claim appeal should be supplied by telephone, fax, hand delivery or other similar method. A denial of an Urgent Care Claim may be appealed 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.

If a First Level Appeal of a denial of an Urgent Care Claim involves a refusal by Cigna to preauthorize treatment, the denial may be appealed by hand delivery to the address provided by Cigna, or by telephone or fax to the number provided by Cigna.

A First Level Appeal involves an Urgent Care Claim if following the time limits (set forth above) for deciding 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, or
- ◆ could cause the patient to be in danger to self or others.

In general, whether a service or supply is for Urgent Care is determined by Employer Health Programs or Cigna 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.

All First Level Appeals will be submitted to the EHP or Cigna appeals department. You, your Authorized Representative or your Health Care Provider may submit written comments, documents, records and other information relating to the claim. The appeals department will consider everything submitted, regardless of whether it was submitted or considered in the initial claim determination. Upon written request and free of charge, you, your Authorized Representative or your Health Care

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Provider will be provided with reasonable access to and copies of all Program documents, records and other information relevant to the claim.

If your claim for treatment in an emergency department was denied on the grounds that you did not have an emergency medical condition, 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, the person filing the Appeal will be provided, free of charge, with any new or additional evidence considered, relied upon, or generated by (or at the direction of) the Program in connection with the claim, and with any new or additional rationale for denying the claim. In either case, the evidence or rationale will be provided as soon as possible and sufficiently in advance of the date on which the appeals department will decide the First Level Appeal, so as to give a reasonable opportunity to respond prior to that date.

If the denial of a 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 the appeal. The health care professional will be (i) a licensed physician who is board certified or eligible in the same specialty as the treatment involved in the claim under review, or (ii) a panel of other appropriate health care service reviewers with at least one licensed physician on the panel who is board certified or eligible in the same specialty as the treatment involved in the claim under review. If the claim involves a mental health or substance abuse service, the health care professional will be (i) a licensed physician who (1) is board certified or eligible in the same specialty as the treatment involved in the claim under review or (2) is actively practicing or has demonstrated expertise in the substance abuse or mental health service or treatment under review, or (ii) a panel of other appropriate health care service reviewers with at least one licensed physician on the panel who (1) is board certified or eligible in the same specialty as the treatment involved in the claim under review or (2) is actively practicing or has demonstrated expertise in the substance abuse or mental health service or treatment under review.

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

If the appeals department needs more information to decide a First Level Appeal of an Urgent Care Claim, the claimant will be told by telephone within 24 hours what additional information is needed and will have 48 hours to supply it. The caller will offer to assist the claimant, the claimant's representative or the health care provider in gathering the necessary information. The time limit for the appeals department to decide the First Level Appeal of an Urgent Care Claim is suspended until the claimant supplies the additional information.

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When A First Level Appeal Will Be Decided

The time in which a 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** – the person filing the Appeal will be notified of the decision within 24 hours after the First Level Appeal is filed. If more information is needed to decide the Appeal, the person filing the Appeal will be notified of the decision within 24 hours after the additional information is supplied.
- ◆ **Pre-Service Claim** – the person filing the Appeal will be notified of the decision within 15 days after the First Level Appeal is filed.
- ◆ **Post-Service Claim** – the person filing the Appeal will be notified of the decision within 30 days after the First Level Appeal is filed.
- ◆ **Reduction or termination of an approved course of treatment** – notice of the decision will be given within 30 days after the First Level Appeal is filed. However, if the Appeal was filed within 10 days after notice of the proposed action was given, the course of treatment will not be reduced or terminated before the Appeal is decided. (See below for additional Final Appeal rights that may apply before treatment is reduced or terminated.)
- ◆ **Request to extend an approved course of treatment** – if the First Level Appeal is filed before the additional treatment has been provided, the Pre-Service Claim time applies, unless the appeal involves Urgent Care, in which event the Urgent Care Claim time applies. If the Appeal is filed after the additional treatment has been provided, the Post-Service Claim time applies.

The person filing the First Level Appeal will be notified of the decision on the Appeal within the time frames set forth above. Notice of the decision will be given orally if it involves a utilization review determination that a proposed or delivered health care service is or was not medically necessary, appropriate or efficient, and the determination may result in noncoverage of the health care service. When oral notice is given, written notice of the decision will be provided within five working days after oral notice is given, or within one working day if the Appeal relates to an Urgent Care Claim. If the Appeal is denied in whole or in part, the notice will state why and the specific Program provisions and factual bases on which the denial is based. The notice will state if an internal rule or guideline was relied on to deny the Appeal, and how to request a free copy of the rule or guideline. The notice will

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state if the 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 reference the specific criteria and standards, including interpretive guidelines, on which the decision was based, and will not solely use generalized terms such as “experimental procedure not covered”, “cosmetic procedure not covered”, “service included under another procedure” or “not medically necessary”. The notice will also state how and when to file a Final Appeal. If the claim is an Urgent Care Claim, the notice will explain the expedited Final Appeal process.

If a First Level Appeal is denied, the notice will state that you, your Authorized Representative or your Health Care Provider have the right to file a Complaint with the Maryland Insurance Commissioner within four months after receipt of a denial of the First Level Appeal, as explained below under **Filing Complaints with the Commissioner**. The Final Appeal process does not have to be completed before filing a Complaint with the Commissioner. The notice will also state that you, your Authorized Representative or your Health Care Provider have the right to file a Complaint with the Commissioner without completing the First Level Appeal process, for the reasons set forth below under **Filing Complaints with the Commissioner**. The notice will state the name, business address and business telephone number of an Employer Health Programs employee responsible for the Claims and Appeals process. The notice will include the Commissioner’s address, phone number and fax number, a statement that the Health Education and Advocacy Unit is available to assist you, your Authorized Representative or your Health Care Provider in both mediating and filing an appeal under the Program’s Claims and Appeals process or in filing a Complaint with the Commissioner, and the Health Education and Advocacy Unit’s address, phone number, fax number and email address.

Final Appeal

If a First Level Appeal is denied in whole or in part, you, your Authorized Representative or your Health Care Provider may make a Final Appeal to the Plan Administrator. However, if your First Level Appeal involved a refusal by Cigna to preauthorize treatment, you must instead make the Final Appeal to Cigna. Except for an appeal of a denial of an Urgent Care claim, a Final Appeal must be in writing and must include details about your claim and why you, your Authorized Representative or your Health Care Provider think it should not be denied. A Final Appeal must be submitted to the Plan Administrator in care of the Johns Hopkins HealthCare Appeals Department at the address shown above. However, if your First Level Appeal involved a refusal by Cigna to preauthorize treatment, you must submit the Final Appeal to Cigna at the address provided in the First Level Appeal denial.

If your First Level Appeal for treatment in an emergency department 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. All information for an Urgent Care Claim Appeal should be supplied by telephone, fax, hand delivery or other similar

OTHER INFORMATION ABOUT YOUR BENEFITS

method. A Final Appeal of a denial of an Urgent Care Claim may be made 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.

If your First Level Appeal of a denial of an Urgent Care Claim involved a refusal by Cigna to preauthorize treatment, you must make the Final Appeal of the denial by hand delivery to the address provided by Cigna, or by telephone or fax to the number provided by Cigna.

Except for an appeal of a reduction or termination of an approved course of treatment, a Final Appeal must be filed within the later of (1) 90 days after notice is given of the appeals department's denial of a First Level Appeal or (2) 180 days after initial notice was given that a claim was denied.

Note: if you file a Complaint with the Maryland Insurance Commissioner after receipt of a denial of the First Level Appeal as explained above, doing so does not extend the time deadline for filing a Final Appeal. Failure to timely file a Final Appeal means you lose all rights to appeal. However, failure to timely file a Final Appeal does not affect your right to pursue your Complaint with the Maryland Insurance Commissioner.

If a First Level Appeal of a proposed reduction or termination of an approved course of treatment was denied and you, your Authorized Representative or your Health Care Provider wish to file a Final Appeal and have a decision on the Appeal before the proposed action takes effect, the Final Appeal must be filed within five days after notice of the denial is given. If a Final Appeal is filed more than five days after notice of the denial is given, the reduction or termination will probably take effect before a decision is made on the Final Appeal.

If a Final Appeal is not filed within the time allowed, you lose all rights to appeal.

A Final Appeal will be considered by the Plan Administrator or Cigna. You, your Authorized Representative or your Health Care Provider may submit written comments, documents, records and other information relating to the claim. Everything you submit will be considered, regardless of whether it was submitted or considered in the initial benefit determination or the First Level Appeal. Upon written request and free of charge, you, your Authorized Representative or your Health Care Provider will be provided with reasonable access to and copies of all Program documents, records and other information relevant to the claim.

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

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

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

The time limit for deciding a 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 – the person filing the Appeal will be notified of the decision within 24 hours after the Final Appeal is filed.

Pre-Service Claim -- the person filing the Appeal will be notified of the decision within 15 days after the Final Appeal is filed.

Post-Service Claim -- the person filing the Appeal will be notified of the decision within 30 days after the Final Appeal is filed.

Reduction or termination of an approved course of treatment – the person filing the Appeal will be notified of the decision within 30 days after the Final Appeal is filed. However, if the Final Appeal is filed within five days after notice was given of the denial of the First Level Appeal, the approved course of treatment will not be reduced or terminated before the Final Appeal is decided.

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

The person filing a Final Appeal will be notified of the decision within the time frames set forth above. Notice of the decision will be given orally if it involves a utilization review determination that a

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proposed or delivered health care service is or was not medically necessary, appropriate or efficient, and the determination may result in noncoverage of the health care service. When oral notice is given, written notice of the decision will be provided within five working days after oral notice is given, or within one working day if the Appeal relates to an Urgent Care Claim. If a 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 Final Appeal decision, you may bring a civil action against the Program under ERISA Section 502 if you are an employee of your School and if you are covered by ERISA. If a First Level Appeal is denied, the notice will state that you, your Authorized Representative or your Health Care Provider have the right to file a Complaint with the Maryland Insurance Commissioner within four months after receipt of a denial of a First Level Appeal, without completing the Final Appeal process, as explained below under **Filing Complaints with the Commissioner**. The notice will also state that you, your Authorized Representative or your Health Care Provider have the right to file a Complaint with the Commissioner without completing the First Level Appeal process, for the reasons set forth below under **Filing Complaints with the Commissioner**. The notice will state the name, business address and business telephone number of an Employer Health Programs employee responsible for the Claims and Appeals process. The notice will include the Commissioner's address, phone number and fax number, a statement that the Health Education and Advocacy Unit is available to assist you, your Authorized Representative or your Health Care Provider in both mediating and filing an appeal under the Program's Claims and Appeals process or in filing a Complaint with the Commissioner, and the Health Education and Advocacy Unit's address, phone number, fax number and email address.

Employer Health Programs, the Plan Administrator and Cigna 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.

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).

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 or your Health Care Provider 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.

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You must submit the completed Request for External Review Form to EHP or to Cigna 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 Program under ERISA Section 502 (if you are an employee of your School and if you are covered by ERISA) or to file a Complaint with the Maryland Insurance Commissioner. Whether or not you submit your claim to External Review will have no effect on your rights to any other benefits under the Program. There is no charge for you to submit your claim to 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, the Plan Administrator or Cigna 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 by EHP, the Plan Administrator or Cigna 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, the Plan Administrator's or Cigna's control, and part of an ongoing good faith exchange between you and EHP, the Plan Administrator or Cigna.

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

Preliminary Review

Within six business days following receipt of your request for External Review, EHP or Cigna 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

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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, an accredited IRO will be assigned to conduct the External Review, and will be provided 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). You will be notified 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 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, Cigna, you or your treating provider;
- The terms of the Program (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 or by Cigna (unless inconsistent with the Program or the law); and
- The opinion of the IRO's clinical reviewer(s) after considering the above information.

You will be provided 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 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 Program will provide coverage or payment in accordance with the decision, subject to the right of the Program

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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 Program, 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 Program (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, you will be notified in writing whether you are eligible for expedited External Review and whether your request contains all necessary paperwork. If eligible, your request will be assigned to an IRO as explained above using the most expeditious means of transmission reasonably available.

You will be provided 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, you will be provided written confirmation of the IRO's decision within 48 hours after the oral notice was given.

Filing Complaints with the Commissioner

When a Complaint Can Be Filed

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Within four months after receipt of a First Level Appeal decision (including a decision involving a Rescission Determination), you, your Authorized Representative or your Health Care Provider may file a Complaint with the Commissioner of the Maryland Insurance Administration for review of the First Level Appeal decision.

You, your Authorized Representative or your Health Care Provider may file a Complaint with the Commissioner without filing a First Level Appeal or receiving a First Level Appeal decision if:

- The Plan Administrator waives the requirement that the internal Claims and Appeals process be exhausted before filing a Complaint with the Commissioner;
- The Plan Administrator, Employer Health Programs or Cigna have failed to comply with any of the requirements of the internal Claims and Appeals process;
- You, your Authorized Representative or your Health Care Provider provides a compelling reason to do so as determined by the Commissioner. For example, you, your Authorized Representative or your Health Care Provider could provide sufficient information and supporting documentation in the Complaint to demonstrate that the potential delay in receipt of a health care service until after exhaustion of the internal Claims and Appeals process could result in loss of life, serious impairment to a bodily function, serious dysfunction of a bodily organ, or the patient remaining seriously mentally ill with symptoms that cause the patient to be a danger to self or others;
- The Complaint involves an Urgent Care Claim condition for which care has not been rendered; or
- You, your Authorized Representative or your Health Care Provider do not receive the Program's decision on an appeal within the following timeframes:
 - Within 30 days after the filing date of an appeal regarding a Pre-Service Claim
 - Within 45 days after the filing date of an appeal regarding a Post-Service Claim
 - Within 24 hours after the receipt of an appeal regarding an Urgent Care Claim.

How Complaints are Handled

The following provisions generally describe the Commissioner's handling of Complaints. Actual handling of Complaints will be made in accordance with Md. Insurance Code Ann. § 15-10A-03 and §15-10D-02.

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- The Commissioner will notify the Plan Administrator, Employer Health Programs or Cigna of the Complaint within five working days after the date the Complaint is filed with the Commissioner.
- Except for an Urgent Care condition, the Plan Administrator, Employer Health Programs or Cigna will provide to the Commissioner any information requested by the Commissioner no later than seven working days from the date the Plan Administrator, Employer Health Programs or Cigna receives the request for information.
- Except as provided below, the Commissioner will make a final decision on a Complaint:
 - within 45 days after a Complaint is filed regarding a Pre-Service Claim
 - within 45 days after a Complaint is filed regarding a Post-Service Claim
 - within 24 hours after a Complaint is filed regarding an Urgent Care Claim.
- The Commissioner may extend the period within which a final decision on a Complaint is to be made for up to an additional 30 working days if the Commissioner has not yet received information requested by the Commissioner and the information requested is necessary for the Commissioner to render a final decision on the Complaint.
- The Commissioner will seek advice from an independent review organization or medical expert for Complaints filed with the Commissioner that involve a question of whether a treatment is medically necessary.
- The Plan Administrator, Employer Health Programs or Cigna will have the burden of persuasion that its claim denial or Appeal decision (including a Rescission Determination) is correct during the review of a Complaint by the Commissioner, and in any hearing held regarding the Complaint.
- As part of the review of a Complaint, the Commissioner may consider all of the facts of the case and any other evidence deemed relevant.
- In responding to a Complaint, the Plan Administrator, Employer Health Programs or Cigna usually may not rely on any basis not stated in its claim denial or appeal decision. However, the Commissioner may allow the Plan Administrator, Employer Health Programs or Cigna, you or your Authorized Representative or Health Care Provider to provide additional information as may be relevant for the Commissioner to

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make a final decision on the Complaint. The Commissioner will allow you, your Authorized Representative or your Health Care Provider at least five working days to provide the additional information. The Commissioner's use of additional information may not delay the Commissioner's decision on the Complaint by more than five working days.

- The Commissioner will require you or your Authorized Representative to sign a consent form authorizing the release of your records to the Commissioner that are needed in order for the Commissioner to make a final decision on the Complaint.
- The Commissioner may delegate the authority to review and decide Complaints to any person, including an administrative law judge.

Assistance From Health Education and Advocacy Unit

The Health Education and Advocacy Unit is available to assist you, your Authorized Representative or your Health Care Provider in both mediating and filing an appeal. Contact the Health Education and Advocacy Unit at:

Health Education and Advocacy Unit
Consumer Protection Division
Office of the Attorney General
200 St. Paul Place, 16th Floor
Baltimore, MD 21202
410- 528-1840 or 1-877- 261-8807
Fax: 410- 576-6571
[E-mail: heau@oag.state.md.us](mailto:heau@oag.state.md.us)

Protected Health Information

The Program may create or obtain information which relates to a Program participant's physical or mental health condition, treatment or payment for health care. When this information is individually identifiable, it is called "Protected Health Information" (PHI) under the Health Insurance Portability and Accountability Act of 1996 and its implementing regulations (collectively "HIPAA").

Permitted Use and Disclosure

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

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

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

Plan Sponsor's Certification

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

- ◆ Not use or further disclose PHI other than as permitted above, or as otherwise permitted by HIPAA or as required by law;
- ◆ Ensure that any agents or subcontractors who receive PHI from the Plan Sponsor that was obtained from the Program will agree to the same restrictions and conditions that apply to the Plan Sponsor;
- ◆ Not use or disclose PHI for employment related actions and decisions or in connection with any other benefit or employee benefit plan of Plan Sponsor;
- ◆ Report to the Program any known use or disclosure of PHI that is inconsistent with the uses or disclosures allowed above;
- ◆ Make PHI available to the Program for response to a participant's request for access to the participant's PHI in a designated record set, as provided by HIPAA;
- ◆ Make PHI available to the Program for amendment, and incorporate any amendments to PHI, as provided by HIPAA;
- ◆ Make available to the Program the information required to provide an accounting of disclosures as provided by HIPAA;

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- ◆ Make its internal practices, books, and records relating to use and disclosure of PHI received from the Program available to the Secretary of the Department of Health and Human Services, for purposes of determining the Program's compliance with HIPAA;
- ◆ If feasible, return or destroy all PHI received from the Program when the Plan Sponsor no longer needs the PHI for the purpose for which it was disclosed to the Plan Sponsor, except if return or destruction is not feasible, the Plan Sponsor will limit further uses and disclosures to those purposes that make the return or destruction infeasible; and
- ◆ Ensure adequate separation between the Program and the Plan Sponsor, as stated below.

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

Separation Between Program and Plan Sponsor

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

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

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

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Security of Electronic PHI

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

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

- ◆ Implement administrative, physical and technical safeguards that reasonably and appropriately protect the confidentiality, integrity and availability of the Electronic PHI that it creates, receives, maintains or transmits on behalf of the Program;
- ◆ Ensure that the separation between the Program and the Plan Sponsor as required above is supported by reasonable and appropriate security measures;
- ◆ Ensure that any agent, including a subcontractor, to whom the Plan Sponsor provides Electronic PHI agrees to implement reasonable and appropriate security measures to protect the information; and
- ◆ Report to the Program any security incident of which it becomes aware. (For purposes of this provision, “security incident” means the attempted or successful unauthorized access, use, disclosure, modification or destruction of information or interference with system operations in an information system.)

The Program 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, or you may view the Notice at www.ehp.org.

Your Rights Under ERISA

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

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

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Additional ERISA Rights

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

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

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

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

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

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

Student Health Program's Rights

The schools that participate in the Student Health Program expect to continue the Program indefinitely, but reserve the right to modify, amend, suspend, or terminate the Program at any time, and for any

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reason without prior notification except as required by law. You will be notified of any changes to this Program and how they affect your benefits, if at all. You should not rely on any oral descriptions of the Program, since the written description in this SPD will always govern. To the extent any benefits under the Program are provided by an insurance policy, no benefits are provided by the Program except for those benefits, if any, which are paid by the insurance company which issues the policy.

Plan Administrator's and Cigna's Authority

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

Minimum Essential Coverage

The benefits provided by the Student Health Program constitute “minimum essential coverage” under the Affordable Care Act.

For More Information

Please see your Student Health Program enrollment materials for additional information about the Program. If you have questions, you can speak with a Student Health Program Customer Service Representative by calling 888-400-0091 or 410-424-4485. Or, contact the benefits representative for your School at the following numbers:

- JHU School of Medicine – Registrar’s Office at 410-614-3301.
- Bloomberg School of Public Health – Student Accounts Office at 410-955-5725.
- JHH Schools of Medical Imaging – 410-528-8208.
- JHU School of Nursing – 410-955-7547.
- JHU Berman Institute for Bioethics – Finance and Administration at 410-614-5222
- JHU Sheridan Libraries – Human Resources at 410-516-8326
- JHU Krieger School of Arts and Sciences – Human Resources at 410-516-6808
- JHU Whiting School of Engineering – Human Resources at 410-516-6808
- JHU School of Education – Human Resources at 410-516-4475