

**The Johns Hopkins Hospital /The Johns Hopkins Health System
Corporation Medical, Dental, and Short Term Disability Summary Plan
Description for Non-Represented Employees**

Important Telephone Numbers and Websites

Claims or Coverage Questions	Johns Hopkins EHP HR Service Center	(410) 424-4450 or (800) 261-2393 www.ehp.org (443) 997-5400
Care Management Program (Preauthorization of services)	Johns Hopkins EHP	(410) 424-4450
COBRA Questions	HR Service Center	(443) 997-5400
Flexible Spending Accounts	HR Service Center WageWorks	(443) 997-5400 (855) 774-7441 www.wageworks.com
Short Term Disability Benefits	HR Service Center Johns Hopkins EHP	(443) 997-5400 (410) 762-5312
Claim Forms	HR Service Center	(443) 997-5400 www.ehp.org
Confidential Help With Personal Problems	Faculty and Staff Assistance Program	(443) 997-7000
Credit Union Services	Credit Union	(410) 534-4500 or (800) 543-2870

Table Of Contents

General Information About Your Benefits	1
Who Is Eligible.....	2
<i>Employee Coverage</i>	2
<i>Dependent Coverage</i>	2
<i>Domestic Partner Coverage</i>	3
<i>Qualified Medical Child Support Order (QMCSO)</i>	3
When Coverage Begins	4
Changing Your Coverage	4
Special Enrollment Rights For EHP Medical and Dental Coverage	6
<i>Losing other coverage</i>	6
<i>New Children</i>	6
<i>Medicaid and Children’s Health Insurance Program</i>	6
Coverage Costs.....	7
The Johns Hopkins EHP Medical Plan	8
Network Providers.....	8
Primary Care Physicians.....	8
Three Ways to Receive Care	9
<i>Option 1 – EHP Network and Hopkins Preferred Providers</i>	9
<i>Hopkins Preferred Providers</i>	10
<i>Option 2 – Out-of-Network Providers</i>	10
Payment Terms You Should Know	11
Care Management Program	13
Chronic Care Management Program	15
Health Coach Program	15
EHP Customer Service.....	16
What’s Covered by the Johns Hopkins EHP Medical Plan.....	17
Medical Benefits At-A-Glance.....	17
Covered Services and Supplies	23
<i>In General</i>	23
<i>Prescription Drug Benefits</i>	28
EHP Network Pharmacies	28
Copay.....	29
Medication Copay Waiver Program	29
Prior Authorization and Quantity Limits	30
What’s Not Covered	30
Over-the-Counter Drugs	31
Preventive Care Drugs	32

<i>Smoking Cessation</i>	32
<i>Emergency Services</i>	32
Emergency Medical Situation.....	32
Urgent Care Centers.....	33
<i>Out-Of-Area Care and Coverage for Students</i>	34
<i>Ambulance Services</i>	34
<i>Vision Benefits</i>	35
<i>Maternity Benefits</i>	36
<i>Infertility Treatment Benefits</i>	37
<i>Medical and Modified Foods</i>	38
<i>Women’s Health and Cancer Rights Act</i>	39
<i>Alternative Care</i>	40
Home Health Care Benefits	40
Skilled Nursing/Rehabilitation Facility Benefits.....	41
Hospice Care Benefits	42
<i>Transplants</i>	43
Mental Health and Substance Abuse Treatment	44
What’s Not Covered by The EHP Medical Plan.....	46
Johns Hopkins EHP Dental Plans	52
Dental Benefits At-A-Glance	53
What the EHP Dental Plans Cover.....	55
<i>Preventive and Diagnostic Services</i>	55
<i>Basic Services</i>	55
<i>Major Services</i>	55
<i>Orthodontia</i>	56
Pre-Treatment Review.....	56
Use Network Dentists and Save	57
Alternate Treatment.....	57
What The EHP Dental Plans Do Not Cover.....	58
Election of No Dental Benefits.....	59
Flexible Spending Accounts	60
When You Can Contribute to an FSA.....	60
How Much You Can Contribute to an FSA	61
How to Use the FSAs	61
<i>Use It or Lose It</i>	62
<i>Eligible Health Care Expenses</i>	62
Health Care FSA Worksheets.....	64
Paying Eligible Expenses From the Health Care FSA	65
<i>Debit Card</i>	65

<i>Paper Claims</i>	66
<i>Your FSA Balance</i>	66
Using the Dependent Care FSA	67
<i>Eligible Dependent Care Expenses</i>	67
<i>Eligible Day Care Providers</i>	67
When You May Use the Dependent Care FSA	68
<i>When Both Spouses Participate in Dependent Care FSAs</i>	68
The Dependent Care Tax Credit.....	68
Paying Eligible Expenses From the Dependent Care FSA.....	71
Short Term Disability Benefits	73
Payment of Benefits	73
<i>Benefits From Other Sources</i>	74
<i>Return to Work</i>	74
<i>Recurring Disabilities</i>	74
Partial Disability.....	74
What's Not Covered By Short Term Disability Benefits	75
When Short Term Disability Benefits End.....	76
Mid Term Disability Benefits.....	76
Administrative Information About Your Johns Hopkins EHP Benefits	77
Filing A Claim With Employer Health Programs	77
What Happens When You Have Duplicate Coverage.....	78
Prior Coverage Under the EHP Basic and Premium Plans	79
Employees Whose Worksite Is Outside The United States.....	79
When the EHP Medical Plan and Short Term Disability Plan May Recover Payment.....	80
<i>Reimbursement</i>	80
<i>Subrogation</i>	81
Benefits Paid by Mistake.....	81
When Benefit Plan Coverage Ends	82
COBRA Continuation Coverage	83
<i>Length of COBRA Coverage</i>	83
<i>Electing COBRA Coverage</i>	86
<i>When COBRA Coverage Ends</i>	86
Benefit Coverage During FMLA Leaves of Absence	87
Benefit Coverage During Other (Non-FMLA) Leaves of Absence.....	88
<i>Approved Medical Leaves</i>	88
<i>Approved Non-Medical Leaves</i>	88
When You Become Covered By Medicare	88
Medicare and End Stage Renal Disease	89
Plan Information.....	89
Prohibition On Assignment Of Benefits	91

Claims And Appeals.....	91
<i>Filing a Claim</i>	93
<i>Reducing or Terminating an Approved Course of Treatment</i>	94
<i>Extending an Approved Course of Treatment</i>	94
<i>Authorized Representative</i>	94
<i>Claims and Appeals Procedures</i>	94
<i>If Additional Information is Needed</i>	95
<i>If Your Claim is Denied</i>	96
<i>First Level Appeal</i>	96
<i>When Your First Level Appeal Will Be Decided</i>	98
<i>Final Appeal</i>	99
External Review.....	101
Protected Health Information.....	104
Your Rights Under ERISA.....	105
JHHSC/JHH's Rights.....	106
<i>Not A Contract Of Employment</i>	106
<i>Plan Administrator's Authority</i>	106
For More Information.....	106

GENERAL INFORMATION

General Information About Your Benefits

Benefits For You And Your Family

The Johns Hopkins Health System Corporation/The Johns Hopkins Hospital (JHHSC/JHH) offers you and your family health care benefits under the EHP Medical and Dental Plans to help you pay for medical, vision and dental care when you need it. Health Care and Dependent Care Flexible Spending Accounts (FSAs) are available to help you save on your out-of-pocket health care and dependent day care expenses.

Short Term and Mid Term Disability benefits also offer necessary income protection should you become ill or injured and are unable to work for an extended length of time.

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

The benefits described in this SPD are for eligible non-represented employees of the Johns Hopkins Health System Corporation and The Johns Hopkins Hospital. (Benefits for employees of the members of the Johns Hopkins Home Care Group and for employees of Intrastaff are set forth in separate SPDs).

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

Long Term Disability, Life and Accidental Death and Dismemberment insurance benefits are described in a separate summary plan description.

This January 2016 version of the SPD replaces the prior version of the SPD which was dated January 2014. This January 2016 version applies to all claims incurred on or after January 1, 2016.

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

GENERAL INFORMATION

Who Is Eligible

Employee Coverage

Employees are generally eligible for the benefits described in this SPD as follows:

Benefit Plan:	Full-Time Employee (30+ Hours/Week)	Part-Time Employee (20-29 Hours/Week)	Weekend Option Nurse
EHP Medical Plan (includes vision and prescription drugs)	Yes	Yes	Yes
EHP Dental Plans	Yes	Yes	Yes
Salary Protection			
• Short Term Disability (11 Weeks)	Yes	Yes	No
• Optional Mid Term Disability	Yes	Yes	No
• Optional Long Term Disability	Yes	Yes	Yes
Flexible Spending Accounts			
• Health Care Account	Yes	Yes	Yes
• Dependent Care Account	Yes	Yes	Yes

Dependent Coverage

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

- ◆ Your legal spouse. You must submit proof that you are married (such as a copy of your marriage license/certificate or income tax return) the first time you enroll your spouse. You may not cover your former spouse after a divorce has become final.
- ◆ Your children, through the end of the month in which they turn age 26. You must submit a copy of your child's birth certificate the first time you enroll your child. To be eligible, a child must be your natural child, a stepchild who resides with you, a foster child, a child legally adopted or placed with you for adoption, or a child for whom you are the legal guardian. A stepchild who does not reside with you is not eligible; and
- ◆ Your physically or mentally disabled dependent child of any age, provided the physical or mental disability began while the child was eligible as described above.

GENERAL INFORMATION

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

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

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

If you have any questions about coverage, please contact the HR Service Center at 443-997-5400.

Domestic Partner Coverage

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

Expenses of a domestic partner (or the partner's child) cannot be reimbursed under the Health Care Flexible Spending Account, unless the partner (or the child), qualifies as the employee's dependent for federal health plan tax purposes. Expenses of a domestic partner's child cannot be reimbursed under the Dependent Care Spending Account, unless the partner's child qualifies as the employee's dependent for federal health plan tax purposes and meets other requirements set forth later in this SPD under **Using the Dependent Care FSA**.

Qualified Medical Child Support Order (QMCSO)

You may enroll children who are not otherwise eligible as described above in the EHP Medical or Dental Plans if called for by a Qualified Medical Child Support Order (QMCSO). A QMCSO is a court order setting responsibility for health care expenses for non-custodial children. If you are served with a QMCSO, please send the court order to the HR Service Center as soon as possible. Coverage will only be provided if the Plan Administrator determines that the QMCSO meets applicable legal requirements.

GENERAL INFORMATION

When Coverage Begins

Coverage under the EHP Medical and Dental Plans and Short Term Disability begins the first day of the month following your date of hire, if you are eligible and you complete the online enrollment process within 30 days from your first day of work. To be eligible, you must be a full-time employee who is regularly scheduled to work at least 30 hours per week, or a part-time employee who is regularly scheduled to work at least 20 hours per week. You are also eligible if you are classified by your employer as a weekend option nurse. You are not eligible if you are classified by your employer as a temporary employee or if you are included in a unit of employees covered by a collective bargaining agreement that does not expressly provide for participation in the Plans. If you do not complete the online enrollment process within 30 days from your first day of work, you will not have coverage until the next annual open enrollment unless you have a family status change or qualify for ***Special Enrollment*** as explained in the Special Enrollment Rights for EHP Medical and Dental Coverage section.

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

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

Changing Your Coverage

During the annual open enrollment period, you may change your EHP Medical or Dental Plans coverage, or change your contributions to a Health Care or Dependent Care Flexible Spending Account. Outside of the annual open enrollment period, you may start or stop coverage, add new dependents, or drop a dependent from your coverage *only* if you have a qualifying family status change or a ***Special Enrollment*** situation (see the **Special Enrollment Rights for EHP Medical and Dental Coverage** section). In the case of a Flexible Spending Account, you may also increase or decrease your contributions if you have a qualifying family status change, subject to the minimum and maximum limitations described later in this SPD under **Flexible Spending Accounts**.

GENERAL INFORMATION

Examples of IRS-qualified changes in family status include:

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

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

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

GENERAL INFORMATION

Special Enrollment Rights For EHP Medical and Dental Coverage

Losing other coverage

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

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

New Children

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

Medicaid and Children's Health Insurance Program

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

If you or your child become eligible to receive assistance from Medicaid or CHIP to pay your required contributions for coverage under the EHP Medical Plan, you may enroll for EHP Medical Plan coverage. You must request this special enrollment via the online enrollment process within 60 days of becoming eligible for the assistance. If enrolled on time, coverage under the EHP Medical Plan will become effective on the first day of the month following the date you complete the online enrollment process.

GENERAL INFORMATION

Coverage Costs

JHHSC/JHH pays the majority of the cost of your coverage under the EHP Medical and Dental Plans. JHHSC/JHH also offers you “Wellness Rewards” under the Healthy at Hopkins Rewards Program, which you can use to help cover the cost of those benefits that require employee contributions, including the EHP Medical and Dental Plans.

Required employee contributions are deducted from your paycheck on a pre-tax basis. Because your contributions are deducted before taxes, you reduce your taxable income and save on federal and state income taxes, and Social Security taxes. Special rules may apply for state taxes if you live in Pennsylvania or New Jersey.

For the exact contributions required by the EHP Medical and Dental Plans, please refer to your Guide to Benefits booklet or contact the HR Service Center. JHHSC/JHH pays the full cost of your Short Term Disability benefits.

EHP MEDICAL PLAN

The Johns Hopkins EHP Medical Plan

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

Network Providers

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

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

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

Primary Care Physicians

You are encouraged (but not required) to designate a Primary Care Physician (PCP) to coordinate your medical care. However, you never need a referral from a PCP. (Certain services require preauthorization, as explained later in this SPD). Having a designated PCP ensures that preventive

EHP MEDICAL PLAN

services are addressed and allows you the opportunity for a relationship with your PCP and to feel comfortable with your choice of provider. Also, if you designate a PCP, a lower copay applies to primary care office visits to your designated PCP.

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

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

Go online for the Johns Hopkins EHP provider search for PCPs, available on the EHP Web site at www.ehp.org. You and your dependents may designate any listed PCP who is available.

Three Ways to Receive Care

The EHP Medical Plan offers **three** ways to receive care. The Plan incorporates the cost-efficiencies that result from using the EHP Network of highly qualified health care professionals and facilities. You can also use Out-of-Network providers, although lower benefits are provided. The Plan offers you the reassurance of being treated by any doctor you choose, in a location convenient to you.

Option 1 – EHP Network and Hopkins Preferred Providers

The Plan pays benefits under Option 1 if you go to a provider in the Johns Hopkins EHP Network or a Hopkins Preferred Provider. You do not have to designate a Primary Care Physician and you never need a referral. Certain services require preauthorization, as explained later in this SPD.

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

Most services are covered at either 90% or 100% under Option 1, after meeting the annual deductible of \$100 per person/\$200 per family. Most inpatient services also require a \$150 copay per admission.

For services covered at 90%, you pay the remaining 10% until you reach an annual out-of-pocket maximum of \$2,000 per person/\$4,000 per family. After you reach the out-of-pocket maximum, benefits for covered services are paid at 100% of the charge for the remainder of that calendar year.

EHP MEDICAL PLAN

Hopkins Preferred Providers

Option 1 provides higher benefits for many services if you go to a Hopkins Preferred Provider, all of whom are part of the Johns Hopkins EHP Network. The following hospitals are Hopkins Preferred Providers:

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

Physicians associated with the following groups are Hopkins Preferred Providers:

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

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

Services and supplies are covered at 100% from Hopkins Preferred Providers, with no annual deductible. Inpatient admissions only require a \$150 copay. A small copay applies to certain other services.

Option 2 – Out-of-Network Providers

The Plan pays benefits under Option 2 if you go to a provider outside of the Johns Hopkins EHP Network. You must first meet an annual deductible of \$750 per person/\$1,500 per family. After the deductible and any applicable copay, the Plan pays 70% of the Reasonable and Customary Charge (see **Payment Terms You Should Know** discussed below), and you pay the remaining 30%, until you reach an annual out-of-pocket maximum of \$3,500 per person/\$7,000 per family. After you reach the out-of-pocket maximum, benefits for covered services are paid at 100% of the Reasonable and Customary Charge for the remainder of that calendar year. You are responsible for any amounts over the Reasonable and Customary Charge, and those amounts do not count towards the deductible or the annual out-of-pocket maximum.

EHP MEDICAL PLAN

Payment Terms You Should Know

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

- ◆ **Coinsurance:** Your percentage share of the charge for certain medical expenses.
 - If you receive care under Option 1 from an EHP Network provider that is not a Hopkins Preferred Provider, the Plan pays either 90% or 100% of the charge, after the Option 1 deductible and any copay, and you pay the remaining 10% if applicable. The **Medical Benefits At-A-Glance** chart later in this SPD lists the specific coinsurance amounts.
 - No coinsurance applies under Option 1 for care from a Hopkins Preferred Provider. The Plan pays 100% of the charge after any copay, with no deductible.
 - If you receive care under Option 2 from an Out-of-Network provider, the Plan generally pays 70% of the Reasonable and Customary Charge (R&C), after the Option 2 deductible, and you pay the remaining 30%, plus any amounts over R&C.

- ◆ **Copay:** The amount you pay for certain services and prescription drugs. The **Medical Benefits At-A-Glance** chart later in this SPD lists the specific copay amounts. You pay the copay directly to the provider at the time of service.

- ◆ **Deductible:**
 - If you receive care under Option 1 from an EHP Network provider that is not a Hopkins Preferred Provider, the Option 1 deductible (\$100 per person/\$200 per family) is the amount you must pay each calendar year before the Plan begins to pay benefits for certain services. The **Medical Benefits At-A-Glance** chart later in this SPD lists which services the Option 1 deductible applies to and which services the deductible is waived for.
 - Except for infertility treatment, no deductible applies under Option 1 for care from a Hopkins Preferred Provider.
 - If you receive care from an Out-of-Network provider under Option 2, the Out-of-Network deductible (\$750 per person/\$1,500 per family) is the amount you must pay each calendar year before the Plan begins to pay any benefits (other than for emergency and observation care as shown on the **Medical Benefits At-A-Glance** chart).
 - Expenses incurred and applied to your Option 1 deductible apply to your Option 2

EHP MEDICAL PLAN

deductible, and vice versa.

- Expenses incurred and applied to your deductible in October, November and December of a calendar year are also carried over and applied to the next calendar year's deductible. Expenses incurred by two or more individuals can meet the family deductible. However, no one individual will be required to satisfy more than the individual deductible.
- ◆ **Out-of-Pocket Maximum:** Since you are responsible for a portion of the cost of certain of your medical expenses, the Plan includes two annual out-of-pocket maximums to protect you in the event of high medical bills.

The **Medical Out-of-Pocket Maximum** applies to all your expenses under the EHP Medical Plan other than expenses under the ***Prescription Drug Benefit*** and the ***Vision Benefit***. Under Option 1 (EHP Network and Hopkins Preferred Providers), after you have paid the annual medical out-of-pocket maximum of \$2,000 per person/\$4,000 per family, the Plan pays any additional covered medical expenses at 100% for the remainder of that calendar year. Under Option 2 (Out-of-Network), after you have paid the annual medical out-of-pocket maximum of \$3,500 per person/\$7,000 per family, the Plan pays any additional covered medical expenses at 100% of the Reasonable and Customary Charge (R&C) for the remainder of that calendar year. If you receive care from an Out-of-Network provider under Option 2, you are still responsible for any amounts over the Reasonable and Customary Charge. Medical expenses incurred and applied to your Option 1 out-of-pocket maximum apply to your Option 2 out-of-pocket maximum, and vice versa.

The **Medical Out-of-Pocket Maximum** includes the deductible, coinsurance and copays, but does not include penalties, amounts in excess of the Reasonable and Customary Charge (R&C), amounts in excess of Plan maximums and any charges for services which are not covered. Please note that ***Vision Benefit*** expenses are not subject to the out-of-pocket maximum.

The **Prescription Drug Out-of-Pocket Maximum** applies to copays under the ***Prescription Drug Benefit*** for drugs obtained from an EHP Network Pharmacy. After your prescription drug copays reach the annual out-of-pocket maximum of \$4,600 per person/\$9,200 per family, you pay no copays for covered prescription drugs for the remainder of that calendar year.

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

- ◆ **Providers:** a provider is any hospital, skilled nursing/rehabilitation facility, individual, organization, or agency licensed to provide professional services and acting within the scope of that license. Benefits will only be paid for covered services from providers who meet this definition.

EHP MEDICAL PLAN

Benefits will not be paid for any services and related charges provided by a close relative of the patient (spouse, child, grandchild, brother, sister, brother-in-law, sister-in-law, parent or grandparent).

- ◆ **Reasonable and Customary Charge (R&C):** This is the prevailing, reasonable fee paid to similar providers for the same services or supplies in the same geographic area. Johns Hopkins Employer Health Programs calculates what is the Reasonable and Customary Charge by using a vendor that determines the prevailing fees paid by health plans in the area where the service or supply was provided. EHP Network providers (including Hopkins Preferred Providers) will not charge more than the Reasonable and Customary Charge, but Out-of-Network providers can charge more and you are responsible for charges above the Reasonable and Customary Charge.

Care Management Program

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

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

Before you can receive benefits for certain medical services and supplies under the EHP Medical Plan, you must have these services and supplies preauthorized by the Johns Hopkins EHP Care Management Program. Your EHP Network doctor will initiate the preauthorization process if you receive care under Option 1 from a Network provider (including a Hopkins Preferred Provider). You or your Out-of-Network doctor are required to initiate the preauthorization process if you receive Out-of-Network care under Option 2. If you do not obtain preauthorization, coverage for services and supplies may be reduced or denied entirely. The following services and supplies require preauthorization by the Care Management Program:

- ◆ Durable medical equipment and medical supplies;
- ◆ Hearing aids for dependent children;
- ◆ Home health care;

EHP MEDICAL PLAN

- ◆ Hospice care;
- ◆ Hospital inpatient stays;
- ◆ Hypnosis or biofeedback training for treatment of voiding dysfunction
- ◆ Infertility treatment
- ◆ Mental health and substance/alcohol abuse inpatient treatment
- ◆ Physical/occupational therapy after 12 visits per calendar year
- ◆ Prosthetic devices and orthotics;
- ◆ Skilled nursing/rehabilitation facility stays;
- ◆ Speech therapy;
- ◆ Surgical procedures (certain procedures only, including gastric bypass, as described on a list maintained by Johns Hopkins Employer Health Programs);
- ◆ Transplant services; and
- ◆ Use of certain drugs and medications (as described on a list maintained by Johns Hopkins Employer Health Programs).

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

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

EHP MEDICAL PLAN

Chronic Care Management Program

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

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

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

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

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

Health Coach Program

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

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

EHP MEDICAL PLAN

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

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

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

EHP Customer Service

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

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

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

Only you and your covered dependents are permitted to use the identification card. It is illegal to loan your card to persons who are not covered under the EHP Medical Plan. If you lose your identification card, call a Johns Hopkins EHP Customer Service Representative immediately to request a new card. You may also print a temporary ID card by going to www.ehp.org and signing into HealthLink@Hopkins.

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

COVERED SERVICES AND SUPPLIES

What's Covered by the Johns Hopkins EHP Medical Plan

Medical Benefits At-A-Glance

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

SERVICES PROVIDED	EHP NETWORK PROVIDERS	OUT-OF-NETWORK PROVIDERS	HOPKINS PREFERRED PROVIDERS
CALENDAR YEAR DEDUCTIBLE			
Per person	\$100	\$750	None
Per family	\$200	\$1,500	None
OUT-OF-POCKET MAXIMUM (includes deductibles, coinsurance and copays)			
Per person	\$2,000 Medical \$4,600 Prescription Drugs	\$3,500 Medical Prescription Drugs not covered	Combined with EHP Network Providers Out-of-Pocket maximum
Per family	\$4,000 Medical \$9,200 Prescription Drugs	\$7,000 Medical Prescription Drugs not covered	
PENALTY FOR NOT OBTAINING PREAUTHORIZATION			
	Not applicable	\$500 or denial of benefits	Not applicable
1. TREATMENT OF ILLNESS OR INJURY			
Primary care office visit for medical treatment	100% after \$10 copay if medical PCP is designated 100% after \$20 copay if medical PCP is not designated	70% of R&C after deductible	Refer to EHP Network Providers Benefit
Primary care office visit for GYN treatment	100% after \$10 copay	70% of R&C after deductible	Refer to EHP Network Providers Benefit
Specialty care office visit	\$30 copay, then 100% after deductible	70% of R&C after deductible	100% after \$30 copay
Diagnostic services and treatment	90% after deductible	70% of R&C after deductible	100%

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

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

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COVERED SERVICES AND SUPPLIES

SERVICES PROVIDED	EHP NETWORK PROVIDERS	OUT-OF-NETWORK PROVIDERS	HOPKINS PREFERRED PROVIDERS
2. PREVENTIVE SERVICES			
General preventive exam (adult physical, GYN and well child care)	100%	70% of R&C after deductible	100%
Diagnostic services for exam	100%	70% of R&C after deductible	100%
Mammogram and well-woman care	100%	70% of R&C after deductible	100%
Screening colonoscopy	100%	70% of R&C after deductible	100%
3. IMMUNIZATIONS AND INOCULATIONS			
As recommended by Centers for Disease Control and Prevention	100%	70% of R&C after deductible	100%
4. PRESCRIPTION DRUGS			
In-network pharmacy only; 30-day supply; No copay for certain generic contraceptives	\$10 copay – generic \$30 copay – brand preferred \$50 copay – brand non-preferred \$65 copay – brand if generic available/prescription Nexium		
In-network pharmacy only; 30-day supply; for these prescribed Over-the-Counter drugs	\$10 copay – prescribed Prilosec OTC, Nexium 24HR, Prevacid 24HR, Zegerid OTC No copay for prescribed OTC Claritin and Claritin D Must have prescription and present it to the pharmacy		
90-day supply for maintenance drugs (excludes specialty medications)	<u>Mail order:</u> \$20 copay – generic \$60 copay – brand preferred \$100 copay – brand non-preferred \$130 copay – brand if generic available/prescription Nexium <u>In-Network pharmacy:</u> \$30 copay – generic \$90 copay – brand preferred \$150 copay – brand non-preferred \$195 copay – brand if generic available/prescription Nexium		
Specialty medications	\$50 copay for 30-day supply, available from In-network pharmacy only		
5. ALLERGY TESTS AND PROCEDURES			
Allergy tests	90% after deductible	70% of R&C after deductible	100%
Desensitization materials/serum	90% after deductible	70% of R&C after deductible	100%

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COVERED SERVICES AND SUPPLIES

SERVICES PROVIDED	EHP NETWORK PROVIDERS	OUT-OF-NETWORK PROVIDERS	HOPKINS PREFERRED PROVIDERS
6. LABORATORY			
Laboratory tests	90% after deductible	70% of R&C after deductible	100%
7. RADIOLOGY			
CT scans, PET scans and MRIs	90% after deductible	70% of R&C after deductible	100% after \$50 copay
All other imaging studies, including x-rays and ultrasound	90% after deductible	70% of R&C after deductible	100% after \$10 copay
8. SURGERY			
Professional services for inpatient and outpatient surgery; Care Management preauthorization may be required	90% after deductible	70% of R&C after deductible ⁽¹⁾	100%
Gastric bypass surgery; Care Management preauthorization required	Covered at Bayview Medical Center and Sibley Memorial Hospital only	Covered at Bayview Medical Center and Sibley Memorial Hospital only	\$150 copay, then 100% Covered at Bayview Medical Center and Sibley Memorial Hospital only
9. REPRODUCTIVE HEALTH			
Physician office visits (for prenatal care only)	90% after deductible	70% of R&C after deductible	100%
Inpatient maternity care and delivery, including physician, hospitalization, lab and X-ray services	\$150 copay, then 90%; no deductible	\$500 copay, then 70% of R&C after deductible ⁽¹⁾	\$150 copay, then 100%
Newborn nursery care; copay applies to NICU admission	90% after deductible	70% of R&C after deductible ⁽¹⁾	100%
Birthing centers (licensed facility)	100% after deductible	70% of R&C after deductible ⁽¹⁾	Refer to EHP Network Providers Benefit
Voluntary sterilization	100%	70% of R&C after deductible ⁽¹⁾	100%
Interruption of pregnancy	90% after deductible	70% of R&C after deductible ⁽¹⁾	100%
Infertility treatment (such as artificial insemination and in-vitro fertilization); Care Management preauthorization required	Covered at Johns Hopkins Fertility Center only	Covered at Johns Hopkins Fertility Center only	Covered at Johns Hopkins Fertility Center only 100% after separate \$1,000 deductible

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EHP Network Providers and Hopkins Preferred Providers have agreed to accept the EHP fee schedule as full payment and will not balance bill, other than required copays, coinsurance, and deductibles. Out-of-Network providers can balance bill for charges in addition to deductibles and coinsurance. This chart is not a complete description of benefits. For more information, please refer to the rest of this SPD.

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(1) Failure to obtain preauthorization for hospitalization will result in a \$500 penalty or possible denial of benefits.

COVERED SERVICES AND SUPPLIES

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

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COVERED SERVICES AND SUPPLIES

SERVICES PROVIDED	EHP NETWORK PROVIDERS	OUT-OF-NETWORK PROVIDERS	HOPKINS PREFERRED PROVIDERS
15. ACUPUNCTURE			
For anesthesia, pain control and therapeutic purposes (\$1,500 calendar year combined maximum)	\$30 copay per visit, then 100% after deductible	70% of R&C after deductible	Refer to EHP Network Providers Benefit
16. HOME HEALTH CARE			
40 visits per calendar year combined maximum; Care Management preauthorization required	100%	70% of R&C after deductible	Refer to EHP Network Providers Benefit
Home infusion therapy; Care Management preauthorization required	90% after deductible	70% of R&C after deductible	100% thru Johns Hopkins Home Care Group
17. HOSPICE CARE			
Inpatient and home; Care Management preauthorization required	100%	70% of R&C after deductible ⁽¹⁾	100%
18. SPEECH THERAPY			
Care Management preauthorization required (30 visits per calendar year combined maximum)	90% after deductible	70% of R&C after deductible	100% after \$10 copay per visit
19. PHYSICAL/OCCUPATIONAL THERAPY			
Licensed therapist only; 60 visits per calendar year combined maximum; Care Management preauthorization required after 12 visits	90% after deductible	70% of R&C after deductible	100% after \$10 copay per visit
20. HABILITATIVE SERVICES			
Under age 19 only; Care Management preauthorization required	90% after deductible	70% of R&C after deductible	100% after \$10 copay per visit
21. CHIROPRACTIC CARE			
Restricted to initial exam, X-rays and spinal manipulations; \$1,500 calendar year combined maximum	\$15 copay per visit, then 100% after deductible	70% of R&C after deductible	Refer to EHP Network Providers Benefit

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Only medically necessary services and supplies are covered.

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COVERED SERVICES AND SUPPLIES

SERVICES PROVIDED	EHP NETWORK PROVIDERS	OUT-OF-NETWORK PROVIDERS	HOPKINS PREFERRED PROVIDERS
22. DURABLE MEDICAL EQUIPMENT AND SUPPLIES (Care Management preauthorization required)			
Non-custom equipment and medical supplies	90% after deductible	70% of R&C after deductible	100% thru Johns Hopkins Home Care Group
Custom equipment/wheelchairs	100%	70% of R&C after deductible	Refer to EHP Network Providers Benefit
Insulin pumps and related supplies	100%	70% of R&C after deductible	Refer to EHP Network Providers Benefit
Breast pumps (standard) and related supplies	100%	70% of R&C after deductible; Pre-authorization required	100% thru Johns Hopkins Home Care Group
Contraceptive devices	100%	70% of R&C after deductible	Refer to EHP Network Providers Benefit
Custom molded orthotics	90% after deductible	70% of R&C after deductible	100%
Prosthetic appliances	100%	70% of R&C after deductible	Refer to EHP Network Providers Benefit
Hearing aids for children under 26	100%	70% of R&C after deductible	Refer to EHP Network Providers Benefit
23. NUTRITION COUNSELING			
Care Management preauthorization required after sixth visit per calendar year	\$30 copay per visit, then 100% after deductible	70% of R&C after deductible	100% after \$15 copay per visit
24. MENTAL HEALTH AND SUBSTANCE ABUSE			
Inpatient care for mental health and substance/alcohol abuse	100% after \$150 copay per admission	\$500 copay per admission, then 70% of R&C after deductible ⁽¹⁾	100% after \$150 copay per admission
Outpatient treatment for mental health and substance/alcohol abuse	100% after \$10 copay per visit	70% of R&C after deductible	100% after \$10 copay per visit
Partial hospital facility days	100% after \$10 copay per day	70% of R&C after deductible ⁽¹⁾	100% after \$10 copay per day

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

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Only medically necessary services and supplies are covered.

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(1) Failure to obtain preauthorization for hospitalization can result in a \$500 penalty or possible denial of benefits.

COVERED SERVICES AND SUPPLIES

Covered Services and Supplies

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

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

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

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

In General

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

Covered services and supplies include 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;
- ◆ Ambulance services;
- ◆ Ambulatory surgical center;
- ◆ Anesthetics and oxygen, and their administration;

COVERED SERVICES AND SUPPLIES

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

COVERED SERVICES AND SUPPLIES

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

COVERED SERVICES AND SUPPLIES

- ◆ Immunizations for routine use in children, adolescents, and adults that have in effect a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention;
- ◆ Laboratory tests;
- ◆ Mental health and substance abuse treatment (Care Management preauthorization required for inpatient care, partial hospitalization days and intensive outpatient care);
- ◆ Midwifery services;
- ◆ Newborn care;
- ◆ Nursing services (professional) by a registered nurse or licensed practical nurse who is not a close relative (spouse, child, grandchild, brother, sister, brother-in-law, sister-in-law, parent, or grandparent) of the patient;
- ◆ Obesity treatment – non-surgical treatment for employees only, as part of the Johns Hopkins Weight Management Program. Your employer pays 50% of the charges for your participation in the Program. The other 50% is charged to you and covered by the Plan as follows. You must first pay a \$300 annual deductible. After that, the Plan covers 70% of the amount charged to you and you pay the remaining 30%. The maximum benefit payment by the Plan per calendar year is \$1,000;
- ◆ Obesity treatment – surgical treatment for morbid obesity when Body Mass Index (BMI) (weight in kilograms/height in meters squared) is greater than 40, or equal to or greater than 35 with a co-morbid medical condition, including hypertension, a cardiopulmonary condition, sleep apnea, or diabetes. Care Management preauthorization required and all services must be provided at Johns Hopkins Bayview Medical Center or Sibley Memorial Hospital;
- ◆ Obesity treatment – surgical treatment for overhanging, stretching or laxity of skin, but only if medically necessary as a result of surgical or non-surgical treatment for morbid obesity. Limited to a lifetime benefit maximum of \$5,000 (Care Management preauthorization required);
- ◆ 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;

COVERED SERVICES AND SUPPLIES

- ◆ Prosthetic devices and orthotics that are integral to the device (Care Management preauthorization required);
- ◆ Rehabilitation services (Care Management preauthorization required);
- ◆ Second surgical opinions;
- ◆ Skilled nursing/rehabilitation facility services (Care Management preauthorization required);
- ◆ Surgical dressings and medical supplies;
- ◆ Surgical procedures (Care Management preauthorization required for certain procedures);
- ◆ Telephone consultation charges, if the consultation is medically necessary for treatment of a condition otherwise covered by the Plan;
- ◆ Temporomandibular Joint Syndrome (TMJ) treatment and/or orthognathic surgery, limited to physical therapy, surgery and ortho devices such as mouthguards and intraoral devices (excludes orthodontics and prosthetics);
- ◆ Therapies, including:
 - Chemotherapy;
 - Dialysis treatment;
 - Nutrition counseling (annual visit exclusive of procedures and testing);
 - Occupational, physical and speech therapy provided by a licensed occupational, physical, or speech therapist, that is required because of an illness or accidental injury. Occupational, physical and speech therapy is also covered if required for the treatment of a person under age 19 with a congenital or genetic birth defect in order to enhance the person's ability to function. Congenital or genetic birth defect means a defect existing at or from birth, including a hereditary defect, and includes autism or an autism spectrum disorder, cerebral palsy, intellectual disability, Down syndrome, spina bifida, hydroencephalocele, and congenital or genetic developmental disabilities. Unless caused by a congenital or genetic birth defect, treatment of stuttering, articulation disorders, tongue thrust and lispings, and maintenance therapy are not covered. Care Management preauthorization is required except for the first 12 occupational and physical therapy visits;
 - Radiotherapy;
- ◆ Transplants (Care Management preauthorization required);

COVERED SERVICES AND SUPPLIES

- ◆ Vasectomies and tubal ligations;
- ◆ Well-child care, including evidence-informed preventive care and screenings provided for in comprehensive guidelines supported by the Health Resources and Services Administration;
- ◆ Well-woman care, including evidence-informed preventive care and screenings for women provided for in comprehensive guidelines supported by the Health Resources and Services Administration; and
- ◆ X-ray, radium, and radioisotope treatment.

Following are descriptions of other services and supplies covered by the EHP Medical Plan.

Prescription Drug Benefits

Benefits are paid for prescription drugs designated as such under federal law, as well as injectable insulin, diabetic supplies (needles and syringes when prescribed with insulin only), and other medicines and supplies designated by Johns Hopkins Employer Health Programs. Prescription drug benefits also cover erectile dysfunction medications, provided:

- The member is male;
- There is a documented organic cause of erectile dysfunction;
- The treating provider is an EHP Network provider; and
- The maximum monthly number of doses is limited to six units of all erectile dysfunction medications combined, with refills limited to three months per prescription.

EHP Network Pharmacies

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

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

Please note: As explained below, your physician may need to obtain preauthorization before certain

COVERED SERVICES AND SUPPLIES

drugs may be dispensed.

Copay

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

Otherwise, the copay is \$30 for brand name preferred drugs and \$50 for brand name non-preferred drugs. The copay is \$65 for brand name drugs if a generic version is available and for prescription Nexium. The copay is \$50 for specialty medications, which are only covered at an In-Network retail pharmacy and only for up to a 30-day supply.

For maintenance drugs (excluding specialty medications), you may obtain a 90-day supply at an In-Network retail pharmacy for three times the normal monthly copay for that prescription. Or, you may use the EHP Medical Plan's Mail Order program, presently offered through Caremark. Through this program, you can obtain a 90-day supply of maintenance drugs each time you order for only two times the normal monthly copay. Your copay through the Mail Order program is \$20 for each separate prescription or refill of a generic drug. The Mail Order copay is \$60 for brand name preferred drugs and \$100 for brand name non-preferred drugs. The copay is \$130 for brand name drugs if a generic version is available and for prescription Nexium. If you have any questions about the Mail Order program, call EHP.

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

Medication Copay Waiver Program

As part of the "Healthy Savings" program, if you receive treatment for asthma or diabetes that is covered by the EHP Medical Plan, you may be eligible to have the copay waived for certain medications you take for treatment of your condition.

Contact the Care Management Program by phone at 800-557-6916, or by email at populationhealth@jhhc.com. Ask for a copy of the Healthy Savings Agreement and the Frequently Asked Questions piece. They will provide you with details about the program and what you must do to have your copay waived. You may be required to report routine test results and/or discuss your progress with a personal care nurse assigned to you. If you are already enrolled in the Chronic Care Management Program, you should automatically receive a copy of the Healthy Savings Agreement

COVERED SERVICES AND SUPPLIES

from your care manager.

Not all medications for treatment of asthma and diabetes are eligible for copay waiver, but many of the most widely prescribed medications are. The Frequently Asked Questions piece contains a list of the medications that are currently eligible. JHHSC/JHH may add or remove medications from the list in the future.

Prior Authorization and Quantity Limits

Certain medications require prior authorization before coverage is approved, to assure medical necessity, clinical appropriateness and/or cost effectiveness. Coverage of these medications is subject to specific criteria approved by physicians and pharmacists on the Johns Hopkins Health Care Pharmacy and Therapeutics Committee. Also, certain medications have specific dispensing limitations for quantity and maximum dose, and step-therapy requirements. Because of this, your EHP Medical Plan includes a Prior Authorization requirement and a Quantity Limit program for certain drugs.

A current list of drugs subject to Prior Authorization and the Quantity Limit program can be found at the EHP website (www.ehp.org) or by calling EHP customer service at 410-424-4450. The list is subject to change.

A complete explanation of Prior Authorization and the Quantity Limit program is available at any time by going to the websites listed above, or by calling EHP customer service.

If your physician determines that use of a drug that requires prior authorization is warranted, your physician must complete a Prior Authorization Request Form and fax it to EHP at the number shown on the Form. If your physician determines that coverage of a prescription drug in a greater quantity than is allowed under the Quantity Limit program is medically warranted, your physician can submit a request by also using the Prior Authorization Request Form. EHP will notify you and your physician of approval or denial of either request. If additional information regarding a denial is needed, your physician may contact EHP at the number shown on the denial notice. You may appeal the denial in accordance with the appeal rules for pre-service claims set forth below in this Summary Plan Description.

What's Not Covered

No prescription drug benefits will be paid for the following:

- ◆ Any amounts you are required to pay directly to the pharmacy for each prescription or refill
- ◆ Any charge for administration of drugs or insulin
- ◆ Smoking cessation drugs, except as described below under *Smoking Cessation*

COVERED SERVICES AND SUPPLIES

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

Over-the-Counter Drugs

Prescription drug benefits are normally not provided for a drug or medication that is available “over-the-counter” (OTC). A drug or medication is considered to be 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 OTC medications, but only if your doctor prescribes these drugs and you show the pharmacist your prescription at time of purchase.

- Claritin OTC and Claritin D OTC – no copay
- Prilosec OTC, Nexium 24HR, Prevacid 24HR and Zegerid OTC – \$10 copay per 30-day supply

COVERED SERVICES AND SUPPLIES

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.

Smoking Cessation

The Johns Hopkins EHP Medical Plan covers both prescription and OTC smoking cessation products, limited to FDA approved dosages. For coverage of OTC products, a prescription from a physician is required. No copay applies to many prescribed smoking cessation medications.

The smoking cessation benefit also covers a 90 day supply per calendar year of Chantix. An additional 90 day supply of Chantix per calendar year will be covered if prescribed by your physician.

When you first enroll and during annual open enrollment, you will have the opportunity to certify that you do not use tobacco products. If you certify that you do not use tobacco, you will receive a discount on your required contributions for coverage under the Medical Plan. If you cannot certify that you do not use tobacco, you can still receive the discount if you agree to take a smoking cessation program and/or obtain a prescription for smoking cessation medications. More information about the discount program is contained in the enrollment materials. For more information about available smoking cessation programs, contact Healthy at Hopkins Wellness Services, Osler Building Seventh Floor, 410-955-9538 or by email to healthyathopkins@jhmi.edu. You may also contact EHP Health Coaching at 1-800-957-9760 or healthcoach@jhhc.com.

Emergency Services

It is not easy to think clearly in a medical emergency. Knowing what to do before you are faced with an emergency can help you get appropriate care at the higher benefit level.

Emergency Medical Situation

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

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

- ◆ Place the health of the patient (including the unborn child of a pregnant woman) in serious

COVERED SERVICES AND SUPPLIES

jeopardy;

- ◆ Result in serious impairment to bodily functions; or
- ◆ Result in serious dysfunction of any bodily organ or part.

Treatment by an emergency room (hospital or freestanding) for an emergency medical situation is covered under the Option 1 Network benefit regardless of whether or not the emergency room participates in the EHP Network. Emergency room facility charges are covered in full, after a \$150 copay. The copay is waived if you are admitted. No deductible applies for the treatment in the emergency room, but the Option 1 or Option 2 deductible does apply if you are admitted to the hospital. If you go to an Out-of-Network emergency room, the EHP Medical Plan will not pay more than the Reasonable and Customary Charge for your treatment.

If you are being treated at an Out-of-Network emergency room and your condition stabilizes so that it is no longer an emergency medical situation, and if you can be moved to an EHP Network facility and you choose not to be moved, then services and supplies provided after you can be moved will be paid under Option 2 at 70% of the Reasonable and Customary Charges, after the Option 2 deductible.

If you receive treatment in an emergency room for a condition that is not an emergency medical situation, the EHP Medical Plan will not pay benefits. You must still pay the \$150 copay.

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

Urgent Care Centers

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

If you go to an EHP Network urgent care center, your care will be covered at 100% under Option 1, after a \$25 copay.

If you go to an Out-of-Network urgent care center, your care will be covered at 70% of the Reasonable and Customary Charge, after the Option 2 deductible. You are responsible for any amounts over the Reasonable and Customary Charge.

COVERED SERVICES AND SUPPLIES

Out-Of-Area Care and Coverage for Students

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

Claims for **unforeseeable** medical care or prescription drugs received while outside the EHP Network service area will be paid on the same terms as apply to care received from an In-Network provider under Option 1. However, benefits are calculated based only on the Reasonable and Customary Charge for the care received. In addition to any copay or coinsurance that might apply, you are responsible for all charges above the Reasonable and Customary Charge. Remember that a MultiPlan provider is an In-Network provider and therefore will not charge you above the Reasonable and Customary Charge.

Claims for **foreseeable** out-of-area medical care from a MultiPlan provider will be paid under the Option 1 EHP Network level. Claims for **foreseeable** out-of-area medical care from a non-MultiPlan provider or for prescription drugs will be covered under Option 2 at the Out-of-Network benefit level. This means that no coverage is provided for **foreseeable** prescription drugs that are obtained from a non-Network pharmacy.

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

You (or someone on your behalf) must notify Johns Hopkins EHP at 410-424-4450 or 800-261-2393 of any Out-of-Area Care that results in an inpatient hospitalization within 48 hours after admission. If notice is not given on time, a \$500 penalty may apply or coverage may be denied entirely.

Ambulance Services

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

- ◆ Because of an accident or emergency medical situation, it is medically necessary to transport you to the hospital.
- ◆ It is medically necessary to transport you from a hospital as an inpatient to another hospital, because:

COVERED SERVICES AND SUPPLIES

- The first hospital lacks the equipment or expertise necessary to care for you;
 - You are transported directly from a hospital to a skilled nursing/rehabilitation facility; or
 - As determined medically appropriate by the Care Management Program.
- ◆ You are medically stable and wish to transfer from a facility that is not a Hopkins Preferred Provider to a facility that is a Hopkins Preferred Provider.

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

Vision Benefits

The EHP Medical Plan covers a full range of optometry and ophthalmology vision care services through the Johns Hopkins Routine Vision Care Network. The Plan also covers vision care services from Out-of-Network providers. You can receive Johns Hopkins Routine Vision Care Network services at any of these provider sites: Wilmer Comprehensive Eye Care Services (located at The Wilmer Eye Institute at The Johns Hopkins Hospital), Green Spring Station, Severna Park, and the Bayview Medical Center. You can also receive Network optometry services at Pearle Vision Centers, Penn Optical, 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 you use a Johns Hopkins Routine Vision Care Network provider or an Out-of-Network provider:

<i>Covered Vision Services</i>	<i>Johns Hopkins Routine Vision Care Network</i>	<i>Out-of-Network</i>
Routine exam or contact lens fitting fee (once every 12 months)	100%, after \$10 copay	Up to \$35
Materials (once every 12 months):	\$10 copay, then:	
Single Vision	Up to \$75	Up to \$70
Bifocal	Up to \$92	Up to \$80
Trifocal	Up to \$117	Up to \$110
Lenticular	Up to \$176	Up to \$160
Frames	Up to \$70	Up to \$70

COVERED SERVICES AND SUPPLIES

Contact Lenses		
Medically Necessary	Up to \$165	Up to \$165
Elective	Up to \$95	Up to \$95

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

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

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

Maternity Benefits

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

The Plan covers 90% of your prenatal care and routine tests when you receive care that is provided by an EHP Network OB/GYN after you meet the Option 1 deductible. The Plan covers 100% of your prenatal care and routine tests when care is provided by a Hopkins Preferred Provider OB/GYN, with no deductible. Midwife delivery services provided by a licensed midwife are also eligible for coverage.

COVERED SERVICES AND SUPPLIES

Delivery at an EHP Network licensed birthing center is covered at 100% under Option 1 after the deductible. For delivery at an EHP Network hospital under Option 1, you pay a \$150 copay and the Plan pays 90% of covered charges with no deductible. If you deliver at a Hopkins Preferred Provider hospital, the copay is \$150 and the Plan pays 100% of covered charges with no deductible.

Under Option 2, care received from an Out-of-Network OB/GYN and Out-of-Network hospital or birthing center expenses are covered at 70% of the Reasonable and Customary Charges, after the deductible, and you are responsible for any remaining charges. You must pay a \$500 copay for a hospital admission. Midwife delivery services provided by a licensed midwife are also eligible for coverage.

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

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

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

Infertility Treatment Benefits

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

In all cases:

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

COVERED SERVICES AND SUPPLIES

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

For married opposite sex couples:

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

For single females:

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

For married female same sex couples:

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

Medical and Modified Foods

The EHP Medical Plan covers medical foods and low protein modified food products for the treatment of inherited metabolic diseases if the foods or products are prescribed as medically necessary for the

COVERED SERVICES AND SUPPLIES

therapeutic treatment of inherited metabolic diseases and administered under the direction of a physician. For this purpose:

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

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

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

Women's Health and Cancer Rights Act

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

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

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

COVERED SERVICES AND SUPPLIES

Alternative Care

Sometimes, following a serious illness or major surgery, you may need follow-up care. Generally, this care does not need to be provided in a hospital. Alternative care includes home health care and/or skilled nursing care. In the case of a terminal illness, hospice care is often a viable alternative to a hospital setting. The EHP Medical Plan covers a variety of these alternative care services.

Home Health Care Benefits

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

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

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

Under Option 1, the Plan pays 100% of the charges for covered home health care services received from EHP Network providers, without having to meet the annual deductible. The Plan pays 90% of covered charges, after the deductible, for home infusion therapy provided by an EHP Network provider. If the provider is a member of the Johns Hopkins Home Care Group, the Plan pays 100% of covered charges for home infusion therapy, with no deductible.

Under Option 2, the Plan pays 70% of the R&C charges, after the deductible, for covered services (including home infusion therapy) received from Out-of-Network providers and you are responsible for any remaining charges.

Covered home health care services include:

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

COVERED SERVICES AND SUPPLIES

- ◆ Injectable prescription drugs (subject to copay as described under ***Prescription Drug Benefits***);
- ◆ Oxygen and its administration; and
- ◆ Medical and social service consultations.

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

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

Skilled Nursing/Rehabilitation Facility Benefits

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

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

Under Option 1, the Plan pays 100% of the charges, after the deductible, for the first 30 days per calendar year in an EHP Network skilled nursing/rehabilitation facility, and 90% of the charges after the first 30 days. The Plan pays 100% of the charges, with no deductible, for stays in a Hopkins Preferred Provider skilled nursing/rehabilitation facility.

Under Option 2, the Plan pays 70% of the Reasonable and Customary Charges, after the deductible, for stays in an Out-of-Network skilled nursing/rehabilitation services facility and you are responsible for any remaining charges.

Covered skilled nursing/rehabilitation facility services include:

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

COVERED SERVICES AND SUPPLIES

- ◆ Oxygen and other gas therapy; and
- ◆ Drugs, biological solutions, dressings and casts.

The patient's physician must prescribe care in a skilled nursing/rehabilitation facility and the patient must be under a physician's supervision throughout the stay. Charges will not be covered for more than 120 days per calendar year. However, once in an employee's lifetime up to an additional 75 days of charges may be covered during one calendar year, subject to the following:

- ◆ the stay in the skilled nursing/rehabilitation facility must be required in connection with a surgical procedure that is covered under the EHP Medical Plan;
- ◆ only employees are eligible for additional days, not spouses or dependents;
- ◆ home care must have been attempted but determined to be medically unsatisfactory;
- ◆ the employee must have at least 30 years of service with JHHSC/JHH.

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

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

Hospice Care Benefits

*Hospice care must be preauthorized by **Care Management**.*

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

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

Under Option 1, the Plan pays 100% of the charges for covered hospice care services from EHP Network providers, with no deductible.

COVERED SERVICES AND SUPPLIES

Under Option 2, the Plan pays 70% of the R&C charges, after the deductible, for covered hospice care services from Out-of-Network providers and you are responsible for any remaining charges.

Covered hospice care services include:

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

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

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

Transplants

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

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

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

No benefits will be paid for the following:

COVERED SERVICES AND SUPPLIES

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

Mental Health and Substance Abuse Treatment

The Johns Hopkins EHP Medical Plan provides benefits for inpatient and outpatient mental health and substance/alcohol abuse treatment on the same terms that apply to other inpatient or outpatient medical treatment. Mental health and substance/alcohol abuse treatment is subject to the same copay, coinsurance, deductibles, limits and other requirements that apply to medical treatment, based on whether you receive treatment under Option 1 (EHP Network and Hopkins Preferred Providers) or Option 2 (Out-of-Network). However, inpatient mental health and substance/alcohol abuse treatment received at an EHP Network facility under Option 1 will be covered on the terms that apply to treatment received at a Hopkins Preferred Provider facility, regardless of whether or not the Network facility is a Hopkins Preferred Provider.

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

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

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

COVERED SERVICES AND SUPPLIES

to any provider in or out of the EHP Network. The choice is yours. However, if you refer yourself to a provider your treatment will only be covered if it is determined to be medically necessary.

You can contact the Care Management Program at 410-424-4476 or 800-261-2429. You may contact the Faculty and Staff Assistance Program at 443-287-7000 or 443-997-7000.

EHP Network Providers

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

***Note:** You must receive preauthorization by Care Management before all inpatient admissions (including inpatient residential, partial hospitalization day treatment programs and intensive outpatient care) for mental health and substance/alcohol abuse treatment. The confidential number to call is 410-424-4476 or 800-261-2429. Failure to obtain preauthorization will result in reduced benefits as explained in the Medical Benefits At A Glance chart, or possibly a complete denial of coverage if your treatment is determined not to be medically necessary.*

WHAT'S NOT COVERED

What's Not Covered by The EHP Medical Plan

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

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

WHAT'S NOT COVERED

- ◆ Dental treatment except in connection with an accidental injury to sound natural teeth that is part of the initial emergency treatment within 48 hours after the accident;
- ◆ Emergency room services in other than emergency medical situations;
- ◆ Equipment that does not meet the definition of Durable Medical Equipment provided earlier in this SPD under **Covered Services and Supplies**, including air conditioners, humidifiers, dehumidifiers, purifiers or physical fitness equipment, whether or not recommended by a doctor;
- ◆ Experimental treatment, defined as the use of any treatment, procedure, equipment, device, drug or drug usage which the Plan Administrator determines, in its sole and absolute discretion, is being studied for safety, efficiency and effectiveness and/or which has not received or is awaiting endorsement for general use within the medical community by government oversight agencies, or other appropriate medical specialty societies at the time services are rendered.

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

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

WHAT'S NOT COVERED

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

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

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

WHAT'S NOT COVERED

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

WHAT'S NOT COVERED

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

WHAT'S NOT COVERED

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

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

JOHNS HOPKINS EHP DENTAL PLANS

Johns Hopkins EHP Dental Plans

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

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

If you have any questions about your benefits under the EHP Dental Plans, call United Concordia EHP Dental Customer Service at 1-866-851-7576.

Out-of-pocket Expenses

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

Maximum Benefits

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

JOHNS HOPKINS EHP DENTAL PLANS

Dental Benefits At-A-Glance

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

Covered Services	Comprehensive Plan		High Option Plan	
	<i>In-network</i>	<i>Out-of-network</i>	<i>In-network</i>	<i>Out-of-network</i>
Calendar year deductible	None	\$50 per person \$150 per family	None	\$50 per person \$150 per family
Calendar year benefit maximum	\$1,500 combined per person per year		\$3,000 combined per person per year	
Preventive services				
Exams (two per calendar year)	100%	80% of R&C, after deductible	100%	80% of R&C, after deductible
X-rays (once every 36 months)	100%	80% of R&C, after deductible	100%	80% of R&C, after deductible
Bitewing X-rays (once per calendar year)	100%	80% of R&C, after deductible	100%	80% of R&C, after deductible
Sealants for children under age 15	100%	80% of R&C, after deductible	100%	80% of R&C, after deductible
Topical fluoride treatment for children under age 18	100%	80% of R&C, after deductible	100%	80% of R&C, after deductible

NOTE: “R&C” (“Reasonable and Customary”) is the usual fee charged by similar providers for the same services or supplies in the same geographic area. Johns Hopkins Employer Health Programs determines what is a Reasonable and Customary Charge. An Out-of-Network provider can charge more than the Reasonable and Customary Charge and you will be responsible for the difference.

JOHNS HOPKINS EHP DENTAL PLANS

Covered Services	Comprehensive Plan		High Option Plan	
	<i>In-network</i>	<i>Out-of-network</i>	<i>In-network</i>	<i>Out-of-network</i>
Basic services				
Fillings	80%	60% of R&C, after deductible	80%	60% of R&C, after deductible
Endodontics	80%	60% of R&C, after deductible	80%	60% of R&C, after deductible
Oral surgery	80%	60% of R&C, after deductible	80%	60% of R&C, after deductible
Treatment of gum disease (Periodontics)	80%	60% of R&C, after deductible	80%	60% of R&C, after deductible
General anesthesia	80%	60% of R&C, after deductible	80%	60% of R&C, after deductible
Major services*				
Crowns, Inlays and Onlays	50%	30% of R&C, after deductible	60%	40% of R&C, after deductible
Bridges	50%	30% of R&C, after deductible	60%	40% of R&C, after deductible
Dentures (full or partial)	50%	30% of R&C, after deductible	60%	40% of R&C, after deductible
Orthodontia	Not covered	Not covered	50%, up to lifetime max of \$1,500	Not covered

NOTE: "R&C" ("Reasonable and Customary") is the usual fee charged by similar providers for the same services or supplies in the same geographic area. Johns Hopkins Employer Health Programs determines what is a Reasonable and Customary Charge. An Out-of-Network provider can charge more than the Reasonable and Customary Charge and you will be responsible for the difference.

**Pre-treatment review is recommended for all major services.*

JOHNS HOPKINS EHP DENTAL PLANS

What the EHP Dental Plans Cover

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

Preventive and Diagnostic Services

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

Basic Services

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

Major Services

- ◆ Inlays, onlays, gold fillings, crowns and installation of fixed bridges for the first time. Gold fillings are covered only if no other restoration method is possible;
- ◆ Installation of partial or full dentures for the first time, including adjustments for six months following installation (dentures are not covered until you have been covered under an EHP Dental Plan for 12 consecutive months);
- ◆ Repair or recementing of crowns, inlays, or bridges;
- ◆ Repair or relining of dentures (not more than once every 24 months); and

JOHNS HOPKINS EHP DENTAL PLANS

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

Orthodontia

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

Prosthesis Replacement Rule

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

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

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

Pre-Treatment Review

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

JOHNS HOPKINS EHP DENTAL PLANS

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

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

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

Use Network Dentists and Save

Your Johns Hopkins EHP Dental Plans offer you the choice to receive dental services from Network or Out-of-Network dentists. However, you can save money on your dental bills by using Network dentists. That's because the dentists who participate in the EHP Dental Network have agreed to charge reduced fees for their services, and both Plans pay a higher level of benefits for services received from Network dentists. The EHP Dental Network uses the United Concordia Advantage Plus dental network which includes over 3,500 participating dentists. To find a participating dentist go to www.unitedconcordia.com and look under the Advantage Plus network.

Alternate Treatment

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

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

JOHNS HOPKINS EHP DENTAL PLANS

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

What The EHP Dental Plans Do Not Cover

The EHP Dental Plans do not cover the following:

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

JOHNS HOPKINS EHP DENTAL PLANS

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

Election of No Dental Benefits

The EHP Dental Plans are optional benefits and are not included as part of EHP Medical Plan coverage. No coverage by the Dental Plans is provided unless you elect coverage in accordance with your Guide to Benefits booklet.

FLEXIBLE SPENDING ACCOUNTS

Flexible Spending Accounts

Your JHHSC/JHH Employee Benefits Plan for Non-Represented Employees offers you two tax-saving Flexible Spending Accounts (FSAs):

- ◆ The Health Care Flexible Spending Account; and
- ◆ The Dependent Care Flexible Spending Account.

You can contribute part of your paycheck each pay period to one or both of these Accounts. Contributions are deducted from your paycheck on a pre-tax basis. Reimbursements of eligible expenses are non-taxable.

You can contribute to an FSA regardless of whether you elect coverage under the EHP Medical Plan or you waive coverage.

Health Care FSA

When you contribute to the Health Care FSA, you can pay for eligible health care expenses with pre-tax dollars. Eligible expenses are those that meet IRS guidelines explained below and are not otherwise covered by any other health care plan.

Dependent Care FSA

When you contribute to the Dependent Care FSA, you can pay for eligible dependent day care expenses with pre-tax dollars. Eligible expenses are day care charges for qualifying dependent(s) as defined below during the time that you are at work.

When You Can Contribute to an FSA

You must sign up each year during open enrollment if you wish to contribute to an FSA. Your contributions will begin on January 1, or after your election to begin contributing following an eligible family status change (described earlier in this SPD under **Changing Your Coverage**). If you are a new employee, you can begin contributing after you sign up to contribute, provided you complete the online enrollment process within 30 days after your date of hire.

FLEXIBLE SPENDING ACCOUNTS

How Much You Can Contribute to an FSA

Health Care FSA: you can contribute up to \$2,550 per calendar year (minimum of \$5.00 per bi-weekly pay, maximum of \$98.07 per bi-weekly pay).

Dependent Care FSA: you can contribute up to \$5,000 per calendar year (\$2,500 if you are married and file a separate tax return) (minimum of \$10 per bi-weekly pay, maximum of \$192.30 per bi-weekly pay). Note – if you earn more than \$120,000 per year, Internal Revenue Code non-discrimination rules often require us to reduce your Dependent Care FSA contributions to less than \$5,000. The reduced limit cannot be determined until after the year has begun. For calendar year 2015, the reduced limit was \$2,800. You will be advised if the reduced limit applies to you.

It is better to contribute a little less than you think you will need, rather than more. As explained later in this section, if you do not use it, you will lose it.

Each FSA is separate. Money contributed to a Health Care FSA can only be used for eligible health care expenses. Likewise, money contributed to a Dependent Care FSA can only be used for eligible dependent day care expenses. You may not move money from one FSA to the other.

How to Use the FSAs

To best take advantage of the tax savings offered by the FSAs, follow these steps.

Step One -- Estimate Your Expenses

Estimate the amount you spend on health care expenses that are not covered by your or your spouse's health care plan, and/or the amount you spend on dependent day care expenses each year. To do this, you should review your expenses from previous years and think about predictable expenses in the upcoming year. Eligible expenses are described later in this Section.

Please note: If you are a new hire or otherwise start contributing mid-year, estimate your expenses only from the date you start contributing to the end of the calendar year.

Step Two -- Calculate Your Payroll Deductions

Next, determine the amount that you will contribute to your FSA(s) each bi-weekly pay period. To do so, divide your annual expected eligible health care expenses and/or dependent care expenses by 26 pay periods. (The ***Health Care and Dependent Care FSA Worksheets*** set forth below can help you figure

FLEXIBLE SPENDING ACCOUNTS

your expected eligible expenses.) This gives the amount you should elect to contribute to your FSA(s) each bi-weekly pay period (subject to the minimum and maximum contribution amounts set forth above).

For example, suppose you expect to have \$1,200 in uncovered health care expenses next calendar year. To pay for these expenses from your Health Care FSA, you could contribute \$46.15 of your paycheck each pay period. Your taxable income would be reduced by \$1,200 for the year and you would pay taxes on the reduced amount.

Once you elect how much to contribute for a calendar year, you cannot change that election until the next year, unless you have a qualified family status change (see **Changing Your Coverage**, earlier in this SPD). Any change in the amount you contribute must be consistent with your family status change.

If you enroll for part of the calendar year, because you are a new hire or had a qualified family status change, your annual contribution would be divided by the number of remaining pay periods in that year. That amount would then be deducted from your paycheck each pay period and contributed to your FSA for the remainder of that calendar year.

For example, if you contribute to an FSA for 13 pay periods during a year and chose to contribute \$260 for the year, you would contribute \$20 per pay.

Step Three – Use Your Debit Card or Submit a Claim

When you have an eligible expense, you may pay for it with a debit card or you may pay for it in cash and submit a claim form to receive reimbursement from your FSA. Specific information about using the debit card or submitting claim forms to each of the FSAs is described later in this section.

Use It or Lose It

Be sure to estimate your health and dependent care expenses carefully. According to federal law, you lose any money left in your FSAs at the end of the calendar year. However, you do have until March 31 of the next calendar year to submit a claim form for any expenses incurred during the previous year that were not paid for with a debit card. After that time, any remaining money is lost.

Eligible Health Care Expenses

Only eligible health care expenses can be paid from your Health Care FSA. Under the Internal Revenue Code, eligible expenses must be incurred by you, your legally married spouse, or your child under age 26. Expenses incurred by a domestic partner or the partner's child cannot be paid from your Health Care FSA, unless the domestic partner or the partner's child qualifies as your dependent for federal health plan tax purposes.

FLEXIBLE SPENDING ACCOUNTS

Eligible health care expenses must be incurred during the calendar year for which you contribute, and while you are an employee. Expenses incurred after you terminate employment are not eligible expenses and cannot be paid from your Health Care FSA, unless you continue FSA coverage under COBRA.

Some examples of eligible health care expenses that can be paid from your Health Care FSA are:

- ◆ Out-of-pocket medical, vision and dental care expenses, such as deductibles, copays, coinsurance amounts and amounts over annual maximums;
- ◆ Out-of-pocket preventive care expenses;
- ◆ Non-prescription drugs that are used to treat an injury or illness (such as antacids, allergy medications, pain relievers, insulin and cold medicines), but only if the patient has a written prescription from his or her doctor for the drugs (no prescription required for insulin);
- ◆ Laser eye surgery;
- ◆ Vision care, including out-of-pocket expenses for eyeglasses, contact lenses and contact lens solution;
- ◆ Retin-A for acne treatment;
- ◆ Nicotine patches for smoking cessation; and
- ◆ Out-of-pocket hearing care expenses.

Some examples of expenses that may not be paid from the Health Care FSA include:

- ◆ Cosmetic surgery (unless to correct a deformity resulting from a congenital abnormality, an accidental injury, or a disfiguring disease);
- ◆ Health club dues;
- ◆ Non-prescription drugs that are merely beneficial to your health (such as vitamins or dietary supplements);
- ◆ Non-prescription drugs that are used to treat an injury or illness, if the patient does not have a written prescription from his or her doctor (no prescription required for insulin);
- ◆ Cosmetics and toiletries;
- ◆ Weight loss programs (unless directed to participate by your physician to treat a specific disease);
- ◆ Non-prescription sunglasses; and
- ◆ Other health care insurance premiums.

For a complete list of eligible expenses, please see IRS Publication 502, available from the HR Service Center or go to www.irs.gov. Items shown in the list of “What Medical Expenses Are Deductible” in Publication 502 (other than health insurance or HMO premiums) are generally payable from the Health

FLEXIBLE SPENDING ACCOUNTS

Care FSA. Non-prescription drugs (which are not deductible) can also be paid for if they qualify as explained above.

Health Care FSA Worksheets

You may use the following worksheets to help you estimate your eligible health care expenses and calculate how much to contribute to your Health Care FSA.

Take a look at your health care expenses that are not covered by any plan during the year, and try to predict your expenses for the following year. You should review your medical, dental and vision benefits carefully before trying to predict your expenses.

Health Care FSA Worksheet # 1

Use this worksheet to help estimate your eligible health care expenses:

Eligible Expenses	Your estimated out-of-pocket costs
Medical, dental and vision deductibles	\$ _____
Medical, dental and vision copays	\$ _____
Medical, dental and vision expenses over the amount covered by your benefit plans	\$ _____
Hearing expenses not covered by your medical plan	\$ _____
Special education or communication equipment for covered blind or deaf persons	\$ _____
Other non-covered health care expenses	\$ _____
Annual Total	\$ _____
Divided by the number of pay periods (26 for a full calendar year)	\$ _____

Remember, the maximum amount you may contribute to a Health Care FSA is \$2,550, or \$98.07 per bi-weekly pay period (minimum of \$5.00 per bi-weekly pay period).

FLEXIBLE SPENDING ACCOUNTS

Health Care FSA Worksheet # 2

If you itemize uninsured health care expenses and deduct them on your income tax return, you may not pay for the same expenses from your Health Care FSA. You may use this worksheet to help you decide which method will work best for you: deducting health care expenses on your tax return or using the Health Care FSA.

1. Calculate your adjusted gross income \$ _____
2. Multiply this amount by 10% X 10% _____
3. The minimum amount of health care expenses you must have to be eligible to deduct health care expenses on your tax return \$ _____

If your total uninsured health care expenses are ***less than*** the amount on Line 3, you cannot deduct any expenses on your tax return. However, you can pay for these expenses from your Health Care FSA on a pre-tax basis and thus save on your taxes.

If your total uninsured expenses are ***more than*** the amount on Line 3, you have the choice of deducting the ***excess*** expenses on your tax return, or paying for your expenses (up to the amount you contribute) from the Health Care FSA. Keep in mind, you may only deduct those expenses that are more than 10% of your adjusted gross income. Because of that, generally it is more advantageous to use the Health Care FSA.

Paying Eligible Expenses From the Health Care FSA

To pay for eligible expenses from your Health Care FSA, you can use a debit card at the time of purchase, or you can pay for the expenses yourself and submit a paper claim form for reimbursement.

Debit Card

The debit card is an electronic payment option, which allows you to pay for eligible health care expenses with the swipe of a card at the time of the transaction. It eliminates the need to pay up front for eligible purchases, submit claim forms, and then wait for reimbursement.

Please note the following regarding the debit card:

- Your debit card may only be used for eligible expenses that are incurred during the Plan Year while you are employed; paper claims must be submitted for all other expenses.

FLEXIBLE SPENDING ACCOUNTS

- You can only use the debit card at merchants that accept the card. For example, the card will work at most pharmacies, but will be denied at a gas station.
- If you go to a drug store for a number of items - some eligible expenses, some not - ask the clerk to ring them up separately. Then use your debit card to pay only for eligible items.
- Although it is called a debit card, you use it just like a credit card when it is presented to the store or service provider. There is no PIN associated with the card. When given the option to select between debit or credit at the terminal, select credit.
- Save all of your itemized receipts. For some expenses, the plan administrator or the IRS may need additional information, including receipts, to verify eligibility of the expense and compliance with IRS rules. Save all receipts, and be prepared to promptly supply the supporting information upon request.

Paper Claims

If you cannot use the debit card for an eligible expense, you can pay for the expense yourself and submit a claim for reimbursement. Claim forms are available from the HR Service Center, or go to www.wageworks.com. Please provide your medical plan's description of what was paid (if the expenses were covered under your or your spouse's health care plan), as well as bills, receipts, and any other documentation of your expenses.

You will receive an Explanation of Payment with your reimbursement check. Reimbursement checks are processed bi-weekly.

You may fax your claim to 1-877-353-9236 or mail it to:

CLAIMS ADMINISTRATOR
P.O. Box 14053
Lexington, KY 40512

Your FSA Balance

If you use your debit card or submit a paper claim for more than the current balance in your FSA, your card will pay for, or you will be reimbursed for, the full amount you elect to contribute over the entire year minus any debit card purchases you have already made or reimbursements you have already received for the year. Your contributions over the rest of the year will cover the amount of your claim.

FLEXIBLE SPENDING ACCOUNTS

Using the Dependent Care FSA

You can use the Dependent Care Flexible Spending Account to pay for day care expenses incurred for a qualifying dependent who requires care either inside or outside of your home. Payments are tax free. Under the Internal Revenue Code, to qualify a dependent must be:

- ◆ Your child under age 13 for whom you can claim an income tax exemption;
- ◆ Your child (age 13 and older) or your parent, who qualifies as your dependent for federal health plan tax purposes, who is physically or mentally unable to care for him or herself, and who lives in your home for at least half of the calendar year;
- ◆ Your legally married spouse who is physically or mentally unable to care for him or herself and who lives in your home for at least half of the calendar year; or
- ◆ Your domestic partner, or a child of your domestic partner of any age, who qualifies as your dependent for federal health plan tax purposes, who is physically or mentally unable to care for him or herself, and who lives in your home for at least half of the calendar year.

Eligible Dependent Care Expenses

Following are examples of eligible dependent care expenses that may be paid for from the Dependent Care FSA:

- ◆ Day care centers for children or the elderly;
- ◆ Day camp;
- ◆ Nursery school (not kindergarten);
- ◆ Day care in a nursing home; and
- ◆ In-home day care.

You may not use the Dependent Care FSA to pay for dependent health care expenses.

Eligible Day Care Providers

You may use the Dependent Care FSA to pay for dependent care expenses only if the person or organization providing the care is not your own child under age 19 or a dependent you are claiming on your income tax return. If the day care provider is an individual who does not accept your debit card, you must show that person's Social Security Number when you submit your paper claim for reimbursement. If the day care provider is an organization that does not accept your debit card, you must provide their tax identification number when you submit your paper claim for reimbursement.

FLEXIBLE SPENDING ACCOUNTS

When You May Use the Dependent Care FSA

You can pay eligible expenses from a Dependent Care FSA if you are a single parent, or if you are married and your spouse:

- ◆ Works;
- ◆ Is looking for work;
- ◆ Goes to school full-time; or
- ◆ Is mentally or physically incapable of caring for themselves.

When Both Spouses Participate in Dependent Care FSAs

You and your spouse may both contribute to the Dependent Care FSA if you both work for JHHSC/JHH. In addition, if you contribute to the FSA and your spouse's employer also offers a dependent care FSA, you and your spouse may both contribute to these separate FSAs. If you do, the amount that you may contribute depends upon the amount your spouse contributes.

The combined maximum amount that you and your spouse can contribute to dependent care FSAs in a calendar year is \$5,000. You may divide the contributions however you like between your FSA and your spouse's FSA. For example, you may both wish to contribute \$2,500, or you may wish to contribute \$1,000 and your spouse \$4,000. It is up to you.

The Dependent Care Tax Credit

You may be eligible for a dependent care tax credit on your income taxes. You can claim a tax credit on eligible expenses up to \$3,000 per calendar year for one dependent, or \$6,000 per year for two or more dependents. But you can't use your Dependent Care FSA and the tax credit for the same expenses. If you use a combination of tax credits and FSA, the tax credit will be reduced, dollar for dollar, by the amount you pay for from your Dependent Care FSA.

Generally, if your family's annual income is approximately \$25,000 or more, the FSA will save you more in taxes. On the other hand, if your total household income is less than approximately \$25,000, it is probably better to take the tax credit. Use the following worksheet to help determine which method will work best in your situation.

FLEXIBLE SPENDING ACCOUNTS

Dependent Care FSA Worksheet

Use this worksheet to help estimate your eligible dependent care expenses for the next calendar year:

Step 1. Estimate your total eligible expenses:

\$ _____ times _____ = \$ _____
(cost per week) (weeks of care) (annual dependent care expenses)

Step 2. Calculate the FSA tax savings and the Federal Tax Credit:

FSA tax savings

1. Enter your expenses up to \$5,000 if you are single or married and filing jointly, or \$2,500 if married and filing separately: \$ _____
2. Enter your marginal tax rate from Chart 1 (on the next page): _____%
3. **Item 1 X Item 2 = \$ _____ (Your Dependent Care FSA Tax Savings)**

Federal tax credit

1. Enter your expenses up to \$2,400 if care is for one dependent, \$4,800 if for two dependents: \$ _____
2. Enter your tax credit percentage from Chart 2 (on the next page): _____%
3. **Item 1 X Item 2 = \$ _____ (Your Federal Tax Credit Tax Savings)**

Step 3. Compare the tax savings using an FSA vs. the Tax Credit. Which is larger?

FLEXIBLE SPENDING ACCOUNTS

Chart 1: Marginal Federal Tax Rate

This chart approximates the rate at which a reduction in your taxable income affects your income and Social Security taxes, based on 2016 tax tables. Find the range and filing status that fits your family's total income. Then, look in the right-hand column for the marginal tax rate that applies to your income.

Single:

<u>Taxable Income</u>	<u>Marginal Tax Rate***</u>
\$0 – 9,275	10%
\$9,276 – 37,650	15%
\$37,651 – 91,150	25%
\$91,151 – 190,150	28%
\$190,151 – 413,350	33%
\$413,351 – 415,050	35%
\$415,051 and up	39.6%

Married Filing Jointly:

<u>Taxable Income</u>	<u>Marginal Tax Rate***</u>
\$0 – 18,550	10%
\$18,551 – 75,300	15%
\$75,301 – 151,900	25%
\$151,901 – 231,450	28%
\$231,451 – 413,350	33%
\$413,351 – 466,950	35%
\$466,951 and up	39.6%

Head of Household:

<u>Taxable Income</u>	<u>Marginal Tax Rate***</u>
\$0 – 13,250	10%
\$13,251 – 50,400	15%
\$50,401 – 130,150	25%
\$130,151 – 210,800	28%
\$210,801 – 413,350	33%
\$413,351 – 441,000	35%
\$441,001 and up	39.6%

*****Add 7.65% to the percentages above for Social Security taxes for earnings up to \$118,500 in 2016, and add 1.45% for all earnings above that amount.**

FLEXIBLE SPENDING ACCOUNTS

Chart 2 Federal Tax Credit Percentage

<u>Taxable Income</u>	<u>Tax Credit</u>
Up to \$15,000	35%
\$ 15,001 - 17,000	34%
\$ 17,001 - 19,000	33%
\$ 19,001 - 21,000	32%
\$ 21,001 - 23,000	31%
\$ 23,001 - 25,000	30%
\$ 25,001 - 27,000	29%
\$ 27,001 - 29,000	28%
\$ 29,001 - 31,000	27%
\$ 31,001 - 33,000	26%
\$ 33,001 - 35,000	25%
\$ 35,001 - 37,000	24%
\$ 37,001 - 39,000	23%
\$ 39,001 - 41,000	22%
\$ 41,001 - 43,000	21%
\$ 43,001 and up	20%

Paying Eligible Expenses From the Dependent Care FSA

To pay for eligible expenses from your Dependent Care FSA, you must pay for the services yourself and then submit a paper claim form for reimbursement. Claim forms are available from the HR Service Center or go to www.wageworks.com. You must include the following information with your claim:

- ◆ The name of the person receiving the care;
- ◆ The type of service provided (such as day care) and the date the service was provided;
- ◆ The amount paid for the service; and
- ◆ The name and Social Security number or tax identification number of the person or organization providing the care.

If you submit a claim for more than the balance in your FSA, you will be reimbursed only up to your balance at that time. You will be reimbursed for the remainder of the claim after you contribute additional money to your FSA.

Only expenses incurred before you terminate employment can be reimbursed from your FSA. Expenses incurred after termination of employment will not be reimbursed.

FLEXIBLE SPENDING ACCOUNTS

You will receive an Explanation of Payment with your reimbursement check. Reimbursement checks are processed bi-weekly. Fax your claim to 1-877-353-9236 or mail it to:

CLAIMS ADMINISTRATOR
P.O. Box 14053
Lexington, KY 40512

SHORT TERM DISABILITY BENEFITS

Short Term Disability Benefits

Your Short Term Disability benefits are designed to provide you with a continuing source of income during short periods of illness or injury. Coverage is provided by JHHSC/JHH at no cost to you; you do not pay anything for this coverage. You are eligible for benefits if you are regularly scheduled to work 20 or more hours per week, effective the first day of the month following your date of hire and completion of any employment probationary period that may apply to you. ***However, your coverage will not begin unless and until you complete the online enrollment process.*** Weekend option nurses are not eligible for Short Term Disability benefits.

If you are injured in an accident for which you might recover from a third party or from your own insurance (such as personal injury protection), please refer to the reimbursement and subrogation provisions explained below at **When the EHP Medical Plan and Short Term Disability Plan May Recover Payment.**

Payment of Benefits

Short Term Disability pays benefits when you cannot perform the regular duties of your job due to an illness or injury. You will receive benefits equal to 60% of your regular bi-weekly base pay (including regular shift differential and excluding overtime and commissions). This benefit amount is payable to you for up to 11 weeks of disability. Benefits begin after you have been unable to work for 14 consecutive calendar days. You must be under a doctor's care to be considered disabled. Your Short Term Disability benefits will be supplemented by any time you may have available in your Sick Bank or PTO Bank up to 100% of your regular bi-weekly base pay. Please note that you must submit your claim for Short Term Disability benefits within 90 days from the date of the illness or injury that caused your disability to occur.

Short Term Disability benefits are not provided for an illness or injury that is work-related. These kinds of claims should be submitted to Workers' Compensation.

Short Term Disability benefits are not provided for an illness or injury that occurs or begins while you are on a leave of absence.

Short Term Disability benefits are administered through Johns Hopkins HealthCare. If you need to speak with the Short Term Disability Coordinator about the amount or duration of your benefits you can call 410-762-5312.

SHORT TERM DISABILITY BENEFITS

Benefits From Other Sources

You may be eligible to receive benefits from other disability plans, such as other group insurance plans or government disability programs. If that happens, your JHHSC/JHH Short Term Disability benefits will be reduced by any amounts payable under these other plans.

Return to Work

When your Short Term Disability benefits begin, you will usually be approved for a specified number of weeks of benefits based on your doctor's certification of how long you are expected to be unable to work. If you return to work before the approved number of weeks is up, please notify the Short Term Disability coordinator at 410-762-5312.

Recurring Disabilities

If you recover and return to work but then suffer a relapse, you may be eligible for additional disability benefits. The amount of your disability benefits depends on the nature of the disability and how long you have been back to work.

If you have been back to work for less than two weeks and become disabled again from the same or a related cause, the second period of disability will be considered a continuation of the first one.

If you have been back to work for less than two weeks and become disabled from a different and unrelated cause, a new disability benefit period would begin after you have been unable to work for 14 consecutive calendar days.

Any disability that occurs after you have been back to work for two weeks or more, whether it is a relapse or a new condition, will be considered a new disability period. Benefits would begin after you have been unable to work for 14 consecutive calendar days.

Partial Disability

If you are able to continue or return to work at JHHSC/JHH on a part time basis after an illness or injury, you may qualify for Partial Short Term Disability benefits. You will be considered partially disabled and entitled to partial Short Term Disability benefits if the number of hours you are regularly scheduled to work is reduced by at least 20% due to a disabling condition. If you are partially disabled, your Short Term Disability benefits will be reduced by 50% of your JHHSC/JHH reduced schedule pay. The combination of your Short Term Disability benefits and reduced schedule pay may not exceed 100% of your regular bi-weekly base pay.

SHORT TERM DISABILITY BENEFITS

The following example explains how partial disability benefits are calculated:

1. Regular bi-weekly base pay	\$2,000
2. Multiplied by the regular percentage for STD benefit	x 60%
3. Regular weekly STD benefit (<i>one half of Line 1 x Line 2</i>)	\$600 per Week
4. Pay received for reduced schedule employment	\$500 per Week
5. Multiplied by Partial Disability Offset percentage	x 50%
6. Partial Disability Offset	\$250 per Week
7. Regular weekly STD Benefit minus Partial Disability Offset (<i>Line 3 - Line 6</i>)	\$350 per Week
8. Plus pay received for reduced schedule employment	\$500 per Week
9. Total pay and STD Benefits (<i>Line 7 + Line 8</i>)	\$850 per Week

Days of partial disability count the same as days of total disability for determining your entitlement to disability benefits. Thus, partial disability days count as full days to determine if you have been unable to work for the required 14 days before benefits begin. Similarly, days for which partial disability benefits are paid count as full days towards the maximum 11 weeks of benefits.

What's Not Covered By Short Term Disability Benefits

Short Term Disability benefits are not paid for any of the following:

- ◆ Any disability arising from an injury or illness for which coverage is excluded as described under **What's Not Covered by the EHP Medical Plan** earlier in this SPD, regardless of whether you have coverage under the Medical Plan;
- ◆ Any disability for which you are eligible to receive benefits under Workers' Compensation, or which results from an injury or illness you incur in the course of any employment. This exclusion does not apply if a claim for Workers' Compensation benefits is made and is denied on the grounds that the injury or illness that caused the disability was not work related;
- ◆ Any disability for which you are eligible to receive payment under motorcycle insurance or any disability resulting from an injury while riding a motorcycle without a helmet that meets applicable safety standards issued by the National Highway Traffic Safety Administration. This exclusion applies even when riding in a state that does not require wearing a helmet;
- ◆ Any period of disability beginning prior to your effective date of coverage under this Plan;

SHORT TERM DISABILITY BENEFITS

- ◆ Any period of disability during which you are not under the regular care of a physician.
- ◆ Any period of time during which you are employed in a position other than your regular job, and in which position you utilize the skills and/or qualifications of your regular job.

When Short Term Disability Benefits End

Your Short Term Disability benefits will end on the earliest of when you:

- ◆ Are no longer under the regular care of a physician;
- ◆ Are no longer disabled;
- ◆ Fail to supply proof of your illness or injury;
- ◆ End your employment; or
- ◆ Receive the maximum amount of benefits, as described earlier in this section.

Mid Term Disability Benefits

You may extend your Short Term Disability benefits with Mid Term Disability benefits, but only if you have enrolled for Long Term Disability insurance coverage (as explained in your Guide to Benefits booklet). Mid Term Disability benefits extend your Short Term Disability benefits for up to an additional 13 weeks of disability after Short Term benefits run out. The Mid Term Disability benefit is calculated the same way and operates under the same rules as your Short Term Disability benefits.

ADMINISTRATIVE INFORMATION

Administrative Information About Your Johns Hopkins EHP Benefits

Filing A Claim With Employer Health Programs

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

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

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

Itemized bills must include the following information:

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

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

ADMINISTRATIVE INFORMATION

What Happens When You Have Duplicate Coverage

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

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

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

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

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

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

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

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

ADMINISTRATIVE INFORMATION

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

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

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

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

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

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

Prior Coverage Under the EHP Basic and Premium Plans

If you were covered under the EHP Basic Plan and/or Premium Plan before 2013, then any benefits provided by those Plans are treated as benefits provided under the current EHP Medical Plan when applying lifetime limits.

Employees Whose Worksite Is Outside The United States

Employees whose worksite is outside the United States do not have coverage under the EHP Medical or Dental Plans. Instead, a policy offered by MetLife provides the health and dental insurance coverages. Employees whose worksite is outside the United States are still be eligible for Short Term and Mid Term Disability benefits and the Health Care and Dependent Care Flexible Spending Accounts as described in this Summary Plan Description.

ADMINISTRATIVE INFORMATION

When the EHP Medical Plan and Short Term Disability Plan May Recover Payment

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

Reimbursement

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

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

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

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

ADMINISTRATIVE INFORMATION

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

Subrogation

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

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

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

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

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

Benefits Paid by Mistake

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

ADMINISTRATIVE INFORMATION

When Benefit Plan Coverage Ends

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

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

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

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

Your coverage under the EHP Medical Plan will also end if you certify that you do not use tobacco when you enroll for coverage, and it is later determined by the Plan Administrator that your certification was false when made. In that event, you may also be required to reimburse the Plan for any expenses paid by the Plan for medical treatment that was related to tobacco use.

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

ADMINISTRATIVE INFORMATION

COBRA Continuation Coverage

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

If your employment ends during the plan year in which you contribute to a Health Care FSA, COBRA also allows you to continue making after-tax contributions to the FSA. You may continue these contributions until the close of the plan year. You may not continue contributions to your Dependent Care FSA.

Length of COBRA Coverage

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

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

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

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

If you are at least age 62 and have at least 15 “Years of Vesting Service” under the Johns Hopkins Health System Corporation Retirement Plan when you lose regular coverage due to one of the above qualifying events, you may continue coverage under COBRA until the end of the month in which you reach age 65. This allows you to continue coverage under COBRA until you are eligible for Medicare. You may also cover your spouse while you are receiving this extended COBRA coverage. If you

ADMINISTRATIVE INFORMATION

cover your spouse until you reach age 65 (when your COBRA coverage ends), your spouse may thereafter continue COBRA coverage until the end of the month in which he or she reaches age 65 or has been on COBRA for 36 months in total, whichever occurs first.

If you are eligible for extended COBRA coverage as explained in the preceding paragraph, but you do not elect COBRA because you are already eligible for Medicare when you lose regular coverage due to one of the above qualifying events, your spouse may elect COBRA coverage until the end of the month in which he or she reaches age 65 or has been on COBRA for 36 months in total, whichever occurs first.

Extended COBRA coverage for you and your spouse is subject to all the rules that otherwise apply to COBRA coverage as explained in this SPD.

If you, your spouse or any of your dependents is Social Security disabled at any time during the first 60 days of COBRA coverage, coverage for the disabled individual and each of the individual's family members may be extended for an additional 11 months, for a total of 29 months. Premiums for the additional 11 months will increase from 102% to 150% of the full cost. The HR Service Center 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.

However, in the case of a disabled employee (but not a family member) whose application for Social Security disability benefits is pending at the end of the first 18 months of COBRA coverage, written notice of the disability determination may be given to the HR Service Center after the first 18 months of COBRA coverage ends if:

- the employee applied for Social Security disability benefits no later than 60 days after COBRA coverage began;
- the Social Security Administration's failure to make a determination before the first 18 months of COBRA ends is not the employee's fault;
- the employee is found to be disabled under the long term disability plan of the employee's employer;
- the employee requests the additional 11 months of COBRA before the first 18 months of COBRA ends;
- the Social Security Administration makes its determination no later than 210 days after the first 18 months of COBRA ends, which determination finds that the disability began before the start of COBRA coverage, and
- the employee gives written notice to the HR Service Center of the Social Security determination within 30 days after the employee receives the determination.

ADMINISTRATIVE INFORMATION

If notice of an employee's Social Security disability determination is given after the first 18 months of COBRA ends as provided above, only the employee (and not any family member) is entitled to the additional 11 months of COBRA coverage.

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

Please contact the HR Service Center if you have any questions about your eligibility.

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

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

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

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

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

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

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

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

ADMINISTRATIVE INFORMATION

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

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

Electing COBRA Coverage

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

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

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

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

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

When COBRA Coverage Ends

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

ADMINISTRATIVE INFORMATION

- ◆ 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
- ◆ JHHSC/JHH stops providing group medical coverage for all active employees.

Benefit Coverage During FMLA Leaves of Absence

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

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

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

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

For more information about the Family and Medical Leave Act, please contact the HR Service Center.

ADMINISTRATIVE INFORMATION

Benefit Coverage During Other (Non-FMLA) Leaves of Absence

Approved Medical Leaves

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

If you do not return to employment with JHHSC/JHH at the end of your non-FMLA medical leave, you (and your spouse and dependent children) may elect COBRA coverage under the EHP Medical and/or Dental Plans at the level of coverage that you (or your spouse or dependent children) were covered by, if any, on the day your non-FMLA medical leave ended. You may not elect COBRA if your regular coverage under the EHP Medical and/or Dental Plans ends during your leave for failure to make required employee contributions or for any other reason.

Approved Non-Medical Leaves

An approved leave of absence that is not FMLA protected and that is not a medical leave of absence is treated as a termination of employment for benefits purposes. Your benefit plan coverage ends on the last day of the month in which you are treated as terminating employment, except to the extent you elect to continue coverage in accordance with the COBRA continuation of coverage rules described above.

When You Become Covered By Medicare

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

Before your 65th birthday, you should get an explanation of Medicare benefits from the Social Security Administration. Make sure that you are actually enrolled for Medicare when you turn age 65. Enrollment does not happen automatically – you must go to the Social Security Administration and apply in order to have Medicare coverage.

ADMINISTRATIVE INFORMATION

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

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

Medicare and End Stage Renal Disease

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

Plan Information

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

Plan Sponsor

The Johns Hopkins Hospital sponsors the Johns Hopkins Health System Corporation/The Johns Hopkins Hospital Employee Benefits Plan for Non-Represented Employees, which contains the benefit plans described in this SPD. The Employee Benefits Plan covers eligible non-represented employees of the Johns Hopkins Hospital and the Johns Hopkins Health System Corporation.

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

ADMINISTRATIVE INFORMATION

Plan Administrator

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

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

Benefits Office
Attention: Senior Director of Benefits
Johns Hopkins at Eastern
1101 East 33rd Street
Baltimore, MD 21218
Telephone: 443-997-5400

Plan Year

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

Plan Funding

Except for Long Term Disability, Life and Accidental Death and Dismemberment insurance benefits, the benefits provided by the Employee Benefits Plan are not financed or administered by an insurance company. Benefits are paid from the general assets of JHHSC/JHH through a contract with Johns Hopkins Employer Health Programs. You can contact Johns Hopkins Employer Health Programs at:

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

Information about the funding of the Long Term Disability, Life and Accidental Death and Dismemberment insurance benefits is contained in their separate summary plan description.

Plan Number

The plan number is 506.

ADMINISTRATIVE INFORMATION

Legal Action

The agent for service of legal process is:

JHHSC/JHH General Counsel
600 N. Wolfe Street
Administration Building
Baltimore, Maryland 21287

You may also serve legal process on the Plan Administrator.

Prohibition On Assignment Of Benefits

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

Claims And Appeals

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

All claims for benefits under an insured plan (Long Term Disability, Life and Accidental Death and Dismemberment) must be made to the insurance company that issues the policy for the plan in accordance with the policy's rules.

Claims for the Health Care and Dependent Care Flexible Spending Accounts must be made as explained earlier in this SPD under **Flexible Spending Accounts**.

ADMINISTRATIVE INFORMATION

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

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

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

The filing requirements, and other procedures related to claims and appeals, differ depending on whether you have an "Urgent Care Claim," a "Pre-Service Claim" or a "Post-Service Claim". There are special rules if a pre-approved course of treatment is reduced or terminated, or if you want to extend a pre-approved course of treatment. Medical benefits claims can be any of the foregoing types of claims. On the other hand, claims for Dental or Short Term and Mid Term Disability benefits are always handled under the Post-Service Claims rules.

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

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

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

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

ADMINISTRATIVE INFORMATION

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

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

Filing a Claim

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

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

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

Itemized bills must include the following information:

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

Claim forms are available at the Johns Hopkins Hospital HR Service Center and 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.*

ADMINISTRATIVE INFORMATION

Reducing or Terminating an Approved Course of Treatment

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

Extending an Approved Course of Treatment

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

Authorized Representative

An authorized representative may file a claim or appeal a denial of benefits for you. To name an authorized representative, you must use a Designation of Authorized Representative form which you can get from Employer Health Programs on www.ehp.org or by calling an EHP Customer Service Representative.

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

Claims and Appeals Procedures

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

ADMINISTRATIVE INFORMATION

Urgent Care Claims

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

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

Pre-Service Claims

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

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

Post-Service Claims

Unless additional information is needed, if a Post-Service Claim for medical or dental benefits is denied, you will be notified within 30 days after the claim is properly filed. You will be notified within 45 days for a denial of a Short Term or Mid Term Disability benefit claim. If there are matters beyond Employer Health Programs' control, this period may be extended up to 15 more days (up to two 30 day extensions for Disability benefits). If an extension is needed, you will be told before the initial 30 day (or 45 day) period ends why an extension is needed and when a decision is expected.

If Additional Information is Needed

Pre-Service and Post-Service Claims

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

ADMINISTRATIVE INFORMATION

Urgent Care Claims

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

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

If Your Claim is Denied

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

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

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

First Level Appeal

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

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

ADMINISTRATIVE INFORMATION

reduction or termination, the reduction or termination will probably take effect before you have a decision on your Appeal.

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

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

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

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

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

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

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

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

ADMINISTRATIVE INFORMATION

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

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

When Your First Level Appeal Will Be Decided

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

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

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

Post-Service Claim -- You will be notified of the decision on a medical or dental benefit claim within 30 days after your First Level Appeal is filed. You will be notified within 45 days for a Short Term or Mid Term Disability benefit claim. (If more time is needed to decide a Disability claim, this period may be extended up to another 45 days. If an extension is needed, you will be told before the initial 45 day period ends why an extension is needed and when a decision is expected.)

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

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

You will be sent a written notice of the Appeals Department's decision. If your appeal is denied, the notice will tell you why and the specific Plan provisions on which the denial is based. The notice will tell you if an internal rule or guideline was relied on to deny your appeal, and how to request a free copy of the rule or guideline. The notice will tell you if your appeal was denied because the treatment

ADMINISTRATIVE INFORMATION

is not medically necessary or is experimental, and how to request a free explanation of the scientific or clinical judgment relied upon. The notice will also tell you how and when you can file a Final Appeal. If your claim is an Urgent Care Claim, the notice will explain the expedited Final Appeal process.

Final Appeal

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

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

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

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

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

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

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

Your Final Appeal will be submitted to the Plan Administrator. You may submit written comments, documents, records and other information relating to your claim. The Plan Administrator will consider everything you submit, regardless of whether it was submitted or considered in the initial benefit

ADMINISTRATIVE INFORMATION

determination or your First Level Appeal. Upon written request and free of charge, you will be provided with reasonable access to and copies of all Plan documents, records and other information relevant to your claim.

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

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

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

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

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

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

Post-Service Claim -- You will be notified of the decision on a medical or dental benefit claim within 30 days after your Final Appeal is filed. You will be notified within 45 days for a Short Term or Mid Term Disability benefit claim.

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

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

ADMINISTRATIVE INFORMATION

Appeal is filed after the additional treatment has been provided, the Post-Service Claim time applies.

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

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

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

External Review

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

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

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

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

You are not required to submit your claim to External Review, and doing so will not affect your right to bring a civil action against the Plan under ERISA Section 502. Whether or not you submit your claim to External Review will have no effect on your rights to any other benefits under the Plan. There is no charge for you to submit your claim to External Review. The External Review process will be

ADMINISTRATIVE INFORMATION

administered in accordance with regulations and guidance issued by the Department of Labor under Public Health Service Act Section 2719.

Request for External Review

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

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

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

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

Preliminary Review

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

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

Referral to IRO

If your request is eligible for External Review, EHP will assign an accredited IRO to conduct the External Review, and will provide the IRO with the documents and other information considered during the internal appeal process. Note that information submitted to the IRO will include your "Protected Health Information" (described below in this SPD). EHP will notify you in writing when your request is accepted for External Review by the IRO. Within 10 business days after you receive

ADMINISTRATIVE INFORMATION

this notice, you may submit to EHP any additional information that you want considered by the IRO as part of the External Review. The IRO may, but is not required to, consider information that you submit after 10 business days.

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

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

EHP will provide you with written notice of the IRO's External Review decision within 45 days after the IRO receives the request for the External Review. The IRO will maintain records of all materials associated with its External Review decision for six years, and will make the records available for your examination upon written request, except where disclosure would violate State or Federal privacy laws.

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

Expedited External Review

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

ADMINISTRATIVE INFORMATION

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

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

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

Protected Health Information

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

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

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

ADMINISTRATIVE INFORMATION

Your Rights Under ERISA

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

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

Additional ERISA Rights

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

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

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

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

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

ADMINISTRATIVE INFORMATION

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

JHHSC/JHH's Rights

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

Not A Contract Of Employment

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

Plan Administrator's Authority

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

For More Information

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