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JOHNS HOPKINS EHP CLASSIC PLAN

Benefits For You And Your Family

The benefits provided under the Johns Hopkins University EHP Classic Plan are described in this Summary Plan Description (SPD). Please read it carefully. EHP Classic is sometimes referred to in this SPD as the Medical Plan.

Benefits under the Medical Plan are administered through Johns Hopkins Employer Health Programs, Inc. (EHP). The Medical Plan is part of the Johns Hopkins University Welfare Plan.

This SPD reflects EHP Classic as amended effective January 1, 2007. For periods before January 1, 2007, please refer to the January 1, 2006 version of the SPD.

Who Is Eligible

Employee Coverage

You are generally eligible for the Medical Plan benefits described in this SPD if you are:

- ◆ A full-time non-union wage earning employee of JHU scheduled to work at least 28 hours per week on a regular (not temporary or seasonal) basis;
- ◆ A part-time non-union employee of JHU scheduled to work at least 19 hours but less than 28 hours per week on a regular (not temporary or seasonal) basis;
- ◆ A limited-time non-union wage earning employee of JHU (as determined by JHU) regularly scheduled to work less than 19 hours per week;
- ◆ A retired employee of JHU as defined by JHU.

Dependent Coverage

Eligible dependents may also be covered under the Medical Plan. Eligible dependents are:

- ◆ Your legal spouse or same-sex domestic partner, provided that you have satisfied the criteria of JHU. For a copy of the same-sex domestic partner affidavit, or for additional information, please contact the JHU Benefits Service Center at 410-516-2000;
- ◆ You or your spouse/same-sex domestic partner's unmarried dependent child, until the end of the calendar year of his/her 19th birthday, if the child depends primarily on you for financial support and lives in your household;

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- ◆ You or your spouse/same-sex domestic partner's unmarried dependent child who is a full time student at a degree-granting university or college, until the end of the calendar year of his/her graduation or the end of the calendar year of his/her 25th birthday, whichever comes first. The child must take the required minimum number of credits to be considered "full time" under the school's rules. You must provide proof of eligible student status as set forth below.
- ◆ You or your spouse/same-sex domestic partner's physically or mentally disabled dependent child(ren) of any age, provided the physical or mental disability began while they were eligible as explained above. 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. EHP may require proof of any of these qualifications at any time.

Children whom you may enroll must be you or your spouse/same-sex domestic partner's natural children, stepchildren, children legally adopted or placed for adoption, children covered by a Qualified Medical Child Support Order (QMCSO), and any other children for whom you are the legal guardian.

Please note: You may not cover your former spouse after the divorce has become final.

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

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

If you have any questions about this coverage, please contact the JHU Benefits Service Center.

Proof of Student Status

You must provide proof of eligible student status. Verification letters will be mailed in January to employees with coverage for a child whose 20th thru 25th birthday falls in that calendar year. The letter will specify a deadline (usually February 15) by which the required proof of student status must be returned. If the required proof is returned by the deadline, student status will be considered verified through the following December 31. If the required proof is not returned by the deadline, the child's coverage will terminate retroactively to the preceding December 31. If termination of your child's coverage results in a change in your membership, JHU will also change your membership election automatically.

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Qualified Medical Child Support Order (QMCSO)

You may enroll children who are not otherwise eligible as dependents (as described above) in your Medical Plan 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 JHU Benefits Service Center as soon as possible. Coverage will only be provided if the Plan Administrator determines that the QMCSO meets certain requirements imposed by law.

When Coverage Begins

Your Medical Plan coverage begins on the date determined by JHU. You must complete and submit your enrollment form on or before that date. If you fail to properly complete and submit your enrollment form to JHU on or before that date, you will not be eligible for Medical Plan coverage.

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, holiday, jury duty, or other similar reasons, you will still be considered actively at work and coverage will be effective.

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

Changing Your Coverage

During the annual open enrollment period, you may change your Medical Plan coverage, or you may switch to another health plan offered by JHU. Please note, however, that retirees and visiting faculty do not have open enrollment periods. If you are a retiree or a visiting faculty member, please contact the JHU Benefits Service Center for additional information. After you complete your medical enrollment application form, your initial benefit election will remain in effect indefinitely until you make a new benefit election by requesting, completing, and submitting a new medical enrollment application form during any later enrollment period. Outside of the annual open enrollment period, you may obtain or cancel 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 **Special Enrollment Rights** discussed below). You must notify the JHU Benefits Service Center within 30 days of the change in status. Complete rules regarding changing your election for a change in status are set forth in the JHU Personal Benefit Elections Program.

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An employee, spouse/same-sex domestic partner, or dependent child whose coverage under any other group health plan ends is permitted to enroll in coverage under the Medical Plan within 30 days of the date of the loss of other coverage as explained below under Special Enrollment Rights. Please notify the JHU Benefits Service Center about your situation to see if coverage is available.

Any change in your benefit enrollment must correspond directly to the change in family status. If you submit your enrollment/change form, and a copy of proof of the family status change (such as a marriage or birth certificate or adoption papers) within 30 days after the change, coverage becomes effective retroactively to the date of the event. If you delay past 30 days, you must wait until the next annual open enrollment before Medical Plan coverage can become effective or changed. Please keep the JHU Benefits Service Center informed of any changes in family status.

Special Enrollment Rights For Medical Coverage

Losing other coverage

If you did not enroll in the Medical Plan (or another health plan offered by JHU) because you had coverage through another source (such as a spouse's employer or under COBRA), and should you subsequently lose that coverage, you may enroll for medical care coverage under the Medical Plan. You must request this ***special enrollment*** by submitting new enrollment forms to the JHU Benefits Service Center within 30 days of losing your other coverage. Medical Plan coverage will become effective retroactively to the date of the loss of other coverage.

New Dependents

Dependents whom you acquire through marriage, birth, adoption, or placement for adoption may be granted a ***special enrollment***, as long as you enroll them for coverage by submitting the proper enrollment materials to the JHU Benefits Service Center within 30 days following the date you acquired the dependent. If you do not have coverage for yourself or your spouse/same-sex domestic partner, you may also enroll yourself or your spouse/same-sex domestic partner when you enroll your new dependent. Medical Plan coverage will become effective on the date of the event.

Certificates Of Coverage (HIPAA)

If you or a covered dependent lose your Medical Plan coverage (including COBRA coverage), be sure to notify Johns Hopkins Employer Health Programs at 410-424-4450 or 800-261-2393 and request a certificate of coverage. This certificate of coverage is available at no cost to you. At a minimum, this certificate will state the length of time you (or your covered dependent) had uninterrupted Medical Plan coverage. It will also show the date coverage ended. This certificate of coverage may allow you to reduce any pre-existing condition limits that apply to future medical coverage.

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Please note that certificates are not automatically provided for dependents until Johns Hopkins Employer Health Programs is aware that the dependent has lost coverage (for example, when a dependent no longer qualifies for coverage because of age). You may request a certificate of coverage for up to 24 months from the date your coverage ended.

Coverage Costs

You and JHU share the cost of your medical benefits. Any contributions you will be required to make to obtain the benefits will be determined by JHU, and will be communicated to you from time to time.

Johns Hopkins EHP Classic Plan

The Medical Plan benefits described in this SPD are administered by Johns Hopkins Employer Health Programs.

The Medical Plan is designed to provide you and your family with quality health care services in the most cost-effective settings. It 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 Medical Plan also offers vital preventive care benefits usually not provided under traditional health care options. These include coverage for routine physicals; well-woman care, including Pap tests and mammograms; and well-child care, including immunizations and check-ups.

The Medical Plan offers two ways to *receive* care; each and every time you *need* care. The two options are described next.

Option 1: In Network Care

The Medical Plan incorporates the cost-efficiencies that result from using a network of highly qualified health care professionals and facilities. It offers you the reassurance of being treated by a participating doctor you choose, in a location convenient to you. To receive Option 1 benefits, you may go to any doctor in the Johns Hopkins Employer Health Programs network, and the Medical Plan will pay benefits for covered services. Most services are covered at 80%, and you pay the remaining 20% until you reach an annual out-of-pocket maximum as described later in this SPD.

Please note that some services are only available under Option 1.

Network Hospitals

The Medical Plan also gives you access to The Johns Hopkins Hospital, Johns Hopkins Bayview Medical Center, and a network of local and regional community hospitals. For a complete listing, please see the provider directory.

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Option 2: Out-Of-Network Care

You may choose to receive care outside of the Johns Hopkins EHP network. To receive benefits, you must first pay a calendar year deductible of \$250 per person (\$750 per family). After meeting the calendar year deductible, the Medical Plan will pay 70% of the Reasonable and Customary (R&C) charge (see **Payment Terms You Should Know** discussed below), and you pay the remaining 30%, plus any amounts over the Reasonable and Customary charge, until you reach the annual out-of-pocket maximum, as described later in this SPD. After you reach the out-of-pocket maximum, your benefits for covered services are paid at 100% of the R&C charge for the remainder of that calendar year. You are responsible for any amounts over the R&C charge, and these amounts do not count towards the annual out-of-pocket maximum.

When You Need To See A Specialist (Referrals)

Although you are not required to select a Primary Care Provider, you are encouraged to maintain a relationship with a network provider. This provider may assist in directing you to an appropriate network specialist. However, because referrals are not required under this plan, you may self-refer to any specialist in the Employer Health Programs network to receive Option 1 benefits.

Services provided by an out-of-network provider will be paid under Option 2, unless the services have been reviewed and authorized in advance by EHP Care Management for coverage under Option 1.

Payment Terms You Should Know

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

- ◆ **Actual Charge** — This is the amount the hospital, doctor or other provider charges for the treatment you received.
- ◆ **Allowed Charge** — This is the maximum amount the Medical Plan will allow for coverage of specific health care services. Any co-pay and coinsurance amounts you are responsible for paying are deducted from the allowed charge.
- ◆ **Deductible and deductible carryover feature** — Under Option 2 of the Medical Plan, the deductible is the amount you must pay within the calendar year before the Medical Plan begins to pay benefits. 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 three or more individuals can meet the family deductible. However, no one individual will be required to satisfy more than the individual deductible. Please note that your co-pays and coinsurance payments (i.e., your percentage or share of expenses) and any amounts over the R&C charges do not apply toward the deductible.

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- ◆ Reasonable and Customary Charge (R&C) — This is the usual fee charged by similar providers for the same services or supplies in the same geographic area. Johns Hopkins Employer Health Programs determines what is a Reasonable and Customary charge. EHP network providers (Option 1) will not charge more than the Reasonable and Customary charge, but non-network providers can charge more.
- ◆ Cost Sharing Provision — The terms *co-pay* and *coinsurance* describe ways that you share in the cost of your medical expenses.
 - **Co-pay:** The co-pay is the amount you pay for prescription drugs and hospital inpatient admissions. Please refer to the **Medical Benefits-At-A-Glance** chart, later in this SPD for specific co-pay amounts. The co-pay does not apply toward the annual out-of-pocket maximum or the calendar year deductible. You pay the co-pay directly to the pharmacy when you obtain your prescription or to the hospital when you are admitted.
 - **Coinsurance:** The coinsurance is your share for certain medical expenses. Under Option 1, the Medical Plan generally pays 80% for most services and you pay 20%. Under Option 2, the Medical Plan generally pays 70% of the Reasonable and Customary (R&C) charge, after the calendar year deductible, and you pay the remaining 30%, plus any amounts over R&C.
 - **Out-of-Pocket Maximum:** Since you are responsible for a portion of the cost of your medical expenses under Options 1 and 2, the Medical Plan includes an annual out-of-pocket maximum to protect you in the event of high medical bills. After you have paid the annual out-of-pocket maximum (\$1,500 per person, \$4,500 per family under Option 1, or \$3,000 per person, \$9,000 per family under Option 2), the Medical Plan pays any additional covered expenses at 100% (of the R&C charges under Option 2) for the rest of that calendar year. Under Option 2, you are still responsible for any amounts over the R&C charges.

Please note: The annual out-of-pocket maximums are calculated separately for Options 1 and 2. In other words, payments that you make out of your pocket for care received under Option 1 are not applicable to your annual out-of-pocket maximum under Option 2, and vice versa.

The annual out-of-pocket maximum is calculated on a calendar year basis and includes the calendar year deductible and coinsurance but does not include penalties; prescription drug co-pays and expenses; hospital admission co-pays; amounts in excess of the Reasonable and Customary (R&C) charge; amounts in excess of Plan maximums; any charges for services which are not covered, or mental health and substance abuse charges, including treatment of alcoholism.

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- ◆ Providers — a provider is any hospital, skilled nursing facility, individual, organization, or agency licensed to provide professional services and acting within the scope of that license. Benefits will be paid for covered services from providers who meet this definition, depending upon whether you access care through Option 1 or 2. Benefits will not be provided under the Medical Plan for any services and related charges provided by an immediate relative of the patient (spouse, same-sex domestic partner, child, grandchild, brother, sister, in-law, grandparent, or parent).
- ◆ Maximum Benefit — This is the maximum amount the Medical Plan will pay for a covered individual during a calendar year. The annual benefit maximum for the Medical Plan is \$5,000,000. There is a separate lifetime benefit maximum of \$5,000 for outpatient substance abuse treatment and 120 days/visits for inpatient and outpatient alcohol abuse treatment. Certain other medical treatments or procedures may also have lifetime or annual maximums that are defined elsewhere in this SPD.

Care Management Program

The Medical Plan has several features designed to help both you and the Medical Plan manage health care costs, while still providing you with quality care. While part of increasing health care costs result 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 JHU and you. To help control these costs, the Medical Plan features a Care Management Program.

Before you can receive benefits for certain medical services and supplies under the Medical Plan, you must have these services and supplies pre-certified and coordinated through the Johns Hopkins EHP Care Management Program. Your network doctor will initiate this pre-certification process under Option 1. You or your out-of-network doctor must initiate this pre-certification process under Option 2. If you do not obtain pre-certification, coverage for benefits may be limited or denied entirely. The following services and supplies require pre-certification through the Care Management Program:

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

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- ◆ Hospital stays;
- ◆ Infertility services;
- ◆ Prosthetic devices and orthotics;
- ◆ Rehabilitation;
- ◆ Skilled nursing facility stays;
- ◆ Speech therapy;
- ◆ Surgery for morbid obesity
- ◆ Surgical procedures (certain procedures only, as described on a list maintained by Johns Hopkins Employer Health Programs. Under Option 1, your network doctor obtains this pre-certification on your behalf. Under Option 2, you are required to contact EHP Customer Service to see if a proposed surgical procedure is on this list. If it is, it is your responsibility to obtain pre-certification.);
- ◆ Temporomandibular Joint Syndrome (TMJ) treatment;
- ◆ Transplant services; and
- ◆ Use of certain drugs and medications. (Certain drugs and medications only, as described on a list maintained by Johns Hopkins Employer Health Programs. Under Option 1, your network doctor obtains this pre-certification on your behalf. Under Option 2, you are required to contact EHP Customer Service to see if a prescribed drug is on this list. If it is, it is your responsibility to obtain pre-certification.)

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

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

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Your Medical Plan Identification Card

A 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 any health care provider whenever you receive medical care.

Only you and your covered dependents are permitted to use the identification card. It is illegal to loan your card to persons who are not covered under the Medical Plan. If you lose your identification card, call a Johns Hopkins EHP Customer Service Representative immediately to request a new card.

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

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 Medical 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.

COVERED SERVICES AND SUPPLIES

Covered Services And Supplies

Medical Benefits At-A-Glance

The following chart summarizes most of the benefits and services available under the Medical Plan.

Services Provided	Option 1	Option 2
	Self Referral In-Network	Out-of-Network
CALENDAR YEAR DEDUCTIBLE		
Per individual	None	\$250
Per family	None	\$750
COINSURANCE OUT-OF-POCKET MAXIMUM (Including Deductible)		
Per individual	\$1,500	\$3,000
Per family	\$4,500	\$9,000
MAXIMUM ANNUAL BENEFIT PER PERSON		
All options combined	\$5,000,000 per calendar year	
MAXIMUM LIFETIME BENEFIT PER PERSON FOR SUBSTANCE ABUSE		
All options combined	\$5,000 for outpatient substance abuse treatment 120 days/visits for outpatient and inpatient alcohol abuse treatment	
PENALTY FOR FAILURE TO OBTAIN PRE-CERTIFICATION		
All inpatient admissions	N/A	\$500, or complete denial of coverage
TREATMENT OF ILLNESS OR INJURY		
Primary care office visit	80%	70% of R&C, after deductible
Specialty care office visit	80%	70% of R&C, after deductible
Diagnostic services and treatment	80%	70% of R&C, after deductible
PREVENTIVE SERVICES		
General physical exam	80%	Option 1 only
Diagnostic services	80%	Option 1 only
Well-child care	80%	70% of R&C (deductible waived)
Mammogram	80%	70% of R&C, after deductible
GYN exam	80%	Option 1 only
IMMUNIZATIONS AND INOCULATIONS		
For common communicable diseases (as approved by Care Management Program)	80%	70% of R&C, after deductible
VISION CARE	JH Routine Vision Network	Out of Network
One exam every two years	100%	Not available

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

NOTE: R&C is explained under **Payment Terms You Should Know**, earlier in this SPD.

COVERED SERVICES AND SUPPLIES

Services Provided	Option 1	Option 2
	Self Referral In-Network	Out-of-Network
ALLERGY TESTS AND PROCEDURES		
Allergy tests	80%	70% of R&C, after deductible
Desensitization materials and serum	80%	70% of R&C, after deductible
PRESCRIPTION DRUGS (In-Network Only)		
Pharmacy (30-day supply)	\$10 co-pay – Generic;\$25 co-pay – Brand	
Pharmacy (90-day supply)	\$30 co-pay – Generic;\$75 co-pay – Brand	
Mail Order Program (90-day supply)	\$20 co-pay – Generic;\$50 co-pay – Brand	
LABORATORY and X RAY PROCEDURES		
Laboratory tests, imaging exams, X-ray exams, and ultrasound	80%	70% of R&C, after deductible
SURGICAL PROCEDURES		
Professional services for inpatient and outpatient surgery (must be pre-certified by Care Management)	80%	70% of R&C, after deductible ^(a)
Medically necessary reconstructive and/or surgically implanted prosthetic devices (must be pre-certified by Care Management)	80%	70% of R&C, after deductible ^(a)
MEDICAL SUPPLIES		
Disposable supplies (e.g., ostomy bags, diabetic supplies, syringes)	80%	70% of R&C, after deductible
REPRODUCTIVE HEALTH		
Physician office visits (for prenatal care only)	80%	70% of R&C, after deductible
Birthing centers (licensed facility)	80%	70% of R&C, after deductible
Full care for the mother during pregnancy including physician, hospitalization, laboratory, and X-ray services.	80% \$250 co-pay for mother's hospital admission ^(b)	70% of R&C, after deductible \$250 co-pay for mother's hospital admission ^(b)
Artificial insemination and in-vitro fertilization (must be pre-certified by Care Management)	80%	70% of R&C, after deductible ^(a)
Interruption of pregnancy	80%	70% of R&C, after deductible ^(a)

(a) Failure to obtain pre-certification will result in a denial of benefits.

(b) Co-pay does not apply to newborn's admission.

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NOTE: R&C is explained under **Payment Terms You Should Know**, earlier in this SPD.

COVERED SERVICES AND SUPPLIES

Services Provided	Option 1	Option 2
	Self Referral In-Network	Out-of-Network
URGENT CARE CENTERS		
Physician visit	80%	70% of R&C, after deductible
Diagnostic services and treatment	80%	70% of R&C, after deductible
EMERGENCY SERVICES		
Emergency care (medical emergencies only, i.e. the onset of a sudden and serious condition requiring immediate care)	Facility - Covered in full Physician - 80%	Facility - covered in full Physician - 70% of R&C, after deductible
AMBULANCE TRANSPORTATION		
Transportation when medically necessary to and/or from a hospital or skilled nursing facility	80%	70% of R&C after deductible
HOSPITAL CARE		
Inpatient care (semi-private unless private accommodations are medically necessary) (must be pre-certified by Care Management)	80% after \$250 co-pay ^(b)	70% of R&C, after deductible and \$250 co-pay ^{(a)(b)}
Intensive care	80%	70% of R&C, after deductible ^(a)
Inpatient services, including pre-admission testing	100%	70% of R&C, after deductible ^(a)
Hospital inpatient days limitation	None	None
Skilled nursing/Rehabilitation facility (120 days per calendar year combined maximum) (must be precertified by Care Management)	80%	70% of R&C, after deductible ^(a)
Outpatient services including outpatient testing prior to outpatient surgery	80%	70% of R&C, after deductible
Outpatient surgery facility charges including freestanding surgical centers	100%	70% of R&C, after deductible ^(a)
CHEMOTHERAPY/RADIATION		
Includes physician services and materials	80%	70% of R&C, after deductible
HOME HEALTH CARE		
Must be precertified by Care Management (90 visits per calendar year combined maximum)	100%	70% of R&C, after deductible ^(a)
HOSPICE CARE		
Inpatient and home (must be precertified by Care Management)	80%	70% of R&C, after deductible ^(a)

(a) Failure to obtain pre-certification will result in a denial of benefits.

(b) Co-pay does not apply if patient has primary Medicare coverage.

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

NOTE: R&C is explained under **Payment Terms You Should Know**, earlier in this SPD.

COVERED SERVICES AND SUPPLIES

Services Provided	Option 1	Option 2
	Self Referral In-Network	Out-of-Network
SPEECH THERAPY		
Non-developmental care (must be precertified by Care Management) (30 visits per calendar year combined maximum)	80%	70% of R&C, after deductible
PHYSICAL/OCCUPATIONAL THERAPY		
By licensed physical therapist only (45 visits per calendar year combined maximum)	80%	70% of R&C, after deductible
ACUPUNCTURE		
Anesthesia, pain control and therapeutic purposes (\$1000 calendar year combined maximum)	80%	70% of R&C, after deductible
CHIROPRACTIC CARE		
Restricted to initial exam, X-rays and spinal manipulation	80%	70% of R&C, after deductible
DURABLE MEDICAL EQUIPMENT AND SUPPLIES		
Hearing aids for dependent children up to \$1400 per aid (must be precertified by Care Management)	80%	70% of R&C, after deductible
Equipment, prosthetic appliances and medical supplies (must be precertified by Care Management)	80%	70% of R&C, after deductible

(a) Failure to obtain pre-certification will result in a denial of benefits.

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

NOTE: R&C is explained under **Payment Terms You Should Know**, earlier in this SPD.

COVERED SERVICES AND SUPPLIES

MENTAL HEALTH AND SUBSTANCE ABUSE SERVICES	Care Coordinated by Clinical Case Managers	Care Not Coordinated by Clinical Case Managers^(a)
Inpatient care for mental health	30 days per calendar year covered at 80% after \$250 co-pay 31 st day and beyond covered at 60% ^(c)	30 days per calendar year covered at 70% of R&C, after deductible and \$250 co-pay 31 st day and beyond covered at 50% of R&C ^{(a)(c)}
Outpatient treatment for mental health (100 visits per calendar year combined maximum)	Visits 1-10: covered at 80% ^(c) Visits 11-30: covered at 65% ^(c) Visits 31+ : covered at 50% ^(c)	50% of R&C, after deductible ^{(a)(c)}
Inpatient care for substance abuse (21 days per calendar year combined maximum)	80% after \$250 co-pay ^(c)	70% of R&C, after deductible and \$250 co-pay ^{(a)(c)}
Outpatient treatment for substance abuse (\$5,000 lifetime maximum, \$1,000 calendar year maximum)	80% ^{(b)(c)}	70% of R&C, after deductible ^{(a)(b)(c)}
Inpatient care for alcohol abuse (lifetime maximum of 120 days/visits combined for outpatient alcohol abuse and inpatient alcohol abuse-7days detoxification maximum, 30 days rehabilitation maximum per calendar year)	80% after \$250 co-pay ^{(c)(d)}	70% R&C, after deductible and \$250 co-pay ^{(a)(c)(d)}
Outpatient treatment for alcohol abuse (lifetime maximum of 120 days/visits combined for outpatient alcohol abuse and inpatient alcohol abuse)	80% for 30 visits up to \$1,000 per calendar year 50% for 31 st visit and beyond up to an additional \$1,000 per calendar year ^{(c)(d)}	30 visits at 70% of R&C after deductible up to \$1,000 per calendar year 31 st visit and beyond at 50% of R&C up to additional \$1,000 per calendar year ^{(a)(c)(d)}

(a) You must still receive pre-certification from a Clinical Case Manager or benefits will not be provided.

(b) Lifetime outpatient substance abuse maximum is \$5,000.

(c) This coinsurance and the co-pay do not apply to the annual out-of-pocket maximum.

(d) Lifetime maximum for inpatient and outpatient alcohol abuse is limited to 120 days/visits.

Inpatient care \$250 co-pay does not apply if patient has primary Medicare coverage.

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

NOTE: R&C is explained under **Payment Terms You Should Know**, earlier in this SPD.

All day and visit limits described are combined for care coordinated or not coordinated by a Clinical Case Manager.

COVERED SERVICES AND SUPPLIES

Covered Services and Supplies

The 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.

Benefit limits, coinsurance and co-pay amounts are described in the **Medical Benefits At-A-Glance** chart. The chart highlights the major benefits that will be payable for Options 1 and 2. You will receive the highest level of benefits for services and supplies provided by Network providers (Option 1).

In General

Covered services and supplies include the following (when medically necessary and subject to any conditions or limitations as described elsewhere in this SPD):

- ◆ Abortion (elective);
- ◆ Acupuncture (for anesthesia, pain control, and therapeutic purposes provided by a licensed acupuncturist) limited to a calendar year maximum of \$1,000;
- ◆ Adult preventive services (available under Option 1 only);
- ◆ Allergy testing and treatment to determine the nature of allergies and desensitization treatment including test of treatment materials;
- ◆ Ambulance service (professional) both air and ground transportation, to the nearest hospital where necessary care can be given if the emergency is life-threatening;
- ◆ Anesthetics and oxygen, and their administration;

COVERED SERVICES AND SUPPLIES

- ◆ Birthing facilities — eligible provided the physician in charge is acting within the scope of his or her license and the birthing facility is a freestanding licensed facility for childbirth which meets state licensing requirements (all Option 2 birthing facility confinements must be pre-certified by Care Management). Outpatient facility ancillary expenses for services and supplies also are covered. These include: use of operating, delivery, and treatment rooms; prescribed drugs; medical and surgical dressings, supplies; diagnostic services and therapy services;
- ◆ Blood products, if not replaced;
- ◆ Casts, splints;
- ◆ Chiropractic care (out-of-network providers must be licensed and qualified to perform chiropractic services). Services are covered for initial examination, X-rays, manipulation, misalignment or partial dislocation of or in the vertebral column, and correction by manual or mechanical means of nerve interference;
- ◆ Colorectal screening;
- ◆ 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, limited to IUDs and diaphragms only;
- ◆ Convalescent facility care;
- ◆ Dental services if rendered as initial emergency treatment as a result of an accident and treatment is provided within 48 hours of the accident;
- ◆ Diabetes education;
- ◆ Diabetic supplies;
- ◆ Diagnostic medical procedures consisting of EKG or EEG, and other electronic diagnostic medical procedures;
- ◆ Diagnostic X-rays (including radiology, ultrasound, nuclear medicine, and magnetic resonance imaging, as well as laboratory services and pathology tests);
- ◆ Doctors' (including surgeons') fees for treatment of illness or injury;
- ◆ Doctors' fees and hospital charges for maternity care;

COVERED SERVICES AND SUPPLIES

- ◆ Doctors' fees for office visits;
- ◆ Durable medical and surgical equipment (rental), including wheelchairs. 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 an integral part of a leg brace and the cost is included in the orthotist's charge, or they are custom-molded and related to a specific medical diagnosis.
- ◆ Hearing aids for dependent children up to \$1400 per aid. The aid must be prescribed, fitted, and dispensed by a licensed audiologist. Replacement aids are available only once every three years.
- ◆ Home health care;
- ◆ Hospice care;
- ◆ Hospital charges for covered semi-private room and board and other hospital-provided services and supplies (including inpatient rehabilitation). Private room, intensive care, coronary care and other specialized care units of a facility are covered only when it is consistent with professional standards for the care of the patient's condition. Facility ancillary expenses for services and supplies also are covered. These expenses include the following:
 - Use of operating, delivery, and treatment rooms;
 - Prescribed drugs;
 - Medical and surgical dressings, supplies, casts and splints;
 - Diagnostic services and therapy services;
- ◆ Outpatient hospital expenses eligible for outpatient hospital coverage;
- ◆ Infertility treatment;
- ◆ Laboratory tests;
- ◆ Mental health and substance abuse benefits;

COVERED SERVICES AND SUPPLIES

- ◆ Midwife delivery services, provided that the state in which such services are performed has a licensing or certification process for midwifery, and the midwife is licensed at the time delivery is performed;
- ◆ Newborn care — newborn care, routine nursing care, prematurity services, preventive health care services, as well as coverage for illness or injury, including the necessary care and treatment of medically diagnosed congenital defects and birth abnormalities if the baby is eligible for enrollment and the newborn is enrolled within 30 days of birth;
- ◆ Nursing services (professional) by a registered nurse or licensed practical nurse who is not a close relative (spouse, child, grandchild, brother, sister, in-law, parent, or grandparent) of the patient;
- ◆ Obesity — surgical treatment for morbid obesity when Body Mass Index (BMI) is greater than 40 kilograms per meter squared or equal to or greater than 35 kilograms per meter squared with a co-morbid medical condition, including hypertension, a cardiopulmonary condition, sleep apnea, or diabetes. Surgery must be pre-certified by the Care Management Program.
- ◆ Pre-admission tests which are made before an inpatient or outpatient surgery;
- ◆ Preventive care — including but not limited to periodic physicals, prostate screenings, routine GYN visits, mammography screenings, routine PAP smears, well-child care, and immunizations (some of these services are covered under Option 1 only);
- ◆ Prosthetic devices and orthotics that are integral to the device (including artificial limbs and eyes);
- ◆ Reconstructive surgery when due to:
 - Accidental injury or illness (unless the Plan would exclude coverage for the injury or illness for a reason other than it occurred before coverage began);
 - Correction of a congenital malformation of a child; or
 - A mastectomy (see **Women's Health and Cancer Rights Act of 1998**);
- ◆ Rehabilitation services at a rehabilitation facility that is licensed to provide comprehensive rehabilitation services to patients recovering from an accident or an illness, and for evaluation and treatment of individuals with physical disabilities with emphasis on education and training. The program must be coordinated and provided by or under the supervision of physicians who are qualified and experienced in rehabilitation. These services (defined later under therapies) include but are not limited to:

COVERED SERVICES AND SUPPLIES

- Physical therapy;
 - Occupational therapy;
 - Speech and language therapy;
 - Psychotherapy;
 - Rehabilitation nursing; and
 - Respiratory therapy;
- ◆ Second surgical opinions for elective surgeries to determine medical necessity when provided by a board-certified specialist in the treatment of your particular medical condition, who is not associated professionally or financially with the physician that provided the first surgical opinion consultation. One additional consultation, as a third opinion, is eligible under this clause when the second opinion disagrees with the first. An elective surgery is surgery, which is not of an emergency or life-threatening nature. A second surgical/medical opinion consultation is required to be pre-certified through the Care Management Program.

Consultation services by a physician will be paid if rendered to an inpatient member in a covered facility at the request of a professional provider and the consulting physician is a specialist in the medical field to which the consultation relates. Consultations do not include staff consultations, which are required by a facility provider's rules and regulations, that do not satisfy the requirements of the previous sentence.

- ◆ Skilled nursing facility services;
- ◆ Surgical dressings and medical supplies — ordered by an appropriate professional provider in connection with medical treatment (except self-administered supplies or convenience items);
- ◆ Surgical procedures;

Separate payment will not be made for inpatient pre-operative care or post-operative care normally provided by the surgeon as part of the surgical procedure. For related operations or procedures performed through the same incision or in the same operative field, the Plan will pay the surgical allowance for the highest paying procedure plus 50% of the surgical allowance for the second highest paying procedure and 25% of the surgical allowance for each additional procedure. When two or more unrelated operations or procedures are performed at the same operative session, the Plan will pay the surgical allowance for each procedure.

Surgeon fees include fees for surgery for the treatment of disease or injury, and any incision or puncture which requires the use of surgical instruments.

COVERED SERVICES AND SUPPLIES

Assistant surgeon's fees are eligible for coverage, up to 20% of the allowed charge for the primary surgeon, when it is determined that the condition of the patient or the type of surgical service requires such assistance.

- ◆ Temporomandibular Joint Syndrome (TMJ) treatment and/or orthognathic surgery, limited to physical therapy, surgery, and orthodontic devices such as mouth guards and intraoral devices (excludes orthodontics and prosthetics);
- ◆ Therapies, including:
 - Chemotherapy (inpatient and outpatient) — the treatment of malignant disease by chemical or biological antineoplastic agents, including the cost of the antineoplastic;
 - Dialysis treatment — the treatment of acute renal failure or chronic irreversible renal insufficiency for removal of waste materials from the body, to include hemodialysis or peritoneal dialysis;
 - Physical therapy — the treatment by physical means, hydrotherapy, heat, or similar modalities; physical agents; bio-mechanical and neuro-physical principles; and devices to significantly relieve pain, restore maximum function lost or impaired by disease or accidental injury, and prevent disability following disease, injury or loss of body part (does not include maintenance therapy);
 - Speech therapy — the treatment for the correction of a speech impairment when therapy is aimed at restoring the level of speech that the individual had attained before the onset of a disease, surgery, or occurrence of an accidental injury. Non-medical conditions such as stuttering, articulation disorders, tongue thrust, and lispings are not covered;
 - Occupational therapy — the treatment of a physically disabled person by means of constructive activities designed and adapted to significantly improving the functional restoration of the person's abilities lost or impaired by disease or accidental injury, to satisfactorily accomplish the ordinary tasks of daily living in the home setting (does not include maintenance therapy);
 - Radiotherapy (inpatient and outpatient) — the treatment of disease by X-ray, gamma ray, accelerated particles, measons, neutrons, radium, or radioactive isotopes;
- ◆ Transplants;
- ◆ Vasectomies and tubal ligations;
- ◆ Vision exam (in-network only);
- ◆ Well-child care;

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

Prescription Drug Benefits

Benefits are paid for prescription drugs designated as such under federal law, as well as federal legend drugs, compound medications, legend oral contraceptives, AIDS-specific medications, infertility

COVERED SERVICES AND SUPPLIES

medications, prenatal vitamins, injectable insulin, and other medicines and supplies designated by Johns Hopkins Employer Health Programs. You can receive a supply of up to 30 days for any drugs, or up to 90 days for maintenance drugs. Prescription drug benefits also cover Viagra, 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 with refills limited to three months per prescription.

Network Pharmacies

Except for an emergency medical situation (see ***Emergency Services***, below), the Plan only covers prescription drugs purchased at a Johns Hopkins EHP network pharmacy. Your Johns Hopkins EHP provider directory has a complete list of network pharmacies. When you buy covered drugs from a network pharmacy, present your Medical Plan identification card to the pharmacist. You should request and retain a paid receipt for your co-pay amount if you need it for income tax purposes or to submit a claim to a flexible spending account.

Please note: Your pharmacist may need to obtain pre-certification before dispensing certain prescription drugs, which may delay filling your prescription.

Co-Pay

You pay a \$10 co-pay for each separate 30-day prescription or refill for a generic drug, or \$25 for a brand name drug. For maintenance drugs purchased at a pharmacy, you pay a \$30 co-pay for each separate 90-day prescription or refill for a generic drug, or \$75 for a brand name drug. You may also use the Medical Plan's Mail Service Prescription Drug Benefit Program. For maintenance drugs purchased thru the Mail Service Program, you pay a \$20 co-pay for each separate 90-day prescription or refill for a generic drug, or \$50 for a brand name drug. In all cases, if you purchase a brand name drug you pay the brand name co-pay if a generic version is available. However, if a generic version is not available, you only have to pay the generic co-pay for a brand name drug. If you have any questions about the Mail Service Program, call an EHP Customer Service Representative at 410-424-4450 or 800-261-2393.

If you purchase drugs from an out-of-network pharmacy in an emergency medical situation, the Plan will cover 100% of the Reasonable and Customary charge for your prescription drug purchase, after you pay the network pharmacy co-pay (\$10 generic/\$25 brand). You will be responsible for any amounts over the R&C charge. If you purchase drugs from an out-of-network pharmacy for any reason other than an emergency medical situation, the Plan will not pay benefits.

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What's Not Covered

No prescription drug benefits will be paid for the following:

- ◆ Prescription drugs dispensed for any illness or injury eligible or covered by any federal, state, or local government Workers' Compensation act or occupational disability law;
- ◆ Prescription drugs to which you are entitled, with or without charge, under a plan or program of any government or governmental body;
- ◆ Any medication furnished by any other drug or medical service for which no charge is made to the patient;
- ◆ Drugs which are not considered to be medically necessary, including but not limited to, psoralens and tretinoin for cosmetic use, nicotine gum, anorexians, minoxidil lotion, nystatin oral powder, and Schedule V exempt narcotics;
- ◆ Any prescription for more than a 30-day supply; for Mail Order benefits, not more than a 90-day supply;
- ◆ Any amounts you are required to pay directly to the network pharmacy for each prescription or refill;
- ◆ Any medication taken or administered at the place where it is dispensed (i.e. hospital, rest home, extended care facility, nursing home, etc.);
- ◆ Charges for a prescription refill in excess of the number specified by the physician, or any refill dispensed after one year from the order of the physician;
- ◆ Charges for a prescribed drug or medication that is not approved for treatment of the condition by the FDA;
- ◆ Replacement of lost or stolen medication;
- ◆ Drugs purchased outside the United States that are not legal inside the United States;
- ◆ Any charge for *administration* of drugs or insulin;
- ◆ Contraceptive devices – IUDs, diaphragms, and Norplant;
- ◆ Vitamins, except those which by law require a prescription;
- ◆ Hypodermic needles and syringes;
- ◆ Support garments;
- ◆ Immunization agents, biological sera, blood or blood plasma;
- ◆ Experimental drugs;
- ◆ Any other drug or medication that is available over the counter;

Emergency Services

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

In an emergency medical situation, you should go to the nearest medical facility for immediate care. An emergency medical situation is one in which a prudent, lay person determines that:

COVERED SERVICES AND SUPPLIES

- ◆ Immediate care is needed as the result of a sudden and serious illness or injury; and
- ◆ Care is required to prevent:
 - permanently placing your health in danger;
 - causing other serious medical consequences;
 - causing serious impairment to bodily functions; or
 - causing serious permanent dysfunction of any bodily organ or part.

For treatment of an emergency medical situation, your care will be covered under Option 1, regardless of whether or not the facility participates in the EHP network. You (or someone on your behalf) must notify Johns Hopkins Employer Health Programs at 410-424-4450 or 800-261-2393 within 48 hours of receiving emergency room care outside the State of Maryland in order to receive benefits. Option 1 emergency room care facility charges are covered in full and physician charges are paid at 80%. After you are medically stable and if you are able to move to an in-network facility and you choose not to be transferred, benefits will be paid at Option 2. If you receive treatment in an emergency room for a condition that is not an emergency medical situation, the Medical Plan will not pay benefits.

You (or someone on your behalf) must notify Johns Hopkins Employer Health Programs of all emergency room care received outside the State of Maryland within 48 hours or coverage will not be provided.

Urgent Care Centers

An urgent care center is a facility licensed to provide medical services for unexpected illnesses or injuries that require prompt medical attention, but are not life- or limb-threatening.

If you go directly to a Johns Hopkins EHP network urgent care center, your care will be covered at 80% (Option 1). You will be responsible for paying the other 20%. If you go to an out-of-network urgent care center, your care will be covered at 70% of the R&C charges, after the calendar year deductible (Option 2). You will be responsible for the remaining 30%, plus any amounts over R&C.

Out-Of-Area Care

Medical care received while out of the Johns Hopkins EHP network service area, including out-of-area emergency room care, will be covered as follows:

- ◆ *Unforeseeable* medical treatment required while traveling outside the Johns Hopkins EHP network service area will be paid at 80% for most services (Option 1). This provision only applies to treatment provided before it is safe to return to the network service area and does not include treatment that could have reasonably been anticipated before leaving the area. You (or someone on your behalf) must notify Johns Hopkins Employer Health Programs within 48 hours after the care is received or it will be covered as foreseeable treatment.

COVERED SERVICES AND SUPPLIES

- ◆ *Foreseeable* medical treatment will be paid at 70% of the R&C charges, after the calendar year deductible for most services (Option 2). You will be responsible for the remaining 30%, plus any amounts over the R&C charges.

Coverage for Students

If your dependent child goes to school outside the Johns Hopkins EHP network service area, care received for *unforeseeable* medical treatment and emergency medical situations is covered at 80% (Option 1), provided Johns Hopkins Employer Health Programs is notified within 48 hours after the care is received. If your dependent child receives out-of-network care that could have reasonably been anticipated before leaving the area, or if Johns Hopkins Employer Health Programs is not notified within 48 hours after the care is received, claims will be paid at 70% of the R&C charges, after the calendar year deductible for most services (Option 2). You are responsible for the remaining 30%, plus any amounts over R&C. Routine or foreseeable care provided outside the service area will be covered under Option 2.

Ambulance Services

Your Medical Plan covers both air and ground professional ambulance transportation services, when the following criteria are met:

- ◆ Because of an accident or emergency medical situation, it is medically necessary to transport you to the hospital; or
- ◆ It is medically necessary to transport you from a hospital as an inpatient to another hospital, because;
 - The first hospital lacks the equipment or expertise necessary to care for you;
 - You are transported directly from a hospital as an inpatient to a skilled nursing facility or rehabilitation facility;
 - As determined medically appropriate through the Care Management Program.

Air ambulance services are covered only if it is medically necessary to be transported by air and not by ground.

Maternity Benefits

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

The Medical Plan covers 80% of your prenatal care, routine tests, and delivery when you receive care coordinated by a participating network OB/GYN. Care received from an out-of-network OB/GYN is covered at 70% of the R&C charges, after the calendar year deductible (Option 2). You will be responsible for the remaining 30%, plus any amounts over R&C. Hospital or birthing center expenses are

COVERED SERVICES AND SUPPLIES

treated just like any other covered hospital stay. Midwife delivery services provided by a licensed midwife are also eligible for coverage.

The Medical Plan will provide maternity benefits for a mother and an eligible 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), Johns Hopkins Employer Health Programs must authorize the additional time.

Infertility treatment

Outpatient artificial insemination (AI) or outpatient in vitro fertilization (IVF) procedures are covered as follows:

- ◆ Services must be pre-certified by the Care Management program.
- ◆ Coverage is provided for an employee and covered spouse or for covered female same-sex domestic partners only.
- ◆ In the case of married couples, the employee and spouse must have a history of continuous infertility through natural means of reproduction for at least two consecutive years immediately before receiving infertility treatment, OR they must have a specific, medically documented infertility diagnosis, such as:
 - endometriosis
 - exposure in womb to diethylstilbestrol (DES)
 - blockage of or surgical removal of one or more fallopian tubes (lateral or bilateral salpingectomy)
 - abnormal male factors, including oligospermia, contributing to the infertility
 - any other documented medical condition that caused the infertility
 - for IVF, failure to conceive after completing Artificial Insemination treatment
- ◆ In the case of same-sex domestic partners, the same-sex domestic partnership must have satisfied the JHU same-sex domestic partnership eligibility criteria for at least two consecutive years immediately before receiving infertility treatment.
- ◆ No coverage is provided for a period of two years after reversal of an elective sterilization procedure.
- ◆ All expenses connected with obtaining donor sperm or donor eggs are not covered, including expenses for acquisition, freezing, storing or thawing of sperm, eggs or embryos; coverage is provided only for implantation.

COVERED SERVICES AND SUPPLIES

- ◆ In the case of married couples, the husband's sperm and the wife's egg must be used, unless there is a documented medical condition that makes this not possible.
- ◆ No coverage for infertility services (or resulting maternity benefits) is provided for surrogate motherhood, which is defined as a woman carrying a baby to term on behalf of another woman, with the intention of assigning her parental rights to that woman.
- ◆ IVF procedures must be performed at medical facilities that are found by Johns Hopkins Employer Health Programs to conform to The American College of Obstetricians and Gynecologists guidelines for IVF clinics or The American Fertility Society minimal standards for IVF programs.
- ◆ There is a \$100,000 lifetime maximum (per employee) for all Infertility treatment benefits combined. Subject to that dollar limit: (a) there is no limit on the number of AI attempts, and (b) there is a limit of three IVF implantation attempts per live birth.
- ◆ Covered infertility services are limited to the following artificial insemination (AI), in vitro fertilization (IVF) and/or gamete intra fallopian transfer (GIFT) procedures:
 - diagnostic imaging including ultrasonographic and related methods of follicular evaluation
 - pathology and laboratory services such as blood chemistries, hormonal assays, ova and sperm processing prior to fertilization
 - fertilization and culture of fertilized ova
 - examination of the products of conception
 - surgical services including ova harvesting and transfer
 - laparoscopy and the GIFT procedure
 - infertility drugs
 - medical visits for evaluation, embryo implantation and follow-up care
 - other services that are determined by Johns Hopkins Employer Health Programs to be medically necessary for the success of the procedures described above

Women's Health And Cancer Rights Act Of 1998

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

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

The manner of coverage is determined in consultation with the attending physician and patient. Normal Medical Plan calendar year deductibles, co-pays, coinsurance, and any annual or lifetime maximums will apply.

Alternative Care

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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 Medical Plan pays benefits toward a variety of these alternative care services.

Home Health Care Benefits

Please note: All home health care benefits must be pre-certified under the Care Management Program described earlier in this SPD.

Home health care is often recommended when you are able to handle tasks like feeding and bathing yourself, but still require 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 relative or anyone living in your household. Please note that each visit is limited to four hours. The maximum allowed per calendar year is 90 visits. Covered home health care services include:

- ◆ Part-time or intermittent skilled nursing care by a nurse;
- ◆ Part-time or intermittent home health aide services for a patient who is receiving covered nursing or therapy services;
- ◆ Physical, respiratory, occupational, and speech therapy when provided by a home health care agency;
- ◆ Medical and surgical supplies when provided by a home health care agency (excluding prescription drugs);
- ◆ Oxygen and its administration; and
- ◆ Medical and social service consultations.

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

- ◆ Domestic or housekeeping services;
- ◆ Rental or purchase of equipment or supplies;
- ◆ Meals-on-wheels or other similar food arrangements;

COVERED SERVICES AND SUPPLIES

- ◆ Care provided in a nursing home or skilled nursing facility (see ***Skilled Nursing Facility Benefits***, discussed below);
- ◆ More than 90 home health care visits per calendar year;
- ◆ Home care for mental health conditions; and
- ◆ Custodial care.

Skilled Nursing Facility Benefits

Please note: Your stay in a skilled nursing facility must be pre-certified under the Care Management Program described earlier in this SPD.

A skilled nursing facility is a special facility that offers 24-hour nursing care outside of a traditional hospital setting.

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

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

The maximum allowed per calendar year is 120 days. If you are confined in a licensed skilled nursing facility, the Medical Plan pays 80% of the charges for medical services for care received from network providers (Option 1), and 70% of the R&C charges, after the calendar year deductible, for care received outside of the network (Option 2). You will be responsible for any amounts over R&C. Covered services include:

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

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

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

COVERED SERVICES AND SUPPLIES

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

Hospice Care Benefits

Please note: Hospice care must be pre-certified under the Care Management Program described earlier in this SPD.

Hospice care is often recommended for terminally ill patients. Hospice care helps keep the patient as comfortable as possible and provides supportive services to the patient and his or her family. Patients who can no longer be helped by a hospital, but require acute medical care, can be moved to a hospice facility, if available.

Hospice care is covered at 80% when provided by a network provider (Option 1); and at 70% of the R&C charges, after the calendar year deductible, when care is provided outside the network (Option 2). You will be responsible for any amounts over R&C.

The patient is cared for by a team of professionals and volunteer workers, which generally includes a doctor and a registered nurse, and may include a dietary counselor, home health aide, medical social worker, and others.

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

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

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

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

Certain benefits may be paid for outpatient (in-home) hospice care. For details, please call Johns Hopkins EHP Customer Service.

COVERED SERVICES AND SUPPLIES

Transplants

Please note: All transplants must be pre-approved and pre-certified under the Care Management Program described earlier in this SPD. Procurement of the organ and performance of the transplant must take place at a Johns Hopkins Employer Health Programs designated transplant center in the United States.

The 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 Medical Plan**). Coverage is contingent upon continuing to meet the criteria for Johns Hopkins Employer Health Programs transplant approval until the date of the transplant. Covered services include:

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

Please note that no benefits will be paid for the following:

- ◆ Organ transplant charges incurred without prior approval by the Care Management Program, or at a transplant center which was not designated by Johns Hopkins Employer Health Programs;
- ◆ The transplant of an organ which is synthetic, artificial, or obtained from other than a human body;
- ◆ An organ transplant or organ procurement performed outside the United States;
- ◆ An organ transplant which the Plan Administrator determines to be experimental; and
- ◆ Expenses of an organ donor, except when the recipient is a participant in this Plan who receives the organ in a covered organ transplant. When coordinating with the donor's health plan, the 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 Services

The Medical Plan provides benefits for inpatient and outpatient mental health and alcohol or substance abuse care. Outpatient care includes psychotherapy and counseling.

There is a total lifetime combined maximum benefit of \$5,000 for outpatient substance abuse care. There is a total lifetime maximum benefit of 120 days/visits combined for inpatient and outpatient alcohol abuse care. These maximums include benefits for all care received, whether or not a Clinical Case Manager coordinates care. The role of the Clinical Case Manager is discussed next.

COVERED SERVICES AND SUPPLIES

To receive any inpatient or outpatient mental health and alcohol or substance abuse benefits, you must first contact a Clinical Case Manager to discuss your proposed care. A Clinical Case Manager is a mental health professional who will help you determine the best course of treatment for you. Your Clinical Case Manager can coordinate your care by referring you to a provider (usually a Johns Hopkins EHP network provider). If you wish, instead of having a Clinical Case Manager coordinate your care, you can refer yourself to another provider in or out of the Johns Hopkins EHP network. ***However, if you refer yourself to a provider, a Clinical Case Manager must still precertify your care or coverage will not be provided.***

You can contact a Clinical Case Manager at 410-424-4476 or 800-261-2429 to coordinate or precertify your care.

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 network providers are experienced professionals, licensed in the state where they practice. They share the network's philosophy of quality care provided in the least restrictive manner. Mental health and alcohol or substance abuse network providers offer a full range of counseling services, including individual therapy, family counseling, group therapy, addiction recovery programs and special therapy sessions.

Care Coordinated By A Clinical Case Manager

Outpatient mental health care: If you obtain outpatient mental health care that ***is coordinated*** by a Clinical Case Manager, covered services are paid on a graduated scale, as shown in the **Medical Benefits At-A-Glance** chart earlier in this SPD, up to 100 visits per calendar year. This limit is in combination with any care you receive that is not coordinated by a Clinical Case Manager.

Outpatient substance abuse care: If you obtain outpatient substance abuse care that ***is coordinated*** by a Clinical Case Manager, covered services are paid at 80% up to \$1,000 per calendar year. There is also a lifetime maximum benefit of \$5,000 for outpatient substance abuse care. These limits are in combination with any care you receive that is not coordinated by a Clinical Case Manager.

Outpatient alcohol abuse care: If you obtain outpatient alcohol abuse care that ***is coordinated*** by a Clinical Case Manager, covered services are paid at 80% for the first 30 visits, up to a \$1,000 calendar year maximum. After 30 visits, your care is covered at 50%, up to an additional \$1,000 calendar year maximum. Both \$1,000 maximums are in combination with any care you receive that is not coordinated by a Clinical Case Manager. There is a combined lifetime maximum of 120 days/visits for inpatient and outpatient alcohol abuse care, whether or not a Clinical Case Manager coordinates care.

COVERED SERVICES AND SUPPLIES

Inpatient mental health care: If you obtain inpatient mental health care that ***is coordinated*** by a Clinical Case Manager, covered services are paid at 80% after a \$250 co-pay for up to 30 days of care per calendar year and you pay the remaining 20%. After 30 days, your inpatient care is covered at 60% and you pay the remaining 40%. Days are counted in combination with any care you receive that is not coordinated by a Clinical Case Manager. Eligible expenses include certain charges for semi-private room and board, plus certain services and supplies. Certain inpatient doctor visits are also covered. Psychiatric day care is considered the same as inpatient care. Each day of day care will count as one half day of inpatient care. The care must meet all Care Management Program requirements.

Inpatient substance abuse care: If you obtain inpatient substance abuse care that ***is coordinated*** by a Clinical Case Manager, covered services are paid at 80% after a \$250 co-pay for up to 21 days of care per calendar year and you pay the remaining 20%. You may not receive benefits for more than 21 days of inpatient substance abuse care per calendar year. Days are counted in combination with any care you receive that is not coordinated by a Clinical Case Manager.

Covered substance abuse charges include:

- ◆ Emergency care and detoxification services in a general hospital or licensed non-hospital detoxification facility;

- ◆ Residential rehabilitation services in a licensed and certified facility. Services include:
 - Semi-private room and board charges;
 - Medical and nursing services;
 - Individual and group therapy;
 - Individual, group and family counseling;
 - Drugs, biologicals and solutions dispensed by the facility;
 - Psychological testing;
 - Outpatient rehabilitation services in a licensed outpatient alcoholism treatment facility.

Inpatient alcohol abuse care: If you obtain inpatient alcohol abuse care that ***is coordinated*** by a Clinical Case Manager, covered services are covered at 80% after a \$250 co-pay for up to 30 days of care per calendar year and you pay the remaining 20%. Care for alcohol detoxification is limited to seven days per calendar year. Days of care for alcohol detoxification count against the 30-day per year limit for alcohol abuse care, and all days of care are combined whether or not a Clinical Case Manager coordinates your care. There is a combined lifetime maximum of 120 days/visits for inpatient and outpatient alcohol abuse care. Days are counted in combination with any care you receive that is ***not coordinated*** by a Clinical Case Manager.

Care Not Coordinated By A Clinical Case Manager – Precertification Required

Instead of having a Clinical Case Manager coordinate your care, you may choose to refer yourself for care by contacting a licensed psychiatrist, psychologist or certified social worker who is practicing within the scope of

COVERED SERVICES AND SUPPLIES

his or her license. When you refer yourself, you pay the required deductible and coinsurance amounts before the Medical Plan will pay benefits, as described in the **Medical Benefits At-A-Glance** chart earlier in this SPD.

Note – If you refer yourself for inpatient or outpatient mental health and alcohol or substance abuse care, a Clinical Case Manager must still precertify your care or benefits will not be provided. The confidential number to call is 410-424-4476 or 800-261-2429.

Outpatient mental health care: You may refer yourself for outpatient mental health care. ***Your care will not be covered unless a Clinical Case Manager precertifies your care.*** Benefits for covered services will be paid at 50% of the R&C charges, after the calendar year deductible. You pay the remaining 50%, plus any amounts in excess of the R&C charges. Covered services are paid for up to 100 visits per calendar year. This limit is in combination with any care you receive that is coordinated by a Clinical Case Manager.

Outpatient substance abuse care: You may refer yourself for outpatient substance abuse care. ***Your care will not be covered unless a Clinical Case Manager precertifies your care.*** Benefits for covered services will be paid at 70% of the R&C charges, after the calendar year deductible. You pay the remaining 30%, plus any amounts in excess of the R&C charges. In addition, there is a calendar year maximum benefit of \$1,000 and a lifetime maximum benefit of \$5,000 for outpatient substance abuse care. These limits are in combination with any care you receive that is coordinated by a Clinical Case Manager.

Outpatient alcohol abuse care: You may refer yourself for outpatient alcohol abuse care. ***Your care will not be covered unless a Clinical Case Manager precertifies your care.*** Benefits for covered services will be paid at 70% of the R&C charges, after the calendar year deductible for the first 30 visits, up to a \$1,000 calendar year maximum. After 30 visits, your care is covered at 50% of the R&C charges, up to an additional \$1,000 calendar year maximum. You pay the remaining 30% and 50%, respectively, plus any amounts in excess of the R&C charges. There is a lifetime maximum of 120 days/visits for inpatient and outpatient alcohol abuse care. Both \$1,000 calendar year maximums and the lifetime maximum on days/visits are in combination with any care you receive that is coordinated by a Clinical Case Manager.

Inpatient mental health care: You may refer yourself for inpatient mental health care. ***Your care will not be covered unless a Clinical Case Manager precertifies your care.*** Once you receive pre-certification, benefits for covered services will be paid at 70% of the R&C charges, after the calendar year deductible and a \$250 co-pay, for the first 30 days of treatment per calendar. You pay the remaining 30%, plus any amounts in excess of the R&C charges. After 30 days, your inpatient care is covered at 50% of the R&C charges. You pay the remaining 50%, plus any amounts in excess of the R&C charges. Days are counted in combination with any care you receive that is coordinated by a Clinical Case Manager. Eligible expenses include certain charges for semi-private room and board, plus certain services and supplies. Certain inpatient doctor visits are also covered. Psychiatric day care is considered the same as inpatient care. Each day of day care will count as one half day of inpatient care. The care must meet all Care Management Program requirements.

COVERED SERVICES AND SUPPLIES

Inpatient substance abuse care: You may refer yourself for inpatient substance abuse care. ***Your care will not be covered unless a Clinical Case Manager precertifies your care.*** Once you receive pre-certification, benefits for covered services will be paid at 70% of the R&C charges, after the calendar year deductible and a \$250 co-pay, for up to 21 days of treatment per calendar year. You pay the remaining 30%, plus any amounts in excess of the R&C charges. Days are counted in combination with any care you receive that is coordinated by a Clinical Case Manager.

Inpatient alcohol abuse care: You may refer yourself for inpatient alcohol abuse care. ***Your care will not be covered unless a Clinical Case Manager precertifies your care.*** Once you receive pre-certification, benefits for covered services will be paid at 70% of the R&C charges, after the calendar year deductible and a \$250 co-pay, for up to 30 days of care per calendar year. You pay the remaining 30%, plus any amounts in excess of the R&C charges. Care for alcohol detoxification is limited to seven days per calendar year. Days of care for alcohol detoxification count against the 30-day per year limit for alcohol abuse care, and all days of care are combined whether or not a Clinical Case Manager coordinates your care. There is a combined lifetime maximum of 120 days/visits for inpatient and outpatient alcohol abuse care. Days are counted in combination with any care you receive that is coordinated by a Clinical Case Manager.

Please note: Coinsurance and co-pays for all mental health, alcohol and substance abuse care do not count toward your annual out-of-pocket maximum.

What's Not Covered By The Medical Plan

The Medical Plan does not cover the following:

- ◆ Any condition arising from or occurring while engaged in any illegal activity;
- ◆ Any injury sustained or disease resulting from riot, rebellion, civil disobedience, or from military service in any country;
- ◆ Charges covered by no-fault auto insurance, or any other federal or state-mandated law;
- ◆ Charges for administration of any drug, including insulin;
- ◆ Charges for equipment that does not meet the definition of Durable Medical Equipment provided earlier in this SPD, including air conditioners, humidifiers, dehumidifiers, purifiers, or physical fitness equipment, whether or not recommended by a doctor;
- ◆ Charges excluded under the Coordination of Benefits provisions set forth later in this SPD;
- ◆ Charges that would not be made if no coverage by this Plan existed;

COVERED SERVICES AND SUPPLIES

- ◆ 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 in connection with:
 - an injury arising out of, or in the course of, any employment for wage or profit; or
 - a disease covered with respect to employment, by any Workers' Compensation law, occupational disease law, or similar legislation;
- ◆ Claims filed more than 12 months after the expenses were incurred. (This applies to services and supplies rendered by non-network providers, for which you are required to submit the claims. Network providers submit claims for you.);
- ◆ Confinement, treatment, services or supplies received *before* your (or your eligible dependent's) effective date of coverage under the Plan or *after* the termination date of coverage;
- ◆ Controlled substances, hallucinogens, or narcotics not administered on the advice of a doctor;
- ◆ Convenience items, such as telephone and television rental, slippers, meals for family members, or first aid kits and supplies;
- ◆ Cosmetic surgery except:
 - when resulting from an accidental injury or illness (unless the Plan would exclude coverage for the injury or illness for a reason other than it occurred before coverage began);
 - because of a congenital malformation of a child; or
 - because of a mastectomy (see **Women's Health And Cancer Rights Act Of 1998**, earlier in this SPD);
- ◆ Coverages refused by another plan as a penalty for non-compliance with that plan's requirements;
- ◆ Custodial care, residential care, or rest cures;
- ◆ Dental treatment except in connection with an accidental injury to sound natural teeth that is part of the initial emergency treatment within 48 hours after the accident;
- ◆ Drugs that are non-prescription, non-legend, or over-the-counter;
- ◆ 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;
- ◆ Emergency room services or treatments in cases other than emergency situations;

COVERED SERVICES AND SUPPLIES

- ◆ 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;
- 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;
- If Reliable Evidence shows that the prevailing opinion among experts regarding the drug, device, equipment, treatment or procedure is that further studies or clinical trials are necessary to determine its maximum tolerated dose, its toxicity, its safety, its efficacy or its efficacy as compared with a standard means of treatment or diagnosis.

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

- ◆ Foot devices, unless (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), supportive devices for the feet and orthotics used for sport and leisure activities are not covered;

COVERED SERVICES AND SUPPLIES

- ◆ Glasses, contact lenses, eye refractions, or the examinations for their fitting or prescription, except for a general vision exam once every two years at a JH Routine Vision Network provider or when medically necessary after cataract surgery;
- ◆ Hearing aids or the examination for their fitting or prescription (except for dependent children as described earlier in this SPD);
- ◆ Hypnosis or biofeedback training;
- ◆ 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 while riding a motorcycle, unless the covered person was wearing a helmet approved by Maryland state law; this exclusion applies even if wearing a helmet would not have prevented or reduced the injury;
- ◆ Marital counseling;
- ◆ Maternity care for persons other than you, your spouse/same-sex domestic partner, or eligible dependents;
- ◆ Myopia or hyperopia correction by means of corneal microsurgery, such as keratomileusis, keratophakia, and radial keratotomy or laser surgery and all related services;
- ◆ Nicotine addiction treatment or smoking cessation programs;
- ◆ Obesity treatment, including surgical procedures for weight reduction or for treatment of conditions resulting from being overweight, except for surgical treatment of morbid obesity as described under **Covered Services and Supplies** earlier in this SPD;
- ◆ Private room charges beyond the amount normally charged for a semi-private room, unless a private room is medically necessary;
- ◆ 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);

COVERED SERVICES AND SUPPLIES

- ◆ Services and supplies not recommended and approved by a doctor;
- ◆ Services and supplies paid in full or in part under any other plan of benefits provided by JHU, a school, or a government, or for services you are not required to pay for;
- ◆ Services and supplies not specifically listed as covered in this SPD;
- ◆ Services performed by a doctor or other professional provider enrolled in an education, research, or training program when such services are primarily provided for the purposes of the education, research, or training program;
- ◆ Sexual dysfunction treatment not related to organic disease;
- ◆ Support garments, unless pre-certified by the Care Management Program;
- ◆ Surrogate motherhood treatment, including any charges related to giving birth or for treatment of the newborn child resulting from the surrogate motherhood;
- ◆ Telephone consultation charges, missed appointment charges, or charges for the completion of claim forms;
- ◆ Transsexualism, gender dysphoria, or sexual reassignment or change, including medication, implants, hormone therapy, surgery, medical, or psychiatric treatment;
- ◆ Treatment of educational and developmental disorders including but not limited to mental health services, diagnostic testing, physical, speech, or occupational therapy;
- ◆ Treatment which is not medically necessary;
- ◆ Treatment which is not performed by an appropriate licensed professional provider acting within the scope of the provider's license;
- ◆ Treatment for which a third party may be liable, unless otherwise payable as described under **When the Medical Plan May Recover Payment (Reimbursement and Subrogation)**, later in this SPD;
- ◆ Treatment by a provider who is a close relative of the covered person (spouse, same-sex domestic partner, child, brother, sister, in-law, grandparent, or parent) or who resides in a covered person's home;
- ◆ Vision training or eye exercises to increase or enhance visual activity or coordination;

COVERED SERVICES AND SUPPLIES

- ◆ 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 12 months as coordinated through the Care Management Program. The maximum allowable benefit is \$350.).

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.

OTHER INFORMATION ABOUT YOUR EHP BENEFITS

Other Information About Your EHP Benefits

Filing A Claim With Johns Hopkins Employer Health Programs

You do not have to file a claim form with Johns Hopkins Employer Health Programs if you receive services from a network provider under Medical Plan Option 1. Network providers will file claims on your behalf.

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 a non-network provider (Option 2), unless the non-network provider files the claim for you. It is your responsibility to determine if the non-network provider files a claim for you; or
- ◆ If you use the Mail Order Drug program (or receive emergency prescription drugs from a non-network pharmacy).

For non-network providers, the procedures are as follows:

Hospitalization —Present your identification card to the admitting personnel at the hospital. This card provides all the necessary information for your admission. The card also instructs the hospital to send their bill directly to Johns Hopkins Employer Health Programs, along with their standard assignment form for payment. If you should receive the bill directly from the hospital, please mail it to Johns Hopkins Employer Health Programs in the self-addressed envelopes provided for this purpose.

All other expenses — Obtain a Health Claim Form from the JHU Benefits Service Center. Instructions on how to submit a claim are found on the reverse side of the form. Also, special pre-addressed envelopes are available to simplify the claims procedure.

You must complete Part I of the form in full, indicating your Social Security number, name, address, the dependent's name, etc. You must also indicate whether or not you wish to authorize payment directly to the physician.

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. Claim forms can be obtained from Johns Hopkins Employer Health Programs or the JHU Benefits Service Center.

OTHER INFORMATION ABOUT YOUR EHP BENEFITS

Itemized bills must include the following information:

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

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

What Happens When You Have Duplicate Coverage

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

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

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

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

The plan of the patient's employer is the Primary Plan. To determine benefits for covered dependent children, the plan of the parent whose birthday falls earlier in the year 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.

OTHER INFORMATION ABOUT YOUR EHP BENEFITS

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

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

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

The Medical Plan is the Primary Plan if you are covered under the Medical Plan as an active employee and you are also covered by Medicare. Similarly, the 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 Secondary to Medicare if your same-sex domestic partner is covered by Medicare.

If you have retiree coverage under the Medical Plan and are eligible for Medicare, then the Medical Plan is your Secondary Plan. Remember, if you are eligible for Medicare but do not enroll for Medicare, the Medical Plan will pay secondary benefits as though you had enrolled for Medicare.

When the 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 pre-certification for treatment, the 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 pre-certification.

When The Medical Plan May Recover Payment

Reimbursement

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

OTHER INFORMATION ABOUT YOUR EHP BENEFITS

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

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

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

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

Subrogation

The 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 Medical Plan has already paid benefits for treatment of the injury, illness or other condition.

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 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.

OTHER INFORMATION ABOUT YOUR EHP BENEFITS

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. You and your dependents' legal costs will be borne by you and your dependents.

When Medical Coverage Ends

Your coverage under the Medical Plan 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 because of a decrease in the number of hours worked;
- ◆ The date the Medical Plan is discontinued;
- ◆ The date when you report for active duty as a member of the armed forces of any country, unless you qualify to continue Medical Plan coverage under the Johns Hopkins University Military Leave Policy;
- ◆ The date on which you stop making the required contributions for coverage;

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 under the Plan as explained earlier in this SPD under **Who is Eligible**;
- ◆ The effective date of your election to drop dependent coverage;
- ◆ The date the Medical Plan is discontinued;
- ◆ The date on which you stop making contributions for your dependents; or
- ◆ The date on which your dependent enters military service.

For certain of the above events, you or your dependents may be able to continue coverage by self-payment under COBRA, as explained below. If you take an unpaid 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 Medical Plan coverage to remain in effect. If you do not make your required contributions, your Medical Plan coverage will end. If your leave is covered under FMLA, you may be allowed to resume coverage upon your return from leave.

COBRA Continuation Coverage

OTHER INFORMATION ABOUT YOUR EHP BENEFITS

COBRA allows you, your spouse or former spouse, and your dependents to continue your Medical Plan coverage for a specified period of time after certain qualifying events take place. Except as explained below for newborn or adopted children, only persons who are actually covered under the Medical Plan on the date of the qualifying event may continue coverage 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 you elect COBRA coverage, it will not apply to your same-sex domestic partner or his/her dependent children. Same-sex domestic partners and their dependent children may not elect COBRA coverage themselves.

Coverage under the Medical Plan may be continued under COBRA for up to 18 months for you, your spouse and your eligible dependents, if coverage is lost 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.

Coverage may be continued for up to 24 months 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 JHU Benefits Service Center and elect COBRA coverage for the new child as soon as possible, but in no case later than 30 days after the event. If notice is given and the election is made on a timely basis, the newborn or adopted child will be covered as of the date of the birth, adoption, or placement for adoption.

If you, your spouse, 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 JHU Benefits Service Center must be notified in writing of Social Security disability within 60 days after the date of the determination and before the 18 months of regular COBRA coverage ends, or the 11 additional months of COBRA coverage will not be provided. If Social Security notifies you 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 JHU Benefits Service Center within 30 days of the Social Security notice.

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

OTHER INFORMATION ABOUT YOUR EHP BENEFITS

Your spouse and dependent children may individually elect COBRA continuation coverage for up to 36 months if 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 continuation coverage for up to 36 months 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 JHU Benefits 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.

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 first event. If another event occurs, you, your spouse or dependent child must notify the JHU Benefits Service Center in writing within 60 days after the second event. If the JHU Benefits Service Center is not notified in time, COBRA may not be continued past 18 months.

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

Electing COBRA Coverage

OTHER INFORMATION ABOUT YOUR EHP BENEFITS

You, your spouse or dependent children will have 60 days from the date coverage would otherwise end or from the time notice of COBRA rights is given (whichever is later) to elect to continue Medical Plan coverage under COBRA. If COBRA is not elected, Medical Plan coverage 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 Medical Plan will not pay any claims made in the interim. Upon reinstatement of coverage, invoices may be submitted or re-submitted to the Medical Plan for payment.

If the Medical Plan benefits or coverage costs change for active employees, the COBRA continuation 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 18, 29 or 36 month period, whichever applies, if:

- ◆ A covered individual becomes covered under another group medical plan after COBRA coverage is elected (unless a pre-existing condition limitation would prevent the individual from receiving benefits from the new plan for a particular illness or injury);
- ◆ A covered individual becomes covered by Medicare after COBRA coverage is elected (*Please note: your spouse or dependent children are entitled to COBRA continuation coverage for 36 months if **you** become covered by Medicare after COBRA coverage for them is elected—this 36-month period begins with the date your COBRA coverage began*);
- ◆ The premium is not received on a timely basis; or
- ◆ JHU stops providing group medical coverage for all active employees.

Benefit Coverage And FMLA

OTHER INFORMATION ABOUT YOUR EHP BENEFITS

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 Johns Hopkins University. If you are approved for FMLA leave, there are certain rules that apply for you to continue coverage under your benefit plans.

Required Employee Contributions for Regular Coverage

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.

Eligibility For COBRA

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

If properly elected, COBRA continuation coverage will begin at the end of your FMLA leave. For example, if you take all your FMLA leave and do not to return to work, your COBRA continuation coverage (if properly elected) would begin on your *last* day of FMLA leave. If you notify the JHU Benefits 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 day after you notify the JHU Benefits Service Center.

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

When You Become Eligible For Medicare

When you reach age 65, you will be eligible for Medicare hospital (Part A) and medical (Part B) 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 Medical Plan coverage will continue as your primary medical plan unless you elect to waive Medical Plan coverage.

Before your 65th birthday, you should obtain an explanation of Medicare Parts A and B 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 for Social Security benefits in order to have Medicare coverage.

OTHER INFORMATION ABOUT YOUR EHP BENEFITS

If you do not enroll in Medicare Part A when first eligible, you may incur penalties and delays in obtaining Medicare coverage later. You may delay enrolling in Medicare Part B without penalty as long as you remain actively employed with JHU.

The Medical Plan's 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 Medical Plan's 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 JHU Benefits Service Center.

Administrative Information

Following is information regarding the administration and funding of the Medical Plan.

Plan Sponsor

The Johns Hopkins University sponsors the Medical Plan, which contains the benefits described in this SPD.

The JHU Employer Identification Number (EIN) is 52-0595110.

Plan Administrator

The Plan Administrator manages the Medical Plan on a day-to-day basis and resolves questions about Medical Plan details and entitlement to benefits. The Plan Administrator for the Medical Plan is the Johns Hopkins University.

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

Senior Director, Office of Benefits Services
Johns Hopkins University
Johns Hopkins at Eastern
1101 E. 33rd St., Suite D100
Baltimore, MD 21218

Telephone: 443-997-5800

Plan Year

OTHER INFORMATION ABOUT YOUR EHP BENEFITS

The Plan Year is January 1 – December 31.

Plan Funding

Benefits under the Medical Plan are not financed or administered by an insurance company. They are paid from the general assets of the Johns Hopkins University through a contract with Johns Hopkins Employer Health Programs. You can contact Johns Hopkins Employer Health Programs at:

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

Plan Number

The Medical Plan is a component plan in the Johns Hopkins University Welfare Plan, which has plan number 513.

Legal Action

The agent for service of legal process is:

Senior Director, Office of Benefits Services
Johns Hopkins University
Johns Hopkins at Eastern
1101 E. 33rd St., Suite D100
Baltimore, MD 21218

Telephone: 443-997-5800

You may also serve legal process on the Plan Administrator.

Claims and Appeals

In order for you to receive Medical benefits under the Plan, you or your provider must file a claim. Claims are filed for you by your network provider under Option 1. A non-network provider can file your claim for you under Option 2, but if your provider doesn't file the claim you must file it yourself.

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

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

OTHER INFORMATION ABOUT YOUR EHP BENEFITS

for precertification of coverage by Employer Health Programs for treatment you want to receive. A decision by your doctor or other provider that you do not need a certain treatment is not a claim covered by the procedures.

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

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

Certain services and supplies must be “pre-certified” through the Care Management Program in order to be covered or to avoid a penalty. See the earlier discussion in this SPD about the **Care Management Program** and the **Medical Benefits At-A-Glance** chart. If a service or supply must be pre-certified, a request for pre-certification is a “**Pre-Service Claim**”.

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

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

In general, whether a service or supply is requested 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 requested for Urgent Care, it will be treated as such.

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

Filing a Claim

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

To file a Post-Service Claim, you or your provider must complete and submit a claim form and attach itemized bills with the information described below. (Remember, a Network provider will file claims for you.) Claims should be reported promptly, and no claims will be accepted more than 12 months

OTHER INFORMATION ABOUT YOUR EHP BENEFITS

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

Johns Hopkins University EHP Classic 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 from the JHU Benefits Service Center and from Johns Hopkins Employer Health Programs. To avoid delay in handling your claim, answer all questions completely and accurately. *Claims cannot be processed without your signature where required on the form.*

Reducing or Terminating an Approved Course of Treatment

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

Extending an Approved Course of Treatment

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

Authorized Representative

OTHER INFORMATION ABOUT YOUR EHP BENEFITS

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

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

Claims and Appeals Procedures

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

Urgent Care Claims

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

Unless additional information is needed, you will be notified of an Urgent Care Claim decision within 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

OTHER INFORMATION ABOUT YOUR EHP BENEFITS

Unless additional information is needed, if a Post-Service Claim is denied, you will be notified within 30 days after the claim is properly filed. If there are matters beyond Employer Health Programs' control, this period may be extended up to 15 more days. If an extension is needed, you will be told before the initial 30 day period ends why an extension is needed and when a decision is expected.

If Additional Information is Needed

Pre-Service and Post-Service Claims

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

Urgent Care Claims

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

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

If Your Claim is Denied

You will be notified in writing if your claim (Urgent, Pre- or Post-Service) is denied in whole or in part. The notice will tell you why the claim was denied and the specific 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.

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

First Level Appeal

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

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

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

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

Johns Hopkins University EHP Classic Plan
c/o Johns Hopkins Employer Health Programs
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 Complaint and Grievance Committee. You may submit written comments, documents, records and other information relating to your claim. The Complaint and Grievance Committee will consider everything you submit, regardless of whether it

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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.

If the denial of your claim involved a medical judgment (such as whether a treatment is experimental or medically necessary), the Complaint and Grievance Committee 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 claim was denied, they will be identified upon your request.

When Your First Level Appeal Will Be Decided

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

Urgent Care Claim -- You will be notified of the decision within 36 hours after your appeal is filed.

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

Post-Service Claim -- You will be notified of the decision within 30 days after your appeal is filed.

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

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

You will be sent a written notice of the Complaint and Grievance Committee's decision. If your appeal is denied, the notice will tell you why and the specific Plan provisions on which the denial is based. The notice will tell you if an internal rule or guideline was relied on to deny your appeal, and how to request a free copy of the rule or guideline. The notice will tell you if your appeal was denied because the treatment is not medically necessary or is experimental, and how to request a free explanation of the scientific or clinical judgment relied upon. The notice will also tell you how and

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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 Employer Health Programs 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 Complaint and Grievance Committee's denial of your First Level Appeal or (2) 180 days after you were initially notified that your claim was denied.

If the Complaint and Grievance Committee 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 Committee's decision. If you file a Final Appeal more than five days after you are notified of the Committee's decision, the reduction or termination will probably take effect before you have a decision on your Final Appeal.

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

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

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provided with reasonable access to and copies of all Plan documents, records and other information relevant to your claim.

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

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

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

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

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

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

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

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

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

Protected Health Information

OTHER INFORMATION ABOUT YOUR EHP BENEFITS

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

Permitted Use and Disclosure

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

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

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

Plan Sponsor's Certification

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

- ◆ Not use or further disclose PHI other than as permitted above, or as otherwise permitted by HIPAA or as required by law;
- ◆ Ensure that any agents or subcontractors who receive PHI from the Plan Sponsor that was obtained from the Plan will agree to the same restrictions and conditions that apply to the Plan Sponsor;
- ◆ Not use or disclose PHI for employment related actions and decisions or in connection with any other benefit or employee benefit plan of Plan Sponsor;
- ◆ Report to the Plan any known use or disclosure of PHI that is inconsistent with the uses or disclosures allowed above;

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- ◆ Make PHI available to the Plan for response to a participant's request for access to the participant's PHI in a designated record set, as provided by HIPAA;
- ◆ Make PHI available to the Plan for amendment, and incorporate any amendments to PHI, as provided by HIPAA;
- ◆ Make available to the Plan the information required to provide an accounting of disclosures as provided by HIPAA;
- ◆ Make its internal practices, books, and records relating to use and disclosure of PHI received from the Plan available to the Secretary of the Department of Health and Human Services, for purposes of determining the Plan's compliance with HIPAA;
- ◆ If feasible, return or destroy all PHI received from the Plan when the Plan Sponsor no longer needs the PHI for the purpose for which it was disclosed to the Plan Sponsor, except if return or destruction is not feasible, the Plan Sponsor will limit further uses and disclosures to those purposes that make the return or destruction infeasible; and
- ◆ Ensure adequate separation between the Plan and the Plan Sponsor, as stated below.

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

Separation Between Plan and Plan Sponsor

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

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

These Plan Sponsor Representatives may have access to and may use PHI from the Plan only for Plan administration functions performed by the Plan Sponsor. Plan personnel will assure that the minimum necessary PHI is made accessible to the Plan Sponsor Representatives for these purposes. These Plan Sponsor Representatives will be trained in the limits on access to, and the proper use of, PHI from the Plan. In addition, these Plan Sponsor Representatives will be subject to appropriate sanctions, as

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provided by the Plan Sponsor's policies, for improper access to, or use or disclosure of, PHI from the Plan, and for any failure to comply with any provision of the Plan Sponsor's certification.

Security of Electronic PHI

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

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

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

Your Rights Under ERISA

As a participant in the Medical Plan, 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 Medical Plan (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 these documents by writing to the Plan Administrator. You may have to pay a reasonable charge to cover the cost of photocopying.

Additional ERISA Rights

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In addition to creating rights for Medical Plan participants, ERISA imposes duties upon the people who are responsible for the operation of the Medical Plan. These people are called fiduciaries. ERISA requires that fiduciaries act prudently and solely in the interest of you and other Medical 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 this Medical Plan 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 Medical 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 Medical Plan fiduciaries misuse the Medical Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a federal court.

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

If you have any questions about the Medical 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.

JHU's Rights

JHU expects to continue the Medical Plan indefinitely, but reserves the right to modify, amend, suspend, or terminate the Medical Plan at any time, and for any reason without prior notification. You will be notified of any changes to the Medical Plan and how they affect your benefits, if at all. The Medical Plan described in this SPD is governed by contracts and plan documents, which are available for examination in the Office of Benefits Services. We have attempted to make the explanation of the Medical Plan in this SPD as accurate as possible. However, should there be a discrepancy between

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this SPD and the provisions of the contracts or other plan documents, the provisions of the contracts or other plan documents will govern. You should not rely on any oral descriptions of the Medical Plan, since the written description in this SPD will always govern. To the extent any benefit under the Medical Plan is provided by an insurance policy, no benefits are provided by the Medical Plan except for those benefits, if any, which are paid by the insurance company which issues the policy.

Not A Contract Of Employment

It is also important to understand that this SPD does not constitute a contract of employment. You have the right to terminate your employment at any time. JHU 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 Medical Plan and to decide any questions of fact, which relate to entitlement to benefits under the Medical Plan.

For More Information

Please see your Medical Plan enrollment materials for additional information about the benefits administered by Johns Hopkins Employer Health Programs. If you have any questions, you can speak with an EHP Customer Service Representative by calling 800-261-2393 or 410-424-4450. Or, contact the JHU Benefits Service Center.

PLEASE NOTE: This Summary Plan Description has been changed from the version of the Summary Plan Description that was distributed in 2006 so as to reflect certain benefit changes that take effect January 1, 2007. If you have any questions, please contact the JHU Benefits Service Center at 410-516-2000.