The Johns Hopkins Health System Corporation/The Johns Hopkins Hospital

Employee Benefits Plan

For Non-Represented Employees

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Summary Plan Description

for the

EHP Medical, Dental, Vision and Short Term Disability Plans

Preferred Provider Organization Benefits

January 1, 2022

Important Contact Information

Claims or Coverage Questions	Johns Hopkins EHP Customer Service HR Solutions Center	410-424-4450 or 800-261-2393 www.ehp.org 443-997-5400
Utilization Management Preauthorization of services	Johns Hopkins EHP	410-424-4480
COBRA Questions	HealthEquity (WageWorks)	877-502-6272
Flexible Spending Accounts	HR Solutions Center HealthEquity (WageWorks)	443-997-5400 855-774-7441 www.wageworks.com
Short Term Disability Benefits	MetLife	833-622-0136
Claim Forms	Johns Hopkins EHP	www.ehp.org
Confidential Help With Personal Problems	Johns Hopkins Employee Assistance Program	888-978-1262

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General Information About Your Benefits

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

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

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

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

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

This SPD describes the Preferred Provider Organization (PPO) plan of benefits under the EHP Medical Plan. A separate SPD describes the Exclusive Provider Organization (EPO) plan of benefits under the EHP Medical Plan.

This January 2022 version of the SPD replaces the prior version of the SPD dated January 2021. This January 2022 version applies to all claims incurred on or after January 1, 2022.

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

GENERAL INFORMATION

Who Is Eligible

Employee Coverage

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

Benefit Plan:	**Full-Time Employee (regular schedule 30+ hours/week)**	**Part-Time Employee (regular schedule 20-29 hours/week)**	**Weekend Option Nurse**
EHP Medical Plan (includes prescription drugs)	Yes	Yes	Yes
EHP Dental Plans	Yes	Yes	Yes
Vision Plan	Yes	Yes	Yes
Salary Protection			
• Short Term Disability (26 Weeks)	Yes	Yes	No
• Optional Long Term Disability	Yes	Yes	No
Flexible Spending Accounts			
• Health Care Account	Yes	Yes	Yes
• Dependent Care Account	Yes	Yes	Yes

Dependent Coverage

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

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

- ♦ Your child or sibling of any age for whom you are a legal guardian. Normally, you may not cover someone for whom you only have legal custody. However, you may cover your sibling, grandchild, niece or nephew for whom you have legal custody, but only if both of their parents are either deceased or incarcerated.

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

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

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

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

Domestic Partner Coverage

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

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

Qualified Medical Child Support Order (QMCSO)

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

GENERAL INFORMATION

When Coverage Begins

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

If you are employed in a position that is not benefits eligible as explained above, and you change to a benefits eligible position, coverage begins the first day of the month after the change takes effect, provided you complete the online enrollment process within 30 days from the effective date of the change. Short Term Disability coverage will not begin until after you complete any employment probationary period that applies to you.

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

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

Changing Your Coverage

During the annual open enrollment period, you may change your EHP Medical, Dental or Vision Plan coverage, or change your contributions to a Health Care or Dependent Care Flexible Spending Account. Outside of the annual open enrollment period, you may start or stop coverage, add new dependents, or drop a dependent from your coverage *only* if you have a qualifying family status change

or a ***Special Enrollment*** situation (see the **Special Enrollment Rights for EHP Medical, Dental or Vision Coverage** section). In the case of a Flexible Spending Account, you may also increase or decrease your contributions if you have a qualifying family status change, subject to the minimum and maximum limitations described later in this SPD under **Flexible Spending Accounts**.

Examples of IRS-qualified changes in family status include:

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

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

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

process within 30 days after the status change, you must wait until the next annual open enrollment before the new coverage can become effective.

Special Enrollment Rights for EHP Medical, Dental or Vision Coverage

Losing other coverage

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

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

New Children

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

Marriage

If you get married, your new spouse may be granted special enrollment, as long as you enroll your new spouse for coverage via the online enrollment process within 30 days following the date of marriage. If enrolled on time, coverage will become effective on the first day of month following the date you complete the online enrollment process. If you do not have EHP coverage for yourself or any of your children, you must also enroll yourself, and you may also enroll any of your children when you enroll your new spouse.

Medicaid and Children's Health Insurance Program

If you, your spouse or your child have health insurance coverage under Medicaid or a Children's Health Insurance Program ("CHIP") and you, your spouse or your child lose eligibility for that coverage, you, your spouse or your child may enroll for EHP Medical Plan coverage. You must

request this special enrollment via the online enrollment process within 60 days of losing the Medicaid or CHIP coverage. If enrolled on time, coverage will become effective on the first day of the month following the date you complete the online enrollment process.

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

If you do not have EHP coverage for yourself, your spouse or any of your other children, you must also enroll yourself, and you may also enroll your spouse or any of your other children when you enroll your spouse or child.

Coverage Costs

JHHSC/JHH pays the majority of the cost of your coverage under the EHP Medical, Dental and Vision Plans. JHHSC/JHH also offers you cash rewards under the Healthy at Hopkins wellness program, which you can use to help cover the cost of those benefits that require employee contributions, including the EHP Medical, Dental and Vision Plans.

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

If your Plan coverage is continued while you are absent from work and you do not make the required employee contributions while absent, and you terminate employment before making up the unpaid contributions, the unpaid contributions can be withheld from any PTO payout you might be entitled to.

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

The Johns Hopkins EHP Medical Plan

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

Network Providers

The EHP Medical Plan gives you access to the affiliate hospitals of the Johns Hopkins Health System, plus a Network of local and regional community hospitals and other medical providers. There are three parts to the Network that you can use:

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

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

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

Primary Care Physicians

You are encouraged (but not required) to designate a Primary Care Physician (PCP) to coordinate your medical care. If you designate an EHP Network PCP, a lower copay applies to primary care office visits to your PCP. However, you never need a referral from a PCP. (Certain services require preauthorization, as explained later in this SPD.)

A good way to receive consistent, quality health care is by establishing a relationship with your PCP. PCPs help guide your care including specialists, lab work and prescriptions and focus on preventing

problems before they begin. Using your PCP's office as your first contact for most medical needs helps you get the care you need when you need it.

To find a PCP, go to www.ehp.org and search for primary care providers at Find a Provider. To designate or change your PCP, sign into your online HealthLink@Hopkins membership account to send a secure email to EHP, or call EHP Customer Service at 410-424-4450 or 800-261-2393. You may select a pediatrician as the designated PCP for your children.

Direct Primary Care (DPC)

During open enrollment, you can elect to be covered by the Direct Primary Care (DPC) benefit during the next calendar year. The DPC benefit provides primary care treatment that is different from the traditional practice arrangement. Access to care is available 24/7 through a combination of office visits and electronic communications (phone, mobile messaging, video visits, MyChart web portal, etc.). The DPC practice's patient numbers are limited, allowing for longer office visits and more personalized care. The DPC practice is presently located in the Medical Arts Building on the Howard County General Hospital campus. For more information about the DPC practice, go to www.jhcp.org/dpc.

There is no additional cost for the DPC benefit. You pay the same employee contribution regardless of whether you have the DPC benefit or designate a traditional primary care physician. In addition, your first eight office or video visits per year to the DPC practice and an annual physical are covered at 100%, with no copay, coinsurance or deductible.

With the DPC benefit, you are still covered by all the other benefits provided by the EHP Medical Plan on the same terms as apply to members who do not have the DPC benefit. The DPC practice serves as your designated PCP. There are limits on the number of visits and other services provided under the DPC benefit. Any care you receive from the DPC practice that exceeds the DPC benefit limits is covered by the EHP Medical Plan like any other care from a PCP.

If you elect the DPC benefit and you have family members on the EHP Medical Plan, you can, but do not have to, enroll family members age 18 and older under the DPC benefit as well. The DPC practice does not currently provide pediatric services, so family members under age 18 cannot at this time enroll in the DPC benefit. They would designate a pediatrician as their PCP.

Enrollment in the DPC benefit is not guaranteed, as the DPC practice can only accommodate a limited number of patients per year. The DPC practice can establish rules that limit who can have the DPC benefit.

If your election of the DPC benefit is rejected, you may appeal that rejection in accordance with the Claims and Appeals rules for post-service claims set forth later in this SPD. However, there is no First

Level Appeal. Instead, your appeal is made in accordance only with the Final Appeal rules.

Three Ways to Receive Care

The EHP Medical Plan offers ***three*** ways to receive care:

- The highest level of benefits is paid for treatment by EHP Preferred providers in the EHP Network.
- The next highest level of benefits is paid for treatment by EHP or Cigna PPO Network providers that are not EHP Preferred providers.
- The lowest level of benefits is paid for treatment by Out-of-Network providers.

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

EHP Preferred Providers and Network Providers

If you receive treatment from an EHP Preferred provider, most services are covered at 90%, after meeting the annual deductible (explained below).

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

An annual out-of-pocket maximum (explained below) applies to treatment from EHP Preferred and EHP/Cigna PPO Network providers.

There are no claims to file — EHP Preferred and EHP/Cigna PPO Network providers receive payment directly from the Plan. Some services are only available from EHP Preferred, or EHP/Cigna PPO Network providers, as shown on the **Medical Benefits At-A-Glance** chart later in this SPD.

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

The following hospitals are EHP Preferred providers:

- Johns Hopkins Hospital
- Johns Hopkins Bayview Medical Center
- Howard County General Hospital

- Suburban Hospital
- Sibley Memorial Hospital
- Johns Hopkins All Children's Hospital (St. Petersburg, FL)
- Mt. Washington Pediatric Hospital
- Anne Arundel Medical Center
- Greater Baltimore Medical Center

Physicians associated with the following groups are EHP Preferred providers:

- Johns Hopkins Clinical Practice Association/School of Medicine
- Johns Hopkins Community Physicians
- Johns Hopkins Part-Time Faculty
- Anne Arundel Medical Group
- GBMC Health Partners
- Greater Baltimore Health Alliance
- Gilchrist

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

Deductible and Out-of-Pocket Maximum

EHP Preferred and EHP/Cigna PPO Network Providers

Annual deductible

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

- less than $50,000, you are in the "Lower Pay Tier", and your annual deductible is $150 per person and $300 per family

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

- $120,000 or more, you are in the "Higher Pay Tier", and your annual deductible is $300 per person and $600 per family

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

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

Annual medical out-of-pocket maximum

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

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

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

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

Out-of-Network Providers

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

See **Special Rules for Certain Treatment by Out-of-Network Providers** later in this SPD for information about when certain treatment by an Out-of-Network provider will be covered on the terms that apply to treatment by an EHP/Cigna PPO Network provider.

Payment Terms You Should Know

The following terms are used throughout this SPD.

- **Allowed Benefit (AB)**: For any service or supply, the lesser of (1) the provider's actual charge to the patient or (2) the amount that would be allowed by Medicare, increased when appropriate by a percentage determined by Johns Hopkins Employer Health Programs. If Medicare does not provide an allowance for a service or supply, then Allowed Benefit means the prevailing, reasonable fee paid to similar providers for the same service or supply in the same geographic area, as determined by Johns Hopkins Employer Health Programs. EHP Preferred and EHP/Cigna PPO Network providers will not charge more than the Allowed Benefit, but Out-of-Network providers can charge more and you are responsible for charges above the Allowed Benefit.

- **Coinsurance:** Your percentage share of the charge for certain medical expenses. The **Medical Benefits At-A-Glance** chart later in this SPD lists the specific coinsurance amounts.

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

- **Deductible:** The amount you must pay each calendar year before the Plan begins to pay benefits for most services, as explained above under ***Deductible and Out-of-Pocket Maximum***. The **Medical Benefits At-A-Glance** chart later in this SPD lists the services to which the deductible applies.

  Expenses applied to your EHP Preferred and EHP/Cigna PPO Network deductible apply to your Out-of-Network deductible, and vice versa.

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

- **Facility charges and Professional fees:** Some providers may separately bill for professional fees and facility charges. If so, you might receive two separate bills. The professional fee covers the services delivered to you by a physician or other healthcare practitioner. The facility charge covers the cost of maintaining the facility where the professional services are provided.

  Usually, professional fees and facility charges for a particular treatment are covered by the same coinsurance and copay. If there is a difference, it will be shown on the **Medical Benefits At-A-**

Glance chart later in this SPD.

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

  The **medical out-of-pocket maximum** is explained above under ***Deductible and Out-of-Pocket Maximum***, and applies to all your expenses under the EHP Medical Plan other than expenses under the ***Prescription Drug Benefit***.

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

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

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

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

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

Preauthorization Requirement – Utilization Management

Certain services and supplies are not covered by the EHP Medical Plan unless they are preauthorized. Your EHP Preferred or EHP Network provider will request preauthorization for you from EHP Utilization Management. Cigna handles preauthorization requests if you receive care from a Cigna PPO Network provider (who is not in the EHP Network) or from an Out-of-Network provider. If you receive Out-of-Network care, you or your Out-of-Network provider must request preauthorization

from Cigna. **Unless preauthorization is received, there is no coverage for the services and supplies in question.** The services and supplies that currently require preauthorization are set forth in the ***Medical Benefits At-A-Glance*** chart and under ***Covered Services and Supplies*** later in this SPD.

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

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

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

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

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

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

- Any cost sharing you pay for the Out-of-Network provider charges will be applied against your In Network deductible and out-of-pocket maximum.

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

Recognized amount means the median in network rate recognized by the EHP Medical Plan in accordance with regulations issued under ERISA Section 716.

Notice and Consent Exception

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

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

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

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

Continuity of Care

If you are a continuing care patient (defined below) who is being treated by an EHP/Cigna PPO Network provider or as an inpatient in an EHP/Cigna PPO Network facility, and the provider or facility leaves the Network and becomes an Out-of-Network provider, the following continuity of care provisions will apply to you. These provisions do not apply if the provider or facility leaves the Network due to failure to meet applicable quality standards or for fraud.

You will be notified that the provider or facility is leaving the Network, and of your right to notify the EHP Medical Plan that you need continuing transitional care. If you notify the EHP Medical Plan that you need continuing transitional care, you will be given the opportunity to elect continuing transitional care from the provider or in the facility. If you make the continuing transitional care election, your

treatment by that provider or in that facility as a continuing care patient will be covered by the Plan as though the provider or facility had not left the Network. This continuing transitional care will last until 90 days after the notice that the provider or facility is leaving the Network was sent to you, or until you are no longer a continuing care patient of that provider or in that facility, whichever comes first.

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

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

Serious and complex condition means:

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

Care Management Programs

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

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

- **Transition of Care** -- if you are faced with an inpatient admission, care management will assist in making sure you have everything you need in the transition period after discharge.

- **Complex Care** -- if you are faced with a serious medical event or a long-term health condition, care management can provide support by coordinating care, understanding and managing your

medical event or condition, and facilitating necessary services covered by your EHP Medical Plan benefits.

- **Preventive Care** -- if you have a chronic health condition, care management can support you with understanding and managing your condition, getting connected to providers and community resources, and helping you maintain or reach your best level of health.

- **Behavioral Health Care** -- if you are living with a mental health condition such as depression, autism spectrum disorder, anxiety or addiction, care management can provide confidential care coordination.

- **Maternal/Child Health Care** -- supporting you through your pregnancy and delivering a healthy baby is everyone's goal. After delivery, care management provides tools to assist in caring for your child when they have additional needs through young adulthood.

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

Health Education

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

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

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

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

EHP Customer Service

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

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

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

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

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

What's Covered by the Johns Hopkins EHP Medical Plan

Medical Benefits At-A-Glance

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

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

EHP Preferred providers are listed above under Three Ways to Receive Care.

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

This chart is not a complete description of benefits. For more information, please refer to the rest of this SPD. Only medically necessary services and supplies are covered.

MEDICAL BENEFITS AT-A-GLANCE

SERVICES PROVIDED	EHP/Cigna NETWORK PROVIDERS	OUT-OF-NETWORK PROVIDERS	EHP PREFERRED PROVIDERS
1. TREATMENT OF ILLNESS OR INJURY			
Primary care office visit for medical treatment, adult and pediatric No copay with Direct Primary Care	100% after $10 copay if medical PCP* is designated 100% after $20 copay if medical PCP not designated (no deductible)	70% of AB after deductible	100% after $10 copay if medical PCP is designated 100% after $20 copay if medical PCP not designated (no deductible)
Primary care office visit for GYN treatment from GYN PCP	100% after $10 copay (no deductible)	70% of AB after deductible	100% after $10 copay (no deductible)
Specialty care office visit	80% after deductible	70% of AB after deductible	90% after deductible
Diagnostic services and treatment in the office	80% after deductible	70% of AB after deductible	90% after deductible
2. PREVENTIVE SERVICES			
General preventive exam (adult physical, GYN and well child care)	100% (no deductible)	70% of AB after deductible	100% (no deductible)
Diagnostic services for exam	100% (no deductible)	70% of AB after deductible	100% (no deductible)
Mammogram and well-woman care	100% (no deductible)	70% of AB after deductible	100% (no deductible)
Screening colonoscopy	100% (no deductible)	70% of AB after deductible	100% (no deductible)
Routine hearing exam	100% (no deductible)	70% of AB after deductible	100% (no deductible)
3. IMMUNIZATIONS AND INOCULATIONS			
As recommended by Centers for Disease Control and Prevention	100% (no deductible)	70% of AB after deductible	100% (no deductible)
Travel immunizations	100% (no deductible)	70% of AB after deductible	100% (no deductible)
4. ALLERGY TESTS AND PROCEDURES			
Allergy tests	80% after deductible	70% of AB after deductible	90% after deductible
Desensitization materials/serum	80% after deductible	70% of AB after deductible	90% after deductible

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

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

*Medical PCP must be an EHP Network provider for the lower copay to apply.

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

MEDICAL BENEFITS AT-A-GLANCE

SERVICES PROVIDED	EHP/Cigna NETWORK PROVIDERS	OUT-OF-NETWORK PROVIDERS	EHP PREFERRED PROVIDERS
5. LABORATORY			
Laboratory tests and pathology	80% after deductible	70% of AB after deductible	90% after deductible
6. RADIOLOGY			
CT scans, PET scans and MRIs; preauthorization required	80% after deductible	70% of AB after deductible	90% after deductible
All other imaging studies, including x-rays and ultrasound	80% after deductible	70% of AB after deductible	90% after deductible
7. SURGERY			
Professional fees for inpatient surgery; preauthorization required	80% after deductible	70% of AB after deductible	90% after deductible
Professional fees for outpatient surgery; preauthorization required	80% after deductible	70% of AB after deductible	90% after deductible
Surgical treatment for morbid obesity; preauthorization required	Covered at Bayview Medical Center and Sibley Memorial Hospital only	Covered at Bayview Medical Center and Sibley Memorial Hospital only	$150 copay, then 90% after deductible Covered at Bayview Medical Center and Sibley Memorial Hospital only
8. REPRODUCTIVE HEALTH			
Physician office visits (prenatal care only)	Routine prenatal visits 100%; All other prenatal visits 80% after deductible	70% of AB after deductible	Routine prenatal visits 100%; All other prenatal visits 90% after deductible
Inpatient maternity care and delivery, including professional fees, hospitalization, lab and X-ray services; preauthorization required	$150 copay, then 80% after deductible	$500 copay, then 70% of AB after deductible (1)	$150 copay, then 90% after deductible
Newborn nursery care and NICU	80% after deductible; $150 copay for NICU	70% of AB after deductible	90% after deductible; $150 copay for NICU
Birthing center facility charges	90% after deductible	70% of AB after deductible	Not Available
Birthing center professional fees	80% after deductible	70% of AB after deductible	90% after deductible
Contraceptive devices	100% (no deductible)	70% of AB after deductible	100% (no deductible)
Voluntary sterilization	100% (no deductible)	70% of AB after deductible	100% (no deductible)
Interruption of pregnancy	80% after deductible	70% of AB after deductible	90% after deductible
Infertility treatment (such as artificial insemination and in-vitro fertilization); preauthorization required; lifetime dollar and attempt maximums apply	Covered at Johns Hopkins and Shady Grove Fertility Centers only	Covered at Johns Hopkins and Shady Grove Fertility Centers only	90% after deductible, including a separate $1,000 lifetime deductible Covered at Johns Hopkins and Shady Grove Fertility Centers only

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

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

MEDICAL BENEFITS AT-A-GLANCE

(1) Failure to obtain preauthorization for hospitalization will result in a denial of benefits. Because medical treatments are constantly changing, Johns Hopkins EHP and Cigna can determine that preauthorization is required for additional services and supplies not shown in this chart.

MEDICAL BENEFITS AT-A-GLANCE

SERVICES PROVIDED	EHP/Cigna NETWORK PROVIDERS	OUT-OF-NETWORK PROVIDERS	EHP PREFERRED PROVIDERS
9. URGENT CARE CENTER			
Urgent care visit	100% after $25 copay (no deductible)	70% of AB after deductible	100% after $25 copay (no deductible)
Diagnostic services and treatment	100% (no deductible)	70% of AB after deductible	100% (no deductible)
10. EMERGENCY CARE			
Care in emergency department for emergency medical conditions only	100% after $250 copay and deductible (copay waived if admitted)	100% after $250 copay and deductible (copay waived if admitted) (1)	100% after $250 copay and deductible (copay waived if admitted)
11. AMBULANCE TRANSPORTATION			
Ground or air transportation when medically necessary; preauthorization required for air ambulance in non-emergencies	100% after deductible	100% of AB after deductible (1)	100% after deductible
12. HOSPITAL CARE			
Inpatient facility charges (semi-private, unless private room is medically necessary); preauthorization required	$150 copay per admission, then 80% after deductible	$500 copay per admission, then 70% of AB after deductible (2)	$150 copay per admission, then 90% after deductible
Inpatient professional fees (excluding surgical)	80% after deductible	70% of AB after deductible	90% after deductible
Skilled nursing/rehabilitation facility charges; 120 days per calendar year combined maximum; preauthorization required	90% for first 30 days per year, then 80% for remaining days after deductible	70% of AB after deductible (1)	90% after deductible
Outpatient professional fees, including testing prior to surgery	80% after deductible	70% of AB after deductible	90% after deductible
Outpatient surgery facility charges	80% after deductible	70% of AB after deductible	90% after deductible
Observation care facility charges	100% after $250 copay and deductible (copay waived if admitted)	100% of AB after $250 copay and deductible (copay waived if admitted)	100% after $250 copay and deductible (copay waived if admitted)
Observation care professional fees	100% after deductible	100% of AB after deductible	100% after deductible
13. CHEMOTHERAPY/ RADIATION THERAPY			
Provider fees	80% after deductible	70% of AB after deductible	90% after deductible
Materials and treatment	80% after deductible	70% of AB after deductible	90% after deductible

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

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

(2) Failure to obtain preauthorization for hospitalization will result in a denial of benefits. Because medical treatments are constantly changing, Johns Hopkins EHP and Cigna can determine that preauthorization is required for additional services and supplies not shown in this chart.

MEDICAL BENEFITS AT-A-GLANCE

SERVICES PROVIDED	EHP/Cigna NETWORK PROVIDERS	OUT-OF-NETWORK PROVIDERS	EHP PREFERRED PROVIDERS
14. ACUPUNCTURE			
For anesthesia, pain control and therapeutic purposes; 20 visit per calendar year combined maximum	80% after deductible	70% of AB after deductible	90% after deductible
15. HOME HEALTH CARE			
40 visits per calendar year combined maximum; preauthorization required	90% after deductible	70% of AB after deductible	90% after deductible
16. HOSPICE CARE			
Inpatient and home; preauthorization required	100% after deductible	70% of AB after deductible	100% after deductible
17. SPEECH THERAPY			
30 visits per calendar year combined maximum; preauthorization required	80% after deductible	70% of AB after deductible	90% after deductible
18. PHYSICAL/OCCUPATIONAL THERAPY			
Licensed therapist only; 60 visits per calendar year combined maximum; preauthorization required after 12 visits	80% after deductible	70% of AB after deductible	90% after deductible
19. HABILITATION SERVICES			
Under age 19 only; preauthorization required	80% after deductible	70% of AB after deductible	90% after deductible
20. CHIROPRACTIC CARE			
Restricted to initial exam, X-rays and spinal manipulations; 20 visit per calendar year combined maximum	80% after deductible	70% of AB after deductible	90% after deductible

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

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

MEDICAL BENEFITS AT-A-GLANCE

SERVICES PROVIDED	EHP/Cigna NETWORK PROVIDERS	OUT-OF-NETWORK PROVIDERS	EHP PREFERRED PROVIDERS
21. DURABLE MEDICAL EQUIPMENT AND SUPPLIES			
Non-custom equipment and medical supplies	80% after deductible	70% of AB after deductible	90% after deductible, thru Johns Hopkins Home Care Group/Pharmaquip
Custom equipment/wheelchairs; preauthorization required	90% after deductible	70% of AB after deductible	90% after deductible
Insulin pumps, continuous glucose monitors and related supplies	90% after deductible	70% of AB after deductible	90% after deductible
Breast pumps (standard) and related supplies	100% (no deductible)	70% of AB after deductible	100% (no deductible) thru Johns Hopkins Home Care Group/Pharmaquip
Custom molded orthotics; preauthorization required	80% after deductible	70% of AB after deductible	90% after deductible
Prosthetic devices; preauthorization required	90% after deductible	70% of AB after deductible	90% after deductible
Hearing aids for children under 26; preauthorization required	90% after deductible	70% of AB after deductible	90% after deductible
Blood pressure cuffs	80% (no deductible)	70% of AB after deductible	90% (no deductible)
22. NUTRITION COUNSELING			
Preauthorization required after six visits per calendar year	80% after deductible	70% of AB after deductible	90% after deductible
23. DIALYSIS			
Preauthorization required	80% after deductible	70% of AB after deductible	90% after deductible at Fresenius/Davita Dialysis Centers
24. HYPERBARIC OXYGEN THERAPY			
Preauthorization required	80% after deductible	70% of AB after deductible	90% after deductible
25. CARDIAC AND PULMONARY THERAPY			
Preauthorization required	80% after deductible	70% of AB after deductible	90% after deductible

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

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

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

MEDICAL BENEFITS AT-A-GLANCE

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

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

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

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

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

MEDICAL BENEFITS AT-A-GLANCE

29. PRESCRIPTION DRUGS		
In-network pharmacy only; 30-day supply; No copay for certain generic contraceptives	\$10 copay – generic (Tier 1) \$40 copay – brand preferred (Tier 2) \$65 copay – brand non-preferred (Tier 3) \$65 copay – brand if generic available, plus cost difference (Tier 4)	
In-network pharmacy only; 30-day supply for these prescribed generic Over-the-Counter drugs	\$10 copay – prescribed OTC generic equivalents of Prilosec, Nexium, Prevacid and Zegerid No copay for prescribed OTC generic equivalents of Claritin, Claritin D, Allegra, Allegra D, Zyrtec or Zyrtec D Must have prescription and present it to the pharmacy	
90-day supply for maintenance drugs (excludes specialty medications); No copay for certain generic contraceptives	<u>Mail order</u>: \$20 copay – generic (Tier 1) \$80 copay – brand preferred (Tier 2) \$130 copay – brand non-preferred (Tier 3) \$130 copay – brand if generic available, plus cost difference (Tier 4)	<u>In-network pharmacy</u>: \$30 copay – generic (Tier 1) \$120 copay – brand preferred (Tier 2) \$195 copay – brand non-preferred (Tier 3) \$195 copay – brand if generic available, plus cost difference (Tier 4)
Specialty medications; 30-day supply; In-network pharmacy only	\$10 copay – generic (Tier 1) \$40 copay – brand preferred (Tier 2) \$65 copay – brand non-preferred (Tier 3) \$65 copay – brand if generic available, plus cost difference (Tier 4)	

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

Only medically necessary services and supplies are covered.

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

COVERED SERVICES AND SUPPLIES

Covered Services and Supplies

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

A medically necessary service or supply is one that the Plan Administrator, Cigna or CVS Caremark determines:

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

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

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

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

Ambulance Services

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

- ♦ Because of an **emergency medical condition** (defined below under ***Emergency Care***), it is medically necessary to transport you to the hospital,
- ♦ It is medically necessary to transport you from a hospital as an inpatient to another hospital, because the first hospital lacks the equipment or expertise necessary to care for you,
- ♦ You are transported directly from a hospital to a skilled nursing/rehabilitation facility,
- ♦ You are medically stable and wish to transfer from a facility that is not an EHP Preferred provider to a facility that is an EHP Preferred provider, or

- ♦ As preauthorized by EHP Utilization Management or Cigna based on special medical circumstances

Air ambulance is covered only if it is medically necessary to be transported by air and not by ground. It is not medically necessary to be transported by air if a facility that can provide the necessary medical care can be safely accessed by ground transportation. *Except for an **emergency medical condition**, air ambulance transportation must be preauthorized, or it will not be covered.*

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

Air Ambulance Transportation by Out-of-Network Provider

Charges for transportation by an Out-of-Network air ambulance provider are covered as though you received transportation by an EHP/Cigna PPO Network air ambulance provider. This means any deductible you pay for the Out-of-Network air ambulance transportation charges will be applied against your In Network deductible and out-of-pocket maximum.

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

Emergency Care

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

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

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

Emergency Department

Emergency services provided by the emergency department of a hospital or by an independent freestanding emergency department for treatment of an **emergency medical condition** are covered under the EHP Preferred provider benefit regardless of whether the emergency department is an EHP Preferred provider or participates in the EHP/Cigna PPO Network. Emergency department charges are covered in full, after the deductible and a $250 copay. The copay is waived if you are admitted to the hospital as an inpatient.

If you go to an Out-of-Network emergency department, any cost sharing you pay for Out-of-Network **emergency services** will be based on the **recognized amount** and applied against your In Network deductible and out-of-pocket maximum. **Recognized amount** means the charges for **emergency services** that are recognized by the EHP Medical Plan in accordance with regulations issued under ERISA Section 716, or when applicable the rate established by state law for facility charges.

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

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

- *Initial services* – an appropriate medical screening examination within the capability of the emergency department, including ancillary services routinely available in the emergency department, to evaluate whether an **emergency medical condition** exists.

- *Post-stabilization services* – additional services and supplies furnished in any department of the hospital after the patient is stabilized and as part of outpatient observation, or an inpatient or outpatient stay, with respect to the visit for which the initial services were provided.

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

If you are being treated at an Out-of-Network emergency department, or if you are admitted to an Out-of-Network hospital from the emergency department, your condition stabilizes so that it is no longer an **emergency medical condition**, and your attending physician determines that you can travel to an EHP/Cigna PPO Network facility within a reasonable travel distance using nonmedical transportation or non-emergency medical transportation, but you choose not to so travel, then services and supplies provided after you can so travel will be paid under the Out-of-Network benefit at 70% of the Allowed Benefit, after the deductible, but only if the determination, notice and consent requirements of Public Health Services Act Section 2799A-1 are met.

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

If you receive treatment in an emergency department for a condition that is not an **emergency medical condition**, the EHP Medical Plan will not pay benefits and you are responsible for all charges.

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

Urgent Care Center

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

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

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

Gender Affirmation

The EHP Medical Plan covers gender affirmation treatment for members as follows. *Preauthorization is required.*

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

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

Habilitation Services

Preauthorization is required for all habilitation services.

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

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

Home Health Care

Home health care must be preauthorized.

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

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

Covered home health care services include:

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

- ♦ Oxygen and its administration
- ♦ Medical and social service consultations

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

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

Hospice Care

Hospice care must be preauthorized.

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

Covered hospice care services include:

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

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

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

Infertility Treatment

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

In all cases:

- *Preauthorization is required.*
- You (the employee) must have one continuous year of coverage by the EHP Medical Plan before treatment begins.
- There must be a physician recommended treatment plan.
- Treatment must be provided at the Johns Hopkins or Shady Grove Fertility Centers. This requirement is waived for IVF services if the Fertility Centers do not have the necessary facilities to provide IVF services for the patient in question. In that event, treatment must be provided at an EHP/Cigna PPO Network provider approved by EHP Utilization Management. Otherwise, treatment received anywhere other than at the Johns Hopkins or Shady Grove Fertility Centers is not covered, even if the provider is in-Network.
- The order of infertility treatment options must have followed a logical succession of medically appropriate and cost-effective care.
- You must first pay a separate $1,000 lifetime deductible for infertility treatment. After the deductible, charges are covered at 90% and you pay the remaining 10%.
- There is a $30,000 lifetime maximum benefit for all non-prescription drug infertility treatment expenses, including lab work and X-rays. There is a separate $30,000 lifetime maximum benefit for all prescription drug infertility treatment expenses. These dollar maximums apply per employee, not per spouse.
  - Expenses incurred for infertility treatment that were covered under the combined $30,000 lifetime maximum that was in effect before January 1, 2020, are applied against the new separate $30,000 lifetime maximums in effect after that date.
- There is a maximum of three IVF attempts (any implantation of oocyte), and a separate maximum of six attempts per live birth for artificial insemination and intrauterine insemination. These attempt maximums apply per birth mother's lifetime. However, if a female employee with individual coverage subsequently becomes covered under the coverage of another employee (husband and wife or family), any attempts during the employee's individual coverage do not count against the attempt limits under the subsequent coverage of the other employee.
- All expenses connected with obtaining donor sperm or donor eggs are not covered.
  - Expenses for acquisition, freezing, storing or thawing of sperm, eggs or embryos, whether or not from a donor, are not covered. Coverage is provided for implantation only.
- Infertility must not be related to a previous sterilization by you or your spouse.

- No coverage is provided for surrogate motherhood or gestational carrier purposes. This exclusion does not apply to charges for treatment of the newborn child if the child is a covered eligible dependent of the member.

For married opposite sex couples:

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

For single females:

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

For married female same sex couples:

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

Injectable Drugs

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

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

Maternity Care

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

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

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

If the doctor and new mother agree that the stay does not need to be 48 (or 96) hours, the new mother and baby may leave the hospital as soon as it is medically approved. *Preauthorization is required if the stay is to be longer than 48 (or 96) hours.*

Medical and Modified Foods

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

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

The EHP Medical Plan covers amino acid-based elemental formula, regardless of delivery method, if the recipient is not eligible to receive the formula through WIC (Special Supplemental Nutrition Program for Women, Infants, and Children) and if the patient’s physician states in writing that the formula is medically necessary for the treatment of one of the following diseases or disorders:

- Immunoglobulin E and non-Immunoglobulin E mediated allergies to multiple food proteins;
- severe food protein induced enterocolitis syndrome,
- eosinophilic disorders, as evidenced by the results of a biopsy, or

- impaired absorption of nutrients caused by disorders affecting the absorptive surface, functional length, and motility of the gastrointestinal tract.

Obesity Treatment

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

- Non-surgical treatment including management by a primary care provider and counseling by a nutritionist *(preauthorization required after 6 visits per year).* Also see the Health and Wellness Programs section earlier in this SPD for information on the Plan's free health education programs.

- Surgical treatment for morbid obesity when Body Mass Index (BMI) (weight in kilograms/height in meters squared) is greater than 40, or equal to or greater than 35 with a co-morbid medical condition, including hypertension, a cardiopulmonary condition, sleep apnea, or diabetes. *Preauthorization is required* and all services must be provided at Johns Hopkins Bayview Medical Center or Sibley Memorial Hospital.

- Surgical treatment for overhanging, stretching or laxity of skin, but only if medically necessary as a result of surgical or non-surgical treatment for morbid obesity. Limited to a lifetime benefit maximum of $5,000. *Preauthorization is required.*

Physical, Occupational and Speech Therapy -- Outpatient

Preauthorization is required after the first 12 physical and occupational therapy visits per calendar year.

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

Physical, occupational and speech therapy for treatment of a person under age 19 with a congenital or genetic birth defect is covered as explained above under Habilitation Services.

Inpatient therapy is covered as explained next under Skilled Nursing/Rehabilitation Facility Care.

Skilled Nursing/Rehabilitation Facility Care

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

A skilled nursing/rehabilitation facility is a special facility that offers 24-hour nursing care outside of a traditional hospital setting. Your stay in a skilled nursing/rehabilitation facility must be for treatment

of the same or related condition for which you were hospitalized. The Plan covers up to 120 days per calendar year in a skilled nursing/rehabilitation facility.

Covered skilled nursing/rehabilitation facility services include:

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

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

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

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

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

Telemedicine

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

You can also use Johns Hopkins OnDemand Virtual Care. This service allows you to connect with a provider for a general medical visit 24/7 from the comfort of your home or anywhere you may travel in the United States. This service can be used as an alternative if you are unable to see your PCP. Use of

this service is intended for common, minor ailments, such as a cough, rash, seasonal allergies, cold and flu symptoms, pink eye, sinus infection, sore throat, and more. This service is not for medical emergencies.

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

Transplants

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

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

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

Covered transplant services ***do not*** include:

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

Other Services and Supplies

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

- Abortion
- Acne and actinic keratosis procedures *(preauthorization required)*
- Acupuncture for anesthesia, pain control and therapeutic purposes, when provided by a licensed acupuncturist
- Adaptive behavior treatment for autism -- see ***Habilitation Services*** above
- Anesthetics and administration
- Back pain invasive treatment such as facet blocks and radiofrequency ablation *(preauthorization required)*
- Biofeedback therapy
- Blood products
- Botox Type A and B *(preauthorization required)*
- Calcium scoring/electron beam computer tomography *(preauthorization required)*
- Capsule endoscopy *(preauthorization required)*
- Cardiac rehabilitation *(preauthorization required)*
- Casts
- Chiropractic care for misalignment or partial dislocation of or in the vertebral column and correction by manual or mechanical means of nerve interference
- Contraceptive devices provided for in comprehensive guidelines supported by the Health Resources and Services Administration and approved by the Food and Drug Administration

- Cosmetic/reconstructive surgery when due to:
  - accidental injury or illness that is or would be covered by the Plan, or
  - correction of a congenital malformation of a child, including cleft lip and cleft palate

- Cosmetic/reconstructive surgery when due to a mastectomy, including:
  - reconstruction of the breast on which the mastectomy was performed,
  - surgery and reconstruction of the other breast to provide a symmetrical appearance,
  - prostheses and physical complications for all stages of a mastectomy, including lymphedemas (swelling associated with the removal of lymph nodes), and
  - 3-D nipple tattooing of a reconstructed breast, but only if the tattoo artist is recommended by the provider of the reconstructive surgery, and possesses a license to provide tattoos if a license is required.

- Dental services if rendered as initial treatment as a result of an accident causing injury to sound natural teeth and treatment is provided within 48 hours of the accident

- Diabetic supplies

- Dialysis *(preauthorization required)*

- Durable medical equipment, including wheelchairs *(preauthorization required)*. Durable medical equipment is medical equipment which:

  - Can withstand repeated use
  - Is primarily and customarily used to serve a medical purpose
  - Is generally not useful to a person in the absence of illness or injury
  - Is appropriate for use in the home, and
  - Is not primarily for the convenience of the patient

- Elastography *(preauthorization required)*

- Electroretinography *(preauthorization required)*

- External beam radiation therapy *(preauthorization required)*

- Feeding programs *(preauthorization required)*

- 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

- Gastric bypass (bariatric) surgery – see ***Obesity treatment*** above

- Genetic testing *(preauthorization required)*
- GERD (gastroesophageal reflux disease) devices *(preauthorization required)*
- Hearing aids for a dependent child under age 26, up to $1,400 per aid. The aids must be prescribed, fitted, and dispensed by a licensed audiologist. Replacement aids are available only once every three years. *(preauthorization required)*
- Hearing devices that are implanted *(preauthorization required)*
- Hospital charges for covered semi-private room and board and other hospital-provided services and supplies *(preauthorization required)*
- Hyperbaric oxygen therapy *(preauthorization required)*
- Immunizations for routine use in children, adolescents, and adults that have in effect a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention
- Injectable drugs provided in a physician's office – see ***Injectable Drugs*** above
- Laboratory tests
- Laser treatment for skin conditions *(preauthorization required)*
- Light box therapy *(preauthorization required)*
- Long term cardiac event monitoring (Zio Patch) *(preauthorization required)*
- Midwifery services – see ***Maternity Care*** above
- Neuropsychiatric testing
- Neurostimulators *(preauthorization required)*
- Newborn care
- Nicotine addiction treatment or smoking cessation programs, as covered by United States Preventive Services Task Force preventive care recommendations with a rating of A or B

- Nursing services (professional) by a registered nurse or licensed practical nurse who is not a close relative (spouse, child, grandchild, brother, sister, brother-in-law, sister-in-law, parent, or grandparent) of the patient

- Nutrition counseling *(preauthorization required after six visits per calendar year)*

- Observation care *(preauthorization required after 24 hours)*

- Orthotics for the foot that are custom-molded and related to a specific medical diagnosis, or an integral part of a leg brace and the cost is included in the orthotist's charge *(preauthorization required)*

- Osteogenic Stimulation for fractures *(preauthorization required)*

- Oxygen and its delivery

- Palliative care *(preauthorization required)*

- Pharmacogenomics genotyping *(preauthorization required)*

- Preventive care for adults, children and adolescents, including evidence based items or services that have in effect a rating of A or B in the current recommendations of the United States Preventive Services Task Force. No cost sharing applies to this preventive care from an EHP Preferred, or EHP/Cigna PPO Network provider.

- Proton beam radiotherapy *(preauthorization required)*

- Prosthetic devices and orthotics that are integral to the device *(preauthorization required)*

- Pulmonary therapy *(preauthorization required)*

- Pulse oximetry at home *(preauthorization required)*

- PUVA phototherapy *(preauthorization required)*

- Radiology:

  - CT Scan *(preauthorization required)*
  - Diagnostic X-ray

- MRI *(preauthorization required)*
- PET scan *(preauthorization required)*
- Prenatal ultrasound *(preauthorization required for more than three procedures per pregnancy, or for 3D ultrasound)*

- Sclerotherapy *(preauthorization required)*
- Splints
- Specialist consultation services. Staff consultation required by the facility is not covered.
- Surgical procedures and second opinions. *Preauthorization required for certain procedures, as set forth on a list maintained by Johns Hopkins Employer Health Programs.*
- Temporomandibular Joint Syndrome (TMJ) treatment and/or orthognathic surgery, limited to physical therapy, surgery and ortho devices such as mouthguards and intraoral devices (excludes orthodontics and prosthetics) *(preauthorization required)*
- Testing and treatment required to be covered by the Families First Coronavirus Response Act
- Vasectomies and tubal ligations
- Well-child care, including evidence-informed preventive care and screenings provided for in comprehensive guidelines supported by the Health Resources and Services Administration
- Well-woman care, including evidence-informed preventive care and screenings for women provided for in comprehensive guidelines supported by the Health Resources and Services Administration
- Wigs in the case of baldness resulting from chemotherapy, radiation therapy or surgery, in which case benefits are limited to one wig once every 24 months, not to exceed $400 *(preauthorization required)*
- Wound clinic *(preauthorization required after 10 visits)*
- Wound vac
- X-ray, radium, and radioisotope treatment

For a free copy of any government guidelines or recommendations described above, contact EHP Customer Service at 410-424-4450 or 800-261-2393.

Mental Health and Substance Use Disorder Treatment

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

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

Like any other medical treatment, *any inpatient admission (including inpatient residential treatment centers) must be preauthorized*.

Outpatient mental health and substance use disorder treatment does not have to be preauthorized. However, if you have your treatment preauthorized, you can be assured that your treatment will be considered medically necessary and therefore covered. Through the preauthorization process you can talk to mental health professionals who will help you determine the best course of treatment for you. They will refer you to an EHP Preferred or EHP/Cigna PPO Network provider. If you wish, you may instead refer yourself to any provider in or out of the EHP/Cigna PPO Network. The choice is yours. However, if you refer yourself to a provider your treatment will only be covered if it is determined to be medically necessary.

You can contact Utilization Management at 410-424-4476 or 800-261-2429. You may contact the mySupport Employee Assistance Program at 443-997-7000.

EHP Preferred and EHP/Cigna PPO Network providers include a variety of specialists to meet your needs, including psychiatrists, psychologists and licensed certified social workers. Providers offer a full range of counseling services, including individual and group therapy, family counseling and addiction recovery programs.

Note: *You must receive preauthorization before all inpatien*t *admissions (including inpatient residential treatment centers) for mental health and substance use disorder treatment. The confidential number to call is 410-424-4476 or 800-261-2429. Failure to obtain preauthorization will result in denial of coverage.*

Prescription Drug Benefits

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

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

EHP Network Pharmacies

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

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

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

Copay

You pay a $10 copay for each separate prescription or refill of up to a 30-day supply of a generic drug (Tier 1). No copay applies for contraceptives that are required to be covered without cost-sharing under comprehensive guidelines supported by the Health Resources and Services Administration. Normally, no copay only applies to generic contraceptives. However, if your provider determines that a brand name contraceptive is medically necessary, no copay will apply to that contraceptive.

Otherwise, the copay for up to a 30-day supply is $40 for brand name preferred drugs (Tier 2) and $65 for brand name non-preferred drugs (Tier 3). The copay is $65 for brand name drugs if a generic equivalent is available (Tier 4). You must also pay the difference in cost between the generic and the brand name drug. (In no event would you have to pay more than the full cost of the brand name drug itself.)

If a brand name drug has a generic equivalent, but the brand name drug is prescribed by your provider as medically necessary, you can request a prior authorization for the drug. If the prior authorization is

approved, you must pay the $65 copay, but do not have to pay the difference in cost between the generic and the brand name drug.

The copay for specialty medications is $10 for generic drugs, $40 for brand name preferred drugs and $65 for brand name non-preferred drugs. Specialty medications are only covered for up to a 30-day supply. Specialty medications include, but are not limited to, biologic medications and medications that are injected or infused.

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

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

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

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

Medication Copay Waiver Program

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

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

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

Prior Authorization, Quantity Limits and Step Therapy

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

You can find out if a drug is subject to Prior Authorization, Quantity Limits and Step Therapy by going to the EHP website at www.ehp.org. Go to "Plan Benefits", then "Pharmacy", then "Prior Authorization" and follow the instructions. Call EHP Customer Service at 410-424-4450 or 800-261-2393 if you need assistance.

If your physician determines that use of a drug that requires Prior Authorization is necessary, your physician must complete the CVS Caremark Electronic Prior Authorization process or call CVS Caremark. The link for the Electronic Prior Authorization process and the phone number are available on the Johns Hopkins HealthCare provider website. If your physician determines that dosage of a drug in a greater quantity than is allowed under the Quantity Limits program is needed, or that a drug subject to Step Therapy should be covered instead of other drugs to treat the condition, your physician can also complete the CVS Caremark Electronic Prior Authorization process or call CVS Caremark. CVS Caremark will review the request and notify your physician of approval or denial of the request. If Caremark denies the request for prior authorization, you or your physician can make a First Level Appeal to Caremark in accordance with the directions included on the denial letter. If Caremark denies the First Level Appeal, you may make a Final Appeal to the Plan Administrator in accordance with the appeal rules for pre-service claims set forth later in this SPD under Claims and Appeals.

Caremark Formulary Drugs

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

If a drug is not listed on the Formulary, you must pay the full cost for the drug unless Caremark issues a prior authorization for medical necessity for the drug. Caremark will only do so if your physician

can demonstrate that it is medically necessary for you to take the non-Formulary drug instead of the other optional drugs that are listed on the Formulary. To request prior authorization for medical necessity for a non-Formulary drug, your physician must complete the CVS Caremark Electronic Prior Authorization process or call CVS Caremark. The link for the electronic process and the phone number are available on the Johns Hopkins HealthCare provider website. If Caremark grants the request for prior authorization for a non-Formulary drug, you must pay the copay that applies to brand name non-preferred drugs. If Caremark denies the request for prior authorization for a non-Formulary drug, you or your physician can make a First Level Appeal to Caremark in accordance with the directions included on the denial letter. If Caremark denies the First Level Appeal, you may make a Final Appeal to the Plan Administrator in accordance with the appeal rules for pre-service claims set forth later in this SPD under Claims and Appeals.

What's Not Covered

No prescription drug benefits will be paid for the following:

- ♦ Any charges you are required to pay directly to the pharmacy for each prescription or refill
- ♦ Any charge for administration of drugs or insulin
- ♦ Smoking cessation drugs that are not prescribed by a physician
- ♦ Drugs that are excluded from coverage for a reason set forth later in this SPD under **What's Not Covered by the EHP Medical Plan**
- ♦ Methadone
- ♦ Schedule V-exempt narcotics
- ♦ Hypodermic needles and syringes (other than for diabetic use and for self-administered injections)
- ♦ Drugs that are non-prescription, non-legend or over-the-counter (except for certain prescribed OTC drugs as explained below, or as required to be covered for preventive care)
- ♦ Drugs or devices not approved by the FDA for marketing and/or for the prescribed treatment of a specific diagnosis unless approved by Utilization Management. This exclusion does not apply to a medical device to the extent Medicare would cover the device in accordance with Medicare Policy Manual Chapter 14
- ♦ Drugs to treat cosmetic conditions resulting from normal aging process
- ♦ Drugs whose sole use is treatment of hair loss, hair thinning or related conditions
- ♦ Drugs dispensed in excess of the amounts prescribed or refills of any prescription in excess of the number of refills specified by the prescriber or allowed by law
- ♦ Replacement of drugs that are lost or stolen
- ♦ Drugs dispensed for any illness or injury covered by any workers compensation or occupational disability law
- ♦ Immunization agents, biological sera, blood or blood plasma (however, Flu, Pneumonia and Shingles vaccines are covered at In-Network pharmacies)

- ♦ Drugs taken by or administered to the member while a patient in a hospital, sanitarium, extended care facility, nursing home, or similar institution that has on its premises a facility for dispensing pharmaceuticals
- ♦ Drug delivery implants or devices
- ♦ Herbal, mineral and nutritional supplements

Over-the-Counter Drugs

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

- Generic non-sedating antihistamines such as OTC Loratadine and Loratadine D (generic equivalents of Claritin/Claritin D), OTC Fexofenadine/Fexofenadine D (generic equivalents of Allegra/Allegra D) and OTC Cetirizine/Cetirizine D (generic equivalents of Zyrtec/Zyrtec D) – no copay
- Generic proton pump inhibitors such as OTC Omeprazole (generic equivalent of Prilosec), OTC Esomeprazole (generic equivalent of Nexium), OTC Lansoprazole (generic equivalent of Prevacid), and OTC Omeprazole/Sodium Bicarbonate (generic equivalent of Zegerid) – $10 copay per 30-day supply

Preventive Care Drugs

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

What's Not Covered by The EHP Medical Plan

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

- Charges excluded under the **Coordination of Benefits** provisions set forth later in this SPD
- Charges that would not be made if no coverage by the Plan existed
- Charges for which you are not legally required to pay
- Charges in excess of the Allowed Benefit or above the allowable lifetime or annual maximums
- Charges denied by another plan as a penalty for non-compliance with that plan's requirements
- Charges for the completion of claim forms
- Claims filed more than 12 months after the expenses were incurred
- Contraceptive devices, unless required to be covered in comprehensive guidelines supported by the Health Resources and Services Administration and approved by the Food and Drug Administration
- Controlled substances, hallucinogens or narcotics not administered on the advice of a doctor
- Convenience items, such as telephone and television rental, slippers, meals for family members, or first aid kits and supplies
- Copying charges
- Cosmetic/reconstructive surgery, except as expressly provided for under ***Obesity Treatment*** and ***Other Services and Supplies*** earlier in this SPD
- Custodial care, residential care or rest cures
- Dental treatment except in connection with an accidental injury to sound natural teeth that is part of the initial emergency treatment within 48 hours after the accident
- Doula services
- Drugs or devices not approved by the FDA for marketing and/or for the prescribed treatment of a specific diagnosis unless approved by Utilization Management. This exclusion does not apply to a

medical device to the extent Medicare would cover the device in accordance with Medicare Policy Manual Chapter 14.

- Emergency department services for other than an emergency medical condition

- Equipment that does not meet the definition of Durable Medical Equipment provided earlier in this SPD under **Covered Services and Supplies**, including air conditioners, humidifiers, dehumidifiers, purifiers or physical fitness equipment, whether or not recommended by a doctor

- Experimental treatment, defined as the use of any treatment, procedure, equipment, device, drug or drug usage which the Plan Administrator, Cigna or CVS Caremark determines, in its sole and absolute discretion, is being studied for safety, efficiency and effectiveness and/or which has not received or is awaiting endorsement for general use within the medical community by government oversight agencies, or other appropriate medical specialty societies at the time services are rendered.

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

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

  "Reliable Evidence" means only published reports and articles in the authoritative medical and scientific literature; the written protocols used by the treating facility or the protocol(s) of another

facility studying substantially the same drug, device, equipment, treatment or procedure; or the written informed consent used by the treating facility or by another facility studying substantially the same drug, device, equipment, treatment or procedure.

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

- Routine patient costs include services and supplies otherwise covered by the Plan for a patient not enrolled in a clinical trial, but do not include (1) the investigational item, device or service itself, (2) services and supplies not used in the direct clinical management of the patient but which instead are provided solely to satisfy data collection and analysis needs, or (3) a service that is clearly inconsistent with widely accepted and established standards of care for the patient's particular diagnosis.
- A qualified individual is a patient who is otherwise covered by this Plan and who is eligible to participate in an approved clinical trial according to the trial protocol for the treatment of cancer or other life threatening disease or condition, and either (1) the referring health care professional is an EHP/Cigna PPO Network provider who has concluded that the patient's participation in the clinical trial would be appropriate based upon meeting the conditions of the trial protocol, or (2) the patient provides medical and scientific information establishing that participation in the clinical trial would be appropriate based upon meeting the conditions of the trial protocol.
- An approved clinical trial is a phase I, II, III or IV clinical trial that is conducted in relation to the prevention, detection or treatment of cancer or other life threatening disease or condition, and that (1) is approved or funded by the federal government, (2) is conducted under an investigational new drug application reviewed by the Food and Drug Administration, or (3) is a drug trial that is exempt from having such an investigational new drug application.

♦ Foot devices, unless (1) they are an integral part of a leg brace and the cost is included in the orthotist's charge; or (2) they are custom-molded and related to a specific medical diagnosis. Orthopedic shoes (not integral to a brace), diabetic shoes, supportive devices for the feet and orthotics used for sport and leisure activities are not covered.

♦ Glasses, contact lenses, eye refractions, or the examinations for their fitting or prescription, except when medically necessary after cataract surgery or as described under the Vision Plan, later in this SPD

♦ Habilitative services (except for therapy for a person under age 19 with a congenital or genetic birth defect as described under ***Habilitation Services*** earlier in this SPD)

WHAT'S NOT COVERED

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

WHAT'S NOT COVERED

- Recreational therapy and all costs associated with a stay in a recreational, outdoor or wilderness type facility. This exclusion does not apply to medically necessary medical, mental health or substance use disorder treatment received in such facility that would otherwise be covered by this Plan, including any preauthorization requirement.

- Replacement of braces or prosthetic devices, unless there is sufficient change in the patient's physical condition to make the original brace or device no longer functional

- Reversals of sterilization procedures, such as vasectomies and tubal ligations

- Routine foot care (including any service or supply related to corns, calluses, flat feet, fallen arches, non-surgical care of toenails, and other symptomatic complaints of the feet)

- Self-inflicted injury or illness and expenses resulting therefrom, unless the self-infliction was the result of a mental illness such that application of this exclusion would violate ERISA Section 702

- Services or supplies received before your (or your dependent's) effective date of coverage under the Plan or after the termination date of coverage

- Services and supplies paid in full or in part under any other plan of benefits provided by JHHSC/JHH, a school, or a government, or for services you are not required to pay for

- Services and supplies not recommended or approved by a health care professional acting within the scope of their license

- Services and supplies required as a condition of employment

- Services and supplies not specifically listed as covered in this SPD

- Services performed by a doctor or other professional provider enrolled in an education, research, or training program when such services are primarily provided for the purposes of the education, research, or training program

- Sexual dysfunction treatment not related to organic disease

- Support garments

- Surgical treatment for overhanging, stretching or laxity of skin, except as described under ***Obesity Treatment*** earlier in this SPD

WHAT'S NOT COVERED

- Surrogate motherhood or gestational carrier treatment, including any charges related to giving birth or for treatment of the newborn child resulting from the surrogate motherhood or gestational carrying. This exclusion does not apply to charges for treatment of the newborn child if the child is a covered eligible dependent of the member.

- Telephone consultation charges, unless covered as described under ***Telemedicine*** earlier in this SPD

- Treatment which is not medically necessary, as described under **Covered Services and Supplies** earlier in this SPD

- Treatment which is not performed by an appropriate licensed professional provider acting within the scope of the provider's license

- Treatment for:
  - an injury arising out of, or in the course of, any employment (including self-employment) for wage or profit, or
  - a disease covered with respect to your employment, by any Workers' Compensation law, occupational disease law, or similar legislation

- Treatment covered by no-fault auto insurance, or any other federal or state-mandated law

- Treatment for which a third party may be liable, unless otherwise payable as described under **Reimbursement and Subrogation,** later in this SPD

- Treatment by a provider who is a close relative of the patient (spouse, child, grandchild, brother, sister, brother in law, sister in law, parent or grandparent) or who resides in the patient's home

- Vision therapy/training or eye exercises to increase or enhance visual activity or coordination

- Wigs and artificial hair pieces, except in cases of baldness resulting from chemotherapy, radiation therapy or surgery, in which case benefits are limited to one wig once every 24 months, not to exceed $400 *(preauthorization is required)*

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.

Vision Plan

The Vision Plan covers a full range of vision care services through the SuperiorVision National Network. The Plan also covers vision care services from Out-of-Network providers. You can receive services from any SuperiorVision National Network provider throughout the United States. For a complete listing of National Network providers, go to www.superiorvision.com, or contact SuperiorVision Customer Service at 800-507-3800.

Vision Benefits At-A-Glance

Vision benefits are paid as follows, depending upon whether you use a SuperiorVision National Network provider or an Out-of-Network provider:

Covered Services and Materials	***In-Network Benefit***	***Out-of-Network Reimbursement***
Routine exam (ophthalmologist)	Covered in full	Up to $60
Routine exam (optometrist)	Covered in full	Up to $52
Contact lens fitting (standard)	Covered in full	Up to $37
Contact lens fitting (specialty)	$50 allowance	Up to $37
Contact lenses, elective	$175 allowance	Up to $158
Contact lenses, medically necessary	Covered in full	Up to $233
Frames	$175 allowance	Up to $112
Lenses		
Single Vision	Covered in full	Up to $45
Bifocal	Covered in full	Up to $65
Trifocal	Covered in full	Up to $86
Lenticular	Covered in full	Up to $119
Progressive	See below	Up to $86
Polycarbonate for children	Covered in full	Not covered

VISION PLAN

Please Note:

- A $10 copay applies to all In-Network services and materials, except for contact lenses themselves. A $10 copay is deducted from all Out-of-Network reimbursements.

- All services and materials are covered only once every 12 months.

- Standard contact lens fitting fee applies to a current contact lens user who wears disposable, daily wear or extended wear lenses only.

- Specialty contact lens fitting fee applies to a new contact lens user, or a user who wears toric, gas permeable or multi-focal lenses.

- Progressive lenses are covered up to the In-Network provider's in office standard lined trifocal lens amount. You pay the difference between the charge for the progressive lenses and the covered amount for standard retail lined trifocal lenses, plus the copay.

- Benefits are provided for contact lenses in lieu of lenses and frames. This means that you can get either glasses or contact lenses in a 12-month period, but not both.

- You are responsible for charges above the maximum benefit.

What The Vision Plan Does Not Cover

Charges for the following are not covered under the Vision Plan:

♦ Any eye examination or any corrective eye wear required as a condition of employment
♦ Blended lenses
♦ Charges for lost or broken lenses and frames, except at the normal intervals when services are otherwise covered
♦ Coating the lens or lenses
♦ Cosmetic lenses and optional cosmetic processes
♦ Laminating the lens or lenses
♦ Material costs which exceed the maximum benefits as shown in the chart above
♦ Oversize lenses
♦ Photochromic or tinted lenses
♦ Services or supplies not provided by a licensed optician, optometrist or ophthalmologist
♦ Special procedure services and supplies such as orthoptics and vision training, or in connection with medical or surgical treatment of the eye
♦ Ultraviolet (UV) protected lenses

VISION PLAN

Discounts

Many SuperiorVision National Network providers offer discounts (including out of pocket limits) on frames, lenses, contact lenses, tints and coatings that are not otherwise covered by the Vision Plan. Ask your Network provider if they offer discounts and what the amounts of the discounts are. Please note that the discounts are not a benefit provided by the Vision Plan, and are offered solely by the provider.

Election of Vision Benefits

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

Johns Hopkins EHP Dental Plans

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

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

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

Out-of-pocket Expenses

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

Maximum Benefits

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

JOHNS HOPKINS EHP DENTAL PLANS

Dental Benefits At-A-Glance

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

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

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

JOHNS HOPKINS EHP DENTAL PLANS

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

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

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

JOHNS HOPKINS EHP DENTAL PLANS

What the EHP Dental Plans Cover

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

Diagnostic and Preventive Services

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

Basic Services

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

Major Services

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

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

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

Orthodontia

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

Prosthesis Replacement Rule

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

- The replacement or addition of teeth is required to replace one or more teeth extracted after the existing crown, denture or bridgework was installed; or

- The present denture, crown or bridgework cannot be made serviceable, and it is at least five years old; or

- The present denture is an immediate temporary one that cannot be made permanent. Replacement by a permanent denture must be necessary and must take place within six months from the date the immediate temporary one was first installed.

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

Pre-Treatment Review

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

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

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

1. Before beginning a course of treatment that is expected to cost $500 or more, ask your dentist to submit to Johns Hopkins Employer Health Programs a pre-treatment review form describing the treatment plan and indicating the itemized services and charges.

2. Based upon the treatment plan, Johns Hopkins Employer Health Programs will determine what expenses are covered by the Plan and notify you and your dentist.

3. Ask your dentist to submit a revised treatment plan to Johns Hopkins Employer Health Programs if there is a major change in your course of treatment.

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

Use Delta Dental PPO Dentists and Save

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

Alternate Treatment

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

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

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

What The EHP Dental Plans Do Not Cover

The EHP Dental Plans do not cover the following:

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

- Temporomandibular joint dysfunction (TMJ) syndrome, disorders of the disc, muscles, and/or inflammation of the joints, Costen-Syndrome or similar disorder (these may be covered under your medical plan);

- Training or supplies used for dietary counseling, oral hygiene or plaque control; and

- Treatment by someone other than a dentist. However, the Plans do cover certain services when provided by a dental hygienist acting within the scope of their license.

Election of Dental Benefits

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

Flexible Spending Accounts

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

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

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

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

Health Care FSA

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

Dependent Care FSA

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

When You Can Contribute to an FSA

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

How Much You Can Contribute to an FSA

> **Health Care FSA:** you can contribute up to $2,750 per calendar year (minimum of $5.00 per bi-weekly pay).

Dependent Care FSA: you can contribute up to $5,000 per calendar year ($2,500 if you are married and file a separate tax return) (minimum of $10 per bi-weekly pay). Note – if you earn more than $135,000 per year, Internal Revenue Code non-discrimination rules often require us to reduce your Dependent Care FSA contributions to less than $5,000. The reduced limit cannot be determined until after the year has begun. You will be advised if the reduced limit applies to you.

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

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

How to Use the FSAs

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

Step One -- Estimate Your Expenses

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

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

Step Two -- Calculate Your Payroll Deductions

Next, determine the amount that you will contribute to your FSA(s) each bi-weekly pay period. To do so, divide your annual expected eligible health care expenses and/or dependent care expenses by 26 pay periods (or by a lesser number of periods if you start contributing mid-year). This gives the amount you should elect to contribute to your FSA(s) each bi-weekly pay period (subject to the minimum and maximum contribution amounts set forth above).

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

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

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

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

Step Three – Use Your Debit Card or Submit a Claim

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

Use It or Lose It

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

Health Care FSA Carryover Rule

An exception to the ***Use It or Lose It*** rule applies to the Health Care FSA, but not to the Dependent Care FSA. Up to $550 of any money left over in your Health Care FSA at the end of the year will be carried over and added to your Health Care FSA for the next year, but only if you are still an employee on the last day of the year. Any amount carried over (1) does not count against the maximum Health Care FSA contribution otherwise allowed for the next year and (2) if necessary can still be used instead to reimburse for claims you submit by March 31 that were not paid for with a debit card.

Special Rule for 2022

The $550 limit does not apply to unused Health Care FSA amounts carried over from 2021 to 2022, which may be carried over without limit. In addition, unused Dependent Care FSA amounts may be carried over without limit from 2021 to 2022.

Carryovers from 2022 to 2023 will return to the regular rules set forth above. That means there will be a $550 limit on Health Care FSA carryovers, and no Dependent Care FSA carryovers will be allowed at all.

Eligible Health Care Expenses

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

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

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

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

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

- Cosmetic surgery (unless to correct a deformity resulting from a congenital abnormality, an accidental injury, or a disfiguring disease)
- Health club dues
- Non-prescription drugs that are merely beneficial to your health (such as vitamins or dietary supplements)
- Non-prescription drugs that are used to treat an injury or illness, if the patient does not have a written prescription from their doctor (no prescription required for insulin)

- Cosmetics and toiletries
- Weight loss programs (unless directed to participate by your physician to treat a specific disease);
- Non-prescription sunglasses
- Other health care insurance premiums

For a complete list of eligible expenses, please see IRS Publication 502, available from the HR Solutions Center or go to www.irs.gov. Items shown in the list of "What Medical Expenses Are Deductible" in Publication 502 (other than health insurance or HMO premiums) are generally payable from the Health Care FSA. Non-prescription drugs (which are not deductible) can also be paid for if they qualify as explained above.

Health Care FSA Worksheets

You may use the following worksheets to help you estimate your eligible health care expenses and calculate how much to contribute to your Health Care FSA. Take a look at your health care expenses that are not covered by any plan during the year, and try to predict your expenses for the following year. You should review your medical, dental and vision benefits carefully before trying to predict your expenses.

Health Care FSA Worksheet # 1

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

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

Remember, the maximum amount you may contribute to a Health Care FSA is $2,750 per year (minimum of $5.00 per bi-weekly pay period).

Health Care FSA Worksheet # 2

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

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

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

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

Paying Eligible Expenses From the Health Care FSA

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

Debit Card

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

Please note the following regarding the debit card:

- Your debit card may only be used for eligible expenses that are incurred during the Plan Year while you are employed; paper claims must be submitted for all other expenses.
- You can only use the debit card at merchants that accept the card. For example, the card will work at most pharmacies, but will be denied at a gas station.
- If you go to a drug store for a number of items - some eligible expenses, some not - ask the clerk to ring them up separately. Then use your debit card to pay only for eligible items.

- Although it is called a debit card, you use it just like a credit card when it is presented to the store or service provider. There is no PIN associated with the card. When given the option to select between debit or credit at the terminal, select credit.

- Save all of your itemized receipts. For some expenses, the plan administrator or the IRS may need additional information, including receipts, to verify eligibility of the expense and compliance with IRS rules. Save all receipts, and be prepared to promptly supply the supporting information upon request.

Paper Claims

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

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

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

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

Your FSA Balance

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

Using the Dependent Care FSA

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

- Your child under age 13 for whom you can claim an income tax exemption;

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

Eligible Dependent Care Expenses

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

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

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

Eligible Day Care Providers

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

When You May Use the Dependent Care FSA

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

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

When Both Spouses Participate in Dependent Care FSAs

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

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

The Dependent Care Tax Credit

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

Whether the Dependent Care FSA or the tax credit will save you more in taxes depends on your own personal tax situation.

Paying Eligible Expenses From the Dependent Care FSA

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

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

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

FLEXIBLE SPENDING ACCOUNTS

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

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

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

Short Term Disability Benefits

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

If you are injured in an accident for which you might recover from a third party or from your own insurance (such as personal injury protection), please refer to the reimbursement and subrogation provisions explained below under **Reimbursement and Subrogation.**

Payment of Benefits

Short Term Disability pays benefits when you cannot perform the regular duties of your job due to your illness or injury. You will receive benefits equal to 60% of your regular bi-weekly base pay (including regular shift differential and excluding overtime and commissions). This benefit amount is payable to you for up to 25 weeks of disability. Benefits begin after you have been unable to work for seven consecutive calendar days. You must be under a doctor's care to be considered disabled. Your Short Term Disability benefits will be supplemented by any time you may have available in your Sick Bank or PTO Bank up to 100% of your regular bi-weekly base pay. Please note that you must submit your claim for Short Term Disability benefits within 90 days from the date of the illness or injury that caused your disability to occur.

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

Short Term Disability benefits are not provided for an illness or injury that occurs or begins while you are on a leave of absence (unless it is an approved Family and Medical Leave).

Short Term Disability benefits are administered by MetLife. Contact the HR Solutions Center for more information about making claims with MetLife.

If Your Short Term Disability Benefits are Denied

If your claim for Short Term Disability Benefits is denied, or if you are approved for less days of disability than you think you are entitled to, you may appeal the decision in accordance with the **Claims and Appeals** rules set forth later in this SPD and the MetLife appeals process.

Benefits From Other Sources

SHORT TERM DISABILITY BENEFITS

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

Return to Work

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

Recurring Disabilities

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

If you have been back to work for less than 60 days and become disabled again from the same or a related cause, the second period of disability will be considered a continuation of the first one.

If you have been back to work for less than 60 days and become disabled from a different and unrelated cause, a new disability benefit period would begin after you have been unable to work for seven consecutive calendar days.

Any disability that occurs after you have been back to work for 60 days or more, whether it is a relapse or a new condition, will be considered a new disability period. Benefits would begin after you have been unable to work for seven consecutive calendar days.

Partial Disability

If you are able to continue or return to work at JHHSC/JHH on a part time basis after an illness or injury, you may qualify for Partial Short Term Disability benefits. You will be considered partially disabled and entitled to partial Short Term Disability benefits if the number of hours you are regularly scheduled to work is reduced by at least 20% due to a disabling condition. If you are partially disabled and continue or return to work on a reduced schedule, the sum of your pay for working plus your Short Term Disability benefits will equal your regular bi-weekly base pay.

Days of partial disability count the same as days of total disability for determining your entitlement to disability benefits. Thus, partial disability days count as full days to determine if you have been unable to work for the required seven days before benefits begin. Similarly, days for which partial disability benefits are paid count as full days towards the maximum 26 weeks of benefits.

SHORT TERM DISABILITY BENEFITS

What's Not Covered By Short Term Disability Benefits

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

- Any disability arising from an injury or illness for which coverage is excluded as described under **What's Not Covered by the EHP Medical Plan** earlier in this SPD, regardless of whether you have coverage under the Medical Plan;
- Any disability for which you are eligible to receive benefits under Workers' Compensation, or which results from an injury or illness you incur in the course of any employment. This exclusion does not apply if a claim for Workers' Compensation benefits is made and is denied on the grounds that the injury or illness that caused the disability was not work related;
- Any period of disability beginning prior to your effective date of coverage under this Plan;
- Any period of disability during which you are not under the regular care of a physician;
- Any period of time during which you are employed in a position other than your regular job, and in which position you utilize the skills and/or qualifications of your regular job.

When Short Term Disability Benefits End

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

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

Administrative Information About Your Johns Hopkins EHP Benefits

Filing A Claim With Employer Health Programs

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

You do need to file a claim form with Employer Health Programs if you receive services from an Out-of-Network provider, unless the Out-of-Network provider files the claim for you. It is your responsibility to determine if the Out-of-Network provider files a claim for you.

You also need to file a claim with MetLife if you apply for Short Term Disability benefits.

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

Itemized bills must include the following information:

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

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

Coordination of Benefits

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Coverage Under Other EHP Medical Plans

Benefits provided by any prior version of the EHP Medical Plan before 2020, such as the Basic Plan, Premium Plan, 90/10 Plan or 80/20 Plan, are treated as benefits provided under this EHP Medical Plan when applying lifetime limits. Benefits provided under the Exclusive Provider Organization version of the EHP Medical Plan are aggregated with benefits provided under the Preferred Provider Organization version of the EHP Medical Plan when applying lifetime limits.

Transferring Employment Within the Health System

If an employee transfers employment between specified employers within the Johns Hopkins Health System, any amounts applied against the annual deductible and/or out of pocket maximum under the EHP Medical Plan of the old employer for the calendar year of transfer will be recognized for the same purpose by the EHP Medical Plan of the new employer for the rest of that calendar year. In addition, any benefits provided under the EHP Medical Plan of the old employer that are subject to annual or lifetime limits or maximums will count against the corresponding annual or lifetime limits or maximums of the new employer.

These transfer provisions apply only to those employers whose Summary Plan Description contains these provisions.

Care Received Outside the United States

The following rules apply when you are travelling outside the United States and need medical care that is not covered by the ***Emergency Care*** provisions described earlier in this SPD. The following rules apply based on whether care is foreseeable or unforeseeable. ***Unforeseeable*** care means medical treatment or prescription drugs received before it is safe to return to the United States and that could not have reasonably been anticipated before leaving the country. ***Foreseeable*** care means all other medical treatment or prescription drugs.

Claims for ***unforeseeable*** medical care received or for ***unforeseeable*** prescription drugs obtained while outside the United States will be paid on the same terms as apply to care received from an EHP/Cigna PPO Network provider. However, benefits are calculated based only on the Allowed Benefit for the care received. In addition to any copay or coinsurance that might apply, you are responsible for all charges above the Allowed Benefit.

Claims for ***foreseeable*** medical care received or for ***foreseeable*** prescription drugs obtained while outside the United States will be covered at the Out-of-Network benefit level. This means that no coverage is provided for ***foreseeable*** prescription drugs obtained outside the United States.

You (or someone on your behalf) must notify Johns Hopkins EHP at 410-424-4450 or 800-261-2393 of any outside the United States inpatient hospitalization within 48 hours after admission. If notice is not given on time, coverage may be denied.

Employees Whose Worksite Is Outside The United States

Employees whose worksite is outside the United States do not have coverage under the EHP Medical or Dental Plans. Instead, an insurance policy (currently issued by MetLife) provides the health and dental insurance coverages. Employees whose worksite is outside the United States are still eligible for Short Term Disability benefits and the Health Care and Dependent Care Flexible Spending Accounts as described in this SPD.

Reimbursement and Subrogation

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

ADMINISTRATIVE INFORMATION

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

Any reference to "Plan" in this section means both the EHP Medical Plan and the Short Term Disability Plan.

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

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

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

Your obligations

You are obligated to cooperate with the Plan and its agents in order to protect the Plan's reimbursement and subrogation rights in this section. 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.

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

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

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

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

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

Reimbursement

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

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

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

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

In order to secure the Plan's reimbursement rights, you, 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 and against any party who is in possession of funds that may ultimately be used for your Recovery; (2)

assign to the Plan any benefits you may have under any insurance policy or other coverage and (3) agree to hold in constructive trust as a fiduciary for the Plan the proceeds of any Recovery received. Failure to hold such proceeds in trust will be deemed a breach of your fiduciary duties to the Plan. By paying, or being obligated to pay, any claims to you or on your behalf, the Plan automatically has the lien and other rights described in this section.

Subrogation

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

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

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

The Plan's rights

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

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

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

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

Workers Compensation Recovery

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

The recovery rights can be applied even though:

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

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

Benefits Paid by Mistake

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

When Benefit Plan Coverage Ends

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

♦ The end of the month in which you end your employment or are no longer an eligible employee. You will be considered an employee who is eligible for benefits so long as you are eligible under the terms of your employer's leave of absence policy, or so long as you are receiving Short Term Disability Benefits under this Plan;
♦ The end of the month preceding the effective date of your waiver of coverage under the plan;
♦ The end of the month for which you last make the required contributions for coverage;
♦ The date the plan is discontinued;

- The date on which you report for active duty as a full-time member of the armed forces of any country.

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

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

For certain of the above events, you or your dependents may be able to continue coverage by self-payment under COBRA, as explained next. Continuing coverage during leaves of absence is discussed below under **Benefit Coverage During Family and Medical Leave and Other Leaves of Absence**.

COBRA Continuation Coverage

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

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

Length of COBRA Coverage

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

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

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

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

If you are at least age 62 and have at least 15 "Years of Vesting Service" under the Johns Hopkins Health System Corporation Retirement Plan when you lose regular coverage due to one of the above qualifying events, you may continue coverage under COBRA until the end of the month in which you reach age 65. This allows you to continue coverage under COBRA until you are eligible for Medicare. You may also cover your spouse while you are receiving this extended COBRA coverage. If you cover your spouse until you reach age 65 (when your COBRA coverage ends), your spouse may thereafter continue COBRA coverage until the end of the month in which they reach age 65 or have been on COBRA for 36 months in total, whichever occurs first.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Electing COBRA Coverage

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

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

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

Each individual who elects to continue coverage under COBRA must pay the full premium cost, plus 2% for administrative expenses. You will be advised of the monthly cost of COBRA coverage per

person at the appropriate time. After you, your spouse or dependent children have elected to continue coverage under COBRA and have paid the required premiums, coverage will be reinstated back to the date regular coverage was lost. The EHP Medical, Dental and Vision Plans will not pay any claims made in the interim. Upon reinstatement of coverage, invoices may be submitted or re-submitted to the Plans for payment.

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

When COBRA Coverage Ends

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

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

Benefit Coverage During Family and Medical Leave (FML)

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

While you are on FML leave, your required employee contributions for the benefit plan coverage you have elected will be withheld from any PTO, short term disability or other pay you receive. For any part of your FML leave for which you do not receive pay, you will be billed for your required employee contributions. If you pay the required contributions by the due date shown on the bill, 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 by the due date, you will be sent a notice that your payment is overdue. If you do not pay the required contributions by the end of the grace period shown on the notice, benefit plan coverage for you (and your spouse and dependent children) will terminate at the end of the grace period.

If you return to employment with JHHSC/JHH at the end of your FML leave, the benefit plan coverage you had in effect before the leave began will continue, or will resume if coverage terminated during the leave for failure to pay contributions.

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

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

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

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

Approved Medical and Dependent Care Leaves

While you are on an approved Medical or Dependent Care leave of absence under your employer's Leaves of Absence policy, but which is not an FML leave, your required employee contributions for the benefit plan coverage you have elected will be withheld from any PTO, short term disability or other pay you receive. For any part of your leave for which you do not receive pay, you will be billed for your required employee contributions. If you pay the required contributions by the due date shown on the bill, 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 by the due date, you will be sent a notice that your payment is overdue. If you do not pay the required contributions by the grace period shown on the notice, benefit plan coverage for you (and your spouse and dependent children) will terminate at the end of the grace period.

If you return to employment with JHHSC/JHH at the end of your non-FML Medical or Dependent Care leave, and if you timely paid your required employee contributions during the leave, the benefit plan coverage you had in effect before the leave began will continue. If your benefit plan coverage terminated during the leave for failure to pay contributions, coverage will not resume after you return

to employment, unless and until you again elect coverage either during open enrollment or as explained earlier in this SPD under Changing Your Coverage.

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

Other Approved Leaves

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

When You Become Covered By Medicare

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

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

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

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

Medicare and End Stage Renal Disease

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

Non-Discrimination in Benefits

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

- ♦ on the basis of race, color, national origin, sex, age or disability
    - the Plan will not discriminate on the basis of pregnancy, gender identity, sex stereotyping and sexual orientation

- ♦ for sex-specific health services provided to transgender individuals just because the individual seeking such services identifies as belonging to another gender
    - the Plan will not discriminate based on the fact that an individual's sex assigned at birth, gender identity or recorded gender is different than the one to which the health care services are ordinarily or exclusively available

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

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

- Provides free aids and services to people with disabilities to communicate effectively with EHP, such as: qualified sign language interpreters, written information in other formats (large print, audio, accessible electronic formats, other formats).

- Provides free language services to people whose primary language is not English, such as qualified interpreters and information written in other languages.

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

If you believe EHP has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with the Johns Hopkins HealthCare Compliance Grievance Coordinator, Johns Hopkins HealthCare Corporate Compliance Department at 7231 Parkway Drive, Suite 100, Hanover, MD 21076, phone: 1-844-422-6957, fax: 1-410-762-1527, and email: compliance@jhhc.com.

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

Plan Information

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

Plan Sponsor

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

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

Plan Administrator

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

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

Benefits Office
Attention: Senior Director of Benefits

Johns Hopkins at Eastern
1101 East 33rd Street
Baltimore, MD 21218
Telephone: 443-997-5400

Plan Year

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

Plan Funding

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

Johns Hopkins Employer Health Programs
7231 Parkway Drive, Suite 100
Hanover, MD 21076
410-424-4450 or 800-261-2393

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

Plan Number

The plan number is 506.

Legal Action

The agent for service of legal process is:

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

You may also serve legal process on the Plan Administrator.

Prohibition On Assignment Of Benefits

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

Claims And Appeals

In order for you to receive Medical, Dental, Vision or Short Term Disability benefits, you or your provider must file a claim. Claims are filed for you by EHP/Cigna PPO Network providers under the EHP Medical Plan, by SuperiorVision network providers under the Vision Plan, and by Delta Dental network providers under the Dental Plans. An Out-of-Network provider can file your claim for you, but if your provider doesn't file the claim you must file it yourself. You must file claims for Short Term Disability benefits.

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

Before you can appeal a claim denial arising under the Dental Plans, you must first complete any available appeal process provided by Delta Dental. Failure to properly make use of the appeal process provide by Delta Dental is grounds for denial of an appeal under these procedures.

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

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

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

For Short Term Disability benefits, the Plan's procedures do not apply until a claim is filed by submitting a disability benefits claim form, available at the Johns Hopkins Hospital HR Solutions Center or from MetLife.

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

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

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

As indicated throughout this SPD, certain services and supplies must be preauthorized by EHP Utilization Management (for EHP Network providers) or by Cigna (for Cigna PPO Network and Out-of-Network providers) in order to be covered. If a service or supply must be preauthorized, a request for preauthorization is a **"Pre-Service Claim"**. (Pre-treatment review for major Dental services is recommended so you and your provider will know in advance what benefits will be paid. However, pre-treatment review is not required in order for the services to be covered and there is no penalty for failing to request review.)

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

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

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

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

Filing a Claim

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

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

JHHSC/JHH
EHP Medical Plan
c/o Johns Hopkins Employer Health Programs
7231 Parkway Drive, Suite 100
Hanover, MD 21076

Claims for Short Term Disability benefits should be sent to MetLife at the address shown on the MetLife claim form.

Itemized bills must include the following information:

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

Claim forms are available at the Johns Hopkins Hospital HR Solutions Center and from Johns Hopkins Employer Health Programs at www.ehp.org. To avoid delay in handling your claim, answer all questions completely and accurately. *Claims cannot be processed without your signature where required on the form.*

Reducing, Terminating or Extending an Approved Course of Treatment

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

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

Authorized Representative

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

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

Claims for Children

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

Claims and Appeals Procedures

If your claim for benefits (Urgent Care, Pre- or Post-Service) is denied in whole or in part, 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, it 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, you will be notified 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, you will be notified 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 the Plan's control, this period may be extended up to 15 more days. If an extension is needed, you will be told before the initial 15 day period ends why an extension is needed and when a decision is expected.

Post-Service Claims

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

If Additional Information is Needed

Pre-Service and Post-Service Claims

If more information is needed 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 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 reasonable presumptions may be drawn from your failure to supply the additional information.

Urgent Care Claims

If more information is needed 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 to decide your Urgent Care Claim is suspended until you supply the additional information.

You will be notified of the decision on your Urgent Care Claim within 24 hours after the earlier of when (1) you supply the additional information or (2) the time for you to supply the additional information expires. If you do not supply the information within 48 hours, your claim will be

processed without the additional information, and reasonable presumptions may be drawn from your failure to supply the additional information.

If Your Claim is Denied

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

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

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

For a Short Term Disability benefit claim, the notice will also explain the basis for disagreeing with or not following: (1) the views of health care professionals treating you and vocational professionals who evaluated you, but only if you presented those views with your claim; (2) the views of medical or vocational experts whose advice was obtained on behalf of the Plan in connection with denying the claim, without regard to whether the advice was relied upon in making the benefit determination, and (3) a Social Security Administration disability determination regarding you, but only if you presented that determination with your claim.

First Level Appeal

If you think a mistake was made 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, in whole or in part. 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 <u>before</u> 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 of a Medical, Dental or Vision claim denial must be in writing and mailed to the following address:

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

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

A First Level Appeal of a denial of an Urgent Care Claim may be made orally or in writing. 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.

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

A First Level Appeal of a denial of a claim for Short Term Disability benefits must be mailed to the address shown on the claim denial notice provided by MetLife.

All First Level Appeals of Medical, Dental or Vision claim denials will be submitted to the EHP or Cigna appeals department. First Level Appeals of Short Term Disability benefit claim denials are handled by the MetLife appeals department. You may submit written comments, documents, records and other information relating to your claim. The appeals department will consider everything you submit, regardless of whether it was submitted or considered in the initial claim determination. Upon written request and free of charge, you will be provided with reasonable access to and copies of all Plan documents, records and other information relevant to your claim.

If your claim for treatment in an emergency department was denied on the grounds that you did not have an emergency medical condition, your First Level Appeal may be referred to an Independent Review Organization (IRO) for determination. In that event, the IRO takes the place of the appeals

department under these claims procedures, and any reference in these procedures to the appeals department should be read as a reference to the IRO.

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

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

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

When Your First Level Appeal Will Be Decided

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

Urgent Care Claim – You will be notified of the decision within 72 hours after your First Level Appeal is filed.

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

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

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

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

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

For a Short Term Disability benefit claim, the notice will also explain the basis for disagreeing with or not following: (1) the views of health care professionals treating you and vocational professionals who evaluated you, but only if you presented those views with your claim; (2) the views of medical or vocational experts whose advice was obtained on behalf of the Plan in connection with denying the claim, without regard to whether the advice was relied upon in making the benefit determination, and (3) a Social Security Administration disability determination regarding you, but only if you presented that determination with your claim.

Final Appeal

If your First Level Appeal is denied in whole or in part, you may make a Final Appeal to the Plan Administrator. However, if your First Level Appeal involved a refusal by Cigna to preauthorize treatment, you must instead make the Final Appeal to Cigna.

There is no Final Appeal process for Short Term Disability benefit claims. Your First Level Appeal is the only appeal provided for Short Term Disability benefit claims. If your First Level Appeal is denied in whole or in part, you have completed the internal claims and appeals process and may bring a civil action against the Plan under ERISA Section 502.

Except for an appeal of a denial of an Urgent Care claim, your Final Appeal must be in writing and must include details about your claim and why you think it should not be denied. You must submit your Final Appeal to the Plan Administrator in care of Johns Hopkins HealthCare Appeals Department at the address shown above. However, if your First Level Appeal involved a refusal by Cigna to preauthorize treatment, you must submit the Final Appeal to Cigna at the address provided in the First Level Appeal denial.

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

A Final Appeal of a denial of an Urgent Care Claim may be made orally or in writing. 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.

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

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

If your First Level Appeal of a proposed reduction or termination of an approved course of treatment was denied 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 denial. If you file a Final Appeal more than five days after you are notified of the denial, 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 considered by the Plan Administrator or by Cigna. You may submit written comments, documents, records and other information relating to your claim. Everything you submit will be considered, regardless of whether it was submitted or considered in the initial benefit determination or your First Level Appeal. Upon written request and free of charge, you will be provided with reasonable access to and copies of all Plan documents, records and other information relevant to your claim.

During the Final Appeal process, you will be provided, free of charge, with any new or additional evidence considered, relied upon, or generated by (or at the direction of) the Plan in connection with your claim, and with any new or additional rationale for denying your claim. In either case, the

evidence or rationale will be provided to you as soon as possible and sufficiently in advance of when your Final Appeal will be decided, so as to give you a reasonable opportunity to respond prior to that date.

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

If medical or vocational experts were consulted when 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 72 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 denial of 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 decision on your Final Appeal. If your Final Appeal is denied, the notice will contain the same type of information as the notice of the denial of your First Level Appeal. If you disagree with the Final Appeal decision, you may bring a civil action against the Plan under ERISA Section 502.

If you want to bring a civil action against the Plan, the Plan Administrator or Cigna, involving a denial of Medical, Dental or Vision benefits, you must do so within one year after the date of the notice of the decision on your Final Appeal. If you want to bring a civil action against the Plan, the Plan Administrator or MetLife, involving a denial of Short Term Disability benefits, you must do so within one year after the date of the notice of the decision on your First Level Appeal. If you do not bring such an action within one year after the date of the notice, you lose all rights to bring an action against the Plan, the Plan Administrator, Cigna or MetLife.

If you take the position that you are entitled to bring a civil action against the Plan, the Plan Administrator, Cigna or MetLife without completing the Plan's claims and appeals process, you must do so within one year after the date of the action (or inaction) which you assert entitles you to bring a civil action without completing the Plan's claims and appeals process. If you do not bring such an action within one year after the date you assert, you lose all rights to bring an action against the Plan, the Plan Administrator, Cigna or MetLife.

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

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

External Review

If your Final Appeal is denied in whole or in part, you may be eligible to request External Review of the denial by an Independent Review Organization (IRO). External Review is <u>not</u> available for Short Term Disability benefits.

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

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

You must submit the completed Request for External Review Form to EHP or to Cigna at the address shown on the Form within 123 days after the date you receive the notice of denial of your Final

Appeal. If you do not request External Review in writing within 123 days, you cannot submit your claim to External Review.

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

Request for External Review

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

- A. Your Final Appeal has been denied in whole or in part; **or** EHP, the Plan Administrator or Cigna do not follow the internal Claims and Appeals process set forth above.

- B. Either (i) your appeal relates to a rescission of your coverage (meaning a retroactive cancellation of coverage that was previously in effect), (ii) your claim being appealed involves medical judgment (meaning whether the treatment was medically necessary or experimental), **or** (iii) your claim involves whether you are protected by the prohibitions against balance billing by certain Out of Network providers set forth in this SPD.

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

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

Preliminary Review

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

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

Referral to IRO

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

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

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

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

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

Plan (and any other defense based on timeliness) is "tolled" (i.e., suspended) from the time you submit until the IRO issues its decision.

Expedited External Review

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

- Your Urgent Care Claim is denied, you have filed a request for an expedited internal appeal, and you have a medical condition where the timeframe for completion of the expedited internal review process would seriously jeopardize your life or health or would jeopardize your ability to regain maximum function; or

- Denial of your Urgent Care Claim is upheld on Final Appeal, and either:

  - you have a medical condition where the timeframe for completion of the standard External Review process would seriously jeopardize your life or health or would jeopardize your ability to regain maximum function; or

  - your Claim concerns an admission, availability of care, continued stay, or health care item or service for which you received emergency services, but have not been discharged from a facility.

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

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

Protected Health Information

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

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

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

Your Rights Under ERISA

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

- You can examine, free of charge, all of the official documents related to the plans (such as plan documents, insurance contracts, annual reports, SPDs, any other plan agreements, or any other documents filed with the U.S. Department of Labor). You can examine copies of these documents in the Plan Administrator's office.

- If you wish, you can get your own copies of the Plan documents by writing to the Plan Administrator. You may have to pay a reasonable charge to cover the cost of photocopying.

Additional ERISA Rights

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

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

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

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

fiduciaries misuse the plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a federal court.

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

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

JHHSC/JHH's Rights

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

Not A Contract Of Employment

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

Plan Administrator's, Cigna's and MetLife's Discretionary Authority

The Plan Administrator, Cigna and MetLife have discretionary authority to interpret the terms of the benefit plans described in this SPD, to determine eligibility for and entitlement to benefits under the plans, and to decide any questions of fact which relate to entitlement to benefits under the plans.

For More Information

ADMINISTRATIVE INFORMATION

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